Sequential Intercept Model Mapping Report for Dane County, WI

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June 25-26, 2025

Madison, WI


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Supported by the John D. and Catherine T.
MacArthur Foundation

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Final Report

Report issue date (September 2025)

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ACKNOWLEDGEMENTS

This report was prepared by Regi Huerter and Violette Cloud of Policy Research, Inc. Policy Research wishes to thank Dane County Office of Justice Reform for hosting the workshop and to Melissa Agard, Dane County Executive, for offering opening remarks. Support for the workshop was provided to Dane County by the John D. and Catherine T. MacArthur Foundation through the Safety and Justice Challenge.

County Executive Melissa Agard welcomed participants and emphasized breaking down silos, centering lived experience, and aligning "the right response at the right time by the right system." She highlighted actions since the 2018 SIM, including: standing up the CJC-Behavioral Health Subcommittee, creating the Behavioral Health Resource Center, and expanding the Community Alternative Response Emergency Services (CARES) into Sun Prairie.

RECOMMENDED CITATION: Policy Research. (2025). *Sequential intercept model mapping report for Dane County, WI.* Troy, NY: Policy Research, Inc.

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Background

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

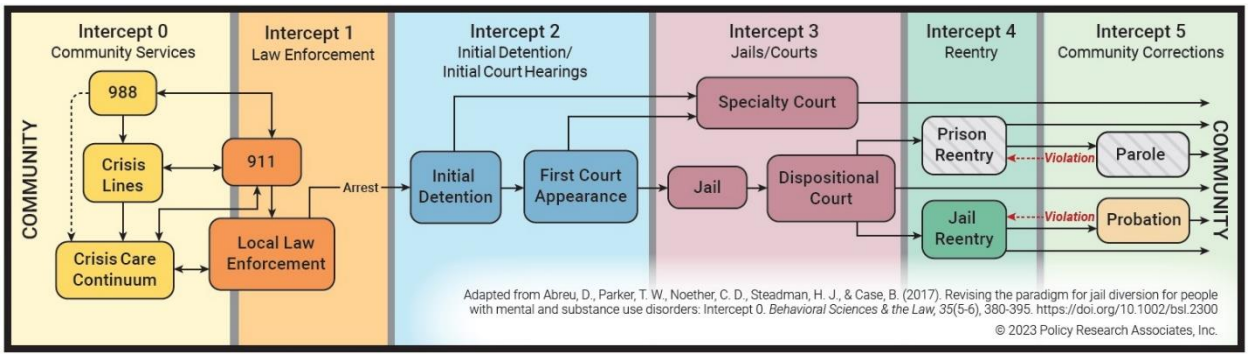
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

The Sequential Intercept Mapping workshop has three primary objectives:

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

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

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



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

AGENDA

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Sequential Intercept Model Mapping Workshop

AGENDA

Dane County, WI

June 25, 2025

8:30 – 9:00am **Registration and Networking**

9:00 – 9:30am **Welcome and Opening Remarks**

- Welcome
  - Opening Remarks: Dane County Executive Melissa Agard
  - Workshop Facilitators: Dr. Violette Cloud and Regina Huerter
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Introductions

9:30 – 10:30am **The Sequential Intercept Model (SIM) Presentation**

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

10:30 – 10:45am **Break**

10:45 – 12:00pm **Cross-Systems Mapping**

- Creating a Local Map
- Examining the Gaps and Opportunities

12:00 – 1:00pm **Lunch**

1:00 – 2:45pm **Cross-Systems Mapping – Continued**

- Creating a Local Map
- Examining the Gaps and Opportunities

2:45 – 3:00pm **Break**

3:00 – 3:30pm **Identification of Priorities for Change**

3:30 – 4:00pm **Voting Exercise**

4:00 – 4:30pm **Setting the Stage for Day 2**

4:30pm **Adjourn**

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Sequential Intercept Model Mapping Workshop

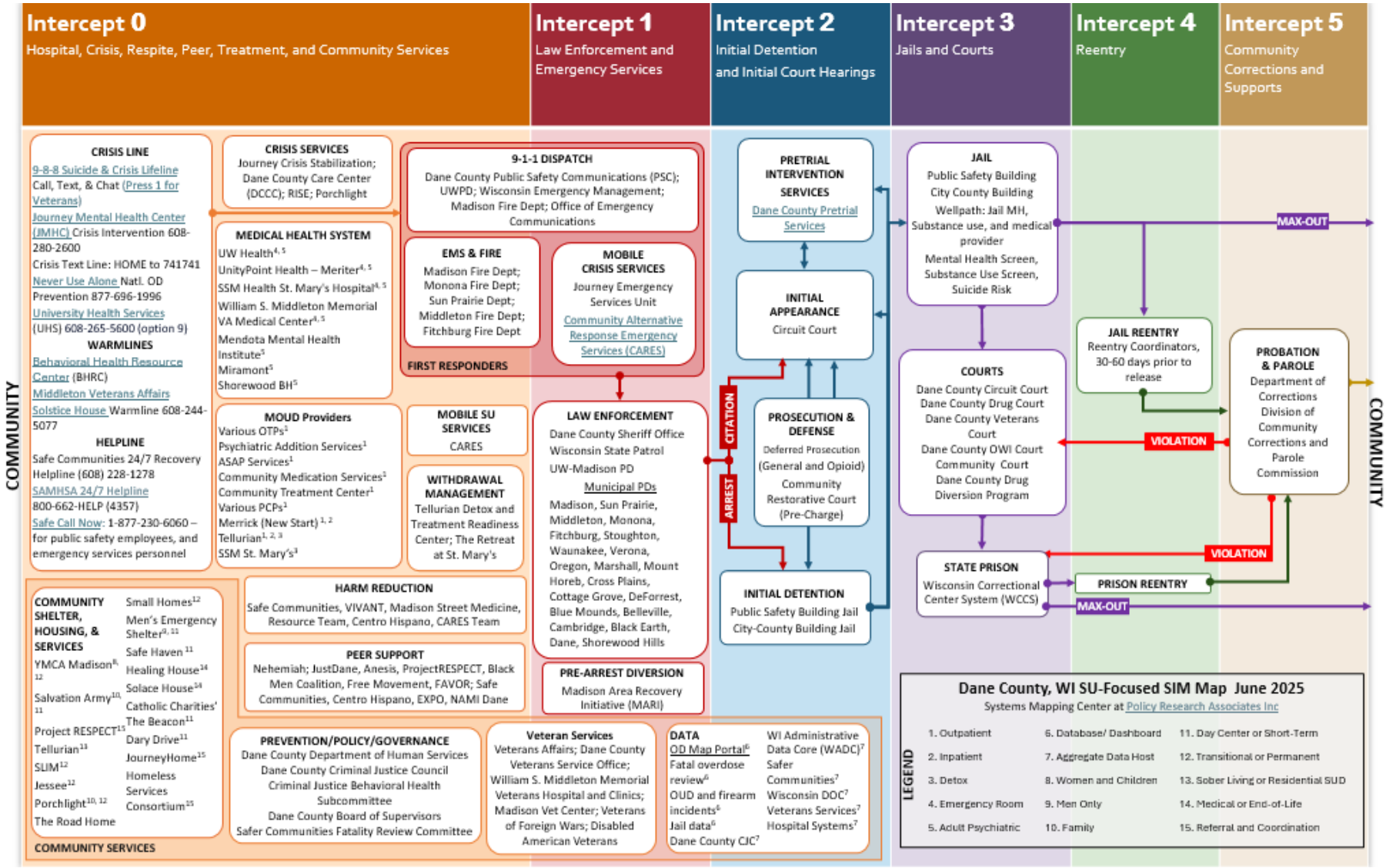
AGENDA

Dane County, WI

June 26, 2025

8:30 – 9:00am	Welcome and Recap from Day 1
9:00 – 9:30am	Discussion of Top Ranked Priorities for Change
9:30 – 11:15am	Strategic Action Planning (self-break included)
11:15 – 11:45pm	Strategic Action Planning Report Outs
11:45 – 12:00pm	Wrap Up and Next Steps
12:00pm	Adjourn

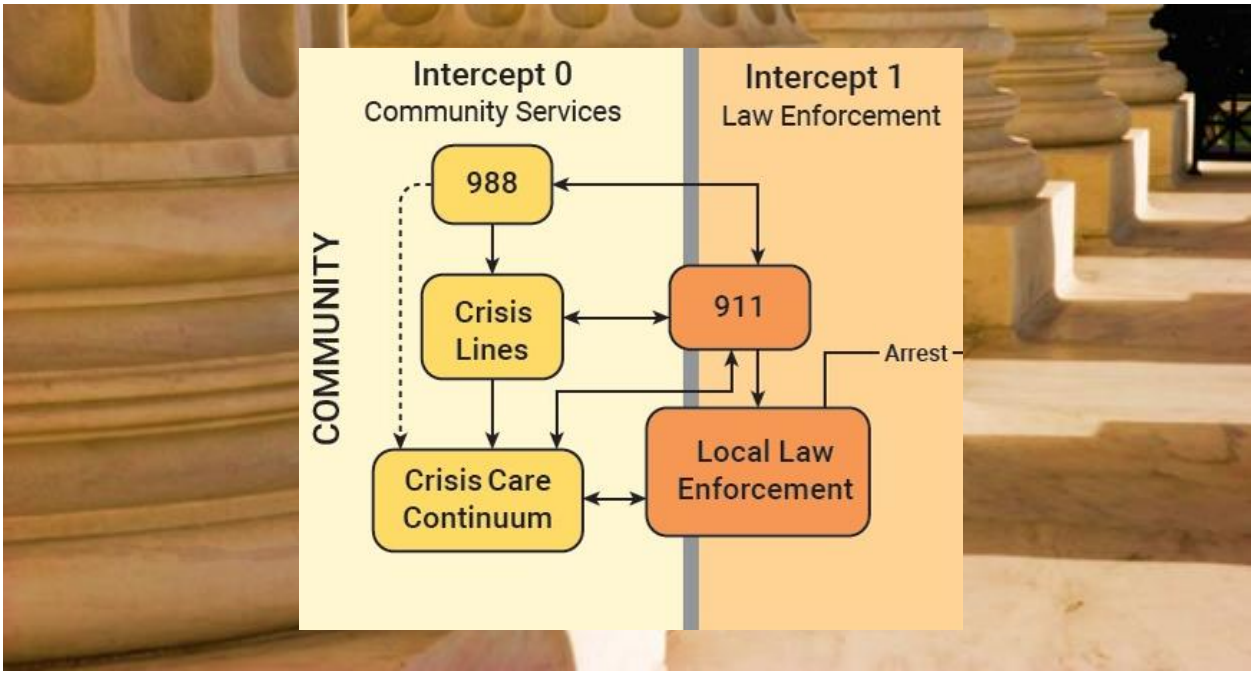
Sequential Intercept Model Map for Dane County, WI



RESOURCES AND GAPS AT EACH INTERCEPT

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

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



INTERCEPT 0 AND INTERCEPT 1

CRISIS RESPONSE, STABILIZATION, AND MEDICAL

Dispatch /911/988

- Dane County operates multiple independent dispatch centers (Madison, Sun Prairie, Fitchburg, University of Wisconsin (UW), etc.), each with distinct procedures and limited coordination.
- Madison is a part of 911 see dashboard for more: https://cjc.danecounty.gov/Data-and-Dashboards/Calls-for-Service
- The Dane County Public Safety Communications (911 Center) answers calls and dispatches sheriff's deputies, municipal police, firefighters, and ambulance services across Dane County. (Contextual note: most (but not all) 911 calls, and dispatches for some (but not all) jurisdictions)
- The 911 center uses the Police Priority Dispatch System (PPDS) and Emergency Police Dispatch (EPD) protocols to standardize call taking.
- A Memorandum of Understanding (MOU) exists to facilitate warm transfers between 988 and 911, but the connection remains limited and somewhat informal.
- Some smaller police departments use Computer Aid Dispatch (CAD) system alerts to track repeat users, but not all systems allow this.

Behavioral Health Call Diversion (In development/Planning)

- Part of Dane County alternative response initiative, which embeds behavioral health professionals in the 911 call center, will provide on-the-moment behavioral health diversion at the point of dispatch.
- Behavioral Health Call Diversion aims to divert mental health and substance use calls from law enforcement to appropriate services.
- Some behavioral health staff are informally identifying high-frequency locations and repeat callers ("familiar faces").

GAP: There is no countywide mechanism for tracking individuals who frequently interface with emergency systems.

GAP: Due to inconsistencies in training, staffing, and cross-agency communication, dispatchers' ability to properly identify and triage behavioral health crises vary widely.

MOBILE CRISIS

Journey Mental Health

- Operates a 24/7 mobile crisis response team across Dane County.
- Manages embedded crisis workers in law enforcement agencies and the Community Alternative Response Emergency Services (CARES) team (a non-law enforcement crisis response).
- While Journey Mental Health Center plays a central role operating the 24/7 crisis hotline, delivering clinical oversight for the county-wide crisis provider network, and staffing mobile outreach (e.g., CARES teams and embedded law enforcement crisis workers) it functions within a broader system (the Dane Crisis Provider Network) that involves other agencies delivering mobile response, stabilization, and crisis case management.

Community Alternative Response Emergency Services (CARES)

- The CARES program launched in Madison on 1 September 2021.
- The CARES teams consist of a Madison Fire Department community paramedic and a crisis worker from Journey Mental Health Center.
- Teams respond to nonviolent behavioral health emergencies, are trained in Crisis Intervention Team (CIT) training, cultural competency, and de-escalation, and spend time in shelters and resource centers.
- CARES has expanded into Sun Prairie.

GAP: logistical challenges remain in how calls are identified, transferred between dispatch centers, and ultimately assigned.

GAP: Related services (e.g., shelter, housing access, stabilization supports) are not available 24/7.

GAP: A planned crisis triage center was funded in 2021, but implementation has stalled due to legal barriers and a lack of provider responses to the Request for Proposals (RFP).

STABILIZATION/MEDICAL

Detox/Emergency Room

- Miramont Behavioral Health: A 72-bed inpatient psychiatric hospital in Middleton. Provides alcohol withdrawal detox services.
- Dane County Care Center (DCCC): A community based residential facility and an emergency mental health crisis stabilization facility. DCCC provides a safe, supportive environment with medication observation and goal-oriented treatment planning for individuals in mental health crisis. Clinical staff are on site 8 hours/day, 7 days/week with clinical on-call after-hours.
- Also known as, The Care Center (Crisis Assessment, Recovery and Empowerment): A 16-bed facility for individuals experiencing a behavioral health crisis.
- Tellurian: Operates a 29-bed (current capacity is less) residential withdrawal management program (Detox). The county has funded 3 beds at Tellurian for individuals without insurance.
- Madison Street Medicine: MSM delivers medical and behavioral health care directly to people experiencing homelessness.

GAP: Miramont Behavioral Health does not accept uninsured individuals.

