Sequential Intercept Model Mapping Workshop

June 2026

Report for:

Burnet County

Prepared by:
The Texas Judicial Commission on Mental Health

In Collaboration with
Lynfro Consulting
& D-Degree
Coaching and Training

JCMH
Texas Judicial Commission on Mental Health

Sequential Intercept Model Mapping
Report for Burnet County, TX

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Workshop Facilitated and Report Drafted By:

Lynda Frost, JD, PhD
Lynfro Consulting

Douglas Smith, MSSW, ACC
D-Degree Coaching and Training

The Texas Judicial Commission on Mental Health (JCMH) was created by a joint order of the Supreme Court of Texas and the Texas Court of Criminal Appeals to develop, implement, and coordinate policy initiatives designed to improve the courts' interaction with—and the administration of justice for—children, adults, and families with mental health needs.

Mission

Engage and empower court systems through collaboration, education, and leadership thereby improving the lives of individuals with mental health needs, substance use disorders, or intellectual and developmental disabilities (IDD).

RECOMMENDED CITATION

TEXAS JUDICIAL COMMISSION ON MENTAL HEALTH, SEQUENTIAL INTERCEPT MODEL MAPPING REPORT FOR BURNET COUNTY (2026).

ACKNOWLEDGEMENTS

The Judicial Commission on Mental Health wishes to recognize the leadership of Burnet County and praise the work they have done to bring JCMH's support to Burnet County, including the warm welcome provided by Judge Evan C. Stubbs. The JCMH is thankful for the assistance of the Burnet County planning team: Dawn Capra, Amanda Coleman, Colleen Davis, Jonathan Lemuel, Judge Roxanne Nelson, Constable Leslie Ray, Chris Sanders, Rosana Sielaff, Judge Tamara Tinney, and Judge Bryan Wilson.

FACILITATOR BIOS

Lynda Frost, JD, PhD, runs Lynfro Consulting, which is committed to helping foundations, nonprofits, and other agencies maximize their impact through clarifying mission-consistent goals, implementing effective programs, and optimizing internal operations. Lynda's skills have been honed through 25+ years in the nonprofit sector working to improve health, human services, education, and criminal justice outcomes for vulnerable communities. She brings to her work a unique combination of deep content knowledge and innovative process skills. She is passionate about designing fair and effective processes to reach each client's goals and is recognized for facilitating effective in-person *and* virtual meetings that inspire participants and deliver results. Prior to founding Lynfro Consulting in 2018, Lynda worked for 14 years at the Hogg Foundation for Mental Health and is an experienced administrator and attorney with expertise in human rights, juvenile and criminal justice, special education, and mediation.

Doug Smith, MSSW, ACC, is the Managing Partner of D-Degree Coaching and Training. He helps organizations develop strategies to address complex problems through creative facilitation and training. He also provides leadership training and coaching, especially for people most directly impacted by mental illness, substance use disorder, past trauma, and/or incarceration. Doug has 12 years of experience in mental health and justice policy, as a Senior Policy Analyst at the Texas Criminal Justice Coalition and as an Adjunct Professor of Social Policy at the University of Texas at Austin. Doug has his master's in social work. Doug also has lived experience of mental illness, substance use disorder, and incarceration, and these experiences drive his passion for prevention and community engagement.

JCMH STAFF CONTRIBUTORS

Kristi Taylor, J.D.
Executive Director

Michael Garcia
Legal Assistant

Christine Busse
Data & Strategic Initiatives Manager

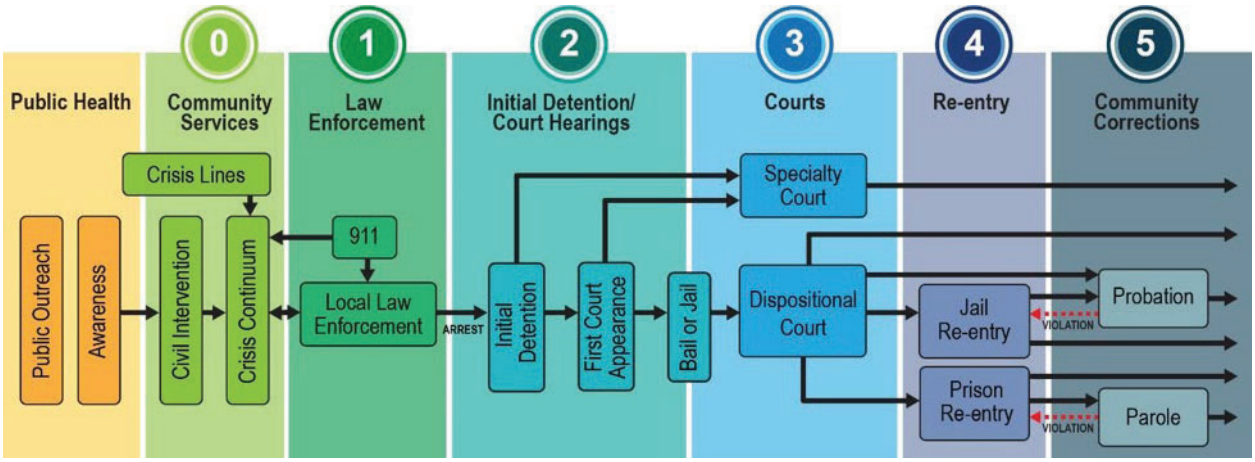
Kiley Phillips
Communications Manager

A NOTE ON LANGUAGE

Across our communities, significant stigma still exists around experience with mental health disorders, substance use disorders, and justice system involvement. In this document, we seek to use respectful language that recognizes the value as well as the challenges that people with these experiences bring to our communities. A number of excellent resources provide detailed guidance about language that feels more courteous and modern to many people. In general, it is a good idea to use "person first" language that references the person before a relevant condition (i.e., "a person with schizophrenia" rather than "a schizophrenic") because we are all more than one diagnosis or experience.

For more information on mental health language, see https://hogg.utexas.edu/news-resources/language-matters-in-mental-health.
For information on substance use, see https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction and https://www.thenationalcouncil.org/wp-content/uploads/2021/11/Language-Matters-When-Discussing-Substance-Use-1.pdf.
For information on disability, see https://www.cdc.gov/ncbddd/disabilityandhealth/pdf/communicating-with-people.pdf.
For information on justice system involvement, see https://fortunesociety.org/wordsmatter/.

CONTENTS



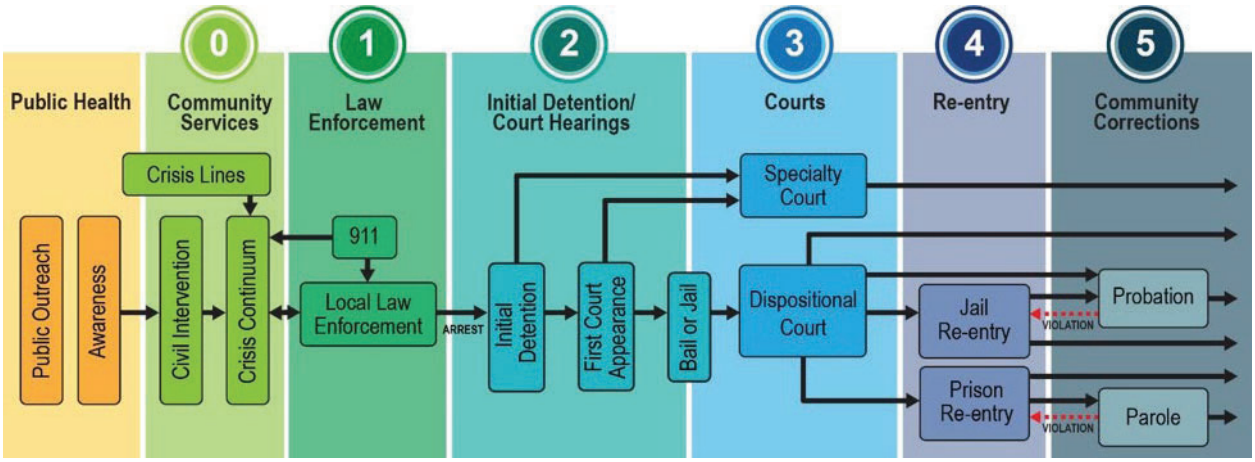
EXECUTIVE SUMMARY

This report was created through a series of online and in-person workshops hosted by the Texas Judicial Commission on Mental Health to address the needs of adults with behavioral health challenges who become involved with the criminal justice system. It draws on the Sequential Intercept Model to support communities in identifying strategies to divert individuals from the justice system and into treatment. The workshops brought together over 80 stakeholders from across systems, including mental health, substance use, courts, and law enforcement to map resources, gaps, and opportunities at each point a person intersects with the justice system.

Through the workshops, the stakeholders developed priority action plans to improve coordination and services. These plans focus on four key priorities for change:

1. Behavioral Health Leadership Team
2. Comprehensive Housing Strategy
3. Diversion Center
4. Mental Health Court/Docket

The report provides a detailed blueprint for Burnet County stakeholders seeking to reduce unnecessary justice involvement for adults with behavioral health needs. As stakeholders move forward to implement the identified changes, it will be crucial for each action team to organize and track its steps as well as coordinate with other action teams. The Judicial Commission on Mental Health will provide ongoing technical assistance as stakeholders review current laws and best practices in order to implement the plans.



BACKGROUND

The Sequential Intercept Model was developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., in conjunction with SAMSHA's GAINS Center. Since its creation, it has been used by communities to assess available resources, determine gaps in services, and plan for change.

A Sequential Intercept Model mapping is a workshop that builds a comprehensive picture of how people with mental illness and co-occurring disorders move through the justice system in a specific community, pinpointing challenges, resources and opportunities along the way. It establishes priorities for strengthening system- and service-level responses and develops an action plan to put those priorities into motion. The process is primed to foster communication across systems, as participants identify opportunities for collaboration to prevent further penetration into the justice system.

KEY FACTORS THAT SUPPORT THE EFFECTIVENESS OF THIS PROCESS

Communities that remain engaged and make significant progress toward their goals have key commonalities. Specifically, they draw on the participation from people with lived experience of mental health and behavioral health challenges or justice involvement. Successful communities also create formal leadership teams to drive priorities forward. They make use of data to identify progress, adapt their plans, and optimize services. They also know the law as it relates to mental health and justice involvement.

THE POWER OF LIVED EXPERIENCE

Community-based peer support services that assist with transition or reentry into community-based mental health services can help individuals achieve long-term recovery. Peer support specialists can provide insight into potential triggers and relapses, and provide:

- Emotional support
- Shared knowledge
- Practical assistance
- Connection to people with resources
- Opportunities and communities of support

In Texas, there are three primary certifications for peer specialists: Mental Health Peer Specialists, Recovery Support Peer Specialists, and Certified Family Partners. A growing number of peer specialists obtain certification as Re-Entry Peer Specialists who have lived experience with incarceration as well as recovery from mental health and/or substance use challenges. Re-Entry Peer Specialists can play important roles at all points along the Sequential Intercept Model.

Several organizations and resources provide helpful guidance:

- Via Hope is a Texas nonprofit organization that provides training, technical assistance and consultations related to the peer workforce. The organization also trains and certifies reentry peer support specialists.
- PeerForce serves as a hub for peers and family partners in Texas, collaborating with communities and organizations to advance and broaden the peer career field. They provide assistance to prospective employers on how to implement peer services and provide training for prospective peers.
- SAMHSA is the federal agency that for decades has worked to promote peers in leadership roles.
- Philadelphia's DBHIDS Peer Support Toolkit

Clubhouse International is a global nonprofit organization that helps communities create clubhouses. Clubhouses provide people living with mental illness opportunities for friendship, employment, housing, education, and access to medical and psychiatric services. Some clubhouses include peer support specialists and can be good resources, particularly during the reentry process. Clubhouse Texas is a key resource for information about the burgeoning clubhouse movement in Texas.

CONTINUED CROSS-SYSTEM COLLABORATION

Experience shows that the counties generating enduring results in their system change efforts are those that create formal coordinating groups such as Behavioral Health Leadership Teams or other coordinating bodies that facilitate and guide countywide justice and behavioral health cross-systems stakeholder planning.

The team of multi-agency stakeholders should lead in designing, implementing, and monitoring mental health-focused diversion efforts. Representatives from across sectors, including behavioral health, probation, the judiciary, defense attorneys, and law enforcement should be included along with people with current knowledge of mental health needs, evidence-based assessments, and treatments.

EFFECTIVE USE OF DATA

Counties that effectively use available data to track progress and shape decision-making are best positioned to achieve their goals. Burnet County is already modeling this practice. Recognizing the need to measure outcomes over time, the county ran a data request before the SIM mapping to establish a baseline across the most important touchpoints: mental health calls and crisis response volume, jail-based mental health assessments, diversions away from jail and the emergency room, and days waiting for state hospital beds. These numbers give Burnet County a starting point to measure whether specific interventions are moving the needle. As priorities advance, the same measures can be revisited to show where the system is shifting.

Burnet County deserves specific recognition for the quality and depth of its data collection efforts. The county's data collection has grown more robust each year, reflecting an increasing commitment to evidence-informed planning. The county tracks the number of Article 16.22 orders issued—the Texas Code of Criminal Procedure mechanism for identifying individuals in the jail who may have a mental illness, substance use disorder, or intellectual disability—and pairs that data with monthly figures on Crisis Intervention Team (CIT) contacts, Bluebonnet Trails Community Services (BBT) contacts, and diversions by pathway. In 2024, 227 Article 16.22 orders were issued, with 281 BBT contacts recorded and 14 total diversions documented across multiple categories. This granular, month-by-month tracking is a meaningful and praiseworthy step that many counties have yet to achieve.

Burnet County is also actively monitoring its competency restoration waitlist, which is a recognized best practice. This effort has yielded concrete results: the county reduced its waitlist from eight individuals to four, a significant achievement that reflects both proactive case

management and effective collaboration among jail staff, courts, and behavioral health partners. The county has also tracked average wait times for state hospital beds, averaging 281.5 days from January 2024 to present. These statistics provide important context for planning local competency restoration alternatives. Burnet County should continue using this waitlist data as a tool to identify individuals who may be candidates for re-evaluation, outpatient competency restoration, or other diversion options.

The data Burnet County has collected on early identification and diversion is also highly valuable. The county's ability to track diversions by category—to family, to a facility, through BBT, and through CIT—provides a level of transparency that enables meaningful analysis. At the same time, this data reveals an important opportunity: the number of individuals identified with possible mental illness through the Article 16.22 process is substantially higher than the number successfully diverted from jail. In 2024, 227 Article 16.22 orders were issued, yet only 14 diversions were documented across all pathways. The county is encouraged to study the barriers to diversion, including access to services, availability of diversion options, and systemic coordination challenges, in order to understand this gap and identify strategies to increase diversion rates for appropriate individuals. The Behavioral Health Leadership Team is ideally positioned to use this data as a foundation for planning priorities, measuring progress, and making the case for additional resources and infrastructure.

Burnet County can build on this foundation and strengthen data collection across the SIM by taking several additional steps. SAMHSA's article Data Collection Across the Sequential Intercept Model: Essential Measures contains insightful techniques that can be reviewed and implemented on a local level. Ensuring the accuracy of Texas Law Enforcement Telecommunications System (TLETS) data is an important part of improving data collection in Texas. SAMHSA has an article on Data Collection Across the Sequential Intercept Model: Essential Measures that contains insightful techniques that can be reviewed and implemented on a local level. Ensuring the accuracy of Texas Law Enforcement Telecommunications System (TLETS) data is an important part of improving data collection in Texas.

Some counties train dispatch centers to ask if the nature of the emergency call is police, fire, or mental health, regardless of the availability of a Crisis Intervention Team or co-responder team to respond. Law enforcement agencies can assign an incident number to every mental health call so that the calls can be tracked and analyzed for trends and patterns. This data can be used to secure grant funding for training and resources, as well as additional resources from the county.

There are several organizations that offer resources to assist with improving data collection, analysis, and creation of performance measures.

Stepping Up Initiative. The Stepping Up Initiative is strongly focused on the use of data to assist in lowering the numbers of people with mental illness in jail. Counties can take advantage of the resources on the Stepping Up website to benefit their residents. Consider developing goals, such as: 1) Reducing the number of people with severe mental illness admitted to the county jail, 2) Reducing the length of stay for people with severe mental illness while in jail, 3) Increasing connections to community-based treatment and support upon release, and 4) Reducing their criminal recidivism. Specific goals will help clarify and direct what data should be collected and how to use that data to further the county's cross-systems efforts.