GAP: Officers frequently encounter individuals under the influence of drugs or alcohol who are not eligible for or interested in shelter, detox, or hospital admission. (Context Note: There are people who may be under the influence but are not incapacitated and are just not interested in going to a shelter or detoxification facility.)

Others Mentioned

- Winnebago Mental Health Institute
    - A state mental health institution located approximately 90 miles from Madison.
- SSM Health St. Mary's Hospital (SSM Health)
    - A community hospital with emergency room.
- UnityPoint Meriter
    - A community hospital with emergency room.
- UW Health
    - A community hospital with emergency room.
- Shorewood
    - A standalone psychiatric hospital like Miramont but does not expressly market withdrawal management.

MENTAL HEALTH AND BEHAVIORAL HEALTH TREATMENT AND ADVOCACY

General

- Community Medications for Opioid Use Disorder (MOUD) access includes multiple Opioid Treatment Program (OTP)/clinic sites with specified hours; CARES/EMS can start buprenorphine; hospital can provide a 2-day bridge supply. Buprenorphine is also available via many Primary Care Providers (PCPs).
- Hospitals provide withdrawal management in Emergency Departments (Eds); county-funded detox beds reportedly reduced to 3, pushing more to Emergency Room (ER); detox sites have exclusions (e.g., cocaine/meth).

Beacon/Catholic Charities

- Operated by Catholic Charities with funding from Dane County and the City of Madison.
- A county-contracted day resource center for people experiencing homelessness, currently serving about 200 individuals per day.
- Beacon operates as a low-barrier facility, providing basic needs and resource navigation.
- Beacon collaborates with UW-Madison on data collection regarding the overlap between homelessness and reentry.

GAP: While Beacon has guest services staff providing direct care, they don't have case management services onsite, which makes it difficult to coordinate follow-up for high-acuity guests who need more intensive services.

National Alliance on Mental Illness (NAMI) Dane County

- Provides education, advocacy, and support for individuals and families affected by mental illness.
- Offers Crisis Intervention Team (CIT) training for law enforcement and community partners.
- NAMI recently hired a parent peer support specialist and has begun tracking peer support calls separately to identify key issues, particularly those involving incarceration and access to care for mental health and substance use disorders.

GAP: While NAMI focuses on mental health, they provide referrals for substance use concerns but are not currently able to offer warm handoffs or direct advocacy.

MOSES (Madison Organizing in Strength, Equity, and Solidarity)

- MOSES is a non-partisan, interfaith organization affiliated with the statewide advocacy network WISDOM.
- WISDOM seeks to build collective power to dismantle mass incarceration and racial disparities.
- MOSES advocates for expanding non-police crisis-response programs like CARES and for reforms that reduce racial bias in the criminal-justice system.

Others mentioned.

- FAVOR: Mentioned during the mapping workshop as an alternative to NAMI, focused on substance use

- Porchlight (SafeHaven): Case management drop-in center
- Porchlight operates a drop-in resource center that provides case management, connecting individuals experiencing homelessness with housing assistance, benefits enrollment, and other supportive services.
- Anesis: Case management drop-in center for mental health and substance use counseling.

PEER SUPPORT

Nehemiah Center for Urban Leadership Development

- Nehemiah's reentry program is staffed mostly by people with direct incarceration experience, and some with indirect experience through close family or friends, and they provide services that are responsive and holistic.
- Offers culturally responsive reentry services including transitional and emergency housing, peer-led support groups, and research/community engagement.
- Supports academic and government research efforts by connecting individuals with lived experience to local resources.

Safe Communities

- Safe Communities runs a 24/7 help line (call/text/chat), embeds peers in justice programs (Madison Area Recovery Initiative-MARI 1.0/2.0), coordinates closely with crisis/Journey/911 and collaborates with Centro Hispano; also provides doulas for pregnant people with SUD.
- Peer specialists work with individuals in early recovery and those who use alcohol or other drugs.
- Programs include pre-arrest diversion, jail-based support, prosecution and treatment court collaborations, and overdose response.
- Safe Communities coordinates across sectors on injury prevention, suicide prevention, and harm reduction.

Peers

- Participants emphasized that community organizations like NAMI, EXPO, Nehemiah, JustDane, and others are fielding direct requests for support from individuals and families impacted by justice involvement, often providing vital gap-filling services without consistent funding or system-level recognition.

Others mentioned.

- Solstice House: A Peer-Run Respite providing short-term stays (one to five days) in a home-like environment for adults seeking additional support for mental health or substance use challenges.
- Off the Square Club: A drop-in day program for individuals with mental health needs. It offers socialization, support, and activities to help members maintain stability.
- JustDane: JustDane provides reentry support through programs such as Journey Home, Circles of Support, and the Phoenix Group, helping individuals transition from incarceration back into the community.

    - Services include mentoring, peer support, housing navigation, employment readiness, and family reunification support.
    - JustDane partners with correctional institutions, faith communities, and service providers to build strong community networks for returning citizens.
    - Programs emphasize restorative justice, reducing recidivism, and strengthening family stability while addressing barriers faced by justice-involved individuals.
- Centro Hispano, as a subcontractor of JustDane, provides Peer Support and Recovery Coaching for Spanish-speaking and other members of the Hispanic community.

GAP: There was broad discussion around barriers in the peer support certification process in Wisconsin. Only one model is currently accepted by the state, and access to training is limited.

GAP: Participants noted that many peers are already doing the work without certification due to the cost, format, and testing requirements. A need for more inclusive credentialing options was identified.

GAP: Peers are not consistently included in CIT training or in the design of crisis response strategies, despite their valuable lived experience.

TRANSPORTATION

- Redi Transport (3rd-party) can move people between jails, courts, hospitals, and provide hospital vigils.
- UnityPoint can provide some transportation.
- Community Access Transportation (Dane County Department of Human Services (DHS)) Offers individual rides when other transportation options are unavailable, including medical and human services appointments. Riders pay a co-pay based on ability; authorization is required through the Transportation Call Center.
- Supplemental Medical Transportation Assistance (SMTA) Provides scheduled door-to-door rides in accessible vehicles for frequent, lengthy, or distant medical appointments; also, income-based copay.
- Rural Transportation (Dane County DHS) Similar to SMTA but focused on rural residents who lack public transit access; arranged through the Transportation Call Center.
- Older Adult Transportation Assistance (OATA) & Group Access Service (GAS) & Rural Senior Group Trips (RSG) Designed for seniors (60+) and adults with disabilities provides rides to community destinations such as grocery stores, meal sites, and healthcare, door to door, accessible service, with very low fares.
- RSVP (Retired & Senior Volunteer Program) Volunteer drivers offer individualized door through door rides (often for medical appointments) for seniors and those with disabilities countywide; rides based on donations with flexible scheduling.
- Veyo (Non-Emergency Medical Transportation (NEMT) provider) Contracts with Wisconsin Medicaid to offer non-emergency medical transportation, including gas reimbursements or arranging rides when no other transportation option is feasible.

- Metro Transit / Paratransit Services Provides accessible, scheduled public transportation in Madison and nearby suburbs, designed for individuals with disabilities who cannot use regular bus service.
- YW Transit (YWCA-a non-profit organization) Offers rides for low-income individuals traveling to work or related activities, including evening "safe rides."
- Dane County Transport LLC: A private non-emergency medical transportation service covering medical appointments, therapy, pharmacy pickups, and wellness visits.
- Black Men's Coalition (BMC) aims to facilitate access to employment by removing the financial burden associated with commuting. By providing free transportation, BMC enables individuals to secure and maintain employment without being hindered by transportation-related challenges.

HOUSING/SHELTERS

Porchlight

- Men's Emergency Shelter: provides overnight lodging for men over age 18. Guests receive two meals, showers, hygiene supplies, and case management, and may arrive intoxicated as long as they do not bring substances inside

Safe Haven

- A day shelter in Madison for adults living with mental illness. It provides two meals daily, showers, laundry facilities, bus tickets, mail and phone services, housing-focused case management, and crisis case management services covered by Medicaid.
- The program also offers 14 single-room occupancy units of permanent housing for participants.

YMCA Madison Family Shelter

- Offers 12 private rooms (about 30 beds and cribs) for families experiencing homelessness.
- YMCA requires households to have at least one minor child or a pregnant individual and provides lodging free of charge regardless of gender, race, or other characteristics.

Salvation Army

- Women's Shelter: A night-only shelter with case management.
- Family Shelter: A 24/7 family shelter that can house up to 35 families, offering meals, laundry, case management, and support services; families are admitted from a waitlist.

JustDane

- Healing House: provides a critical but small-scale 24/7 recuperative care shelter for families exiting the hospital.

Solace Friends

- Solace House: provides end-of-life care for people experiencing homelessness.

Institute for Community Alliances (ICA)

- Manages the Homeless Management Information System (HMIS)
- Recently obtained a new release of information to enable sharing.
- Opportunity: Interested community partners can connect to be included in the information exchange.

Coordinated Entry System

- Efforts are underway to redesign the housing Coordinated Entry System using data from jails and behavioral health systems.

GAP: If an individual is banned from shelter due to behavior or rule violations, there are no backup placements available.

GAP: Participants raised the issue that many familiar faces are chronically unhoused or unstably housed, yet few interventions directly target the intersection of behavioral health crisis and housing needs.

GAP: Some shelters have eligibility limitations that prevent access for individuals under the influence, lacking identification, or with behavioral challenges.

GAP: Providers reported a sharp rise in older adults and guests with significant medical conditions, including those in their 70s, 80s, and even 90s.

ADMINISTRATIVE AND COORDINATING AGENCIES

Public Health Madison & Dane County

- Offers harm reduction services for people who use drugs.
- The harm reduction program distributes free safer use supplies including injection equipment, fentanyl and xylazine test strips, naloxone, safer smoking kits, sharps containers and condoms.
- Public Health runs the Overdose Fatality Review, a multi-disciplinary review of overdose deaths to identify system gaps.
- Provides data to support system improvements and grant applications.

Dane County Human Services

- Behavioral Health Division
    - Oversees treatment courts, outpatient, and residential substance use treatment, among many other services including the mental health crisis response continuum, case management, etc.
    - Provides funding and care coordination for uninsured county residents.
    - Operates the Behavioral Health Resource Center to connect residents to the appropriate services based on preferences and insurance.
- Behavioral Health Resource Center (BHRC)
    - Helps people navigate mental health and substance use treatment systems.
    - Participant reported a 30–60-day connection to services average rate.

GAP: Systems planning processes tend to prioritize government and institutional voices, with insufficient representation from community organizations and directly impacted individuals.

GAP: There is no formal feedback loop or implementation structure to ensure community-generated recommendations are adopted and evaluated.

DATA, RESEARCH, AND SUSTAINABILITY PLANNING

Dane County Office of Justice Reform/ Dane County Community Justice Council:

- The Office of Justice Reform is a standalone department dedicated to data-driven decision making, reduction of racial disparities, and increased public safety. The department also staffs the Dane County Community Justice Council: a collaborative council and subcommittees, made up of County elected leaders, Subject Matter experts, Community Members with lived experience, and city of Madison/community leaders. cjc.countyofdane.com
- The Office of Justice Reform (OJR) leads community court development and criminal justice data integration. OJR coordinates with stakeholders to connect data to current processes and reform initiatives, develops evidence-based evaluation frameworks to improve criminal justice outcomes, supports programs that reduce recidivism and improve public safety, and provides technical assistance and research support to justice system partners.
- University of Wisconsin
    - Madison, School of Social Work
        - Research project on reducing incarceration-related harm, with a focus on diversion strategies for caregivers. (Paja Charles)
        - Quick Fix: UW–Madison (Paja Charles) can help agencies contribute to the Wisconsin Administrative Data Core (WADC) and place student interns in county/state/community agencies.
    - Wisconsin Administrative Data Core (WADC)
        - Links Medicaid, housing, education, employment, and justice data (currently only Milwaukee County Jail data)
    - Center for Healthy Minds, UW-Madison
        - Studies mindfulness-based interventions for individuals involved in the criminal legal system (Dan Grupe).

LAW ENFORCEMENT (LE) AND EMERGENCY SERVICES

*There are 26 different LE agencies in Dane County. Not all were represented at the Sequential Intercept Model (SIM) Mapping Workshop; therefore, the following information is limited in its scope and level of detail.

Madison Police Department (MPD)

- Community Outreach Section (COS)
    - MPD officers have access to training in de-escalation, mental health response, and diversion options.
    - The COS oversees the Mental Health Unit and diversion/deflection officers.

- When an individual over 17 is willing to accept services, workshop participants reported that officers generally delay official action, including citations.
    - Dane County Sheriff's Office (DCSO) and other LE forces also have de-escalation training and experts.
    - MPD partners with youth in marginalized communities through outreach and resource officers.
    - Provides follow-up mental health support after violent incidents.

GAP: Officers noted that discretion plays a large role in determining whether someone is arrested or diverted and not all officers utilize or are trained to divert.

GAP: Law enforcement has limited access to the Wisconsin SOAR database (Suspected Overdose Alerts for Rapid Response).

- Mental Health Unit/Madison Area Recovery Initiative (MARI) Program
    - A specialized mental-health unit with six full-time Mental Health Officers and three embedded Law Enforcement Crisis Workers.
    - MARI is a pre-arrest diversion option for certain low-level offenses, connecting individuals to treatment within five days instead of formal arrest.
    - Applicable to non-traffic offenses such as possession of paraphernalia, prostitution, and certain misdemeanors; individuals also cannot be in a deferred prosecution program.
    - Each officer has completed the 40-hour CIT training and works to de-escalate crises, create safety plans, conduct follow-up visits, and divert people with mental illness from jail or emergency departments.
    - Mental health officers are paired with Journey Mental Health crisis workers.
    - Works with peer support specialists for post-overdose outreach and connections to care (Safe Communities).

GAP: There is no standardized follow-up protocol for individuals revived by first responders who decline further care.

UW-Madison Police Department

- Promotes Crisis Intervention Training for dispatchers.
- Participates in national committees on peer support in public safety.