Bureau of Justice Assistance. The Bureau of Justice Assistance published A Guide to Collecting Mental Health Court Outcome Data in 2005 to help guide mental health court teams on collecting and using data. Outcome data can help courts demonstrate the purpose of the specialty court program and attract funding sources to expand and enhance the program. The Center for Court Innovation has a short document on collecting data for drug courts.

Justice Counts. Justice Counts is a national program that reviews data from all fifty states then develops and builds consensus around a set of key criminal justice metrics that drive budget and policy decisions. The program also creates a range of tools and resources to help local communities to adopt new data metrics. The program provides technical assistance and funding to selected states.

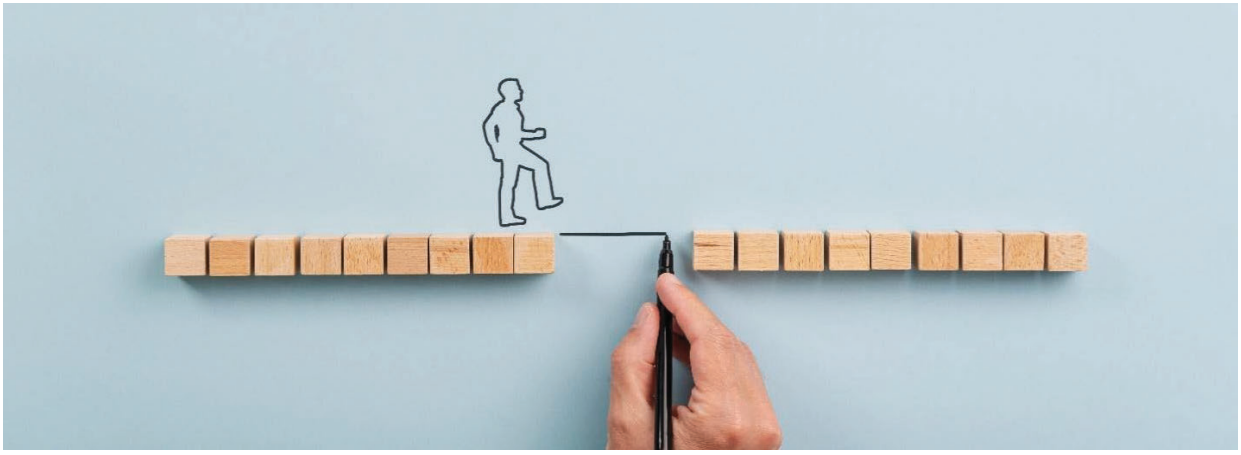
Measures for Justice. Measures for Justice is a nonprofit organization with a mission to make accurate criminal justice data available to spur reform. The organization offers tools and services to communities, including general consulting.

UNDERSTANDING CURRENT STATUTES AND BEST PRACTICES

As communities map gaps and opportunities at each intercept, it is especially important to understand the current laws and responsibilities. Oftentimes, compliance with existing statute is hindered by the lack of cross-system collaboration and a lack of clarity about which entity is responsible for the law's implementation. Courts are uniquely positioned in this regard to bring together stakeholders and mobilize cooperative efforts to implement the law collaboratively.

The Judicial Commission on Mental Health recently released the Fifth Edition of the Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book, which provides

community and justice stakeholders with a comprehensive overview of best practices and existing laws at each point at which people intersect or are at risk of intersecting with the justice system.

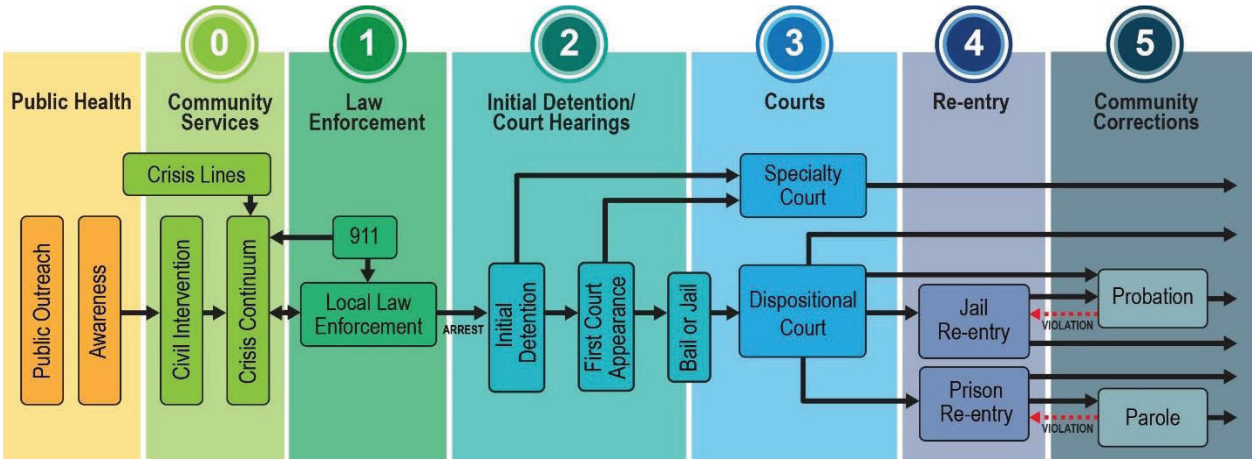


RESOURCES AND CHALLENGES AT EACH INTERCEPT

The primary objective of the workshop is to create a Sequential Intercept Model map. The workshop's facilitators work with the participants to identify resources and gaps at each intercept. This process is essential to success since the criminal justice system and behavioral health services are constantly changing, and identifying the gaps and resources allows for a contextual understanding of the local map. The map can also be used by planners to establish substantial opportunities for improving public safety and public health outcomes for people with mental health and substance use disorders by addressing the gaps and building on existing resources.

Prior to the workshop, a planning team of Burnet County leaders identified specific community goals:

- Facilitate mutual understanding, collaboration and relationship building between a diverse array of stakeholders, all of whom are dedicated to system transformation.
- Identify best practices, resources, gaps in services, and opportunities for improvement and innovation across all SIM intercepts
- Prioritize key steps toward system transformation and improved service delivery and identify relevant best practices.
- Create a longer-term strategic action plan, optimizing use of local resources and furthering the delivery of appropriate services.



INTERCEPT 0

Intercept 0 encompasses the early intervention points for people with mental illness, substance use disorder, and/or intellectual and developmental disability prior to possible arrest by law enforcement. This intercept captures systems and services designed to connect people with treatment before a crisis begins or at the earliest possible stage of system intervention.

INTERCEPT 0 RESOURCES

Workshop participants identified numerous resources already existing in the community that can support individuals with behavioral health challenges and divert them from the justice system.

Intercept 0 Community Services	
Mental Health & Behavioral Supports	
988 Bluebonnet Trails Community Services Crisis Hotline: 1-800-841-1255	
Austin Clubhouse	Austin Oaks Hospital
Bluebonnet Trails Community Services	Canyon Creek Behavioral Health
Cedar Crest Hospital	Cross Creek Hospital

Georgetown Behavioral Hospital	Local counselors and therapists
Phoenix Center	Rock Springs
Samaritan Center	
Health Care	
Ascension Seton Highland Lakes	Ascension Seton Marble Falls Health Center
Baylor Scott & White Medical Center Marble Falls	Burnet County Indigent Healthcare
Lone Star Circle of Care	
Veteran's Services	
TEXVET	VetRide
Veteran Service Officer Bill Worley	Burnet VFW
Housing	
Burnet Housing Authority	Endeavors
Llano Housing Authority	Marble Falls Housing Authority
Texas Housing Foundation	
Substance Use Recovery	
AA & NA	Communities for Recovery
His Joshua House	Infinite Recovery
Open Door Recovery House	OSAR Screening Services: Region 7
Personal Responsibility Recovery	Positive Recovery Centers
Radical Restoration Ministries	
Other Community & Neighborhood Supports	

Ark of Highland Lakes	Austin Shelter for Women and Children
CARTS Marble Falls	Community Resource Centers of Texas
The Helping Center of Marble Falls	Highland Lakes Family Crisis Center
Hill Country Children's Advocacy Center	HOPE Haus
Salvation Army Burnet County	Sharing the Harvest Kingsland
Society of St. Vincent de Paul	Lost Paws Dog Rescue – Burnet County

Housing and Hope in Burnet County

Dawn Capra, Director of Housing Advocacy for the Texas Housing Foundation, brings a practical and compassionate perspective to the challenges facing people with behavioral health needs in Burnet County. Through her work supporting individuals experiencing housing instability, substance use, mental health challenges, and justice involvement, she sees housing as a critical foundation for long-term stability and recovery.

Capra emphasized that stable housing can help prevent people from entering the criminal justice system while also supporting successful reentry for those leaving incarceration. She noted that many individuals face significant barriers to employment and housing, including lack of identification documents, transportation challenges, limited education, and difficulty accessing behavioral health services.

While Burnet County has some affordable housing resources and community partnerships, Capra described the overall housing landscape as limited, particularly for individuals who do not qualify for subsidized housing.

Looking ahead, Capra hopes the county can build a more coordinated and seamless system of care where providers work together to support individuals without forcing them to repeatedly retell traumatic experiences. Her vision is one of stronger collaboration, smoother referrals, and a community response that helps people move toward stability rather than continuing to cycle through crisis systems.

INTERCEPT 0 GAPS AND OPPORTUNITIES

Burnet County has a limited range of behavioral health providers, crisis response services, healthcare resources, and community-based supports. These include mental health providers, hospitals, crisis lines, faith-based organizations, housing resources, and substance use recovery services. Nonetheless, stakeholders consistently identified challenges related to how individuals and families access and move through this system of care.

A central theme that emerged is that, while services exist, they are not always experienced as a coordinated or easily navigable system, particularly for people seeking help during times of stress, crisis, or instability. Stakeholders noted that gaps in communication, awareness, and coordination can make it difficult to connect people to the right services at the right time, especially before situations escalate.

The community members participating in the SIM identified specific challenges, and developed a number of opportunities or innovations to address each challenge:

Limited awareness of available resources among community members and stakeholders:

- Increase community-wide education about mental health, substance use, and available services
- Develop and maintain centralized, accessible resource directories
- Expand outreach through trusted community settings such as churches, schools, and food pantries
- Explore mobile resource delivery models and community-based outreach approaches

Lack of coordination and communication across systems:

- Strengthen collaboration between behavioral health providers, healthcare systems, law enforcement, and community organizations
- Improve communication pathways to support more consistent referrals and follow-up

Insufficient housing options, including supportive and transitional housing

- Expand permanent supportive housing and transitional housing opportunities
- Explore coordinated entry approaches for individuals experiencing housing instability
- Strengthen partnerships across housing providers and community organizations

Transportation barriers limiting access to services

- Expand transportation options and partnerships (e.g., CARTS, community-based solutions)
- Develop and share a centralized transportation resource guide
- Incorporate transportation planning into service coordination efforts

Limited access to healthcare and behavioral health services

- Explore opportunities to expand local healthcare capacity, including primary care access
- Strengthen partnerships with regional behavioral health providers
- Expand medication assistance and access to care

Gaps in early identification and prevention of mental health and substance use challenges

- Increase early screening and identification efforts across community settings
- Expand prevention and early intervention strategies in schools and community organizations
- Improve identification of mental health and IDD needs across systems, including law enforcement

Underserved populations, including adolescents and individuals with substance use disorders

- Expand adolescent-focused substance use treatment and behavioral health services
- Increase access to services for individuals with co-occurring mental health and substance-use challenges

INTERCEPT 0 BEST PRACTICES

At each intercept, it is helpful to understand best practices emerging in communities throughout the country. While not every best practice will be relevant to Burnet County, especially when there are serious resource limitations, these practices provide a useful lens for identifying promising pathways forward. The best practices listed below may provide a reference point for Burnet County as it adapts best practices to its own unique challenges.

BEST PRACTICE: USE ALTERNATIVES TO THE CRIMINAL JUSTICE SYSTEM

Communities with the strongest outcomes do not lean on a single program. They build a connected set of crisis response options so that officers, dispatchers, and families always have

somewhere to turn besides arrest or the emergency department. The basic shape is simple: someone to call, someone to respond, and a safe place to go.

The research on integrated crisis systems is consistent. When call triage, mobile response, and clinical receiving locations are connected and not three separate programs, arrests, emergency department (ED) visits, and repeat crises all decline. No single piece does the job alone. What makes the difference is the handoff between pieces, and whether law enforcement trusts the system enough to use it by default rather than as an exception.

In Texas, Bexar County's coordinated infrastructure is the most established example, with documented reductions in jail utilization. Oklahoma's statewide investment in crisis-system capacity offers a state-level reference, with reductions in jail bookings and significant cost savings. Both are useful phone calls if your community is building from the ground up.

These factors contribute to a successful strategy:

- Continuous (24/7) operation across every component
- A drop-off door that opens in minutes, not hours
- Written agreements between law enforcement, behavioral health, EMS, and crisis centers
- Officer trust built deliberately, as it takes years to build and is easily lost

Any single unreliable component can reduce the positive impacts of another. If dispatch cannot route the call, if mobile response is slow, or if the drop-off door is not open, officers will default to what they know.

BEST PRACTICE: ESTABLISH CRISIS RECEIVING AND STABILIZATION CENTERS

Crisis receiving and stabilization centers are open-door facilities where officers, EMS providers, or walk-ins can bring someone in acute behavioral health crisis for rapid intake and short-term stabilization. Most people are stabilized and discharged within 24-hours with follow-up arrangements in place. The features that make the model successful are simple: individuals can drop someone off in minutes rather than hours, and the facility takes everyone regardless of acuity, insurance, or intoxication.

These centers reliably reduce jail bookings and ED overcrowding, and the clearest effect in the research is on hospital use and length of stay. The direct arrest-reduction case is emerging. The often-cited Miami-Dade figure (about 109 arrests across 50,000 crisis calls over five years) comes

from system reporting, not a controlled study. But officers consistently say the fast handoff is what makes the model work in practice, and without it they stop bringing people.

San Antonio's Restoration Center is the most widely known Texas example and the model most other Texas counties reference. Connections Health Solutions operates a scaled "no wrong door" network nationally and is a useful contact for technical assistance.

Factors that distinguish successful centers from centers that do not divert people from justice involvement include:

- 24/7 operation with a no-refusal intake policy
- Drop-off completed in under 10 minutes from the officer's perspective
- Capacity that can comfortably meet typical demand as well as surges in intakes
- Standing relationships with law enforcement, not just written agreements

The instances where these centers fail are predictable. Wait times grow. Exclusion criteria tighten. Capacity falls short of demand. Any of these will cause officers to stop using the center, and once they stop, rebuilding the habit takes longer than building it the first time.

BEST PRACTICE: DEPLOY MOBILE CRISIS TEAMS

Mobile crisis teams (MCT) send a behavioral health clinician, often paired with a Certified Peer Specialist, directly to the scene of a behavioral health call. The clinician leads the encounter. Officers may provide safety support but are not the primary responder. It is when these interventions are implemented in this manner that overall arrest reduction is a likely outcome. A 2025 Michigan study, the first real head-to-head comparison of mobile crisis, co-response, and police-only response, found significantly fewer arrests in the 11 months following an MCT dispatch than after a police-only response. Mounting evidence confirms that MCTs resolve a majority of behavioral health calls on the scene without further escalation and produce better follow-up linkage to outpatient care.

Denver's STAR initiative is the most widely studied clinician-led model in the country, with documented reductions in low-level arrests. Houston's Crisis Call Diversion Program is a Texas MCT model. Eugene, Oregon's CAHOOTS is the longest-running clinician-led crisis response team in the U.S. and a potential model for rural and small-metro communities.

Mobile crisis teams work when the surrounding system is built to support them:

- An adequate geographic coverage area
- Clear dispatch protocols that route the right calls their way
- A clinical destination (like a stabilization center) where the team can reliably bring individuals in crisis
- A staffing plan that holds up in rural and small-metro counties

An important caution when implementing a mobile crisis team: when the clinician can respond but there is nowhere to take the person, the intervention quickly loses its effectiveness. Staffing is also a constraint. Finding clinicians willing and available to do the work in rural counties is difficult.

BEST PRACTICE: BUILD CO-RESPONDER TEAMS

Co-responder programs send an officer and a behavioral health professional together to a crisis call, where the mental health worker leads the behavioral health engagement and the officer handles safety. Co-responder teams reliably reduce involuntary psychiatric detentions, increase awareness of community resources among people in crisis and their families, and reduce future crisis calls. The evidence on arrest and ED-visit reduction demonstrate favorable long-term reductions in arrests when paired with effective follow up and warm handoff to treatment providers. The Dallas Rapid Integrated Group Healthcare Team (RIGHT) Care program is an example of and a possible blueprint for creating successful co-responder initiatives.