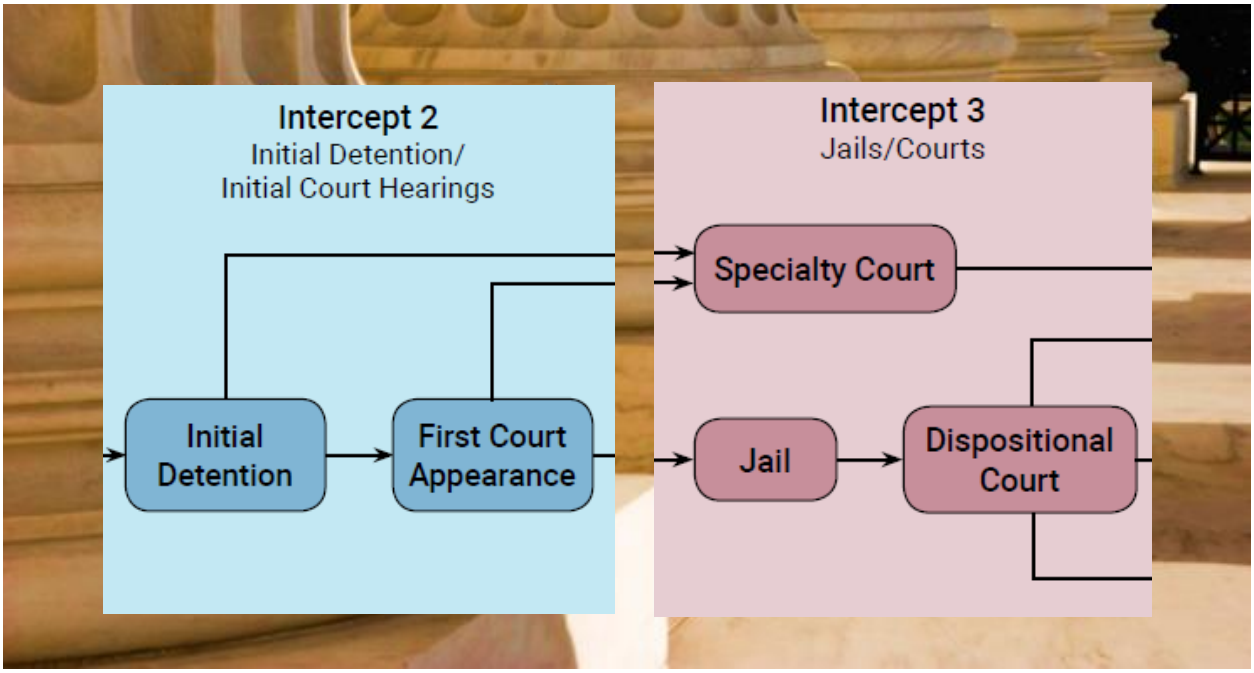
Crisis Intervention Team Training

- CIT training for law enforcement includes modules on brain injury, intellectual/developmental disabilities, substance use, and mental health.
- Community partners contribute to these trainings and voiced a desire for increased emphasis on trauma-informed approaches and cognitive accommodations during law enforcement interactions.

Dane County Community Restorative Court (CRC) pre-charge alternative.

- Can be a direct Law Enforcement referral or a District Attorney referral (if LE submits as a state statute violation vs. Municipal ordinance).
- Community Restorative Court (CRC) is a restorative justice, non-traditional approach which involves people working together to seek a resolution to the harm done to individuals and communities by criminal or other unlawful behavior. The CRC approach holds respondents accountable through the restorative justice process with any necessary reparative elements based on the specific situation. It also provides human services support where appropriate.
- The CRC is designed for young people 17-25 years old who have committed a misdemeanor crime or have received a municipal citation in Dane County. *
- Some eligible misdemeanors and citations include: • Battery • Disorderly Conduct • Obstructing an Officer • Theft • Criminal Damage to Property

GAP: While some CIT in Dane County includes modules on brain injury and substance use, there is limited discussion about how this translates to actionable support or accommodations during law enforcement encounters.



INTERCEPT 2 AND INTERCEPT 3

INITIAL DETENTION/INITIAL COURT HEARINGS

Dane County Sheriff's Office

- Manages population data from jail, mental health, and medical systems to inform planning and transparency.
- Collaborates on public dashboards and shares data upon request (Michelle De Forest)

The Office of Justice Reform

- Leads community court development and criminal justice data integration.
- Coordinates with stakeholders to connect data to community-led reform initiatives.
- Assists with policy and program research and evaluation.

District Attorney's (DA) Office

- Pre-Charge Diversion Authority
    - Operates the second-largest diversion program in the state. The DA's office can divert cases before formal charges.
    - Screening counselors assess eligibility for prosecutorial diversion; certain offenses (e.g., Operating While Intoxicated (OWI)) are restricted by statute from diversion without special judicial findings.
- Four DA attorneys review cases post-arrest; they can decline, accept, send back for investigation, or refer to pre-charge diversion or Community Restorative Court.
    - Staffing challenges: DA's Office has not increased attorney positions since 1987, lost 2 positions recently, and handles ~700 cases with high turnover.

    - Staff include the Deputy and Assistant DAs focused on adult criminal justice matters.
- Diversion Programs
    - Two components: Community Restorative Court (CRC) which can be Law Enforcement (LE) referral or DA referral (direct) non-traditional pre-charge alternative using restorative justice for 17-25 years old. Deferred Prosecution Program also has a pre-charge and Restorative Justice (RJ) process that is separate.
        - Community Restorative Court: The goal is to avoid the Consolidated Court Automation Programs (CCAP) record, pre-charge entry only. Screening is handled by a paralegal; outreach is challenged because letters can appear like scams to recipients.
        - Deferred Prosecution Program (DPP)/Restorative Justice (RJ): Two DA staff support RJ processes. Referrals often come from law enforcement before charge; include victim support and require admission of guilt. Common for battery and disorderly conduct, not set up for substance use disorder (SUD) cases.

Public Defender's (PD) Office

- Public defenders report that many first-time defendants do not understand or trust the system; community education is needed for navigation and rights awareness.
- PD staff: 24–28 trial attorneys plus support staff; workload pressures impact the ability to focus on individual client needs.
- PD's can discuss diversion options with eligible individuals before charging; some review cases after a client spends more than one night in jail.

Pretrial Services

- Participants report that the courts generally try to keep individuals in the community while awaiting trial.
- Pre-trial Services conducts Public Safety Assessments before initial appearances and to inform release conditions.
- Offers supervision and support during pretrial periods.
- Safe Communities is an existing partner, providing peer support for those with deferred prosecution contracts.

Free Movement

- Operates RJ circles in collaboration with the District Attorney's Office and Madison Police Department.
- RJ circles are primarily used for youth (as young as 10) and low-level offenses such as battery and disorderly conduct.
- Works with the Young Women's Christian Association (YWCA) and University of Wisconsin (UW)–Madison in RJ initiatives aimed at keeping cases out of the formal court process and avoiding a CCAP record.
- Emphasizes victim support and requires admission of responsibility from participants.

- RJ is generally not yet configured to address substance use–related offenses.

JAIL AND COURTS

Intake

- Intake includes suicide risk screening, medical review, and withdrawal management planning.
- Buprenorphine can be initiated during withdrawal and continued as maintenance in custody; psychiatric medications are available, but prescribing discretion varies by provider.
- Initial classification determines housing (minimum, medium, maximum, administrative confinement).
- There are currently two facilities in use: the Public Safety Building and the City County Building.
- The initial appearance court is located in the same facility for quick processing.
- The county is building a new jail to replace some single-cell configurations; staffing includes Crisis Intervention Training (CIT) trained deputies.

Wellpath (contract health)

- Provides medical and mental health services in the jail.
- Oversees a team of clinicians, a psychiatrist, a nurse, and Medication Assisted Treatment (MAT) discharge planners.

GAP: A key concern raised was the absence of referrals from jail-based medical providers (e.g., Wellpath) to reentry services. Although jails often assess individuals' medical and behavioral health needs, the inability to bill Medicaid while incarcerated, the lack of prescriber access, and the limited availability of service providers within the jail prevent warm handoffs to community-based care upon release.

Behavioral Health and Reentry Services

- Offers expanded MAT including methadone, suboxone, and Vivitrol.
- Methadone is brought into jail from outside providers.
- Suboxone and Vivitrol are available; buprenorphine induction can occur during withdrawal, with maintenance doses continued in custody.

City of Madison Municipal Court

- Handles truancy cases for ages 12–16.
- RJ models implemented in partnership with YWCA, UW, and Madison Police for youth as young as 10.
- Seen as an underused pathway for early intervention.
- Many officers do not refer to the municipal court; they need more police training on the municipal court's potential for service connection.
- The perceived benefit of diverting cases to Municipal Court is that they do not end up on CCAP.
- Other Municipal Courts exist with assorted services depending on the community.

Dane County Circuit Court

- Supports pretrial release and supervision.
- Collaborates with CJ partners to connect individuals to community resources.

Veterans Treatment Court

- Veterans Justice Program (VJP) with the Madison VA Hospital provides outreach to incarcerated veterans across 17 counties. The VJP participates in Veterans Treatment Courts and offers veteran screening and identification tools and offers/provides training on veteran-specific needs.
- The Veteran's Treatment Court currently serves 10-13 participants. Eligibility requires VA Health Care enrollment.

Diversion Program and Drug Court

- Currently only 8 people are involved in drug diversion; earlier identification to expedite assessment process would be beneficial.
- Participation may be limited by defendant time constraints, lack of transportation, childcare needs, and all court/treatment scheduled during work hours.
- Two tracks: the Diversion Program serves medium risk individuals (post-charge, pre-plea with potential dismissal upon completion); Drug Court serves high risk individuals (post-charge, post-plea) and all participants are involved with the Department of Corrections concurrently (could be probation or extended supervision).
- Current assessment tools: Correctional Offender Management Profiling for Alternative Sanctions (COMPASS) is validated but concerns were raised about bias in the measurement; the Ohio Risk Assessment System (ORAS) will be implemented in 2026.
- Questions were raised about whether existing risk criteria exclude people unnecessarily and whether other validated tools could improve equity.

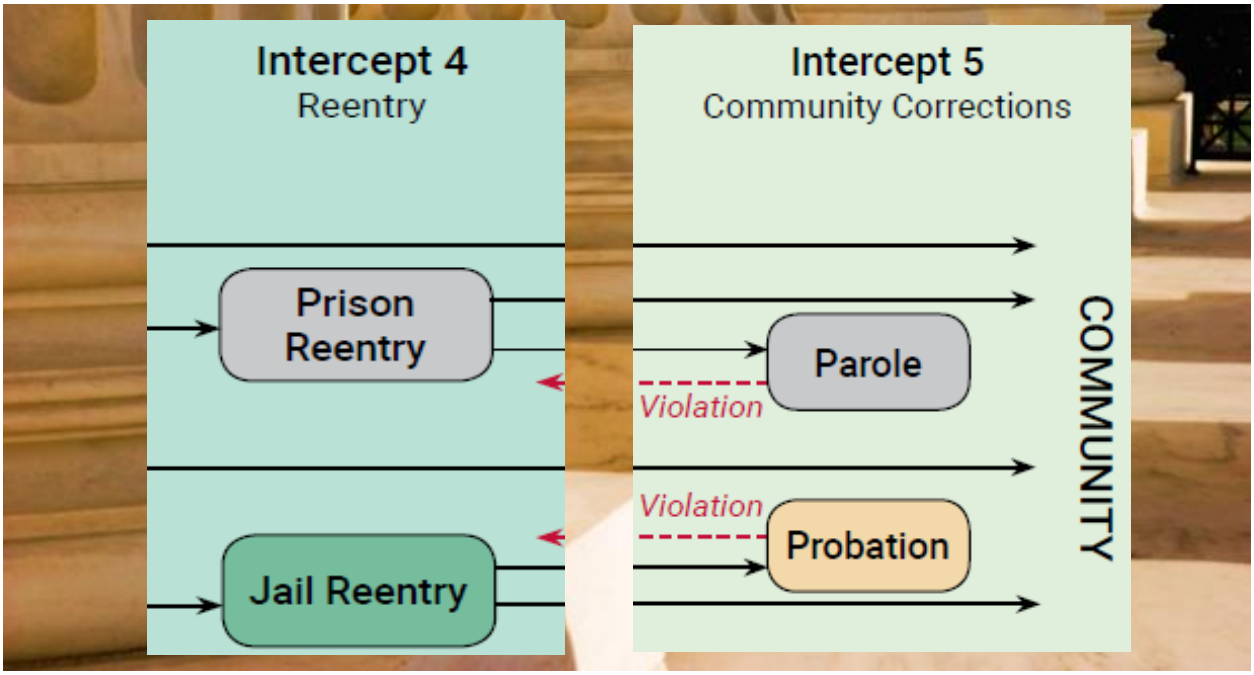
OWI Court

- Serves individuals with repeat OWI offenses (e.g., 3rd offense).
- Operates near capacity (~50 participants) but never turns away eligible cases; participants may be in pre-court status while awaiting program entry.
- Partnership with Journey Mental Health Center provides coordination and case management.

DHS Forensic Mental Health Services

- Competency Restoration
    - Offers outpatient restoration services and conditional release coordination.
- Their objective is to increase community-based treatment for individuals with substance use and co-occurring needs to reduce jail stays.

GAP: The amount of time that defendants must serve in specialty courts is sometimes longer than if a person was to resolve their case. Additionally, some of the requirements and commitments of the specialty courts act as barriers to individuals utilizing these services.



INTERCEPT 4 AND INTERCEPT 5

REENTRY

Dane County Jail Reentry Coordination

- Focuses on planning for individuals with release dates.
- Aims to expand trade-based reentry programs and build partnerships with community agencies.

GAP: Incarcerated individuals lose Medicaid eligibility, which creates a barrier to accessing care coordination or Comprehensive Community Services (CCS) during their stay.

GAP: There is no system in place to use medical assessments from jail as a gateway to CCS or other services upon release.

GAP: Current case management models are typically tied to eligibility for specific programs, rather than following the needs of the individual across systems.

GAP: Veterans have their Service-Connected Disability reduced to the 10% level on the 61st day of incarceration. Additionally, Veterans are not able to access the majority of Veteran Affairs (VA) benefits while incarcerated.

JustDane

- Offers reentry support and housing for older individuals returning from incarceration. It operates in-custody programming (JustBakery and ServSafe) to help jail residents earn certifications, provides peer support services, and collaborates with the VA to connect individuals to veteran-specific services.

EXPO Wisconsin (Ex-Incarcerated People Organizing)

- A small community-based organization providing peer services and responsive support, especially for people who have been incarcerated.
- Provides advocacy, pre-entry, and re-entry housing for women.
- Runs two housing programs in Dane County that offer wraparound services focused on thriving post-incarceration.

Comprehensive Community Services (CCS)

- A Medicaid-funded program offering psychosocial rehabilitation and recovery-oriented services.
- Comprehensive Community Services (CCS) is available for eligible individuals, providing a wide array of psychosocial rehabilitation services that include case management, therapy, individual skill development, and more.
- Participants discussed expanding use of CCS. There was a strong interest in revisiting the centralized intake structure and exploring whether providers themselves could offer intake to reduce bottlenecks.
    - There are more than 2,500 participants enrolled in Dane County's CCS, which makes it the largest behavioral health outpatient program. The concern that was discussed is that the intake process can be complicated for individuals who have a myriad of needs (e.g., homelessness, financial constraints), which results in eligible individuals being unable to access the program.

GAP: CCS requires formal intake through the county, creating a bottleneck that delays or prevents access for individuals already in contact with community-based providers. Many individuals lack access to phones or have unstable housing, making follow-up communication during the CCS enrollment process extremely difficult. CCS enrollment requirements, such as obtaining a physician's prescription for CCS, are difficult to meet for people who have not engaged in healthcare for many years. There is no clear mechanism to allow CCS providers themselves to initiate the intake process directly. (Contextual note: Providers can initiate the intake process, but they can't complete the functional screen. For example, if a CCS provider wanted to help someone make the call to CCS intake they can. They can also help someone obtain the required prescription. They can't complete the required functional screen and formally enroll a person in the program, but they can certainly initiate the process with the client.)