Factors that lead to effective co-responder programs include:

- The mental health worker actually leads the encounter, not advises from the passenger seat
- A warm handoff to follow-up care after the call
- The team has a clinical destination available, not just an ED
- The program is treated as part of the broader continuum, not as the continuum itself

BEST PRACTICE: INVEST IN PEER-RUN CRISIS RESPITE

Peer respites are short-term, non-clinical, home-like settings staffed entirely by people with lived experience of mental illness or substance use recovery. Typical stays run 5 to 14 days. The focus is connection, de-escalation, and stabilization, and they often serve as a voluntary alternative to the ED or an inpatient unit for people who might engage with peers but not with clinical settings.

Research shows that peer-run crisis respite guests are about 70% less likely to use inpatient or ED services afterward than similar non-users. The consumer-experience data (people feeling heard, respected, more in control) is consistently stronger than in other clinical settings.

Thresholds' Living Room in Chicago is one of the best-known models, serving as a blueprint for communities wishing to invest in similar programming. Practical design and operating considerations include ensuring that the peer-run crisis respite is:

- Embedded in the broader crisis system with clear referral paths from MCTs and the crisis line
- Visible enough that the people most likely to use it actually know it exists
- Staffed entirely by certified peer specialists, not clinicians
- Trusted enough in the community that families and clinicians refer to it

Aside from the investment in peer-run crisis respite, which is modest in comparison to other clinical interventions, the primary constraint is workforce. Communities must ensure there are peer certification programs available to local residents, as the inability to recruit and train peers is the most common reason these programs underperform their potential.

BEST PRACTICE: EXPAND ACCESS TO HOUSING FOR PEOPLE IN THE JUSTICE SYSTEM WITH BEHAVIORAL HEALTH NEEDS

For people with serious mental illness, housing instability is one of the strongest predictors of repeat contact with police, EDs, and jails. In Texas, Local Mental Health Authorities and community partners coordinate housing through Medicaid, state programs, and federal supports. The Corporation for Supportive Housing is the national reference for program design and a useful first call. Texas HHS maintains state-level coordination. Counties will not solve the housing shortage on their own, but targeted strategies can make sure people leaving custody or crisis settings have at least one placement option that actually works. Some strategies counties have used successfully include:

- Landlord engagement programs that build a willing landlord pool
- Bridge housing to cover the gap between release and longer-term placement
- Recovery housing for people with co-occurring substance use disorders
- Pre-release housing planning that confirms a placement before the door opens

Importantly, the research is unambiguous on housing stability. Housing First reliably increases retention (typically 70 to 90% at 2 to 3 years versus 30 to 50% in treatment-first models) and

reduces ED visits and hospitalizations. Its effects on substance use and psychiatric symptoms are smaller and more mixed than many SIM documents imply. Its effects on arrest are real but modest on its own. They get larger when housing is bundled with assertive community treatment, peer support, or medications for opioid use disorder. Economic reviews put the return at roughly $1.44 for every $1 invested.

The Council of State Governments Justice Center recommends a four-step action plan for communities experiencing a lack of housing options for people with criminal records who also have mental health and substance use challenges:

Step One: Collaborate

Like SIM Mapping, addressing housing needs for justice-involved people with mental health and substance use challenges requires cross-system collaboration. By sharing data, identifying gaps, and coordinating strategies, communities can create leadership teams to guide efforts, strengthen existing services, and build partnerships with housing providers and landlords.

Step Two: Assess

Communities should analyze available housing resources, identify gaps, and use data from agencies such as mental health authorities and probation to understand housing needs. Shared data helps determine the types of housing needs - supportive, transitional, or sober living - and allows communities to anticipate demand, measure outcomes, and adjust strategies over time.

Step Three: Connect

Housing stability is critical to reducing recidivism and supporting recovery after arrest, detention, or incarceration. When agencies such as probation, parole, housing authorities, and crisis response teams coordinate efforts, they can quickly identify needs, prevent crises, and connect individuals to housing and support services.

Step Four: Expand

Although housing shortages affect most communities, coordinated planning allows partners to make more strategic investments. By using shared data instead of relying solely on subjective priorities, communities can help funders direct resources toward housing solutions that will have the greatest impact.

BEST PRACTICE: DEVELOP COMMUNITY PARAMEDIC CAPACITY

Community paramedicine extends the role of EMS. Paramedics receive additional training so they can respond to lower-acuity calls, do home visits with frequent EMS users, and connect people to services without automatically transporting to an ED. The model is particularly attractive in rural counties that cannot sustain a clinician-led mobile crisis team.

Recent studies show the model improves health engagement and reduces EMS call volume among frequent users. Pilot data from rural jurisdictions suggest real reductions in avoidable ED visits, in the range of 14 to 40%.

The factors that contribute to the success of a community paramedic program include:

- Clear medical and operational protocols that paramedics can act on
- Real authority to divert from traditional ED pathways
- A working list of community providers willing to accept the referral
- Telehealth back-up for clinical assessment when needed

The evidence also points to some cautions when implementing a program. Paramedics without referral options become another ride. Isolation from the local behavioral health system turns the program into transport with extra training. The model needs the same level of support and behind the scenes resource and training infrastructure that mobile crisis teams need.

BEST PRACTICE: STRENGTHEN FRONT-END ACCESS TO BEHAVIORAL HEALTH CARE

Limited access to routine behavioral health care is one of the biggest drivers of crisis-system involvement. When people cannot get in early, symptoms build until police or the ED become the default front door. The core practices for fixing this are the same in most places: same-day or walk-in intake, extended hours, telehealth, and warm handoffs (directly connecting with another provider while patient is still present) at the point a person first asks for help.

The evidence on engagement is clear. A 2023 study found that warm handoffs more than tripled the odds of mental health service engagement. Open-access scheduling consistently reduces no-show rates. Telehealth warm handoffs produce similar engagement gains and reach rural areas in-person models cannot.

In Texas, Tropical Texas Behavioral Health and Tri County Behavioral Healthcare are among the LMHAs that have moved toward same-day and walk-in access. Both are useful calls for counties redesigning intake. Nationally, the Certified Community Behavioral Health Clinic (CCBHC) model, covered separately later in this section, provides the clearest funded vehicle for this practice. Additional factors associated with successful front-end access strategies include:

- Treatment capacity that can absorb the newly engaged patients
- Care coordination that keeps people connected after the first appointment
- Follow-up protocols (warm handoffs, scheduled outreach) for the first 72 hours
- Telehealth integration that extends reach to rural and small-metro areas

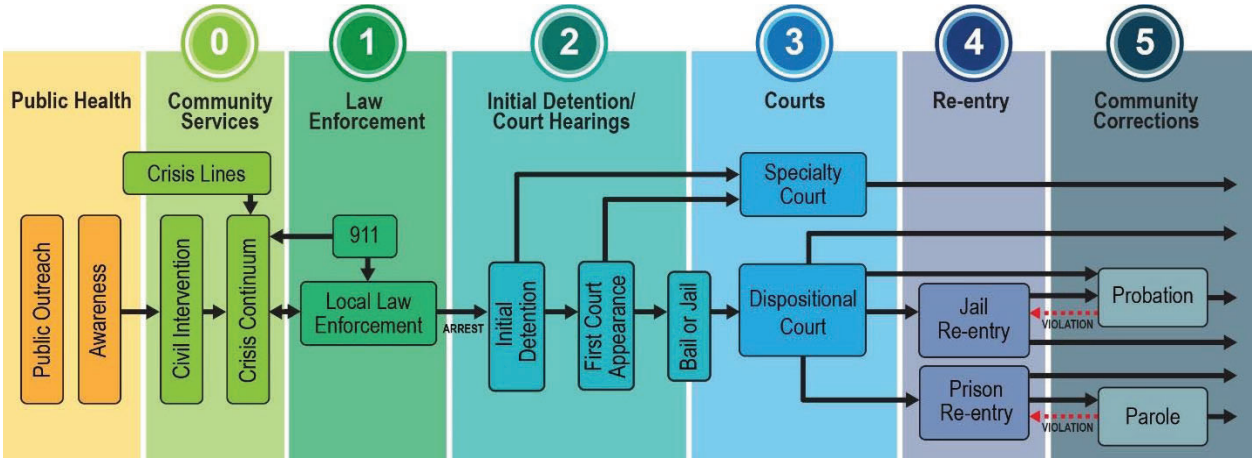
BEST PRACTICE: ADDRESS TRANSPORTATION AS A CORE ISSUE

Transportation shows up in just about every SIM conversation as a top barrier to behavioral health care, especially in rural Texas. When people cannot reliably get to an appointment, their conditions can deteriorate until they re-enter the system through the Emergency Department or an officer's car. The barrier itself is well documented. Urban Institute surveys find that more than one in five adults with limited transit access forgo care because they cannot get to it. The relationship runs in both directions. Anxiety and depression themselves make it harder to arrange a ride.

In Texas, LMHAs coordinate transportation directly, partner with EMS, or contract with providers. Voucher programs, ride-share partnerships, and regional coordination agreements are all in various stages of pilot. The Rural Health Information Hub is a useful cross-state reference for program design. One promising-practice example is the South Texas Transportation Rx program, run in partnership with the nonprofit Feonix Mobility Rising, which coordinates volunteer drivers, taxis, public transit, and rideshare through a single platform to fill rural transportation gaps.

What separates transportation programs that work from ones that do not:

- Predictability. People can count on the ride showing up
- Tied to the care coordination plan, not handled as an informal favor
- Integrated with the behavioral health system rather than parallel to it
- A clear point of accountability for who owns the ride



INTERCEPT 1

Intercept 1 encompasses initial contact with law enforcement and other emergency service responses. This intercept captures systems and services designed to divert people away from the justice system and toward treatment when safe and feasible.

INTERCEPT 1 RESOURCES

Intercept 1 Law Enforcement	
Bertram PD	Burnet CISD Police
Burnet County Constables	Burnet County Sheriff's Office
Burnet PD	Cottonwood Shores PD
Granite Shoals PD	Horseshoe Bay PD
LCRA Public Safety Department	Texas Parks and Wildlife Law Enforcement
Marble Falls PD	Marble Falls ISD School Resource Officers
Sunrise Beach Village PD	Texas Department of Public Safety (DPS)

Leadership in Crisis Intervention

Captain Mike Sorenson of the Burnet County Sheriff's Office has spent more than four decades working at the intersection of law enforcement and mental health crisis response. As the founder of the department's Crisis Intervention Team (CIT) program, Sorenson has helped reshape how Burnet County responds to individuals experiencing behavioral health crises through de-escalation, treatment connection, and diversion from incarceration whenever possible.

Under Sorenson's leadership, the county developed a collaborative crisis response approach involving local law enforcement, emergency departments, and behavioral health providers. Rather than defaulting to arrest, agencies are encouraged to contact the CIT team so trained personnel can assess situations and determine appropriate care and support.

Sorenson described this shift as one of the county's greatest successes. Individuals who may once have been taken to jail are now more likely to receive treatment, mental health services, or inpatient care when needed rather than cycling deeper into the criminal justice system.

He acknowledged that challenges remain, particularly continuing to build buy-in across all law enforcement agencies, because crisis response often requires more time and coordination than a traditional arrest.

Even with those challenges, Sorenson expressed hope about the growing collaboration across Burnet County and the community's increasing commitment to treatment and stabilization over incarceration for people experiencing behavioral health crises.

INTERCEPT 1 GAPS AND OPPORTUNITIES

Law enforcement in Burnet County frequently serves as a primary point of contact for individuals experiencing behavioral health crises. Stakeholders noted that officers often encounter situations involving mental health challenges, substance use, family instability, and circumstances that extend beyond traditional law enforcement roles.

Participants emphasized that while officers are committed to responding appropriately, they often face these situations without consistent access to clear pathways, real-time support, or diversion options. As a result, outcomes can vary depending on the situation, available resources, and connections at the time of the encounter. They emphasized that strengthening coordination, training, and available alternatives could provide law enforcement with more consistent options for safely responding to behavioral health needs.

Lack of clarity on crisis response pathways and appropriate points of contact

- Develop clear, shared protocols outlining response options for behavioral health crises
- Maintain and distribute updated contact lists, including after-hours resources
- Provide accessible resource tools for officers in the field
- Implement community paramedic program

Limited behavioral health training and specialized response capacity

- Expand mental health training for law enforcement personnel
- Increase availability of specialized mental health officers
- Provide training on emergency detention processes and behavioral health identification

Insufficient coordination between law enforcement and service providers

- Strengthen communication between law enforcement, EMS, behavioral health providers, and community organizations
- Develop co-responder models pairing law enforcement with behavioral health professionals
- Improve real-time connection to available services during crisis response

Limited diversion and crisis stabilization options

- Explore development of diversion centers and crisis stabilization facilities
- Expand access to detox and withdrawal management services
- Increase availability of short-term respite options

Gaps in after-hours behavioral health crisis services

- Expand access to behavioral health services outside standard business hours
- Strengthen coordination with mobile crisis outreach teams

INTERCEPT 1 BEST PRACTICES

BEST PRACTICE: DESIGNATE SPECIALIZED MENTAL HEALTH OFFICERS OR UNITS

Many law enforcement agencies have improved outcomes by designating officers or units with advanced training and experience in behavioral health response. These officers serve as internal subject matter experts, back up patrol officers in real time, and often take the lead on complex or repeat cases.

Research on police-mental health collaboration models indicates that specialized units improve coordination with behavioral health providers and increase the likelihood of diversion to services. Agencies with dedicated mental health officers use de-escalation more consistently and connect people to care more often.

In Texas, the Dallas and San Antonio police departments operate dedicated mental health units that work closely with Local Mental Health Authorities and crisis providers. In smaller and rural communities, the model is adapted by designating a subset of officers with enhanced training and strong relationships with behavioral health partners. In regions served by Tropical Texas Behavioral Health, designated officers function as key connectors between patrol and crisis response.

What makes a specialized unit effective in the field:

- Integration with daily patrol operations, not separation from them
- Clear roles that distinguish specialist from patrol response
- Active partnerships with LMHAs and community providers
- Dispatch protocols that actually route appropriate calls to the unit

BEST PRACTICE: ENSURE OFFICERS UNDERSTAND THEIR AUTHORITY AND DISCRETION TO DIVERT

Texas law gives officers two distinct authorities for diverting people in behavioral health crisis away from arrest, but legal authority alone has not produced consistent practice anywhere in the state. The gap between statute and field practice is the variable that most often determines whether someone ends up in jail or in care. Closing that gap requires department-level policy, training, and operational support.

Article 16.23 — Legal Authority to Divert from Arrest

Code of Criminal Procedure Article 16.23 directs law enforcement agencies to make a good-faith effort to divert individuals experiencing mental health or substance use issues to treatment when:

- there is an available and appropriate treatment center in the agency's jurisdiction to which the agency may divert the person;
- it is reasonable to divert the person;
- the alleged offense is a misdemeanor, other than one involving violence; and
- the mental health crisis or substance use issue is suspected to be the reason the person committed the alleged offense.

The Texas Judicial Commission on Mental Health has documented that implementation of Article 16.23 is uneven across the state, with many agencies operating without written policy or local guidance specifying what "available and appropriate" means in their jurisdiction. Research on police discretion in behavioral health encounters consistently finds that officer behavior tracks closely with department expectations: where supervisors visibly back the use of alternatives to arrest, officers use them; where expectations are ambiguous, outcomes vary widely between shifts, between officers, and between calls that look operationally similar.

Chapter 573 — Emergency Detention Without Warrant

The Texas Health and Safety Code Chapter 573 gives officers the authority to take a person into custody without a warrant when they have reason to believe the person has a mental illness, there is a substantial risk of serious harm to self or others, the risk is so imminent that intervention cannot wait, and the belief is grounded in the officer's own observation or a credible representation. Exercised with authority, training, and guidance, this pathway routes people into clinical assessment rather than booking.

However, in the absence of emergency department receiving capacity or clear procedures, the use of an Emergency Detention Without Warrant produces friction without benefit. Officers spend hours on transport and paperwork, the hospital screens and releases within a short window, and the same person is back in front of the same officers a few days later. That pattern is one of the most consistent sources of frustration for patrol officers in smaller jurisdictions.