GAP: Individuals who do not qualify for CCS because they do not qualify for Medicaid, still have complex needs but have no alternative system that is similar to CCS for case management or care navigation.

Other Reentry Partners

- Safe Communities: Recovery coaching, peer services, and harm reduction planning.
- Anesis Family Therapy: Case management, behavioral health therapy, and comprehensive community-based supports.
- Project RESPECT: Case management for survivors of human trafficking.

- EXPO: Peer and reentry support for people currently or formerly incarcerated.
- Tellurian PAIR: Peer advocates in recovery; provides case management, treatment, sober living, and reentry support.
- Black Men's Coalition: Case management, education, peer services, employment, transportation.

GAP: Natural supports such as family and friends are not systematically leveraged or included in reentry planning or care coordination.

GAP: People leaving incarceration may avoid enrolling in CCS because doing so would require them to sever trusted relationships with existing therapists or service providers if that provider is not within the CCS Network.

Employment and Workforce Support

- Centro Hispano: Provides immigration assistance and workforce support for reentering individuals.
- Black Men Coalition: Provides employment placement, case management, transportation, and life skills training.
- WRTP Big Step: A trades training program with case management for justice-involved participants

COMMUNITY CORRECTIONS

Department of Corrections: Parole and Probation

- DOC agents routinely refer supervisees to Safe Communities
- Safe Communities will make peers available, especially after an overdose. Safe Communities does not provide treatment.
- Agents connect individuals to community-based MOUD, behavioral health treatment, and housing supports where possible.

GAP: Workshop participants reported that some probation orders require clients to stay at designated shelters, with probation officers sometimes conducting bed checks, where failure to be present could result in violations.

GAP: Transitional housing options are limited, particularly for women and people with sex offense histories.

Priorities for Change

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place on June 25, 2025. The top three priorities are highlighted in bold text.

Votes	Priority
24	(Crisis Triage)-Front end process/crisis triage center with first responder
8	Policy Change: capacity building (training system awareness and capacity)→caregiver background
3	Restorative Foundational Principles of Accountability and Public safety considerations that consider victims in program initiatives
18	Data: (1) education for agencies/literacy (identify the key outcomes), (2) Centralized Database
1	Strengthening Communities/Partnership with evaluators at the university
2	Review/Revise the peer system model
3	Involve natural supports in all tasks
2	Creative options for diversion for those with violent charges
2	Understanding the CJ best practices
13	Reentry: Having wraparound (one stop) services for un-sentenced individuals upon release.
	Treatment for cocaine and methamphetamine/expanded detox services
20	Housing: help/alignment between existing funding and facilities for (1) transitional housing; (2) detox with better tracking of diagnoses (3) target individuals who are better positioned to utilize the limited resources through robust assessment, create options for housing for problematic demographics (Individuals on the registry)→considerations (DOC funding, grant funding, examine CCAP impact)
5	Information Sharing Mechanisms/Systems and Services (Court)
15	Cultural and language representation Peer workforce, increase representative hiring, remove CJ stipulations that prevents peers from accessing peers in institutionalized settings
1	Provide treatment and services for individuals on electronic monitoring
1	Increase the number of county services that partner with crisis providers
2	Complex Care Case management: high acuity supportive services

Action Plans

Priority Area #1: Housing: Expanding access to safe, affordable, and supportive housing by eliminating exclusionary policies and enhancing coordination for individuals with complex needs and justice involvement.			
Objective	**Action Step**	**Who**	**When**
Reduce exclusionary factors and barriers to housing	Promote pre-charge diversion initiatives to prevent charges from appearing on CCAP. Engage DCHA and CDA in amending administrative plans that restrict access based on criminal records. Conduct a comprehensive review of CCAP policies concerning past charges and eviction histories. Prioritize public investment in housing models that reject exclusionary criteria.	Rebekah and Carousel with the Police Department (Jared) Melissa and Carousel Jessica (FREE) Melissa	September 18th meeting with Melissa (DHS Core committee)
Expand the availability of affordable, supportive housing for individuals with complex challenges	Inform and engage non-traditional housing providers on available funding mechanisms. Integrate peer support structures within community-based housing. Explore incentive-based landlord programs, including tax benefits, for leasing to individuals with criminal backgrounds.	Entire team Jared Jessica (Free)	Pre-meeting in August, to be scheduled by Jared
Strengthen coordination among DOC, jails, and housing service providers to improve reentry outcomes for people reentering community	Develop a structured referral and case coordination system between jail discharge planners, DOC agents, and community-based housing providers to ensure warm handoffs, early identification of housing needs, and continuity of care upon release. Engage organizations such as JustDane, Catalyst for Change, and local shelter networks in pre-release planning and post-release stabilization.	Jerome, Jessica, Jael, Rebekah, Jared, Melissa	Begin development in Q1 of 2026, with initial implementation phases launched by March 2026

Group Members: Jerome, Carousel, Jessica, Jael, Rebekah, Jared, Melissa

Priority Area #2: Data Literacy/Centralized System-Coordination/Key Outcomes GOAL: Improve efficiency, transparency, and coordination of care across government and community partners			
Objective	**Action Step**	**Who**	**When**
Develop integrated data-sharing protocols between government entities and community-based organizations, modeled after an Electronic Health Record (EHR) system	Establish a cross-sector task force to conduct a comprehensive data inventory, mapping current systems, indicators, and unique identifiers in use. Align efforts with State DHS and the Casey Foundation to identify shared priorities and feasibility.	Paja, DOC, Jail, Public Health, Community-Based Organizations, District Attorney's Office, Criminal Justice Reform staff, DHS, Judge Faulkner, K. Reece, Colleen and Tamarine, Human Services, WAIC representatives, and community stakeholders	Task force to be convened within three months.
Build nonprofit sector capacity to collect, interpret, and utilize data for service coordination and accountability	Produce a best practices document for data collection and sharing and identify technical assistance providers that can support local organizations in adopting effective data strategies.	Goodman Center, UW-Madison, Dan G., and participating community members. Use the Roots + Wings Convening to initiate engagement and assess training needs.	Begin groundwork at upcoming Roots + Wings Convening; TA provider list and best practices draft to follow within six months

Group Members: Chee Yang, J. Goodrich, K. Reece, Alder Madison, C. Clark-Bernhardt, M. DeForest, C. Moore, D. Grupe, L. Tuttle, A. Khaleel, C. Schumann

Priority Area #3: Reentry			
Objective	**Action Step**	**Who**	**When**
Ensure warm handoffs to peer support networks upon release to the community	Identify and eliminate policy-based restrictions that limit peer access within correctional settings. Collect and analyze outcome data to demonstrate the efficacy of peer support in reducing recidivism and improving reentry outcomes. Pursue diversified funding streams to expand peer support services and offer competitive compensation. Launch public education and outreach campaigns to increase visibility of peer roles and encourage recruitment.	DCSO, Anesis, Centro Hispano, JustDane, Tellurian, Journey Mental Health Center, Courts, Safe Communities, DOC Region 1, EXPO, State Legislature, County Executive and Board, Black Men's Coalition	Policy review (6 months), data, and funding pursuit (1.5–2 years), recruitment and outreach (6 months)
Strengthen and expand the jail lobby resource center as a reentry touchpoint	Extend operating hours of the resource center to accommodate varying release times and increase accessibility. Hire additional multilingual peer specialists to ensure culturally competent and linguistically accessible support. Conduct a full audit of resource materials to verify accuracy and relevance. Place updated resource guides at critical engagement points, including DOC offices and pretrial supervision programs	DCSO, Pretrial Services, peer agencies, County Executive and Board, DOC Region 1	Full implementation within 1 year
Improve coordination and transparency between jails, prisons, and probation/parole officers	Initiate structured meetings between jail administrators and P&P agents to improve communication around release planning, conditions of supervision, and client needs. Facilitate interagency dialogue aimed at adjusting jail release times to better align with service provider hours and P&P availability.	F. Remington, A. Raymond, J. Hyland, M. Leonard, S. Buie, S. War-Mac, Vargas, S. Krahn, R. Rosin, T. Meurer, S. Pierce	Coordination meetings to begin within the next quarter; proposed release time adjustments to be reviewed by mid-year 2026
Move jail release time	Facilitate meetings between jail and P&P staff		

Group Members: F. Remington, A. Raymond, J. Hyland, M. Leonard, S. Buie, S. Wampole-Mac, Vargas, S. Krahn, R. Rosin, T. Meurer, S. Pierce

Priority Area #4: Crisis Triage			
Objective	**Action Step**	**Who**	**When**
Develop an emergent, coordinated triage response model for behavioral health crises	Assess the feasibility of a voluntary crisis triage center by identifying core needs, existing resources, and service gaps. Form a subcommittee composed of first responders, behavioral health professionals, peer providers, hospital representatives, and community advocates to design a triage framework and define operational pathways.	Fire, EMS, law enforcement, CARES, CPS, crisis response teams, Dane County representatives, peer support providers, behavioral health resource center (BHRC), hospital and emergency department staff, advocates, and individuals with lived experience	Subcommittee formation and needs assessment to begin immediately, with a preliminary triage model drafted within 6 months

Group Members: Tricia Mooney, Sarah Henrickson, Carrie Simon, Todd Campbell, Tanya Kraege, Paul Saeman, Martha Stacker, Jon Triggs, Pete Zallar, Jeanne McLelland, Dawn Varis, Marielle Lowell,

COMMUNITY COMMENT SURVEY RESPONSES

On day one of the SIM Mapping workshop, the facilitators invited participants to respond to an online survey, allowing them to provide additional comments anonymously in response to the following prompt for each intercept: "What is a gap, barrier, or redundancy in services for individuals with SUD needs in Dane County?"

The following are the raw response data, lightly edited for spelling and some grammar.

Intercept 0

- Need to better resource CBOs (especially those utilizing peer approaches) who are doing the work without adequate support and resources. More investment here in prevention, healing, and community building obviates the need for downstream intercepts.
- Need county-wide CARES for monopolize crisis response. Involve families and friends whom individuals want as helpers. 24/7 Crisis/Triage Center
- Lack of resources in rural Dane County- all centralized around Madison.
- Gap - we need to get outcomes data from community orgs combined with government data, community orgs need capacity and potentially expertise to collect data or properly evaluate - this is an opportunity for partnership with UW There needs to be adequate funding to support Peers. Peer support models are very different from how most government agencies or hospital/clinic appointments are. Peers need to spend variable amounts of time with people, and their schedules vary quite a bit. In addition to specific grant funding, government agencies need to set aside a reasonable portion of their budgets to subcontract with community organizations that have expertise in working with peer support. Peers hired within the government system often face barriers due to the misunderstanding of best practices or barriers to hiring due to criminal history or other bias. This intercept on our current map is mostly focused on quick-connect kinds of things but the community organizations that are doing the day to day work with people only have a small corner of the map. Calling Community services an intercept is not accurate as Community Services SURROUND intercepts 1-5. Community Services must be involved in every other intercept to work effectively. This needs to change for the map to be accurate. This might also help government stakeholders respect or have a better understanding of the level of expertise in community services.
- We need more bilingual and bicultural certified peer specialists. Centro of Dane County worked with WIPSEI, the statewide training and employment initiative for peer certification, to create a Spanish language peer certification course with content specific to the Latine and immigrant communities. We need more language and cultural representation to reach diverse communities. And more employers hiring diverse peer specialists.
- Drug detox - voluntary
- The map has empty boxes for community support or services. A key question is whether there is truly an absence of services at intercept 0 in Dane County or are the ones in existence not addressing the underlying issues that lead to CJ involvement?
- Redundancies: many, but that is not necessarily a bad thing. Gaps: Possibly housing is the biggest. Also, public-insured and uninsured folks tend to encounter more barriers for several services. the CCS discussion was informative as well, and gaps appear to exist with eligibility and flexibility of those services.
- Duplication - 988/local crisis line/BHCD; mobile crisis/law enforcement embedded crisis - lack of alignment with best practice standards Barrier - long wait time for residential treatment, hospital emergency depts/hospitals not interested in contributing to solutions Gap - comprehensive and systematic crisis follow up services, access to safe and sober housing, access to harm reduction housing, SUD focused crisis response
- Limited resources for detox and treatment. Access to information for services.
- Behavioral Health Resource Center peer support is a redundancy in peer support services

Responses reflect the views of individual participants and do not represent group consensus or the views of the facilitators.

Intercept 1

- Law enforcement has training on how to directly refer to diversion programs (CRC, MARI) but direct referrals are low; officer discretion/lack of awareness about programs may limit direct referrals
- Need 24/7 crisis diversion workers at 911 because it is a cost-effective way of expanding a part of CARES county- wide.
- CARES does not respond to rural areas of the county
- Law enforcement officers need more than just training to deliver supports and alternatives to people with SUD they interact with. We heard police leadership today state that while they train on this, they have no idea whether or how many officers employ those techniques or offer alternatives in the field. That is unacceptable. They need to be collecting that data, and they may need policies that require officers in the field to do these things. Emergency Services need to be expanded to treat people with SUD outside of alcohol and opioids. Symptoms that come with cocaine or meth use are often identified as non-compliant behavior instead of a symptom of use. Hospitals need to allow mental health assessments for people who come in under the influence of alcohol. It's not reasonable to only do this when someone is at zero. For someone with SUD, their intoxicated state may be closer to their "normal" where they are making their best decisions.
- Immigrant communities have more at risk (in terms of contact with ICE and possible immigration repercussions) when engaging with the justice system. Pair this sensitivity with the dearth of bilingual and culturally appropriate peer services at Intercept 0, and the overall vulnerability is amplified.
- Drug detox - in protective custody (involuntary)
- Mobile SU Services: questions about children and family should be included to know whether 1) child-friendly intervention is needed and 2) whether parent diversion options are appropriate to keep families intact.
- Barriers: despite the large number of local hospitals, a majority of Emergency Detention (Wis. Stat. 51.15) patients are deemed ineligible or inappropriate for local hospital placement, meaning that patients are involuntarily hospitalized at the facility of last resort (Winnebago MH Institute, 2 hours from Madison). This is not the most patient-centered manner of care.
- Gap-Triage Center (a no-wrong door crisis receiving facility), lack of comprehensive integrated mobile crisis response Barrier- emergency response systems are risk averse in ways that inhibit the utilization of non-law enforcement response, law enforcement embedded crisis not focused on immediate response
- Lack of spaces for people to go when in crisis or need of respite for LE. Housing
- Need to ask about kids and safety plan for kids
- What options do we have to divert individuals defined as “violent”?

Responses reflect the views of individual participants and do not represent group consensus or the views of the facilitators.