Factors that lead to successful officer-level diversion include:

- Written department policy that names diversion as the preferred response for non-violent misdemeanors involving behavioral health, and emergency detention as the preferred response for qualifying crisis situations

- Field reference materials - printed, laminated, or in the electronic system - listing current diversion options, LMHA crisis line numbers, and the threshold criteria for warrantless emergency detention
- Initial and refresher training that covers legal thresholds, documentation requirements, and how to articulate observations in a way that is consistently appropriate for clinical and judicial review
- Supervisor reinforcement so officers feel backed when they use discretion, plus after-action review of diversion decisions (both successful and unsuccessful) to build institutional learning
- Active department-level participation in coordination with the LMHA, area hospitals, and JP/magistrate offices, surfacing system gaps rather than absorbing them quietly

BEST PRACTICE: USE CIVIL INTERVENTIONS WHEN APPROPRIATE

Civil interventions refer to legal processes by which people other than the person with mental illness can initiate treatment and includes initiation of civil commitment proceedings and court-ordered treatment, including assisted outpatient treatment (AOT). Civil commitment processes and AOT do not require the involvement of the police or the criminal justice system. Recently, states have begun to provide for civil interventions for behavioral health conditions other than mental illness, including substance use disorders.

Court-ordered treatment can be provided in the community or in an inpatient setting as determined by a clinical evaluation. Inpatient and outpatient treatment can be delivered sequentially or, alternatively, beginning with outpatient options and utilizing inpatient settings as needed. It is important to recognize that more coercive approaches are appropriate only after services have been offered to individuals and they have rejected them on a voluntary basis.

The research base on AOT is mixed: some multisite studies report gains in treatment adherence and reduced hospitalization, while broader federal reviews have been less conclusive. Outcomes tend to be strongest where court orders are paired with intensive voluntary services rather than relying on the order alone.

Most civil commitments in Texas start with an Emergency Detention. Emergency Detentions require a mental health crisis: that the individual displays a mental illness; that the individual displays a substantial risk of serious harm to themselves or others; that the risk of harm is imminent unless the individual is immediately restrained; and a statement of supporting facts describing specific recent behavior for the belief, including overt acts, attempts, or threats that were observed. The Emergency Detention may happen through either of two legal pathways:

- A law enforcement officer may take an individual to an inpatient facility through an Apprehension by Peace Officer Without a Warrant (APOWW, also known as an Apprehend and Detain or A&D) under Texas Health & Safety Code § 573.001; or
- A judge may issue a warrant under Texas Health & Safety Code § 573.011 authorizing a peace officer to transport the individual to an inpatient facility.

Psychiatric Advanced Directives, also known as Declarations for Mental Health Treatment, allow a person to control their mental health treatment in the event that they become unable to make treatment decisions at a later date. It may be possible for a person to carry these documents or pre-submit them to hospitals, jails, and other facilities.

Supported decision making allows individuals to make their own decisions and manage their affairs while receiving the assistance needed to do so. Resources about supported decision making include a handout, a toolkit, an explainer video, and sample agreement forms.

Guardianships can be used to support individuals who, due to age, disease, or injury, need help managing some or all their daily affairs. It should be noted that guardianship removes some of the individual's rights and privileges. More information on guardianships is offered by the Texas Guide to Adult Guardianship, and the Texas Guardianship Association.

Assisted Outpatient Treatment (AOT) Court Programs are programs in civil courts, typically probate courts, that use court-ordered community-based treatment to improve treatment outcomes and reduce involvement in the judicial system. Implementing an AOT Court explains how to set up an AOT court in Texas. The Texas AOT Practitioner's Guide explains how to operate an AOT Court in accordance with Texas laws and procedures.

BEST PRACTICE: EXPLORE PRE-ARREST DIVERSION

Counties across the country have implemented pre-arrest diversion programs, wherein police work with local human service and harm reduction providers to connect individuals with substance use and mental health challenges to appropriate resources in lieu of arrest. For instance, the Law Enforcement Diversion Program (LEAD), which originated in King County, Washington, gives greater authority to police to divert someone from arrest for a set of non-violent, substance-use related offenses and instead require the individual to engage with services in the community. Police remain involved with the service provider to ensure the individual is engaging in services. A similar program is the Yellow Line Project, which provides assessment and

service connection to individuals in lieu of arrest. Police can bring someone in for assessment and delay arrest conditional upon the individual engaging in services.

These programs and others like them can have profound impact on the lives of people with substance use and mental health challenges. According to an evaluation of the LEAD Program, people engaged in pre-arrest diversion programs were less likely to be arrested, more likely to engage in services, and more likely to take psychiatric medications. They were also less likely to experience overdose because the program helped to connect them with medication assisted treatment. These individuals were less likely to experience mental health crisis compared to those who were not referred to the program. All system partners saw the impact of the program, with fewer arrests, lower recidivism, and decreased pressure on a strained system.

BEST PRACTICE: PROVIDE CRISIS INTERVENTION TRAINING FOR LAW ENFORCEMENT

Specialized training, particularly Crisis Intervention Team (CIT) training, helps officers recognize behavioral health conditions, apply de-escalation, and connect people to services. The training is the foundation that other Intercept 1 practices build on.

Studies consistently show CIT improves officer knowledge, attitudes toward mental illness, and confidence in de-escalation. It is also associated with increased use of de-escalation in the field and improved direction into mental health treatment. The Texas CIT Association, including Shawn Edwards (Lavaca County Sherrif's Office CIT Captain and current president), has advanced scenario-based training that emphasizes real-world decision-making and connection to local care. The Association is the most useful Texas starting point for counties building or refreshing training programs.

Factors that lead to successful outcomes include:

- Scenario-based exercises tied to the actual local resources officers can use
- Refreshers and ongoing training, not just initial certification
- Supervisory reinforcement so officers feel supported when they choose diversion
- Clear communication about what receiving facilities and clinical partners are available

While CIT delivered in isolation does not move outcomes, it is foundational infrastructure that pays off when combined with cross-sector strategies to facilitate diversion from the ED and jail. The most common mistake is counting the training as the intervention itself.

BEST PRACTICE: CREATE DIVERSION CENTERS AND OTHER CLINICAL ALTERNATIVES TO ARREST

A clinical alternative to jail is a destination where an officer can hand off a person in behavioral health crisis or facing low-level non-violent charges, complete paperwork in minutes, and return to service. The model works when three conditions hold: the destination accepts everyone regardless of acuity, insurance, or intoxication; the handoff is fast and predictable from the officer's perspective; and downstream capacity exists for what happens after the officer leaves.

Three operational variants are most relevant for a small or mid-sized Texas county. They overlap in clinical content but differ in who they serve and how access happens.

Crisis Receiving and Stabilization

The defining condition is acute behavioral health crisis. Any door: officers, EMS, family, or the person themselves can initiate contact. No offense is required. Clinical work focuses on stabilization and disposition planning within twenty-four hours. The Bexar County Restoration Center in San Antonio is the most widely cited Texas example.

Pre-Booking Diversion

The defining condition is a low-level non-violent offense by someone with a history of mental illness. Active crisis is not required. The mechanism is officer-initiated routing of someone who would otherwise be booked, typically for a misdemeanor such as criminal trespass, to clinical engagement instead of jail. The Judge Ed Emmett Mental Health Diversion Center in Harris County, provides a strong Texas blueprint. Over its first five years, the Emmett Center reported approximately 8,800 diversions and a fifty percent reduction in subsequent bookings for participants.

Sobering Centers

The defining condition is acute intoxication that would otherwise produce a public-intoxication arrest or emergency department visit. The Austin/Travis County Sobering Center provides another Texas blueprint. The Center advanced the sobering center model by creating dedicated stimulant sobering capacity, an innovation other centers can apply with training and dedicated space.

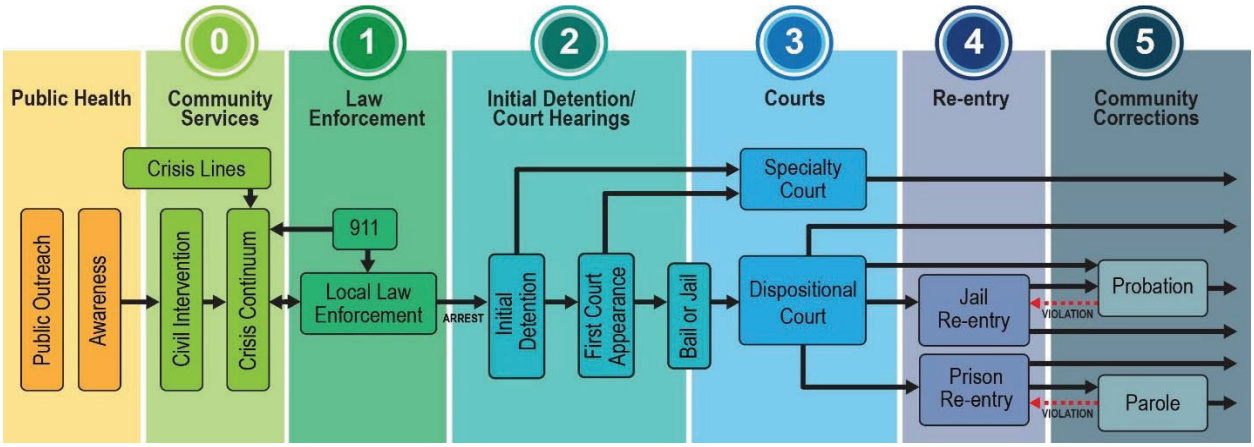
Clinical Service Categories

The clinical work in any of these facilities operates under one or more state crisis service categories defined by the Texas Health and Human Services Commission: Crisis Respite Unit (low-acuity, voluntary), Crisis Residential Unit (higher-acuity, structured), Extended Observation Unit (up to forty-eight hours), and Crisis Stabilization Unit (licensed inpatient-equivalent, up to

fourteen days). A single facility often integrates more than one type on a single campus. The Bluebonnet Trails Diversion Center in Georgetown layers Extended Observation Unit and Crisis Respite Unit capacity under a broader Diversion Center function. The Lubbock County Hope Center for Health and Wellbeing, operated by StarCare, is another Texas facility modeled on existing Texas diversion centers.

Factors leading to successful implementation include:

- Twenty-four-hour operation with a no-refusal intake policy
- Officer drop-off completed in roughly ten minutes
- Capacity sized to typical demand with reasonable surge tolerance
- Standing relationships between facility staff and law enforcement
- Clear transport protocols, including who covers transport when distance is significant
- For pre-booking diversion: a designated point of contact in the District Attorney's office
- For sobering centers: protocols accounting for substances beyond alcohol, with pathways into ongoing care



INTERCEPT 2

Intercept 2 encompasses people who are detained and have an initial hearing with a magistrate. This intercept is the first opportunity for judicial interaction in the criminal justice system, including intake screening, early assessment, appointment of counsel and pretrial release of those individuals with mental illness, substance use disorder, or intellectual and developmental disability.

INTERCEPT 2 RESOURCES

Intercept 2 **Pretrial/Detention**	
Burnet County Jail Administrators Captain Matt Kimbler Lt. Lou Armbruster	**Jail Medical and Psychiatric provided by** Bluebonnet Trails Turnkey Health
Magistrates Judge Tamara Tinney Judge Kristen Tice	

Identify Needs Early, Connect to Care

Judge Tamara Tinney, Chief Magistrate for Burnet County, plays a critical role at the front end of the county's justice system. Every individual who is arrested comes through her office, creating opportunities to identify behavioral health needs early and connect people to appropriate support and services. In addition to overseeing magistration and court-appointed attorneys, Tinney works closely on mental health screenings, Article 16.22 processes, and diversion efforts designed to help individuals stabilize rather than continue cycling through the criminal justice system.

For Tinney, the most rewarding part of the work is seeing people succeed after receiving treatment or support. She described hearing from individuals who were able to reconnect with mental health care, return to medication, or complete substance use treatment and begin rebuilding stability in their lives. She also makes a point to ask individuals directly about the barriers they faced so the county can better understand where systems are falling short and where improvements are needed.

Tinney highlighted several practical strategies that are helping support diversion efforts in Burnet County. Her office maintains and regularly updates a community resource guide that connects individuals to housing, food assistance, job resources, behavioral health care, and substance use services. She also described strong collaboration with Bluebonnet Trails Community Services to identify individuals in need of support and arrange appointments or services before they leave custody whenever possible. In some cases, diversion means connecting individuals to treatment providers; in others, it means reconnecting them with family members or support systems already present in the community.

At the same time, Tinney emphasized that transportation remains one of the county's most significant barriers. In a large rural county with limited transportation options, many individuals struggle to reach appointments, access medication, secure employment, or even get to food pantries. She noted that these gaps often contribute directly to people falling back into crisis and repeated system involvement.

Looking ahead, Tinney hopes the county can strengthen coordination across agencies and create smoother pathways to care and support. She expressed a strong desire to see more individuals leave jail with appointments, medication, and the resources necessary to remain stable in the community rather than returning to the same cycle of crisis and incarceration.

INTERCEPT 2 GAPS AND OPPORTUNITIES

At Intercept 2, Burnet County has processes in place for screening, magistration, and early legal representation. Stakeholders noted the involvement of magistrates in identifying behavioral health needs and facilitating some diversion efforts. Participants also identified challenges that can affect how consistently individuals are assessed, supported, and connected to appropriate services at this early stage.

This point in the system represents a critical opportunity to redirect individuals toward care rather than deeper justice system involvement. Below are key challenges and opportunities identified by participants.

Limited diversion options at early stages of justice involvement

- Expand pretrial diversion opportunities for individuals with behavioral health needs

Gaps in mental health screening and assessment processes

- Ensure screenings are conducted by qualified mental health professionals
- Strengthen consistency and quality of screening practices

Insufficient legal capacity and specialized expertise

- Increase availability of attorneys for timely appointment
- Expand training on mental health laws and behavioral health considerations
- Ensure defense representation at magistration

Challenges with medication continuity during detention

- Strengthen processes to ensure continuity of medications
- Improve coordination between detention and healthcare providers

Transportation and funding barriers impacting access to services

- Expand transportation options related to court and detention processes

INTERCEPT 2 BEST PRACTICES

BEST PRACTICE: IDENTIFY EARLY AND DIVERT WHEN APPROPRIATE

Every person that is arrested and brought to jail should be screened for mental health and substance use disorders and diverted when appropriate. Texas law provides some guidance for this process:

- **Continuity of Care Query (CCQ):** With limited exceptions, the Texas Administrative Code requires every jail to conduct a CCQ check on each individual upon intake into the jail. The CCQ is originated through the Department of Public Safety's Texas Law Enforcement Telecommunications System (TLETS), which initiates a data exchange with HHSC's Clinical Management for Behavioral Health Services system to determine if the individual has previously received state mental healthcare. The CCQ identifies whether an individual has sought services at a Texas local mental health authority (LMHA) in the previous three years. This information is often limited in nature and not as helpful as magistrates, judges, and lawyers would like it to be; the utility of this system depends on the accuracy of TLETS data.

- **Code of Criminal Procedure art. 16.22:** CCP 16.22 details a procedure for identifying a person's possible mental illness or intellectual disability at the earliest stages of—and throughout—a criminal proceeding. Under article 16.22, a magistrate must, under certain circumstances, order an expert to interview the defendant and otherwise collect information regarding whether the defendant has a mental illness or intellectual disability in order to alert the necessary stakeholders if the resulting report indicates possible mental illness or intellectual disability. Once the report is reviewed, diversion options like outpatient treatment, voluntary inpatient treatment, or involuntary civil commitment may be pursued.

- **Code of Criminal Procedure art. 17.032:** Pursuant to CCP 17.032, unless good cause is shown, the magistrate must release the person on personal bond if they are not charged with or previously convicted of a statutorily defined violent offense, the procedures in the statute were followed, and the conditions were met. The magistrate may include bond conditions that address behavioral health needs. Typical conditions of "mental health" bonds include requirements to: check in with the LMHA; abide by the LMHA's recommendations; possess no firearms; possess no marijuana, controlled substances, or cannabidiol (CBD); and attend all appointments for assessments and services. A "warm handoff" to the LMHA can help promote compliance with the conditions.

As discussed above, diversions for defendants with mental health disorders can provide a benefit to the defendant, the judicial system, and the community as a whole. Jail diversion occurs after an arrest has been made, but before an official charge from the state. This type of diversion can also be called a pre-charge diversion or a prosecutor-led diversion.

BEST PRACTICE: CREATE CROSS-SYSTEM REVIEW TEAMS

Cross-system collaboration reaches across fragmented services and systems to build constructive working relationships to accomplish goals. Teams composed of individuals across systems can work together to overcome challenges, such as funding silos, limited resources, and differences in system "cultures" or values.

Court liaisons provide a vital link to mental and behavioral health service providers during the life of court cases. Liaisons are typically clinically trained and connected either with a behavioral health provider or with the court. They are adept at providing program and treatment coordination and communicating with service providers and agencies outside of the court.
Community Diversion Coordinators play a critical role. Typical duties and responsibilities include:

- Engage stakeholders in education on the many diversion opportunities across the SIM.
- Assist the court and attorneys in evaluating cases and defendants to determine if a pathway other than jail would better serve the defendant and the community.
- Develop and foster collaborative relationships between the LMHA, local hospitals, the jail, and the courts.
- Coordinate the creation of treatment plans to ensure appropriate community support for individuals being released into the community.

Solid data and information sharing policies support strong cross-system collaboration. Data-driven indicators measure the effectiveness of behavioral health interventions and allow adjustments to be made to increase the effectiveness of those interventions. Data can also measure the cost effectiveness of behavioral health programs and allow policy makers to allocate resources more effectively. Coordinating data offers an opportunity to identify high cross-system utilizers. Data should be collected about individuals' progress and needs, responses to those needs, and efforts to improve mental health responses. Information sharing is required under Health and Safety Code Sec. 614.017 for continuity of care and continuity of services purposes for certain individuals with special needs.

BEST PRACTICE: APPOINT COUNSEL WITH MENTAL HEALTH TRAINING

There are several ways to increase the Burnet County defense bar's knowledge of mental health laws. One quick-fix recommendation is a focused education and training campaign. Burnet County could identify a larger group of local defense attorneys who can be champions for initiating an education and training campaign among the local defense bar association. These champions can utilize the assistance of TIDC, JCMH, TCDLA, or other entities to develop curriculum for local defense attorneys and to identify the best methods for implementing education and training among the local defense bar. Training should cover several topics regarding mental health laws, including early identification (16.22), transfer and dismissal (16.22(c)(5)), mental health bond conditions (17.032), competency restoration (46B), information sharing (HIPAA & HSC Chapter 611), and resources available from the local mental health authority, Bluebonnet Trails.

In addition to training on mental health laws, the local defense bar can learn how to fully and skillfully incorporate the principles of Holistic Defense and how to effectively use social workers in criminal defense. The Bronx Defenders is a public defender nonprofit that pioneered a ground-breaking, nationally recognized model of defense that achieves better outcomes for defendants. The Bronx Defenders' Center for Holistic Defense provides technical assistance and training to public defender organizations and individual practitioners and currently provides assistance in 38 states, including Texas.

The local defense bar can play an integral role in enhancing Burnet County's justice system by addressing the circumstances driving people into the criminal justice system and the consequences of that involvement. A Harvard Law Review article evaluated the holistic defense model and determined the impact of the program included a reduction in the likelihood of custodial sentences by 16% and expected sentence length by 24%.

There are four pillars at the core of holistic defense:

- Seamless access to services that meet legal and social support needs.
- Dynamic, interdisciplinary communication.
- Advocates with an interdisciplinary skillset.
- A robust understanding of, and connection to, the community served.

Several counties across Texas have begun to incorporate these principles into their local defense organizations, including:

- Harris County
- Bexar County
- Travis County

Many counties offer incentives for defense attorneys to seek training and specialization in mental health laws by offering additional compensation for court appointment cases to attorneys with specialized training or creating a special "wheel" full of attorneys specializing in mental health laws who can be appointed to cases with a defendant identified as having a mental illness. Williamson County is an example of a county with an indigent defense plan that incorporates special qualifications for a mental health wheel.

It is best practice to appoint counsel as soon as practicable upon arrest of an individual. Appointing counsel at an earlier point in the case, such as before indictment, will reduce the length of time people are housed in jail waiting for evaluations or waiting for transportation to facilities for evaluation or restoration. Instead, defense counsel can meet the client and begin assessing the client's needs. Opportunities to better utilize early appointment of counsel include:

- Creating and implementing a process for appointed defense counsel to access certain evidence in the case file, such as the offense report and arrest warrant affidavit, prior to indictment, so they can begin working on the case.
- Creating and implementing a process for defense counsel to request competency evaluations prior to indictment.
- Discussing possibilities of diversion in lieu of competency restoration in certain cases.

BEST PRACTICE: TRANSFER TO CIVIL COURT VIA CCP 16.22(C)(5)

Pursuant to Code of Criminal Procedure art. 16.22(c)(5), after an interview of the defendant provides clinical evidence to support a belief the defendant is a person who has a mental illness or intellectual disability, the court may release the defendant on bail while charges remain pending and enter an order transferring the defendant to the appropriate (civil) court for court-ordered outpatient mental health services under Chapter 574 of the Health and Safety Code. Case transfer under this statute is only for cases where the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person.

BEST PRACTICE: RIGHT-SIZE COMPETENCY RESTORATION SERVICES

The competency to stand trial process is designed to protect the rights of people who do not understand the charges against them and are unable to assist in their own defense. Long-established constitutional law mandates that a criminal prosecution may not proceed unless the defendant has sufficient present ability to consult with their lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against them. This standard is echoed in Texas statute.

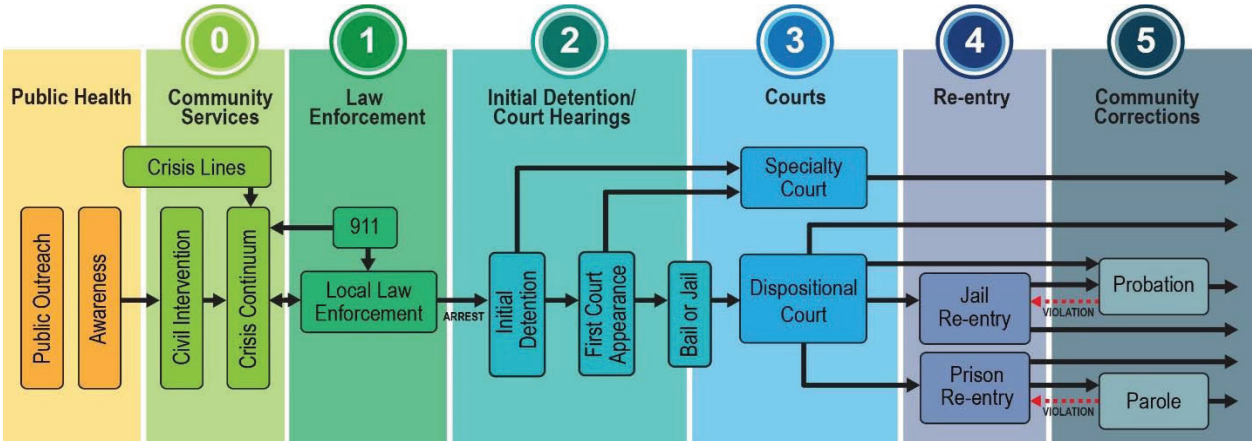
Under Texas Code of Criminal Procedure article 46B.004, if the mere suggestion of incompetency is raised in a case, the court must conduct an informal inquiry to assess whether there is "some evidence from any source" that would support a finding of incompetency. If so, then the court is required to stay (or stop) all proceedings and order a competency exam. If an individual is found competent, the case will proceed to determine adjudication. If the individual is found incompetent, judges can order services, including mental health treatment and medications designed to restore the defendant to legal competence.

For more than a decade, Texas and other states have seen an increasing number of individuals in county jails who have been found to be incompetent to stand trial but who do not have access to a state hospital bed to begin an inpatient competency restoration process. In Texas, several thousand people fail to receive competency restoration services for months or even years, presenting severe challenges to county jails and great personal cost to the individuals. Actively monitoring the local waitlist can help find ways to divert individuals. One method is to have an individual re-evaluated if there is reason to believe the person is stabilized while receiving jail-based mental health services.

JCMH and HHSC partnered to create a statewide initiative to Eliminate the Wait and right-size competency restoration services through education, training, and technical assistance. Every effort should be made to streamline determinations of competency and related proceedings. There is also a growing consensus that because of the likelihood of an increased length of incarceration and confinement, the competency process should be reserved for defendants who are charged with serious crimes, and others should be diverted to treatment.

Outpatient competency restoration and jail-based competency restoration programs are alternative competency restoration options provided by community-based services and in-jail services, respectively. For individuals who meet the criteria, these local programs are effective alternatives to using state hospital beds.

Involuntary medication frequently restores competency for individuals and allows for a more rapid return to the community than involuntary hospitalizations. (Read more at: https://mentalillnesspolicy.org/medical/involuntary-medication.html). Rather than requiring cumbersome guardianship proceedings, the Mental Health Code permits treating physicians to seek court orders to allow the administration of psychoactive medications to persons who lack capacity to consent to such medication. The court-ordered medication process cannot be used for Class B offenses; these cases may be good candidates for transfer to civil court under CCP 16.22(c)(5).



INTERCEPT 3

Intercept 3 encompasses people who are held in pretrial detention at the local jail or released to the community while awaiting disposition of their criminal cases. This intercept includes constitutional protections, services that prevent the worsening of a person's mental or substance use symptoms, and interventions that connect individuals with community treatment options.

INTERCEPT 3 RESOURCES

Intercept 3 Courts	
The Honorable J. Allan Garrett 33rd District Court	The Honorable Evan Stubbs 424th District Court
The Honorable Cody Henson County Court at Law	The Honorable Cheryll Mabray Child Protection Court of the Hill Country
Justice of the Peace, Precinct 1 Roxanne Nelson	Justice of the Peace, Precinct 2 Lisa Whitehead
Justice of the Peace, Precinct 3 Jane Marie Hurst	Justice of the Peace, Precinct 4 Frank Reilly
Burnet CSCD Pre-Trial services	Burnet County 33rd/424th Drug Court

Building Stability Beyond Jail

Lieutenant Lou Armbruster of the Burnet County Jail described the jail's role as closely connected to the broader network of courts, behavioral health providers, and reentry services across the county. Working alongside the magistrate's office, mental health deputies, and Bluebonnet Trails Community Services, the jail helps connect individuals with diversion opportunities, behavioral health care, and reentry resources whenever possible.

Armbruster emphasized that one of the county's greatest challenges is what happens after release. Many individuals struggle with transportation, housing, medication access, and keeping appointments, all of which can contribute to repeated involvement in the criminal justice system.

She also highlighted the strong communication between the jail, courts, probation, parole, attorneys, and other agencies as one of the county's strengths. At the same time, she noted significant gaps in local behavioral health infrastructure, particularly the lack of nearby inpatient treatment and competency restoration facilities.

Looking ahead, Armbruster hopes the community can continue strengthening collaboration while expanding access to basic needs such as housing, transportation, treatment, and ongoing support after release from jail. She emphasized that helping people stabilize in the community is essential to reducing repeated involvement in the justice system.

INTERCEPT 3 GAPS AND OPPORTUNITIES

Burnet County has an engaged judiciary and some specialty court infrastructure, including a post-adjudication drug court. Stakeholders also noted the involvement of multiple courts across the county. At the same time, participants identified gaps in behavioral health integration, competency restoration options, and coordination that can affect how individuals move through the system.

Delays in services, limited alternatives, and variability in available options can create challenges in aligning court processes with behavioral health needs.

Lack of mental health-specific court infrastructure and coordination

- Explore development of mental health courts or specialized dockets
- Strengthen coordination between courts and behavioral health providers

Limited competency restoration options

- Explore development of outpatient competency restoration (OCR)
- Consider jail-based competency restoration (JBCR) options
- Establish regular competency staffing processes

Gaps in medication continuity and court-ordered treatment

- Improve coordination with Bluebonnet Trails for individuals returning from competency restoration
- Expand use of court-ordered treatment when appropriate

Challenges in tracking and coordinating care for individuals with behavioral health needs

- Develop systems to track individuals through court processes
- Strengthen coordination of care and follow-up

INTERCEPT 3 BEST PRACTICES

BEST PRACTICE: USE ALTERNATIVE SENTENCING WHEN POSSIBLE

Post-trial diversion and alternative sentencing options provide opportunities to direct individuals to rehabilitation-focused interventions that balance the interests of justice with treatment. Most importantly, they avoid incarceration for individuals who meet certain sentencing conditions. Often involving suspended sentences and/or probation, alternative sentencing can be as creative and flexible as a judge and community resources will allow. Examples of alternative sentencing include community service, assisted outpatient treatment, and other required participation in appropriate treatment, including problem solving courts. Pursuant to Code of Criminal Procedure art. 46B.004(e), the prosecutor may dismiss all charges pending against a defendant after the issue of the defendant's incompetency to stand trial is raised.

BEST PRACTICE: SEEK TO ESTABLISH MENTAL HEALTH SPECIALTY COURTS OR DOCKETS

A "mental health court program" under Texas Government Code § 125.001 has the following essential characteristics:

- integrates and provides access to MI and ID treatment services in processing cases in the court system;
- uses a non-adversarial approach involving prosecutors and defense attorneys to (1) promote public safety and (2) protect the due process rights of program participants;
- promotes early identification and prompt placement of eligible participants in the program;
- requires ongoing judicial interaction with program participants;
- diverts people with mental illness or intellectual disability to needed services in lieu of prosecution;
- monitors and evaluates program goals and effectiveness;
- facilitates continuing interdisciplinary education on effective program planning, implementation, and operations; and
- develops partnerships with public agencies and community organizations, including LMHAs/LBHAs.

Appendix 2 at the end of this report provides additional resource recommendations on mental health and other specialty court programs that Burnet County may find useful. The Texas Judicial Commission on Mental Health has a wealth of relevant resources and technical assistance.

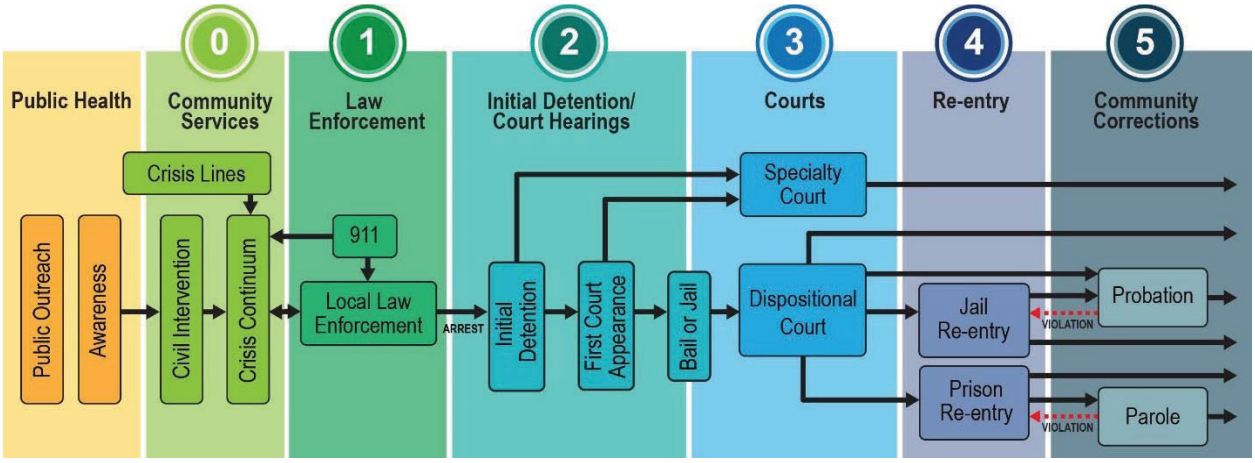
BEST PRACTICE: INCREASE USE OF PEERS FOR JUSTICE-INVOLVED INDIVIDUALS

Certified peers such as Mental Health Peer Specialists, Recovery Support Peer Specialists, and Reentry Peers can make a significant difference for justice involved individuals. The National Judicial Task Force describes examples of how certified peers can add value in court settings.

In reality, certified peers can be utilized effectively at every intercept. Pairing a certified peer with someone with mental health and substance use challenges can foster success for those released on bond conditions or placed on probation.

In studies on the use of peers for justice-involved individuals, researchers found statistically significant improvement in mental health outcomes. They found reduced anxiety and depression, and justice-involved individuals felt more confident that they could abstain from substance use. People paired with peers were less likely to have their bond, probation, or parole revoked. The chance of re-arrest was reduced from 43% to 22%.

More information about certification of peers is available earlier in this report.



INTERCEPT 4

Intercept 4 encompasses people who are planning for and transitioning from jail or prison into the community. Services in this intercept include strong protective factors for justice-involved people with mental illness, substance use disorder, or intellectual and developmental disabilities re-entering a community. These services should include detailed, workable plans with seamless access to medications, treatment, housing, and healthcare coverage.

INTERCEPT 4 RESOURCES

Intercept 4 Reentry	
Texas Workforce Solutions Rural Capital Area	Salvation Army Burnet County
Texas Christian Women's & Men's Job Corps	Texas Housing Foundation Navigators at Community Resource Centers of Texas

INTERCEPT 4 GAPS AND OPPORTUNITIES

Stakeholders identified a number of services that support individuals returning to the community, including workforce programs, housing resources, and behavioral health services. However, participants also noted that the transition from incarceration to the community can be

challenging, particularly when coordination is limited or when key supports are not in place at the time of release.