Intercept 2

Stop doing electronic IA through the door slot. Allow pretrial to serve more people (not just those sent by judges) Explore better options than tiny bail amounts for people who have no money. Continue to ID people who should not be in jail because of mental health issues

- Utilization of technology, such as video initial hearings, can assist in getting people out of jail

STOP USING TOOLS THAT DON'T WORK! If we know certain risk assessment tools are biased and increase disparities, we MUST stop using them. In Dane County, racial bias should be one of the first elements we consider in an assessment tool. Many of the county jail and DA programs include prior arrest history (even conviction history) in their risk assessment. Black people are arrested at a rate 11x higher than white people in our county, so they will systematically be excluded from options. Diversion programs need to set reasonable conditions based on someone's actual needs. Someone with SUD can't be expected to abstain from substances without treatment, for example. The barriers to diversion courts are massive - the eligibility requirements are strict, which screen people out. Then, if people are eligible, the format of these options makes no sense for most of the potential participants. There is a one-size-fits-all format where the reporting requirements and length of time should be tailored to the individual's needs. Initial appearance - this is a formality, usually defendants only see the attorney when they come to the podium unless they have other cases. Someone with SUD may be under high stress or withdrawal at this time and may be more likely to be in seg or not fully understand the proceedings. People are STILL appearing through food slots in cell doors for initial appearances. The jail says this is due to people being in seg or not fit to be taken physically to the courtroom https://nehemiah.org/wp-content/uploads/2023/09/18-by-6-Restricted-Participation-in-Dane-County-Court-Hearings.pdf

- Need interpretation, translation, cultural brokerage, bilingual and bicultural peers, guidance, and resources.
- Missing: family/parent-based diversion. See WA state's Family and Offender Sentencing Alternative program as an example.
- We have robust opportunities for pre-arrest diversion. We don't have a good insert point for programs that are consistent
- Some screenings aren't correctly identifying criminal risk levels.

Intercept 3

- Peer-centered MH and substance use programming in partnership with systems
- Offer services & treatment for convicted people who are on electronic monitoring under Huber. Don't change medications.
- Utilization of technology for court hearings
- In custody - there needs to be an effort to get people the meds they usually take with no gaps. Also, the jail relies on the incarcerated person's memory to state what meds they take. They will not talk to family/advocates, even with an ROI who could help ensure continuity of care. They could allow an individual to have meds delivered directly from the patient's pharmacy, perhaps for things not on formulary. Whether the jail allows this depends on which contracted medical services and who is in charge. There are almost no in custody programs/services. Our Huber program is inactive, and while the electronic monitoring program has expanded somewhat, many more people could be released into the community on monitoring. Risk assessment, which includes arrest or conviction history (racial bias) prevents many from doing this, and many of those people are Black who end up staying in the jail. There is currently extremely limited space for programming in our current jail, but there is no telling when a new one will open. We used to be able to pick jail residents up to take them to our programming if they had Huber/work release privileges, but that ended with covid and has not returned. We could do a better job of making sure courts have up-to-date info on community services to refer people to. There could be a coordinated effort to directly link people with SUD to community services at their hearings. People can sit through long jail/prison sentences without ever receiving SUD treatment or other supporting programming
- People may miss a legal "checkpoint" due to an overdose and are then penalized.
- Need interpretation, translation, cultural brokerage, bilingual and bicultural peers, guidance, and resources.
- Continuity of psych treatment
- Missing: Family Treatment Court (for drug involved individuals with child welfare involvement). See https://www.wicourts.gov/courts/programs/problemsolving/docs/familymatters.pdf
- Need more DAs and Public Defenders
- Need more programming. Easier access to meet with folks referred.
- Funding doesn't allow serving "violent" offenders in some courts.

Responses reflect the views of individual participants and do not represent group consensus or the views of the facilitators.

Intercept 4

- Make sure individuals can get connected to peers, case managers, and others who can help them in the community.
- Peers have a hard time with in-reach if they have criminal histories. We need an easier way for these peers to get approval for jail/prison access to do in-reach. Jail reentry staff are good, but understaffed. The jail could do a better job of working collaboratively with community programs to plan for release. Most DOC required programming is cookie-cutter, sometimes required based on old assessments or mandated based on the nature of the conviction. Case example: a man served time for negligent homicide while intoxicated. The man did not have SUD but was required to complete SUD programming, taking up valuable space in the program for someone who really needed it.
- Need interpretation, translation, cultural brokerage, bilingual and bicultural peers, guidance, and resources.
- Housing Access to jail is a barrier. Sometimes referrals from the jail are made in a matter of hours before the person is released. Release time from the jail is a setup, releasing people at a time of day when nothing is open.

Intercept 5

- Rethink Community Corrections: 2-year maximum, progressive sanctions, more resources.
- Services are not geared towards misrepresented groups within the community. A revolving door.
- We need WAY MORE transparency with community corrections. Almost no case management, inconsistent application of consequences and violations. DOC needs to work collaboratively with community services and treat community services and Peers as actual partners. Some things have improved with supervision, simplifying rules, and reducing holds. But we have a long way to go. I have more to say, but I'm running out of gas :)
- Need interpretation, translation, cultural brokerage, bilingual and bicultural peers, guidance, and resources.
- Housing
- There are many, many, many, many, many different forms of case management.
- Not enough money for housing
- PO Holds are overused, especially for people on monitoring, as equipment fails.
- Housing issues for justice-involved people, in particular those on the registry

Responses reflect the views of individual participants and do not represent group consensus or the views of the facilitators.

Cross-Intercept: Data Collection, data sharing, data leveraging, cross-system work groups and task forces?

How are we engaging University partners with substantial methodological expertise, content knowledge, and access to UW resources (funding, collaboration, students) to evaluate impact and design novel intervention approaches? Where is the community in this conversation? Most people in the room represent systems, community members with lived expertise have so much to offer to what's not working and what else we could be trying, but their representation at this table is dwarfed by that of systems.

Add mental health/substance abuse summary data to CJC dashboard. Evaluate diversion programs with data. Stakeholders should meet regularly to review data and propose changes based on it.

Dane County collects data but does nothing with it.

Government needs to be much more transparent with HOW their programs work and how and why they are using certain tools. They need to treat community services as expert partners, which will make data sharing and collection more robust with shared understanding. We've had numerous work groups and task forces, but it is like pulling teeth to get anything implemented. Implementation dollars are rarely appropriated and if they are, they are held within the county instead of subcontracting with community experts. Also, the community representation on the work groups, task forces, and even CJC is only advisory. The power to actually make change remains with elected officials, who worry about reelection, or staff that have little understanding or respect for the community voice. We are all so tired of being invited to tables, sharing novel and game-changing ideas, only to be ignored.

No one entity has identifiable data that can be linked to see the full picture. Many of us only have access to deidentified data.

1) lack of coordination across services and diversion and ATI models; a 311 (city level but non-existent in Dane) or expansion of 211 (United Way) about programs and diversion pathways could go a long way to help community members understand what is available. Clarity needed about: A group of UW-Madison faculty, staff, and students is seeking to bridge academic-community-agency partnerships to offer research and evaluation expertise to answer CJ-related questions, and assisting with answers to SIM questions in Dane could be a priority area. Contact Paja Charles (Paja.charles@wisc.edu) for info.

Data sharing/ leverage between the justice system and healthcare is lacking, CJC -BH subcommittee is disengaged

There are many task forces and work groups. They don’t always collaborate and continue to work in silos.

Systems are resistant to collecting and sharing certain data, especially race and ethnicity data- which includes law enforcements and courts.

From a data standpoint - Matching people across partners/data systems is very hard. They all use different identifiers and metrics to determine success

There is tremendous competition from community organizations for finite resources, which further contributes to silos.

Community organizations are awarded grants to perform tasks in which they are not expert in.

Responses reflect the views of individual participants and do not represent group consensus or the views of the facilitators.

FACILITATOR RECOMMENDATIONS

1. Recommendation to Increase Cross-System Informed Decision Making
2. Recommendation to Use Data to Drive System Planning and Strategy
3. Recommendation to Focus on “Familiar Faces” with Complex Needs
4. Recommendation to Use Data to Shape Sanctions, Incentives, and Alternatives to Jail
5. Recommendation to Build a Response to Methamphetamine and Stimulant Use Disorder
6. Recommendation to Integrate Peer Support Specialists Across Systems and Crisis Response
7. Recommendation to Build Complex Care Response Teams and Access Pathways
8. Recommendation to Expand Crisis Response Capacity with Telehealth

1. Recommendation to Increase Cross-System Informed Decision Making

During the SIM Workshop, participants identified the need to prioritize cross-system data analysis and information sharing. At present, many communities are "data rich but analysis poor." Data is collected in abundance but often in silos, serving only a single agency's operational needs. Information is not systematically shared, standardized, or analyzed across systems.

Standardized protocols and collaborative data governance allow Dane County to:

- Understand and plan for populations' needs.
- Inform policy development and improve system alignment.
- Standardize and streamline workflows and services.
- Increase operational efficiency and improve resource allocation.
- Manage costs and strengthen real-time decision-making.
- Track progress toward goals and outcomes.
- Improve collaboration and identify systemic barriers.
- Enhance transparency, accountability, and equity.

As Robert McNamara famously stated: "Measure what is important, don't make important what you can measure." This reminds us that not all meaningful outcomes can be easily quantified and that communities should be deliberate in defining priorities. In behavioral health, for example, measures often emphasize process (e.g., appointment attendance) or justice outcomes (e.g., recidivism), rather than symptom improvement or quality of life. These tensions should be openly discussed when creating cross-system data strategies.

Framing Questions:

- What are we trying to manage?
- What are we trying to understand?
- What are we trying to improve?
- What are we trying to change?

Cross-system data governance lays the foundation for all subsequent recommendations. By investing in governance, readiness, data quality, analytic capacity, and training, Dane County can shift from fragmented, siloed data collection to coordinated, actionable insights that drive smarter policies, reduce inequities, and improve outcomes across justice and behavioral health systems.

Action Step: Seat a Cross-System Data Governance Committee

- Charter the work of information sharing, including defining shared goals, setting accountability, and documenting processes for collecting, cleansing, transforming, storing, reporting, and protecting data.
- The governance committee may exist as a criminal justice coordinating body or a subcommittee thereof.

- Establish agreements that ensure all partners (justice, health, housing, social services) have a voice in decision-making.

Model Resources & Reference Materials:

- National Network of Criminal Justice Coordination Councils (NNCJCC)
- National Association of Counties (NACo) Criminal Justice Coordinating Councils (CJCC) Resource Hub
- The Council of State Governments Stepping Up Initiative

Action Step: Use the Wayne State Blueprint for System Integration as a Guide

The Blueprint identifies six key question areas to address and discuss within the data governance committee about cross-system integration:

1	Usefulness:	What data, if shared across systems, could provide the biggest benefits to each participating system, and to the state as a whole?
2	Accessibility:	Who can access the data? When? Who are the 'users'? Who do we want to access the data? How can data be shared?
3	Reporting:	What could be the key content of standardized, cross-system reports? Who could publish such reports? What role would the participating systems play in the production and/or review of such reports?
4	Confidentiality:	Are any protections or restrictions necessary?
5	Transparency:	How is it shared? Are there annual reports? By whom?
6	Protection from Liability	Is there any? What are protections and safeguards?

Model Resources & Reference Materials:

- Wayne State University School of Social Work, Center for Behavioral Health and Justice: Blueprint for Cross-System Integration

Action Step: Assess Data Sharing Readiness

- Inventory how and what data is currently used across systems.
- Identify who controls each dataset, what barriers exist to sharing, and whether proxy measures could be used.
- Clarify why data sharing is needed and how it supports analysis and policy.
- Document what data is already being shared, with whom, in what format, and under what authority.
- Identify barriers (legal, technical, cultural) and facilitators (leadership support, existing MOUs).

Model Resources & Reference Materials:

- SAMHSA: Data Collection Across the Sequential Intercept Model (SIM): Essential Measures
- SAMHSA: Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice

Action Step: Improve Data Quality and Standardization

- Examine how data elements are collected and defined within each system.
- Develop a cross-system data dictionary to standardize terms (e.g., "recidivism," "serious mental illness," "completion").
- Implement data cleansing procedures, identify missing fields, and address incomplete records.
- Ensure all agencies have basic electronic capacity (Excel, Google Sheets, or more advanced systems).
- Provide training and quality control standards for consistent data entry.

Model Resources & Reference Materials:

- Meadows Mental Health Policy Institute: Measurement-Based Care in Mental Health and Substance Use Disorders
- SAMHSA: Certified Community Behavioral Health Clinics (CCBHCs) Quality Measures

Action Step: Build Data Analysis Capacity and Reporting Infrastructure

- Identify staff or agencies with analytic expertise and gaps in capacity.
- Consider pooled funding for a dedicated analyst or contracts with universities or foundations.
- Select secure platforms capable of integration, visualization, and storage (e.g., Power BI Pro, Power BI Premium, Tableau Server, Tableau Cloud).
- Ensure appropriate staff training in data analysis and interpretation.
- Avoid reliance on free platforms (Power BI Desktop, Tableau Public, Looker Studio), which lack adequate security for sensitive data.

Model Resources & Reference Materials:

- Urban Institute: Developing Data Dashboards to Drive Criminal Justice Decisions
- GAINS Center: Data & Information Sharing Across the Sequential Intercept Model (Webinar)
- GAINS Center: Mechanisms for Efficient Data & Information Sharing (Webinar)

Action Step: Provide Cross-System Training on Privacy and Information Sharing

- Develop and deliver training on HIPAA and 42 CFR Part 2, focusing on when and how data may be shared across covered and non-covered agencies.
- Use case examples to clarify how confidentiality laws apply in real-world collaborations.
- Develop FAQs and written guidelines to dispel misconceptions and build trust between justice and health partners.

Model Resources & Reference Materials:

- Council of State Governments Justice Center: Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws
- National Association of Counties: Point-of-Service Information Sharing Between Criminal Justice and Behavioral Health Partners: Addressing Common Misconceptions
- The GAINS Center: Addressing Data Sharing Agreements & Confidentiality Concerns
- The GAINS Center: Effective Data and Information Sharing: Navigating Common Challenges - YouTube

2. Recommendation to Use Data to Drive System Planning and Strategy

While establishing cross-system governance and integration processes is essential (Recommendation 1), Dane County must also apply data strategically to evaluate service gaps, improve equity, and align resources with actual population needs.

Currently, data analysis is often conducted in isolation by individual agencies, making it difficult to identify cross-system trends. As a result, systemic issues—such as competency-to-stand-trial (CST) delays, pretrial detention inequities, gaps in behavioral health services, and misaligned resource allocation—remain hidden or under-addressed.

By developing cross-system data projects, Dane County can:

- Reveal bottlenecks in pretrial and competency processes.
- Identify whether treatment and diversion opportunities match community needs.
- Detect inequities across race, ethnicity, gender, housing, and justice involvement.
- Link program costs to outcomes for better investment decisions.
- Improve continuity of care for individuals reentering the community.
- Create population profiles that guide diversion, release, and resource expansion.