Successful reentry often depends on timely connection to housing, medication, employment, and ongoing care.

Lack of stable housing options for individuals returning to the community

- Expand transitional and supportive housing options
- Strengthen coordination across housing providers

Gaps in continuity of care, particularly medication access

- Improve coordination to ensure individuals leave custody with medications
- Strengthen connections to community-based providers prior to release
- Implement Reentry Peer Support

Limited access to employment and workforce opportunities

- Expand partnerships with workforce development programs
- Increase engagement with employers

Barriers to accessing benefits and services upon release

- Provide assistance with benefits applications prior to release
- Improve coordination to support timely access to services

Transportation challenges affecting reentry success

- Expand transportation options for individuals returning to the community
- Develop targeted resource guides

INTERCEPT 4 BEST PRACTICES

BEST PRACTICE: PROVIDE REENTRY PLANNING

Transition plans offer guidance for community reentry. A comprehensive plan identifies expectations, resources, and services to guide individuals towards independence. Individuals should play an active role in creating their transition plan.

The most effective reentry planning occurs when the planning begins at intake and continues throughout the individual's time in jail. Community-based providers should be engaged in this planning process. Coordination between community providers and the jail - sometimes called jail in-reach - can increase the likelihood of a smooth transition, including medication access upon release, warm hand-offs to service providers, and immediate access to benefits and health care coverage.

In jail, time is of the essence. The time someone remains detained in jail can vary from hours to months. There is rarely a set day or time someone will be released. Even when the individual has been convicted and is serving a sentence in county jail, they will likely not have a determinate day of release, as county sheriffs have authority to give time credits based on number of days served.

Therefore, it is imperative to seize each day as an opportunity to help people prepare for success following release. At a minimum, this might mean providing them with a list of relevant resources. Staff could also help to facilitate connection with services by setting an appointment for them. To the extent authorized by law, jails should assist people in obtaining benefits prior to release by pre-screening for eligibility and starting the application paperwork.

If someone needs substance use treatment, the jail staff could coordinate with the local mental health authority to facilitate the Outreach, Screening, Assessment, Referral (OSAR) process. Similarly, if someone is in need of vocational training, jails can partner with Goodwill or the workforce development board to connect them with those training opportunities. They might consider inviting these providers into the jail to orient people to available services and to do intake. Jails might also go so far as to initiate short-term vocational training and on-the-job training programs for people inside.

BEST PRACTICE: PROVIDE REENTRY PEER SUPPORT

Reentry peer support, described in "The Power of Lived Experience" in the Background section of this report, can be a helpful resource in developing and implementing individualized transition plans. Peer support is one of the most effective engagement strategies for justice-involved individuals, particularly during reentry. Individuals with lived experience are uniquely positioned to build trust, support recovery, and help navigate complex systems.

Research shows that peer support improves engagement in treatment, reduces substance use, and increases retention in services. For justice-involved populations, peers are especially valuable during transitions, helping individuals navigate housing, benefits, treatment systems, and supervision requirements.

In Texas, Certified Reentry Peer Support Specialists are increasingly integrated into jail and community-based programs, providing support both prior to release and during reentry. In practice, peers may meet individuals in jail, develop reentry plans, and continue working with them in the community to maintain engagement. The Texas HHS peer services portal and SAMHSA peer support toolkit are useful starting points for counties building this capacity.

Peer support tends to add the most value during reentry at these transition points:

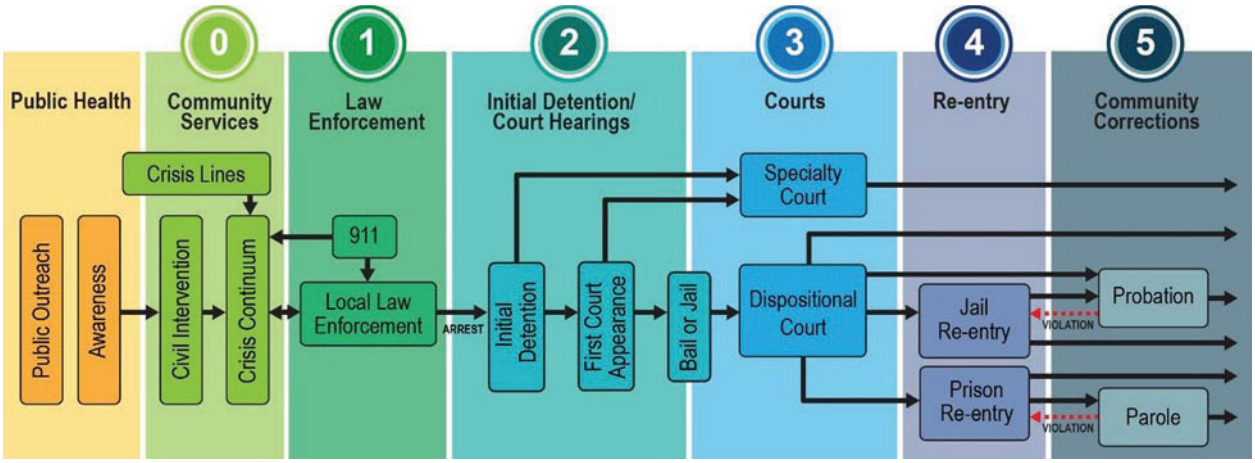
- Pre-release engagement that builds trust before the door opens
- Post-release navigation of housing, benefits, and treatment systems
- Re-engagement after a missed appointment or a setback
- Coordination with treatment providers and case managers as part of a care team

BEST PRACTICE: EXPAND ACCESS TO RECOVERY HOUSING

Recovery housing programs provide a safe, supportive, and drug free environment for people with substance use challenges, especially those transitioning out of jail or inpatient treatment. These programs, such as Oxford Houses, foster mutual accountability and provide a sense of community. Recovery housing has been shown to decrease relapse rates and criminal involvement.

Typically, these are ordinary residential homes with one or two people per bedroom. Residents are often required to engage in recovery programming outside of the home. Often, the residents themselves create and enforce the rules for entry and continued residency, and mutually decide when and if someone can remain in the program if they do not abide by standards.

Communities interested in expanding the number of recovery housing options can contact Recovery People for information.



INTERCEPT 5

Intercept 5 encompasses people under correctional supervision who are usually on probation or parole as part of their sentence, as part of the step-down process from prison, or as required by other state statutes. This intercept combines justice system monitoring with person-focused service coordination to establish a safe and healthy post-criminal justice lifestyle.

INTERCEPT 5 RESOURCES

Intercept 5 Community Supervision
Burnet County CSCD Community Supervision

The Human Side of Supervision

Cristina Meza, a Community Supervision Officer serving the northern portion of Burnet County, works closely with individuals on felony probation who are often navigating both substance use and mental health challenges. With nearly a decade of experience, Meza described probation not simply as accountability, but as an opportunity to understand the barriers people face and connect them with the support needed to succeed.

Meza explained that many individuals on probation experience co-occurring mental health and substance use disorders, particularly involving methamphetamine use. Using the Texas Risk Assessment System (TRAS), probation officers help identify behavioral health needs and connect individuals to services through providers such as Bluebonnet Trails Community Services. Throughout the interview, Meza emphasized how probation officers often develop a deep understanding of the people on their caseloads and are able to recognize when someone is beginning to deteriorate.

At the same time, Meza identified important limitations within the current crisis response system. She expressed concern that some assessments rely too heavily on self-reporting and may fail to capture the larger picture when individuals underreport symptoms or substance use. She also described situations where officers clearly observed signs of psychosis or crisis, yet individuals still failed to meet the narrow criteria for emergency intervention.

Despite these challenges, Meza spoke with hope about the individuals who successfully rebuild their lives while on probation. She described seeing people regain custody of their children, maintain sobriety, secure housing, and complete supervision successfully. She also highlighted the importance of strong partnerships between probation, behavioral health providers, and community supports in helping individuals achieve long-term stability.

INTERCEPT 5 GAPS AND OPPORTUNITIES

At Intercept 5, stakeholders identified several existing supports, including behavioral health services and case coordination. At the same time, participants noted challenges that can affect long-term stability and success, particularly for individuals with complex needs. Meeting supervision requirements can be difficult when individuals face barriers related to housing, transportation, employment, and access to care.

Limited housing options for individuals on supervision

- Expand housing options, including for individuals with complex needs
- Increase access to housing near services and supports

Gaps in services for specific populations

- Increase training and support for community supervision clients with IDD
- Expand co-occurring substance use and mental health disorder treatment options for people on community supervision.

Transportation barriers affecting compliance and engagement

- Expand transportation options, including after-hours availability
- Integrate transportation planning into supervision requirements

Probation conditions overwhelming for some clients with behavioral health challenges

- Explore flexibility in supervision requirements to support stability
- Incorporate reentry peer support

INTERCEPT 5 BEST PRACTICES

BEST PRACTICE: CREATE SPECIALIZED BEHAVIORAL HEALTH SUPERVISION THAT MATCHES INDIVIDUAL NEED AND STABILITY

Traditional probation and parole models are often not designed for people living with serious mental illness, substance use disorders or co-occurring behavioral health conditions. Supervision conditions such as frequent office visits, community service obligations, multiple treatment appointments, and strict compliance expectations can quickly become overwhelming for individuals already struggling to maintain housing, medication access, employment, or basic daily functioning.

As a result, what appears to be "noncompliance" is frequently the result of untreated symptoms, transportation barriers, housing instability, cognitive limitations, or competing survival needs rather than intentional refusal to comply. When supervision conditions are not aligned with a person's behavioral health needs and level of stability, community supervision can unintentionally become a pathway back to jail.

A growing body of research and practice shows that supervision is most effective when it is individualized, treatment-oriented, and proportionate to both risk and clinical need. Specialized

behavioral health caseloads allow probation and parole officers to work more effectively with individuals experiencing mental illness or co-occurring disorders by reducing caseload size, increasing coordination with treatment providers, and focusing supervision on stabilization, recovery, and long-term engagement rather than surveillance alone.

In Texas, several jurisdictions have implemented specialized mental health supervision models that reflect these principles. Harris County Community Supervision and Corrections Department (CSCD), for example, operates specialized mental health caseloads that pair trained supervision officers with behavioral health providers and wraparound services for individuals with significant mental health needs.

Key elements of effective behavioral health supervision include:

- Specialized caseloads staffed by officers trained in behavioral health, trauma, and crisis response
- Smaller caseload sizes that allow for individualized supervision and relationship-building
- Supervision conditions focused on treatment engagement, safety, and stabilization rather than excessive compliance requirements
- Flexible reporting structures, including phone or community-based check-ins when appropriate
- Strong coordination between supervision officers, behavioral health providers, courts, and community supports
- Attention to transportation, medication access, housing, and other practical barriers that directly impact compliance and recovery

PRIORITIES FOR CHANGE

Following the discussion on gaps and opportunities, the participants brainstormed priorities that might address gaps and help the community seize opportunities. They produced dozens of suggestions. They were then asked to rate the priorities on a one-five scale:

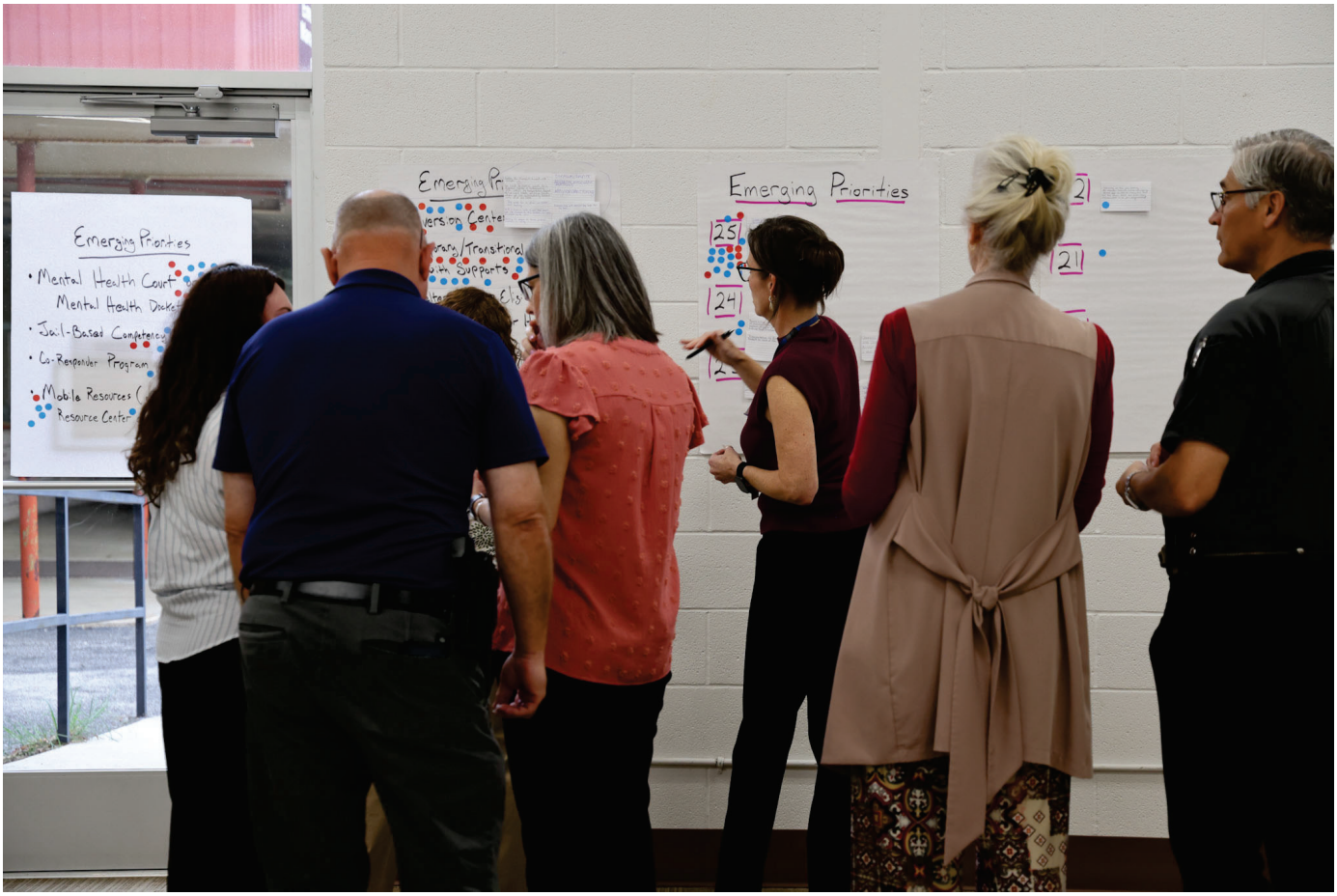
5 = Idea would have tremendous impact, and we should work on it immediately
1= Might be a good idea, but not a high priority at this time

After five rounds of community members reading and rating the ideas, participants identified a list of high/immediate, moderate/near future, and priorities for later

Burnet County Adult SIM Priorities	
High/Immediate	Mental Health Court/Docket
	Comprehensive Housing Strategy
	Jail Based Competency Restoration
	Co-Responder Program
	Expand Peer Programming
	Diversion Center
Moderate/Near Future	Officer Mental Health Response Training
	Expand Mobile Community Resource Center Territory
	Updated List of Community Resources
	Transportation
	Respite Facilities
Priorities for Later	Residential Detox Beds
	Expedited Benefits Prior to Jail Release
	Flexible Probation Requirements
	Dedicated Mental Health Beds

Participants were given three adhesive dots to vote for their top priorities. They wrote their initials on the ideas that they were willing to give their time and effort to make a reality in Burnet County. At the end of this process, four key priorities emerged.

- **Priority 1: Behavioral Health Leadership Team**
- **Priority 2: Comprehensive Housing Strategy**
- **Priority 3: Diversion Center**
- **Priority 4: Mental Health Court/Docket**



ACTION PLANS

Workshop participants were invited to join one of the four priority groups to create an action plan. Each team developed a plan with objectives and near/long term tasks. Afterwards, each group reviewed the plans developed by other teams. All participants were encouraged to make suggestions and raise considerations for these plans, thereby helping each team to improve upon the plans. The teams identified a time and date for their next meetings, as well as champions to coordinate communication among team members.

The purpose of the action planning activity was to create a site-specific action plan with clearly defined, attainable, prioritized short-term and long-term steps addressing the gaps generated earlier in the workshop. The plans will be further refined and implemented by the team following the workshop.

The action plans on the following pages are the initial drafts developed during the course of the workshop. The teams have already made specific plans to continue meeting, so these drafts will not reflect the work done after the workshop and prior to the publication date of this report. Readers should contact team members for the most current information on these action priorities.

PRIORITY 1: BEHAVIORAL HEALTH LEADERSHIP TEAM

Purpose: *Our priority is to create a multidisciplinary group for interagency coordination, cooperation, and communication that is dedicated to identifying local behavioral health needs and advancing best-practice solutions to address them.*

Priority champions: Marc Bittner & Ed Hashbarger

Objectives:

- Bring together CRCG, representation from each school district (Special Education/Counseling), DSHS, DFPS, and TJJD
- Develop a threat-assessment subcommittee/team
- Engage the Ministerial Alliance and Ark (Foster Care Taskforce)
- Explore similar models from other rural counties
- Include Fire and EMS on the team

Tasks:

- Map team members' strengths
- Accumulate data: what resources exist, especially to inform group goals
- Establish structure, organizational meeting, clear agenda for what are we doing

Feedback:

- Boshears Center for Exceptional Programs
- Findhelp.org resource list
- Invite Burnet SHAC; Chief Kyle (Burnet CISD); Shellie Pearce; Stacey Rush (Assistant Superintendent, Burnet CISD); Amanda Langley (Fire); Truancy Courts
- Include behavioral health hospitals
- Differentiate this group's goals and purpose from the Behavioral Health Taskforce
- Recruit a commissioner to engage with the Behavioral Health Leadership Team

Next meeting: Wednesday, May 13, 2026, at 9:00 AM, AgriLife Auditorium, 607 N. Vanderveer, Burnet, TX

Burnet County Data

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
16.22s Issued	12	12	22	21	25	20	25	22	22	23	9	14	**227**
CIT Contact	4	3	0	3	2	0	0	4	2	15	0	0	**33**
BBT Contact	22	33	18	34	51	10	3	20	22	21	11	6	**281**
Diverted to Family	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Diverted to Facility	0	0	0	0	1	1	0	2	1	0	0	0	**5**
Diverted via BBT	1	1	0	0	0	0	0	1	1	0	0	0	**4**
Diverted via CIT	1	1	0	0	1	1	0	1	0	0	0	0	**5**

2023
275 calls[1]
2024
323 calls 8 individuals waitlisted for state hospital bed 1 individual removal based on revaluation Average wait: 297 days
2025
282 calls 4 individuals waitlisted for state hospital bed 1 individual removal based on revaluation 1 individual waitlisted from 170 days 2 individuals currently waitlisted since September 2025
2026 (as of April 14, 2026)
97 calls 3 individuals waitlisted since March 2026
(January 2024-today)
Average wait for state hospital bed: 281.5 days

[1] Totals include calls received for an Emotionally Disturbed Person(s), Agency Assist - EDP's, hospital requests for Mental Health Officer transport to mental health facility, and mental health evaluations performed.

RESEARCH AND PRACTICES RELATED TO PRIORITY ONE

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 1, the priority planning team might benefit from considering these relevant best practices:

Cross System Collaboration

Create Cross System Review Teams

Some County/Regional Examples:

- Denton County Behavioral Health Leadership Team
- Texoma Behavioral Health Leadership Team
- McKenna Behavioral Health Leadership Team
- Dallas County Behavioral Health Leadership Team

PRIORITY 2: COMPREHENSIVE HOUSING STRATEGY

Purpose: Our priority is to build a coordinated housing strategy that addresses barriers, innovates, and is decentralized.

Priority champions: Dawn Capra & George Perry

Objectives:

- Align housing, reentry, justice system, and community resources
- Set benchmarks and track progress
- Set priority population (reentry, probation, parole)
- Create a housing pipeline matched to level of need
- Leverage and strengthen existing housing providers
- Address resident concerns
- Include certified peers

Tasks:

- Convene partners, assign roles, and develop strategy
- Define Year 1 priority population
- Map current resources (ensure accountability for providers)
- Create tracking strategy and data
- Formalize partnerships with probation, drug court, etc. (address criminal history barriers)
- Address criminal history

Feedback:

- Case management
- No inventory
- Identify service gaps within existing tasks
- Coordinate with diversion. They are like emergency housing
- If you identify a grant and need assistance applying, please reach out to me - Tiffany Guerrero, Bluebonnet Trails

Next meeting: Thursday, May 28 at 2:00 PM via Zoom

RESEARCH AND PRACTICES RELATED TO PRIORITY TWO

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 2, the priority planning team might benefit from considering these relevant best practices:

Expand Access to Housing for People in the Justice System with Behavioral Health Needs

Expand Access to Recovery Housing

PRIORITY 3: DIVERSION CENTER

Purpose: *Our priority is to develop a place to be for people in crisis until we find the next best place.*

Priority champions: Amanda Coleman & Mike Sorenson

Objectives and Tasks:

- Gather data to clarify the precise need we're trying to address.
  - Access to substance use treatment and medical detox?
  - Emergency detentions?
- Identify other Texas communities that created diversion centers:
  - Call to learn more
  - Visit most relevant
- Clarify legal constraints and other requirements for different types.
  - Voluntary v. involuntary
  - Nursing contract to cover gaps?
  - Could be a separate extended observation unit within a medical facility (but check JCAHO constraints)
  - Some diversion center models are not owned by the LMHA
  - Pre- or post-arrest?
- Search for graduate students to do feasibility study.
- Explore potential partners.
  - Surrounding counties
  - Hospitals (Rural Texas Strong grant program?)
  - 10 counties - CapCOG?

Feedback:

- Coordinate with Priority 2 (Comprehensive Housing Strategy)
- Identify liabilities
- Conduct cost analysis
- An embedded extended observational unit (48 hours) is most helpful to law enforcement
- Consider regional options in the feasibility study
- Llano and Blanco counties are interested in a diversion center
- Hospitals can be concerned about liability
- Ascension Seton has a new hospital with a 190-bed behavioral health facility
- Contact Ron Conningham, board member at Llano Hospital
- Strong financial opportunity—favorable reimbursement rates

- Are diversion centers controversial? Not when they are used as a resource for law enforcement
- Staffing is difficult—how do we stay competitive?
- Who is eligible? Don't want it filled up with people out of region
- Need to look at resources for where to go after

Next meeting: Monday, June 1, 2026, at 11:00 AM via MS Teams (Amanda to send link)

RESEARCH AND PRACTICES RELATED TO PRIORITY THREE

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 3, the priority planning team might benefit from considering these relevant best practices:

Use Alternatives to the Justice System

Crisis Receiving and Stabilization Centers

Create Diversion Centers and Other Clinical Alternatives to Arrest

PRIORITY 4: MENTAL HEALTH COURT/DOCKET

Purpose: *Our priority is to treat people with mental health needs and decrease recidivism.*

Priority champions: Eduardo Arredondo & Jonathan Lemuel

Objectives:

- Build the Mental Health Docket model
- Establish a champion judge
- Coordinate with community parters to ensure medication compliance, housing, transportation, etc.

Tasks:

- Establish a meeting within 30 days for all decision-makers and stakeholders (CA/DA, judges, probation, PDO, LMHA)
- Determine whether felony vs. misdemeanor, pre-trial vs. post-adjudication
- Create rules and expectations
- Observe larger counties' current models and apply best practices
- Examine data at 90 days and 6 months

Feedback:

- SUD is here to support
- Bell County Mental Health Status Docket
- Jessica Miller and Maria Kapadria can share insight from Williamson County (Wilco) programs
- The Judicial Commission on Mental Health has resources on this and can also provide free technical assistance: https://www.texasjcmh.gov/programs-and-initiatives/mental-health-courts/

Next meeting: Tuesday, May 19, 2026, at 4:00 PM (venue TBD)

RESEARCH AND PRACTICES RELATED TO PRIORITY FOUR

Earlier sections of this report discuss best practices along the SIM continuum. With respect to Priority 4, the priority planning team might benefit from considering these relevant best practices:

Seek to Establish Mental Health Specialty Courts and Dockets

APPENDICES

APPENDIX	TITLE
Appendix 1	Commonly Used Acronyms
Appendix 2	General Resources
Appendix 3	Charts
Appendix 4	Burnet County SIM Map
Appendix 5	Workshop Participant List
Appendix 6	Workshop Agenda
Appendix 7	Key References

APPENDIX 1| COMMONLY USED ACRONYMS

A&D – Apprehend & Detain	AOT – Assisted Outpatient Treatment	BJA – Bureau of Justice Assistance
CCO – County Clerk's Office	CCP – Code of Criminal Procedure	CCQ – Continuity of Care Query
CDC – County District Clerk	CIRT – Crisis Intervention Response Team	CIT – Crisis Intervention Team
CSCD – Community Supervision and Corrections Department ("probation")	CSO – County Sheriff's Office	DAO – District Attorney's Office
D/M – Dismiss or Dismissal	HB – House Bill	HHSC – Health and Human Services Commission
IDD – Intellectual or Developmental Disability	JBCR – Jail Based Competency Restoration	JCMH – Judicial Commission on Mental Health
LE – Law Enforcement	LIDDA – Local IDD Authority	LMHA – Local Mental Health Authority
MAC – Managed Assigned Counsel Program	MH – Mental Health	MHC – Mental Health Court
MI – Mental Illness	MOU – Memorandum of Understanding	MSU – Maximum Security Unit
OCA – Office of Court Administration	OCR – Outpatient Competency Restoration	PC – Probable Cause
PD – Police Department	PDO – Public Defender's Office	PH – Public Health
PTI – Pretrial Intervention	SAMHSA – Substance Abuse & Mental Health Services Administration	SB – Senate Bill
SH – State Hospital	TASC – Texas Association of Specialty Courts	TCIC – Texas Crime Information Center
TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments	TIDC – Texas Indigent Defense Commission	TLETS – Texas Law Enforcement Telecommunications System

APPENDIX 2| GENERAL RESOURCES

FUNDING RESOURCES

Council of State Governments Justice Center https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/funding-resources/	DOJ Office of Justice Programs https://www.ojp.gov/funding/explore/current-funding-opportunities
Humanities Texas https://www.humanitiestexas.org/grants/apply	The Meadows Foundation https://www.mfi.org/
Office of the Texas Governor https://gov.texas.gov/organization/financial-services/grants	Substance Abuse and Mental Health Services Administration https://www.samhsa.gov/grants
Texas Health & Human Services Commission https://www.hhs.texas.gov/business/grants	Texas Indigent Defense Commission http://www.tidc.texas.gov/funding/
U.S. Department of the Treasury: Assistance for State, Local, and Tribal Governments https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments	U.S. Grants https://www.usgrants.org/texas/personal-grants

GRANT WRITING RESOURCES

Grants.gov https://www.grants.gov/web/grants/applicants/applicant-training.html	HHSC Funding Information Center https://www.dshs.texas.gov/fic/gwriting.shtm
Nonprofit Guides http://www.npguides.org/index.html	Nonprofit Ready https://www.nonprofitready.org/grant-writing-classes
Texas Specialty Court Resource Center http://www.txspecialtycourts.org/training-grant.html	University of Texas Grants Resource Center https://diversity.utexas.edu/tgrc/

MENTAL HEALTH COURT PROGRAM RESOURCES

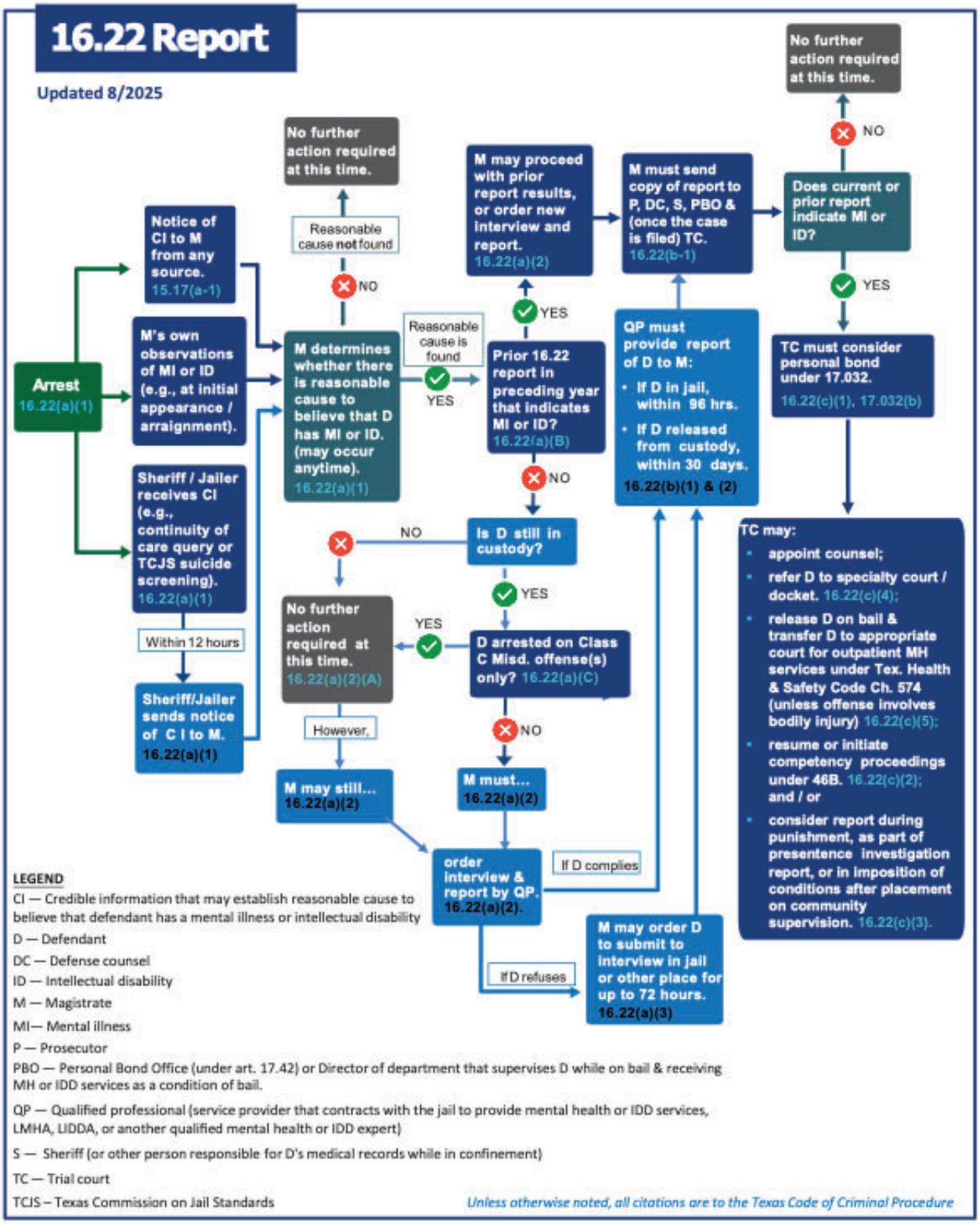
Council of State Governments Justice Center – *Developing a Mental Health Court: An Interdisciplinary Curriculum* https://www.arcourts.gov/sites/default/files/Mental%20Health%20Courts%20-%20Planning%20Guide.pdf	Council of State Governments Justice Center – *A Guide to Collecting Mental Health Court Outcome Data* https://csgjusticecenter.org/wp-content/uploads/2020/01/MHC-Outcome-Data.pdf
Council of State Governments Justice Center – *A Guide to Mental Health Court Design and Implementation* https://csgjusticecenter.org/wp-content/uploads/2020/01/Guide-MHC-Design.pdf	Council of State Governments Justice Center – *Mental Health Courts: A Guide to Research-Informed Policy and Practice* https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/CSG_MHC_Research.pdf
Council of State Governments Justice Center – Mental Health Court Learning Modules https://csgjusticecenter.org/projects/mental-health-courts/learning/learning-modules/	Judicial Commission on Mental Health: *10-Step Guide* http://texasjcmh.gov/media/czaoapye/mhc-the-10-step-guide.pdf
Judicial Commission on Mental Health: *Texas AOT Practitioner's Guide* https://www.texasjcmh.gov/media/svlj51l4/texas-aot-practitioners-guide.pdf	Judicial Commission on Mental Health http://texasjcmh.gov/technical-assistance/mental-health-courts/
Texas Specialty Court Resource Center http://www.txspecialtycourts.org/	Treatment Advocacy Center https://www.treatmentadvocacycenter.org/wp-content/uploads/2024/03/Dismiss-Upon-Civil-Commitment-with-AOT-Handbook.pdf