Dane County's ability to make data-informed strategic decisions hinges on going beyond governance and readiness (Recommendation 1) to practical application. By using integrated data to analyze CST and pretrial populations, assess behavioral health gaps, and evaluate utilization and costs, the County can allocate resources more effectively, promote equity, and implement interventions that improve both justice and health outcomes.

Action Step: Use Data to Improve Competency and Pretrial System Responses

Dane County should conduct integrated analyses of CST and pretrial populations to reduce delays, avoid unnecessary detention, and address inequities.

- Competence to Stand Trial (CST):
  - Track referrals for CST evaluations and restoration.
  - Measure wait times for evaluation and restoration services.
  - Identify bottlenecks causing extended jail stays.

    - Assess opportunities for diversion to treatment in lieu of prolonged case processing.
- Pretrial Populations:
    - Analyze detainees by top charges, bail amounts, CST status, diversion eligibility, and release eligibility.
    - Examine pretrial detention for low-level offenses (trespass, public order, substance use), where detention may be disproportionate to the charge.
    - Sort data by demographics (race/ethnicity, gender, housing status, age) and "familiar face" status.
- Equity and Impact:
    - Disaggregate outcomes to detect racial, gender, and socioeconomic disparities in pretrial and CST processes.
    - Use findings to revise bail practices, expand diversion, and promote equitable alternatives to detention.

Model Resources & Reference Materials:

- Krider, A. & Huerter, R. (2024). Mapping Your Competence to Stand Trial Process: Key Questions to Decrease Waitlists and Length of Stay. Policy Research, Inc.
- NYC Criminal Justice (2020). Pursuing Pretrial Justice Through an Alternative to Bail.
- SAMHSA: Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice.

Action Step: Conduct Behavioral Health Gap and Trend Analysis

To ensure system responses meet community needs, Dane County should perform regular gap analyses and trend monitoring across behavioral health and justice systems.

- Gap Analysis of Interventions:
    - Map the availability and accessibility of mental health, substance use, and co-occurring disorder services.
    - Assess gaps across different groups: race/ethnicity, gender identity, age, housing status, and justice involvement.
    - Identify shortages in culturally responsive or evidence-based practices.
- Cross-System Trends:
    - Track justice and health system patterns using jail data, Medicaid claims, reentry services, ER and crisis utilization, and probation/parole revocation data.
    - Monitor substance use trends and access to treatment, particularly for "familiar faces."
    - Use local sources such as the Overdose Detection Map, Coroner's Office reports, EMS/dispatch data, HUD Point in Time Survey, and HMIS data.
- Continuity of Care:
    - Analyze outcomes for individuals reentering from jail or prison, focusing on treatment engagement and follow-up.

- Use findings to strengthen diversion pathways and community service capacity.

Model Resources & Reference Materials:

- SAMHSA (2019). Data Collection Across the Sequential Intercept Model (SIM): Essential Measures.
- Local Data Sources: Coroner's Office toxicology, EMS/dispatch, probation/parole, HUD CoC PIT Survey, Overdose Detection Map.

Action Step: Evaluate Utilization, Costs, and Outcomes

Understanding how resources are used—and whether they generate positive outcomes—is essential to guide policy and budget decisions.

- Utilization:
  - Track service access patterns across justice and behavioral health systems.
  - Assess whether interventions match individuals' clinical and criminogenic needs.
- Costs:
  - Link utilization data with financial data from county budgets and partner systems.
  - Analyze personnel services (staffing, overtime, contracts), other-than-personnel costs (supplies, travel, equipment), and capital expenditures (construction, major equipment).
  - Catalog funding sources: general fund, federal/state pass-through, block grants, contracts.
- Outcomes:
  - Evaluate impacts such as reductions in recidivism, improved behavioral health, decreased jail utilization, and sustained treatment engagement.
  - Disaggregate outcomes by race/ethnicity, gender, age, and housing status to ensure equity.

Model Resources & Reference Materials:

- Urban Institute: The Criminal Justice Planner's Toolkit for Justice Reinvestment at the Local Level.
- National Institute of Justice (2014). Cost-Benefit Analysis: A Guide for Drug Courts and Other Criminal Justice Programs.
- SAMHSA (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.

3. Recommendation to Focus on "Familiar Faces" with Complex Needs

In addition to analyzing system-wide trends (Section 2), Dane County must pay special attention to individuals often referred to as "familiar faces"—those who cycle repeatedly through jails, hospitals, emergency services, shelters, and crisis systems. These individuals frequently present with chronic behavioral health, housing, and social needs that are inadequately addressed through siloed responses.

Fragmented interventions often treat only the most immediate crisis, without addressing the broader cross-system drivers of instability. The result is:

- Disproportionate utilization of high-cost services (e.g., repeated ER visits, jail stays).
- Increased strain on public safety, healthcare, and human service systems.
- Persistent instability for individuals, particularly those with co-occurring conditions.
- Widening inequities when marginalized populations are overrepresented in this group.

By identifying familiar faces across systems and designing coordinated care pathways, Dane County can:

- Quantify the true costs of fragmented service delivery.
- Target engagement strategies to reduce recidivism, homelessness, and ER reliance.
- Build complex care responses that combine housing, behavioral health, and justice system coordination.
- Improve equity by ensuring culturally responsive interventions.

Familiar faces are not only the individuals most visible in Dane County's justice and health systems, but also those who bear the highest human and financial costs of fragmented care. By identifying them through cross-system data, mapping service utilization, and designing coordinated care pathways, Dane County can break recurring cycles, reduce system strain, and promote stability and recovery for its most complex populations.

Action Step: Define and Identify the Familiar Faces Population

- Establish shared cross-system criteria (e.g., ≥3 jail bookings per year, multiple ER visits, frequent crisis calls, repeated homelessness).
- Link data from jails, EMS/dispatch, Medicaid claims, shelters, and behavioral health providers to build a composite profile of this population.
- Disaggregate findings by race, ethnicity, gender identity, housing status, and age to uncover inequities in how these individuals interact with systems.

Model Resources & Reference Materials:

- Council of State Governments (CSG) Justice Center (2021). Identifying Familiar Faces [YouTube].
- CSG Justice Center (2025). Planning, Implementing, and Assessing Law Enforcement Response to Homelessness.

Action Step: Map Service Utilization and Costs for Familiar Faces

- Track the intensity and frequency of service use across justice, health, and housing systems.
- Connect utilization data with fiscal costs, including jail days, ER visits, Medicaid claims, shelter nights, and crisis contacts.

- Develop person-centered dashboards or profiles that integrate cost and outcome data, helping stakeholders visualize both the human and financial stakes of fragmented care.

Model Resources & Reference Materials:

- Camden Coalition: Complex Care Blueprint.

Action Step: Design Coordinated Complex Care Responses

- Build individualized engagement strategies that address housing, behavioral health, medical needs, and social supports simultaneously.
- Develop cross-system complex care teams (see Section 7) that combine intensive case management, peer support, and mobile crisis services.
- Explore simulation and predictive modeling tools (e.g., New Hampshire's Medicaid strategy) to estimate cost savings and outcome improvements of coordinated responses.
- Ensure interventions are trauma-informed, culturally responsive, and peer-inclusive to improve trust and engagement.

Model Resources & Reference Materials:

- CSG Justice Center (2020). Applying Data to Identify Early Intervention Opportunities for High Utilizers [YouTube].
- SAMHSA (2024). Implementing Complex Care Models to Reduce Frequent Service Utilization Among Individuals with Mental and Substance Use Disorders [YouTube].

4. Recommendation to Use Data to Shape Sanctions, Incentives, and Alternatives to Jail

In Dane County, jail is often used as a sanction for individuals who violate probation, parole, or treatment court conditions—whether for substance use "reuse," missed appointments, or technical violations. These responses are not only costly, but may also disrupt recovery and reduce the likelihood of long-term stability.

By systematically collecting and analyzing data on supervision sanctions and incentives, Dane County can:

- Understand how current practices contribute to jail admissions and length of stay.
- Detect disparities in sanctioning and revocations by race, gender, and behavioral health status.
- Evaluate the effectiveness of alternatives to jail, such as treatment, housing, or community-based sanctions.
- Align supervision responses with evidence-based standards that emphasize proportionality, rehabilitation, and equity.
- Promote the use of incentives—not just sanctions—as tools to support compliance and recovery.

Shifting the balance from punitive sanctions toward data-driven, equitable, and rehabilitative responses can reduce Dane County's reliance on jail, particularly for individuals with behavioral health needs. By tracking revocations, evaluating alternatives, promoting incentives, and strengthening officer training, the County can create a fairer and more effective supervision system that promotes recovery, stability, and public safety.

Action Step: Analyze Supervision Sanctions and Revocations

- Collect data on technical violations, conditions of supervision, and outcomes of revocations (e.g., jail days served, frequency of reincarceration).
- Disaggregate findings by demographics (race, ethnicity, gender, age) and clinical status (mental health, substance use, co-occurring conditions).
- Identify where sanctions are applied inconsistently or result in disproportionate incarceration.
- Compare Dane County's practices to evidence-based supervision standards, which call for swift, certain, but proportionate responses.

Model Resources & Reference Materials:

- Council of State Governments (CSG) Justice Center (2024). Supervision Violations and Their Impact on Incarceration.
- Pew Charitable Trusts (2020). Policy Reforms Can Strengthen Community Supervision.
- Urban Institute (2023). At the Intersection of Probation and Jail Reduction Efforts: Findings from Pima County, AZ.

Action Step: Expand and Evaluate Alternatives to Jail

- Inventory current alternatives to jail sanctions (e.g., day reporting, community service, electronic monitoring, treatment pathways, transitional housing).
- Collect and analyze data on eligibility, usage, and outcomes of alternatives.
- Compare recidivism and compliance rates between individuals in alternatives versus those sanctioned with jail.
- Scale the most effective alternatives, particularly for populations with mental health and substance use needs.

Model Resources & Reference Materials:

- Urban Institute (2022). Assessment of Community Supervision Incarceration Responses in Nebraska and Utah.
- CSG Justice Center (2024). Supervision Violations and Their Impact on Incarceration.

Action Step: Monitor Equity, Practice Standards, and Transparency

Require all sanction, incentive, and revocation data to be disaggregated by demographics and behavioral health status.

- Set measurable goals for reducing disparities in supervision outcomes.

- Develop or refine written policy standards that guide proportional responses, officer discretion, and the prioritization of treatment or housing over jail.
- Publish regular dashboards or reports to promote transparency and accountability.

Model Resources & Reference Materials:

- Vera Institute of Justice. The Perils of Probation: How Supervision Contributes to Jail Populations.
- Sakoda, R. (2023). The Architecture of Discretion: Implications of the Structure of Sanctions for Racial Disparities, Severity, and Net Widening.

Action Step: Strengthen Officer Training and Support

- Provide training for supervision officers in:
  - Motivational Interviewing (MI)
  - Trauma-informed supervision
  - Gender-responsive practices
  - Cognitive-based behavioral interventions (e.g., CBT)
  - Disability accommodations (e.g., for individuals with brain injuries or I/DD)
- Monitor outcomes to ensure training translates into practice, particularly in reducing revocations and supporting long-term client stability.

Model Resources & Reference Materials:

- CSG Justice Center and Policy Research Associates: Trauma Informed Care Across the SIM
- Urban Institute: The Criminal Justice Planner's Toolkit for Justice Reinvestment at the Local Level.

5. Recommendation to Build a Response to Methamphetamine and Stimulant Use Disorder

During the SIM Workshop, stakeholders emphasized that while Dane County has made significant strides in addressing opioid use disorder (OUD), there are growing concerns about the rise of methamphetamine use disorder (MAUD) and polysubstance use. Unlike OUD, there are currently no FDA-approved medications for stimulant use disorders, making effective responses heavily reliant on behavioral interventions, housing, peer support, and long-term recovery strategies.

Without a coordinated strategy, individuals with MAUD often:

- Cycle between jail, emergency departments, and homelessness.
- Overwhelm crisis response and first responder systems.
- Face disproportionate risks of trauma, overdose (often due to fentanyl contamination), and untreated co-occurring conditions.

By building a cross-system MAUD response, Dane County can:

- Expand access to evidence-based behavioral interventions.
- Train the workforce to recognize and treat stimulant use disorders.
- Integrate MAUD strategies into existing recovery and justice initiatives.
- Reduce costly and destabilizing system involvement for individuals living with MAUD.

Methamphetamine use disorder presents unique challenges that cannot be addressed by opioid-focused strategies alone. By convening a dedicated workgroup, adopting evidence-based practices, expanding workforce training, and embedding MAUD response into Dane County's recovery infrastructure, the County can reduce cycles of crisis, jail, and homelessness, while improving outcomes for individuals, families, and communities.

Action Step: Convene a Cross-System Methamphetamine Response Workgroup

- Bring together a wide range of partners, including:
  - First responders (9-1-1, EMS, fire, law enforcement, park rangers).
  - Crisis response teams and hospital emergency departments.
  - Treatment providers and recovery specialists (including MAUD peers).
  - Housing and homeless service providers.
  - Jail health, reentry staff, courts, prosecutors, and defense attorneys.
  - Universities and technical colleges with behavioral health and medical programs.
- Define the system impacts of MAUD, including emergency calls, arrests, jail admissions, and overdose data.
- Prioritize interventions that match Dane County's service capacity and workforce readiness.

Model Resources & Reference Materials:

- National Crime Prevention Council (NCPC). Responding to Methamphetamine: Washington State's Promising Example.
- Toronto Drop-In Network. Good Practices for Working with Participants Who Use Crystal Meth.
- Erinoso, T. (2024). Safety Strategies and Harm Reduction for Methamphetamine Users in the Era of Fentanyl Contamination.

Action Step: Align Interventions with Clinical Guidelines and Best Practices

- Adopt clinical frameworks from the American Society of Addiction Medicine (ASAM) and American Academy of Addiction Psychiatry (AAAP).
- Expand access to four evidence-based interventions, recommended in combination:
  - Contingency Management (CM): Reinforcement through vouchers or gift cards for stimulant-free urine samples or treatment engagement. Considered the standard of care for stimulant use disorders.
  - Cognitive Behavioral Therapy (CBT): Helps individuals challenge harmful thought patterns, develop coping skills, and sustain recovery.

    - Physical Exercise (Behavioral Activation): Proven through meta-analyses to support brain and substance use recovery.
    - Community Reinforcement Approach (CRA): Builds a substance-free lifestyle by adjusting environmental and social factors, especially effective when combined with CM.
- Monitor treatment access and outcomes to ensure equity across race, ethnicity, gender identity, housing status, and justice involvement.

Model Resources & Reference Materials:

- Batki, S., Ciccarone, D., et al. (2024). ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder.
- ASAM (2025). Proposed Framework for the ASAM Criteria, Fourth Edition, Volume 3: Correctional Settings & Community Reentry.
- SAMHSA. Treatment for Stimulant Use Disorders.

Action Step: Expand Workforce Capacity and Training

- Partner with local universities and technical colleges to expand provider expertise in stimulant use disorders.
- Integrate substance use, trauma, and brain injury education into medical, social work, and human services curricula.
- Provide specialized training for:
- Law enforcement, jail staff, probation/parole officers.
- First responders and crisis teams.
- Housing and reentry providers.
- Ensure all OUD providers are also trained in MAUD interventions.
- Embed peers with lived experience of stimulant recovery into crisis and treatment teams to strengthen engagement.

Model Resources & Reference Materials:

- NIATx (Network for the Improvement of Addiction Treatment).
- Tracy, K. & Wallace, S. (2016). Benefits of Peer Support Groups in the Treatment of Addiction.

Action Step: Integrate MAUD Response into Recovery-Oriented Systems of Care (ROSC)

- Embed MAUD treatment strategies within Dane County's broader behavioral health and justice responses.
- Strengthen connections between treatment, housing, employment, and peer recovery supports.
- Ensure recovery strategies are trauma-informed, culturally responsive, and equity-focused.

- Evaluate outcomes such as reduced justice involvement, improved health, and housing stability for individuals with MAUD.

Model Resources & Reference Materials:

- SAMHSA. Recovery-Oriented Systems of Care Resource Guide.
- Davidson, L. (2021). Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future.

6. Recommendation to Integrate Peer Support Specialists Across Systems and Crisis Response

SIM workshop participants agreed on the importance of peer specialists in Dane County's behavioral health and justice systems. Peers bring lived experience with recovery from mental health conditions, substance use, or justice involvement, making them uniquely positioned to:

- Build trust during crisis encounters and reduce resistance to care.
- Model recovery and hope in high-stress moments.
- Provide grounding techniques and emotional regulation strategies in the field.
- Bridge transitions from crisis to community-based services and supports.

While peers are already present in some local programs, gaps remain across the Sequential Intercept Model (SIM). Expanding peer involvement, both in crisis co-response teams and across intercepts (courts, probation, reentry), can improve outcomes such as reduced hospitalization, decreased recidivism, stronger treatment engagement, and sustained recovery.

Peers are not an "add-on," but a core element of recovery-oriented systems of care. By embedding peer specialists into crisis teams, expanding roles across the SIM, supporting workforce development, and securing sustainable funding, Dane County can strengthen its crisis response, promote equity, and improve long-term outcomes for individuals navigating behavioral health and justice systems.

Action Step: Integrate Peers into Crisis Co-Response Teams

- Pair peer specialists with clinicians and law enforcement in mobile crisis teams.
- Define clear peer roles: engagement, de-escalation, support during crisis, and warm handoffs to ongoing services.
- Prioritize culturally and linguistically appropriate peer integration to enhance trust in underserved communities.
- Learn from national models where peers play a central role in crisis intervention (e.g., Cleveland, Durham, SC SHARE partnership).

Model Resources & Reference Materials:

- SAMHSA, National Guidelines for Behavioral Health Crisis Care
- National Association of State Mental Health Program Directors (NASMHPD), Roadmap to the Ideal Crisis System

- LAPPA, Peer Support Services in Justice and Public Safety Settings: A planning and implementation toolkit (2023)
- FrontLine Service (Cleveland, OH); Durham, NC Crisis Response; SC SHARE.

Action Step: Expand Peer Services Across the SIM

- Map current peer involvement across Dane County's SIM intercepts (crisis, courts, probation, reentry).
- Identify intercepts with gaps in peer integration and expand services where peers can improve diversion, engagement, and outcomes.
- Embed peers in specialized dockets (e.g., drug courts, mental health courts, veterans courts), probation case planning, and jail reentry programs.
- Promote use of peers in law enforcement outreach, public defender offices, and recovery support linkages.

Model Resources & Reference Materials:

- Policy Research Associates (PRA). Peer Support Across the Sequential Intercept Model.
- National Center for State Courts. Peers in Courts: State Court Leadership Brief.
- SAMHSA (2017). Peer Support Roles in Criminal Justice Settings.

Action Step: Build and Support a Sustainable Peer Workforce

- Establish training, certification, and credentialing pathways for peer specialists, aligned with state and national standards.
- Partner with local universities, community colleges, and peer-run organizations to expand workforce development.
- Provide ongoing supervision, continuing education, and stigma-reduction training for peer staff and allied professionals.
- Ensure peers have a voice in decision-making bodies (e.g., SIM steering committees, CJCC subcommittees).
- Promote a trauma-informed and recovery-oriented work environment that values peer perspectives.

Model Resources & Reference Materials:

- SAMHSA BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center), Building and Sustaining Peer Support Services: Tips from the Field
- National Alliance on Mental Illness (NAMI), The Role of Peer Supporters in Mobile Crisis Response and Respite Services
- SAMHSA (2015, reaffirmed 2020). Core Competencies for Peer Workers in Behavioral Health Services.
- National Association of Peer Supporters (NAPS) (2019). National Practice Guidelines for Peer Specialists and Supervisors.

Action Step: Create Sustainable Funding and Infrastructure

- Explore braided funding approaches (Medicaid reimbursement, county contracts, federal block grants) to sustain peer services across intercepts.
- Develop policies that support peer career advancement, equitable pay, and integration into multidisciplinary teams.
- Monitor outcomes such as reduced recidivism, improved treatment engagement, housing stability, and cost savings.
- Share evaluation results with policymakers and funders to demonstrate return on investment.

Model Resources & Reference Materials:

- SAMHSA (2024). Examining the Use of Braided Funding for Substance Use Disorder Services.
- NASMHPD: Transformation Transfer Initiative – Funding Opportunities.

7. Recommendation to Build Complex Care Response Teams and Access Pathways

Some individuals in Dane County live with multiple, overlapping behavioral health, medical, and social needs yet fall through the cracks of existing systems. They may not qualify for Medicaid, disengage from fragmented services, or cycle repeatedly through jails, shelters, and emergency departments. These individuals are often high-cost utilizers of public systems without ever receiving coordinated, long-term care.

To address these gaps, Dane County should develop Complex Care Response Teams that integrate clinical care, peer support, housing navigation, and justice system collaboration. These teams can:

- Provide intensive, personalized support for people with complex needs.
- Improve continuity of care across transitions (jail to community, hospital to shelter).
- Reduce costly reliance on emergency and justice interventions.
- Align fragmented funding streams and promote collaborative cross-system approaches.

Complex care teams provide an essential safety net for people whose needs are too great for any single system to address. By building cross-system teams, embedding peers, coordinating care for non-Medicaid populations, and applying predictive data analysis, Dane County can replace fragmented, high-cost interventions with coordinated strategies that stabilize lives, reduce inequities, and improve outcomes for its most vulnerable residents.

Action Step: Establish Cross-System Complex Care Teams

- Develop multidisciplinary teams that include clinicians, peer specialists, housing navigators, and justice system partners.
- Target individuals who meet high-need criteria (e.g., frequent crisis calls, multiple ER visits, repeated jail bookings).

- Ensure teams are mobile and flexible, able to provide in-reach to jails, hospitals, and shelters as well as proactive community follow-up.
- Create shared protocols for referral, case planning, and information-sharing across systems.

Model Resources & Reference Materials:

- Center for Health Care Strategies (CHCS). Complex Care Innovation Lab (2021).

Action Step: Provide Peer Services and Intensive Case Management

- Embed peer specialists in complex care teams to foster trust and sustained engagement.
- Use intensive case management models to coordinate behavioral health, housing, medical, and social services.
- Standardize protocols for post-crisis and reentry follow-up, ensuring warm handoffs into community-based care.
- Employ "relentless engagement" strategies to reach individuals who are eligible for services but reluctant to engage.

Model Resources & Reference Materials:

- SAMHSA: Assertive Community Treatment (ACT) Evidence-Based Practices KIT.
- Pew Charitable Trusts (2020), Policy Reforms Can Strengthen Community Supervision

Action Step: Coordinate Services for Non-Medicaid Populations

- Identify gaps in coverage for individuals who are uninsured or not Medicaid-eligible but still have significant needs.
- Explore blended or braided funding strategies (general fund, justice reinvestment, grants, philanthropy) to sustain care.
- Partner with safety-net providers and community organizations to extend access to uninsured populations.
- Consider adding onsite case management at recovery housing, shelters, and jail medical units to identify and connect high-need individuals earlier.

Model Resources & Reference Materials:

- NACo (2024). Funding Strategies for County Behavioral Health Crisis Care.
- Urban Institute (2024). Guide to Equity for the Uninsured.

Action Step: Leverage Data and Predictive Modeling

- Use cross-system data to simulate "access to care" pathways for individuals with complex needs.
- Apply predictive modeling to test how coordinated responses could reduce service utilization and costs.

- Incorporate data from jail medical reports, crisis calls, housing utilization, and family services to build a fuller care picture.
- Share results with policymakers to guide investments in sustainable complex care approaches.

Model Resources & Reference Materials:

- State of New Hampshire Medicaid Phase 2 Strategy: Using Data to Drive Cross-System Care Planning.
- CSG Justice Center (2024). Applying Data to Identify Early Intervention Opportunities for High Utilizers.

8. Recommendation to Expand Crisis Response Capacity with Telehealth

Dane County stakeholders identified the need for more responsive crisis care options, particularly in rural and underserved areas where in-person response is delayed by distance, staffing shortages, or resource constraints.

Telehealth-enabled crisis services provide a scalable solution. By adding virtual capabilities to existing crisis teams, or partnering with providers who specialize in remote crisis support, Dane County can:

- Expand coverage and timeliness of crisis responses.
- Reduce unnecessary transport to emergency departments or jails.
- Support law enforcement and EMS in the field with immediate clinical expertise.
- Mitigate workforce shortages by allowing clinicians to provide care remotely.
- Enhance crisis diversion at Intercepts 0 and 1 of the Sequential Intercept Model.

Communities across the country, including St. Louis, MO (Behavioral Health Response) and Plattsburgh, NY (Behavioral Health Services North), have implemented virtual crisis response models with success.

Telehealth is not a replacement for in-person crisis care but a powerful tool to expand reach, timeliness, and equity of access. By integrating telehealth across crisis call centers, mobile teams, and emergency departments, Dane County can reduce reliance on jails and emergency rooms, improve outcomes for people in crisis, and build a more resilient and responsive crisis system.

Action Step: Integrate Telehealth into Crisis Call and Dispatch Systems

- Equip 988 call centers and 911 dispatch units with the ability to connect callers directly to licensed clinicians via secure telehealth platforms.
- Train call takers on protocols for deploying telehealth as an alternative to law enforcement response.
- Ensure warm handoffs from telehealth clinicians to mobile crisis teams or community-based providers when in-person follow-up is required.

Model Resources & Reference Materials:

- SAMHSA (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.
- NASMHPD. Roadmap to the Ideal Crisis System.

Action Step: Expand Mobile Crisis Teams with Telehealth Support

- Equip mobile crisis units with telehealth-enabled tablets or smartphones to connect in real time with psychiatrists or other specialists.
- Extend coverage hours and expand service capacity by supplementing in-person teams with remote clinicians.
- Prioritize deployment in rural areas and neighborhoods with limited access to behavioral health professionals.

Model Resources & Reference Materials:

- Missouri Behavioral Health Council (2021). Virtual Mobile Crisis Teams.
- Behavioral Health Response (St. Louis, MO) and Behavioral Health Services North (Plattsburgh, NY) – examples of telehealth-supported crisis models.

Action Step: Partner with Hospitals and Emergency Departments

- Establish telehealth linkages between emergency departments and community crisis providers for rapid psychiatric consultation.
- Reduce behavioral health patient "boarding" in EDs by connecting immediately to remote clinicians.
- Coordinate telehealth-based discharge planning and follow-up to strengthen care continuity.

Model Resources & Reference Materials:

- American Psychiatric Association (2022). Telepsychiatry Toolkit.
- New York State Office of Mental Health (2020). Telehealth and Crisis Services

Action Step: Build Sustainability through Training and Infrastructure

- Provide staff training on clinical, technological, and privacy considerations for telehealth crisis response.
- Ensure access to HIPAA-compliant platforms and secure equipment across crisis teams, law enforcement, call centers, and hospitals.
- Explore braided funding models that combine Medicaid reimbursement, county resources, and federal/state grants to sustain telehealth services.
- Regularly evaluate telehealth effectiveness, access, and outcomes to guide scaling decisions.

Model Resources & Reference Materials:

- SAMHSA (2021). Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.
- Southwest Telehealth Resource Center. Bridging the Gap: Innovations in Telebehavioral Health Access.

ADDITIONAL RESOURCES

SUBSTANCE USE-SPECIFIC

Anti-Stigma Substance Use Language

- Words Matter - Terms to Use and Avoid When Talking About Addiction. National Institute on Drug Abuse (NIDA).
- Overcoming Stigma, Ending Discrimination Resource Guide. SAMHSA.
- Stigma-AddictionLanguageGuide-v3.pdf (shatterproof.org). Shatterproof.

Acquired Brain Injury

- Achieving Healing through Education, Accountability, and Determination. A psycho-educational curriculum for traumatic brain injury. (A.H.E.A.D.)
- National Association of State Head Injury Administrators (NASHIA)
  - Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
  - Supporting Materials including Screening Tools and Sample Consent Forms.
- United States Brain Injury Alliance. (USBIA).
- A Treatment Court Toolkit for Supporting Individuals with Acquired Brain Injury. (All Rise and NASHIA)

ASAM Criteria

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- The ASAM: National Practice Guideline for the Treatment of Opioid Use Disorder. American Society of Addiction Medicine. 2020 Focused Update. American Society of Addiction Medicine (ASAM).

Civil Commitment for SUD

- States with Involuntary Commitment Laws for Addiction Treatment. (2018). National Center for State Courts (NCSC).

Cognitive Behavioral Therapy

- Cognitive-Behavioral Therapy for Substance Use Disorders. (2010). McHugh, Hearon, & Otto. HHS Author Manuscripts.

Collective Impact

- Other Models for Promoting Community Health and Development | Section 5. Collective Impact | Examples. Center for Community Health and Development at the University of Kansas.

Contingency Management

- Contingency Management. Incentives for Sobriety. (1999). Higgins & Petry.

CMS 1115 Reentry Demonstration Waiver

- Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. (2023). Department of Health & Human Services (HHS).

Courts

- Treatment Court Locators. National Treatment Court Resource Center.
- Survey of DWI Courts. (2015). National Highway Traffic Safety Administration (NTHSA).
- The 10 Essential Elements of Opioid Treatment Courts. (2019). Center for Court Innovation.
- San Diego Serial Inebriate Program. San Diego Serial Inebriate Program (S.I.P.).

Drug Diversion Inside Correctional Facilities

- Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion. SAMHSA.

Prescription Drug Monitoring Program (PDMP)

- Prescription Drug Monitoring Programs (PDMPs) | Drug Overdose. U.S. Centers for Disease Control and Prevention (CDC).