TECHNICAL ASSISTANCE RESOURCES

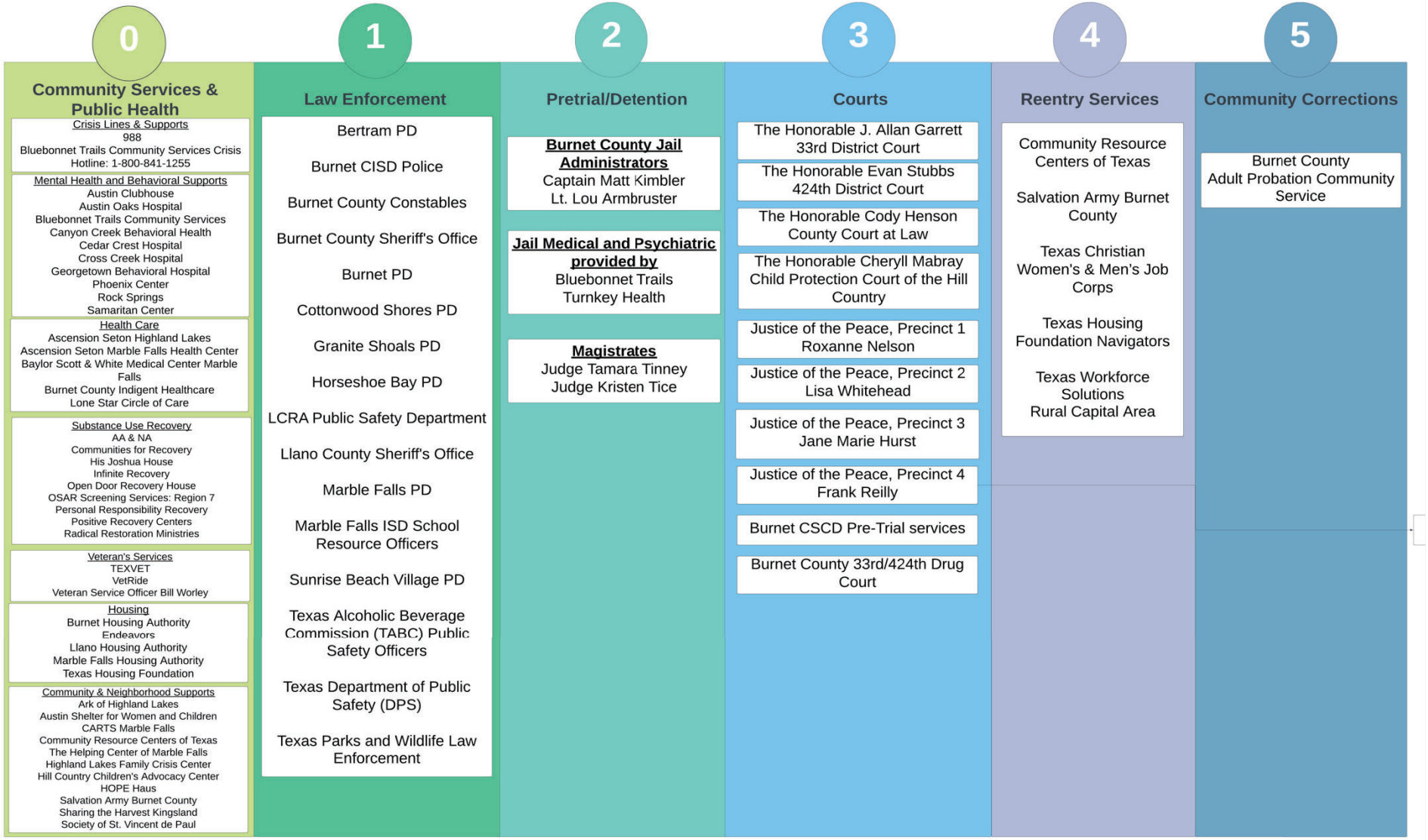
Activities of the Service Members, Veterans, and Their Families Technical Assistance Center https://www.samhsa.gov/smvf-ta-center/activities	Correctional Management Institute of Texas http://www.cmitonline.org/technical-assistance.html
Doors to Wellbeing: National Consumer Technical Assistance Center https://www.doorstowellbeing.org/	HHSC's Technical Assistance Center https://txbhjustice.org/services/sequential-intercept-mapping

Judicial Commission on Mental Health http://texasjcmh.gov/technical-assistance/	Council of State Governments Justice Center https://csgjusticecenter.org/resources/justice-mh-partnerships-support-center/
National Center for State Courts https://www.ncsc.org/services-and-experts/areas-of-expertise/access-to-justice/tech-assistance	National Family Support Technical Assistance Center https://www.nfstac.org/request-ta
National Mental Health Consumers' Self-Help Clearinghouse https://www.mhselfhelp.org/technical-assistance	NPC Research https://npcresearch.com/services-expertise/technical-assistance-and-consultation/
Opioid Response Network https://opioidresponsenetwork.org/	Technical Assistance Collaborative https://www.tacinc.org/what-we-do/customized-ta-training/
Texas Specialty Court Resource Center http://www.txspecialtycourts.org/tta_bureau.html	

APPENDIX 3| 16.22 PROCESS FLOW CHART



APPENDIX 4| BURNET COUNTY SIM MAP



APPENDIX 5| PARTICIPANT LIST

First Name	Last Name	Role	Agency
Tana	Aiken	Manager/Comprehensive Care Mgmt	BS&W Medical Center Marble Falls
Lou	Armbruster	Lieutenant	Burnet County Sheriff's Office
Eduardo	Arredondo	County Attorney	Burnet County
Kelly	Bazie	Assistant District Attorney	Burnet County
Amber	Besancon	Community Supervision Officer	Burnet County
Millicent	Bindseil	Constable	Burnet County, Pct. 4
Marc	Bittner	Chief Juvenile Probation Officer	33rd & 424th Jud. Dist. Juv. Prob. Dept.
Sheri	Bloom	Assistant District Attorney	Burnet County District Attorney's Office
Kathryn	Bowen	Clinic Program Manager	Bluebonnet Trails Community Services
Calvin	Boyd	Sheriff	Burnet County Sheriff's Office
Carisa	Brawley	Assistant Public Defender	North Hill Country Pub. Defender's Off.
Alexandria	Brooks	Court Clerk	Burnet County Magistrate
Stacey	Calabro	Public Health Nurse	Dept of State Health Services (Region 7)
Dawn	Capra	Director of Housing Advocacy	Texas Housing Foundation
Kathrine	Cholcher	Executive Director	Highland Lakes Family Crisis Center
Cheryl	Coldwater	Physician	Big Sky Pediatrics
Amanda	Coleman	Chief Crisis Program Officer	Bluebonnet Trails Community Services
Jessica	Cornelison	Administrative Assistant	Open Door Recovery House
Julianna	Cotton	Clinical Social Worker	Highland Lakes Family Crisis Center
Colleen	Davis	First Assistant County Attorney	Burnet County
Christina	DeLoach	PBIS and Crisis Services Coordinator	Marble Falls ISD
Penny	Dickerson	Warden	Texas Department of Criminal Justice
Hope	Ellett	Drug Court Officer	Adult Probation
Shana	Fancher	Executive Director of Special Services	Marble Falls ISD
Erika	Finmark	RN Comprehensive Care Manager	BS&W Medical Center Marble Falls
John	Green	Service Extension Representative	Salvation Army

Scott	Green	Investigator	North Hill Country Public Defender
Amber	Greer	Executive Director	North Hill Country Pub. Defender's Off.
Greg	Grim	Trauma Program Manager	BS&W Medical Center Marble Falls
Tiffany	Guerrero	Chief of Staff	Bluebonnet Trails Community Services
Amanda	Hackett	MCOT&YCOT Program Manager	Bluebonnet Trails Community Services
Vaughn	Hamilton	Paramedic, Comm. Outreach Coor.	Marble Falls Area EMS
Mike	Harnisch	Constable Pct 1	Burnet County
Alyssa	Hashbarger	Volunteer	VFW Post 6974 Burnet
Eduardo	Hashbarger	Senior Vice Commander	VFW Post 6974/EMS Burnet
Michelle	Haslacker	TCOOMMI Director	Bluebonnet Trails Community Services
Rebecca	Haynes	TCOOMMI ICM	Bluebonnet Trails Community Services
Cody	Henson	Judge Burnet County Court at Law	Burnet County
Tommy	Holloman	Sales	Granite Hills Chevrolet
Andrea	Hoppock	Director of Crisis Services	Bluebonnet Trails Community Services
Shannon	Huggins	Program Dir. - Substance Use Treat.	Management & Training Corporation
Jayme	Ingram	Court Coordinator	Burnet County Court at Law
Rose	Jones	Legal Advocate	Highland Lakes Family Crisis Center
Justice	Kaigler	Assistant Public Defender	North Hill Country Pub. Defender's Off.
Maria	Kapadia	Director of Specialty Programs	Bluebonnet Trails Community Services
Jennifer	Kelly	Behavioral Health Account Manager	Cross Creek Hospital / Ascension Seton
Nathan	Kight	Assistant Public Defender	North Hill Country Pub. Defender's Off.
Rebecca	Lange	Attorney	Brown, Lacallade & Lange, P.C.
Jonathan	Lemuel	Director of Forensic Services	Bluebonnet Trails Community Services
Ivan	LePendu	First Assistant Public Defender	North Hill Country Pub. Defender's Off.
Kimberly	Lewis	Major	Texas Department of Criminal Justice
Daisha	Lucio	ER Nurse Manager	Baylor Scott and White
Andrea	Lyon	Lic. Chem. Dependency Counselor	Bluebonnet Trails Community Services
Mike	Maples	Chief Executive Officer	Bluebonnet Trails Community Services
Paula	Mays	Executive Director	Open Doors Recovery

Corinne	McCann	Service Coordinator	Lost Paws Dog Rescue
Jessica	Miller	Chief Health Programs Officer	Bluebonnet Trails Community Services
Tracy	Miller	Legal Assistant	Law Office of Shell and Shell
Alexis	Mills	Community Supervision Officer	Adult Probation
Matthew	Mitchell	Public Safety Manager	Baylor Scott and White
Michelle	Moore	Chief Public Defender	North Hill Country Pub. Defender's Off.
Marcella	Morris	Assistant Public Defender	Burnet Public Defender's Office
Lucy	Murphy	Housing Innovation Manager	Texas Housing Foundation
Kevin	Naumann	Executive Director	Ark of Highland Lakes
Roxanne	Nelson	Justice of the Peace, Pct. 1	Burnet County
Melissa	Noah	OSAR Region 7 Supervisor	Bluebonnet Trails Community Services
Katy	Oliver	Site Coordinator	Christian Women's Job Corp
Scott	Orrison	Deputy	Burnet County Sheriff's Office
Chris	Orton	1st Resp. Advocate/Crit. Incident Resp.	Bluebonnet Trails Community Services
Madeline	Parker	Administrative Director	Burnet County
Shellie	Pearce	SUD SME	Bluebonnet Trails Community Services
Kaiia	Perkins	Mental Health Caseworker	North Hill Country Pub. Defender's Off.
George	Perry	Pastor	St. Frederick Baptist Church
Kiley	Phillips	Communications Manager	Texas Judicial Comm. on Mental Health
Skylar	Pope	Magistrate Court Clerk	Magistrate's Office
Kaitlin	Puckett	District Social Worker	Marble Falls ISD
Trisha	Ratliff	Assistant Chief	Marble Falls Police Department
Leslie	Ray	Constable, Pct. 1	Burnet County
Annie	Reed	Owner and Therapist	The Well Counseling Services
Frank	Reilly	Justice of the Peace, Pct. 4	Burnet County
Angel	Rios	Emergency Room Nurse Supervisor	Baylor Scott and White Marble Falls
Jennifer	Rock	CRCG Regional Coordinator	Dept of State Health Services (Region 7)
Jan	Rose	Owner/Operator	Taylor-Rose Ranch
Lynore	Samford	Program Director	Opp. for Will./Burnet Co.- Head Start

Chris	Sanders	Lead Social Worker	North Hill Country Pub. Defender's Off.
Elyse	Sellmann	Director of Engagement	Ark of Highland Lakes
Rosana	Sielaff	Prevention and Recovery Advocate	Bluebonnet Trails Community Services
Allison	Smith	Executive Director	Texas Housing Foundation
Chelsea	Smith	Public Health & Prevention Specialist	Department of State Health Services
Danna	Smith	LSW Social Worker/Case Mgmt Liaison	Reg. 7 DSHS Spec. Health & Soc. Serv.
Mike	Sorenson	Captain Support Services	Burnet County Sheriff's Office
David	Speed	Assistant General Counsel	Baylor Scott and White
Venishia	Taylor	TCOOMMI Jail Diversion Coor.	Bluebonnet Trails Community Services
Staci	Terrell	Operational Review Sergeant	Texas Department of Criminal Justice
Nicole	Terry	Community Supervision Officer	33rd/424th Judicial District CSCD
Perry	Thomas	District Attorney	District Attorney's Office
Stephen	Thomas	Texas Divisional Headquarters	Salvation Army
Tamara	Tinney	Chief Magistrate	Burnet County
Ramon	Torres	Guest	Bluebonnet Trails Community Services
Alan	Trevino	Chief Deputy	Burnet County Sheriff's Office
Teresa	Trusner	Pastor	First Christian Church Burnet
Trish	Walker	Housing Navigation CRC	Texas Housing Foundation
Kathy	Walton	Social Worker/Case Management	Ascension Seton Highland Lakes Hosp.
Lisa	Whitehead	Justice of the Peace, Pct. 2	Burnet County
Jennifer	Wills	ER Manager	Ascension Seton Highland Lakes Hosp.l
Bryan	Wilson	County Judge	Burnet County

APPENDIX 6| WORKSHOP AGENDA

Sequential Intercept Model Mapping Workshop

Burnet County
Wednesday, April 29, 2026
AGRILIFE Auditorium, 607 N S Vandeveer St, Burnet, TX

Purpose and Goals:

- Facilitate mutual understanding, collaboration and relationship building between a diverse array of stakeholders, all of whom are dedicated to system transformation
- Identify best practices, resources, gaps in services, and opportunities for improvement and innovation across all SIM intercepts
- Prioritize key steps toward system transformation and improved service delivery and identify relevant best practices
- Create a longer-term strategic action plan, optimizing use of local resources and furthering the delivery of appropriate services

AGENDA

8:30 am	**Registration & Networking**	
9:00 am	**Opening Remarks**	Welcome & Community Goals
9:20 am	**Orienting to This Work** Lynda Frost	Hopes for the Mapping Process Why Collaboration Matters
9:40 am	**Overview of Judicial Commission** Christine Busse	
9:45 am	**Overview of SIM Mapping** Doug Smith	Overview of Model Importance of Lived Experience
10:30 am	**Break**	
10:45 am	**Establishing Priorities** Lynda Frost	Identify Possible Priorities Identify Opportunities for Collaboration
11:45 am	**Lunch**	
12:20 pm	**Action Planning** Doug Smith	Group Work Presentation to Full Group
1:40 pm	**Break**	
1:55 pm	**Refining the Action Plan** Doug Smith	Gallery Walk Group Work
2:35 pm	**Next Steps & Summary** Lynda Frost	Upcoming Meetings Individual Next Steps
3:00 pm	**Adjourn**	

APPENDIX 7| KEY REFERENCES

1	JUDICIAL COMMISSION ON MENTAL HEALTH, *TEXAS MENTAL HEALTH AND INTELLECTUAL DISABILITIES LAW BENCH BOOK* (5th Ed. 2025-2027), https://www.texasjcmh.gov/media/krucujnj/abb-digital-9-26-25.pdf.
2	NATIONAL CENTER FOR STATE COURTS, FAIR JUSTICE FOR PERSONS WITH MENTAL ILLNESS: IMPROVING THE COURT'S RESPONSE 19 (2018), https://www.neomed.edu/wp-content/uploads/CJCCOE_10-Dave-Byers-COURT-RESOURCES-Mental-Health-Protocols-Oct-2018.pdf. *See also*, https://www.ncsc.org/behavioralhealth.
3	POLICY RESEARCH ASSOCIATES, THE SEQUENTIAL INTERCEPT MODEL: NEXT STEPS (HOW TO MAXIMIZE YOUR SIM MAPPING WORKSHOP), https://express.adobe.com/page/dSrgsE34zIea9/. *See also*, https://www.prainc.com/sim/.
4	SAMHSA GAINS CENTER, DEVELOPING A COMPREHENSIVE PLAN FOR BEHAVIORAL HEALTH AND CRIMINAL JUSTICE COLLABORATION: THE SEQUENTIAL INTERCEPT MODEL (3rd ed., 2013); Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCH. SERVICES 544, 544-49 (2006), https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544. The SIM in this report adopts the traditional model but also expands it to include new intercepts that allow for a better understanding of early intervention to effectively address those with mental health issues before they enter the criminal justice system.