Drug Categories and Classifications

- Commonly Used Drugs Charts. National Institute on Drug Abuse (NIDA).
- U.S. Controlled Drug Classifications. Recovery Research Institute (RRI).
- 7 Drug Categories. International Association of Chiefs of Police (IACP).
- The Controlled Substances Act. U.S. DOJ Drug Enforcement Administration (DEA).
- What is methamphetamine? National Institute on Drug Abuse (NIDA).
- Fentanyl Facts. U.S. Centers for Disease Control and Prevention (CDC).
- The Growing Threat of Xylazine and Its Mixture with Illicit Drugs. DEA Joint Intelligence Report. (2022). U.S. DOJ Drug Enforcement Administration (DEA).

Funding Resources

- Maximizing the 21st Century Cures Act through the Sequential Intercept Model. (2017). Policy Research Associates, Inc. (PRA).
- Funding & Awards. Bureau of Justice Assistance (BJA).
- Grants | SAMHSA. Substance Abuse and Mental Health Services Administration (SAMHSA).
    - State Opioid Response (SOR) Grants | SAMHSA.
    - State Targeted Response to the Opioid Crisis Grants | SAMHSA.
    - Substance Abuse and Mental Health Block Grants | SAMHSA (*Note that SUBG and Mental Health Block Grant (MHBG) funds can be used for jail-based services*).
- National Opioids Settlement.
- 2024 Roadmap for Opioid Settlement Funds - VOCAL-US
- FY 2023 Comprehensive Opioid, Stimulant, and Substance Use Site-based Program. Bureau of Justice Assistance.
    - COSSUP Resource Center.

Harm Reduction

- Harm Reduction training/Harm Reduction Specialists. International Certification & Reciprocity Consortium.
- Harm Reduction and Overdose Prevention - 50 State Survey of Harm Reduction Laws. The Network for Public Health Law.
- Information about Naloxone and Nalmefene. U.S. Food and Drug Administration (FDA).
- FDA Approves First Over-the-Counter Naloxone Nasal Spray. U.S. Food and Drug Administration (FDA).
- Testing Strips:
    - Enhancing Harm Reduction Services in Health Departments. Fentanyl Test Strips and Other Drug Checking Equipment. The National Council.
    - Xylazine Test Strips for Drug Checking. (2023). Jones & Bailey. National Center for Biotechnology Information (NCBI).
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Hep C and SUD Medication

- Letter on State Medicaid Coverage for People with HCV and SUD. (2024). Hep C and SUD access to HCV medications called “direct-acting antivirals (DAAs). U.S. Department of Justice, Civil Rights Division.

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- Fact Sheet on Naloxone (Narcan) for CoC, ESG, YHDP and HOPWA Grantees. (2023). US Department of Housing and Urban Development (HUD).
- Oxford House.
- Recovery Residences:
    - Best Practices for Recovery Housing. SAMHSA.

- Recovery Housing: Best Practices and Suggested Minimum Guidelines. National Alliance for Recovery Residences (NARR). 2019.

Hub & Spoke Care Delivery Model

- Hub and Spoke Model. Rural Health Information Hub.

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- Substance Use Confidentiality Regulations. SAMHSA.
- HIPAA Privacy Rule and Sharing Information Related to Mental Health. U.S. Department of Health and Human Services.
- FAQs: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange. Legal Action Center.
- Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws. CSG Justice Center.
- Point-of-Service Information Sharing Between Criminal Justice and Behavioral Health Partners: Addressing Common Misconceptions. National Association of Counties.
- Fact Sheet 42 CFR Part 2 Final Rule.
- Confidentiality of Substance Use Disorder Patient Records. U.S. Department of Health and Human Services.

Integrated Care: CCBHC, FQHCs, Rural Health Clinics, and Street Medicine Institute

- Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria. (2023). SAMHSA.
- Federally Qualified Health Center (FQHC). Medicine Learning Network.
- Rural Health Clinics (RHCs) Overview. Rural Health Information Hub.
- Street Medicine Institute (SMI).

Integrated Dual Diagnosis Treatment (IDDT)

- Efficacy of Integrated Dual Disorder Treatment for Dual Disorder Patients: A Systematic Literature Review. (2018). Neven, Kool, Bonebakker, & Mulder. Tijdschr Psychiatry.
- Effectiveness of Integrated Dual Diagnosis Treatment (IDDT) in severe mental illness outpatients with a co-occurring substance use disorder. (2018). Kikkert, Goudriaan, de Waal, Peen, & Dekker. Journal of Substance Abuse Treatment.
- Peers and Co-Occurring Research-Supported Interventions. (2017). Harrison, Cousins, Spybrook, & Curtis. Journal of Evidence-Based Social Work.

Jail and Correctional Settings

- Managing Substance Withdrawal in Jails: A Legal Brief. Bureau of Justice Assistance.
- Screening for Substance Use Disorders in Jails. Bureau of Justice Assistance.
- Guidelines for Managing Substance Withdrawal in Jails. Bureau of Justice Assistance.

Law Enforcement Deflection and Diversion

- Police, Treatment, and Community Collaborative (P-TACC) is a national collaboration between agencies focused on pre-arrest diversion programs and initiatives.

- The Police Assisted Addiction and Recovery Initiative (PAARI) is a national program emphasizing non-arrest diversions into treatment and recovery programs.
    - PAARI Angel Programs
- Quick Response Teams (QRT) are pre-arrest deflection programs involving interdisciplinary overdose follow-up and engagement with survivors to link to treatment following overdose.
- Law Enforcement Assisted Diversion (LEAD).

Law Enforcement Drug Interdiction and Detection

- High Intensity Drug Trafficking Areas (HIDTA). Office of National Drug Control Policy.
- Organized Crime Drug Enforcement Task Forces (OCDETF). U.S. Department of Justice.
- Drug Recognition Experts (DREs). International Association of Chiefs of Police.

Medications for Opioid Use Disorder (MOUD) in Corrections

- Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion. SAMHSA.
- Jail-Based Medication-Assisted Treatment. Promising Practices, Guidelines, and Resources for the Field. National Commission on Correctional Healthcare (NCCHC).
- Clinical Opiate Withdrawal Scale (COWS). National Institute of Health (NIH). 2003.
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- About Opioid Use During Pregnancy. Centers for Disease Control and Prevention. CDC.

Mobile Health Units

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- Mobile Methadone Unit. SAMHSA.

Overdose Fatality Review

- Overdose Fatality Review: A Practitioner's Guide to Implementation. COSSAP.

Peer Supports and Services

- Peer Supports in Recovery Housing and Coordination Across the Substance Use Disorder Care Continuum. Recovery Housing Program Peer Support Quick Guide. HUD Community Planning and Development.
- How Can a Peer Specialist Support My Recovery From Problematic Substance Use? SAMHSA.

Prevention

- Prenatal Opioid and Substance Exposure. National Center on Birth Defects and Developmental Disabilities (NCBDDD).
- The Institute of Medicine's Continuum of Care (samhsa.gov)
- National Institute of Health:
  - Preventing Drug Misuse and Addiction: The Best Strategy | National Institute on Drug Abuse (NIDA) (nih.gov);
  - Preventing Drug Use Among Children and Adolescents-- A Research-Based Guide for Parents, Educators, and Community Leaders (nih.gov)
- National-Drug-Control-2022Strategy.pdf (whitehouse.gov)
- Principles of Substance Abuse Prevention. U. S. DOJ Office of Justice Programs (OJP).
  - Preventing Drug Misuse and Addiction: The Best Strategy. National Institute on Drug Abuse (NIDA).
  - Substance Use Disorder Prevention Models. Rural Health Information.
  - National Drug Use Survey: 2022 National Survey on Drug Use and Health (NSDUH) Releases. SAMHSA.
- SAMHSA Center for Substance Abuse Prevention (CSAP):
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  - https://www.samhsa.gov/grants/block-grants/subg

Program Examples

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- Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Federal grant launches innovative Massachusetts Trial Court program for court users and loved ones impacted by substance use. Project NORTH (Massachusetts). National Center for State Courts (NCSC).
- At a Glance – Specialized Programs in Community Corrections. Alternatives to Jail: Colorado IRT and STIRT.

Recovery

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- Faces and Voices of Recovery (FAVOR) is the SUD counterpart to NAMI. Often local chapters provide Peer Support Specialist Training, Recovery Oriented System of Care (ROSC) training, WRAP trainings, advocacy, support meetings, harm reduction efforts and distribution, and language of recovery.
- Recovery-Oriented System of Care (ROSC) Guide. (2010). SAMHSA.
- Find Recovery Resources: SAMHSA
  - https://www.samhsa.gov/find-help/recovery
  - https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf
- Wellness Recovery Action Plans (WRAP).

SAMHSA TIP Series: SUD

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- Screening, Brief Intervention, and Referral to Treatment (SBIRT). SAMHSA.
- Commonly Used Tools:
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  - Simple Screening Instrument for Substance Abuse. PsyPack.
  - The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). World Health Organization.
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT). SAMHSA.
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  - The ROUDA and RSUDA are both copyrighted by Sandra A. Springer, MD, and Intellectual Property of Yale University. If you are interested in using the tools, please connect to the link below and enter your information in the form.
- At pre-trial, the Risk and Needs Triage (RANT) may be used to understand drug use, and property crimes. Also see RANT: An evidence based supervision and clinical services recommendation solution.

State Opioid Treatment Authority (SOTA)

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Substance Use Data, Response, and Trend Resources

- Overdose Detection Mapping Application Program. Office of National Drug Control Policy.
  - High Intensity Drug Trafficking Areas (HIDTA) ODMAP (Overdose Map).
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    - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
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SSI/SSDI Outreach, Access, and Recovery (SOAR)

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

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Telehealth

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Transition-Aged Youth

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- Harvard Kennedy School Malcolm Weiner Center for Social Policy. (2016). Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21.
- Roca, Inc. Intervention Program for Young Adults.

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Trauma and Trauma-Informed Care

- SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.
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- National Resource Center on Justice-Involved Women. (2015). Jail Tip Sheets on Justice-Involved Women.
- Bureau of Justice Assistance. VALOR Officer Safety and Wellness Program.

Veterans

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

APPENDIX

Appendix A Participant List – Sequential Intercept Model (SIM) Mapping Workshop

Appendix B Community Self-Assessment Survey Responses

APPENDIX A: SIM WORKSHOP PARTICIPANT LIST

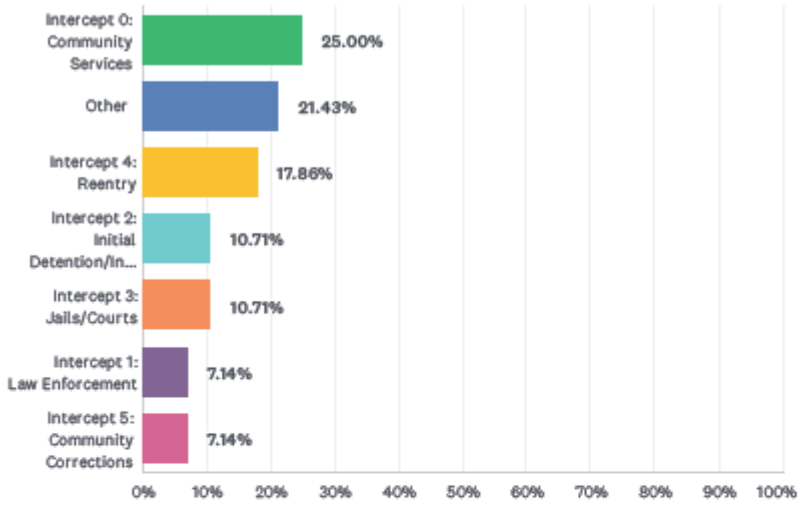
Full Name	Agency/Organization
Grupe, Dan	Center for Healthy Minds, UW-Madison
Vargas, Junior	Centro Hispano
Cruz, Evelyn	Centro of Dane County
Rosin, Rachel	Centro of Dane County
Madison, Sabrina	City of Madison
Becher, Lisa	City of Madison Fire Department
Stacker, Dr. Martha	Dane Co. Dept. of Human Services
Hyland, John	Dane County Circuit Court
Khaleel, Awais	Dane County Corporation Counsel's Office
Raymond, Andrea	Dane County District Attorney's Office
Ozanne, Ismael	Dane County District Attorney's Office
Bayrd, Carousel	Dane County Executive's Office
Moore, Chloe	Dane County Human Services
Mennig, Melissa	Dane County Human Services
Currie, Jael	Dane County Office of Justice Reform
Pierce, Shannon	Dane County Pretrial Services Department
Triggs, Jonathan	Dane County Sheriff’s Office
DeForest, Michelle	Dane County Sheriff's Office
Wampole-Maciejeski, Sarah	Dane County Sheriff's Office
Dudley, Donald	Dane County Sheriff's Office
Jones, Rebekah	Deferred Prosecution Program-DA's Office
Krahn, Sarah	Department of Corrections - Div. of Comm. Corrections
Campbell, Todd	Department of Human Services
Dillard, Jerome	EXPO of Wisconsin
Jacobs, Jessica	FREE Movement/Wisdom
Henrickson, Sarah	Journey Mental Health
Ketcham, Linda	JustDane
Ballweg, Diane	Madison Justice Team
Prado, Jared	Madison Police Department
Nachtigal, Diana	Madison Police Department
Balles, Joe	Madison Police Department

Tuttle, Lisa	Madison VA Hospital
Saeman, Paul	MOSES
Morgan, James	MOSES
McLellan, Jeanne	NAMI Dane County
Reece, Karen	Nehemiah
Clark Bernhardt, Colleen	Office of Justice Reform
Buie, Shar-Ron	Office of Justice Reform, Dane County Wisconsin
Zallar, Peter	PSC 911 BHCD
Schumann, Casey	Public Health Madison & Dane County
Kraege, Tanya	Safe Communities
Landing, Latisha	Sober Living In Madison
Leonard, Melanie	State of WI
Henning, Alisha	The Beacon
Lowell, Marielle	UnityPoint Health - Meriter
Goodrich, Janae	University of Wisconsin Population Health Institute
Veirs, Dawn	UW-Madison Police Department
Charles, Pajarita	UW-Madison Sandra Rosenbaum School of Social Work
Mooney-Fogarty, Tricia	Wellpath
Meurer, Todd	Western Dane County Joint Municipal Court
Middleton, Peter	Wisconsin State Public Defender

Community Self-Assessment

Q4 Where on the Sequential Intercept Model is your role most related?

Answered: 28 Skipped: 0



ANSWER CHOICES	RESPONSES	
Intercept 0: Community Services	25.00%	7
Other	21.43%	6
Intercept 4: Reentry	17.86%	5
Intercept 2: Initial Detention/Initial Court Hearings	10.71%	3
Intercept 3: Jails/Courts	10.71%	3
Intercept 1: Law Enforcement	7.14%	2
Intercept 5: Community Corrections	7.14%	2
TOTAL		28

Supported by the John D. and Catherine T. MacArthur Foundation

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