Behavioral Health and Justice Recommendations

Developed with the Leifman Group

I. Executive Summary

Salt Lake County (SLCo) engaged The Leifman Group (TLG), in partnership with NPC Research, to examine the intersecting behavioral health and justice systems and to develop actionable recommendations to improve public safety, reduce recidivism, and enhance outcomes for individuals with behavioral health needs.

Drawing on extensive stakeholder interviews, document review, and a two-day Behavioral Health and Justice Summit held on November 13–14, TLG found that Salt Lake County is comparatively resource-rich at every intercept of the Sequential Intercept Model. The County benefits from an amazing amount of coordination and political will at the leadership level at the State, City, and County levels, including a strong Criminal Justice Advisory Council (CJAC). In addition, the support from numerous treatment and service providers, and broad business and community leaders is unprecedented. The County invests in a robust pretrial and community supervision program, supervising nearly 6,000 people per month. Many providers collect detailed individual-level data and use it for performance measurement within their own organizations.

The County has also made significant investments in behavioral health treatment services and supportive housing to work to meet the need. Since 2017, Salt Lake County has invested in a network of more than 700 substance use residential beds and 100 mental health residential beds, ACT team capacity to serve 500 people with severe mental illness, as well as group homes and permanent supportive housing for those with mental illness needing additional support to live in the community. A new 16-bed subacute resource for co-occurring mental health/substance use disorders is planned for early 2026. These investments demonstrate a strong commitment to the broader partnership to meet the needs of those experiencing mental illness and substance use disorders.

At the same time, the County faces significant challenges:

- Fragmented coordination across systems and agencies
- Limited data sharing and no unified data hub
- Insufficient housing—especially deeply affordable and supportive housing

- Gaps in diversion, supervision, and care coordination, particularly at critical transition points
- A proliferation of committees and bodies with overlapping mandates but no single, unified implementation structure

This report outlines 25 primary recommendations, organized largely along the Sequential Intercept Model, followed by cross-cutting recommendations concerning housing, data, and system governance. Key themes include:

- Investing in upstream prevention of trauma, substance use, and mental health concerns to slow the future of people entering homelessness and criminal justice systems
- Strengthening crisis response and front-end deflection (e.g., 911 script changes, MCOT/co-responder expansion, transportation protocols, and crisis receiving center options in the South Valley)
- Implementing universal jail screening and wraparound case management tied to transitions
- Building a structured, evidence-based post-arrest diversion system—including the Justice Courts—aligned with risk-needs-responsivity principles
- Expanding the use of Assisted Outpatient Treatment (AOT) and civil commitment options while addressing bed capacity constraints
- Increasing housing resources across the continuum and careful implementation of potential large congregate "campus" models to avoid risk-mixing
- Creating a cross-system data hub and data-sharing protocols to support care coordination, accountability, and data-driven decision-making
- Establishing an overall implementation structure with shared leadership, clear priorities, and subcommittees organized by intercepts and cross-cutting themes

The County is well positioned to build on its considerable strengths. With sustained leadership from the Mayor, County Council, and key partners, a unified implementation structure, and targeted investments guided by data, Salt Lake County can significantly improve public safety, system efficiency, and outcomes for residents with behavioral health disorders.

II. Background and Methodology

Salt Lake County retained The Leifman Group (TLG), including NPC Research, to conduct a comprehensive review of services, policies, and practices at the intersection of behavioral health and the justice system and to develop recommendations for improvement.

A. Scope of Work

TLG was asked to:

- Assess existing services and processes across behavioral health, homelessness, and criminal justice systems
- Identify strengths, gaps, and opportunities at each intercept of the Sequential Intercept Model
- Review existing planning documents and proposals
- Facilitate a Behavioral Health and Justice Summit
- Develop practical, evidence-informed recommendations and an implementation framework

B. Data Sources and Activities

Information for this report was collected from multiple sources:

- **Stakeholder Briefings:** Initial briefings with County leadership and key personnel
- **In-Person Interviews:** A two-day onsite engagement including 15 direct interview sessions with a wide range of stakeholders (justice system, behavioral health providers, homelessness services, law enforcement, advocacy organizations, the philanthropic community, and others)
- **Virtual Interviews:** 20 follow-up virtual interview sessions with additional stakeholders
- **Document Review:**
    - Salt Lake County Area Plan
    - Salt Lake City Public Safety Plan
    - Justice and Accountability Center (JAC) proposal
    - Other County and partner reports and data summaries
- **Behavioral Health and Justice Summit:** A two-day summit (November 13–14) that produced written materials, identified priorities, and generated additional feedback from a broad spectrum of participants

The observations and recommendations in this report reflect this cumulative body of information, including themes repeatedly raised by stakeholders and priorities and opportunities identified during the November convening.

III. Overall Observations

Salt Lake County stands out nationally for the breadth of its behavioral health, homelessness, and justice-related assets.

A. Key Strengths

- **Rich constellation of resources at each intercept:** Compared to many jurisdictions, Salt Lake County has substantial treatment capacity, effective treatment courts, crisis services, and community supports.
- **Justice-focused coordination through CJAC:** The Criminal Justice Advisory Council is an established forum for cross-system conversation and has worked to align stakeholders on criminal-justice-related issues.
- **Strong data collection within organizations:** Many providers collect detailed individual-level data, including demographics, dates and types of services, and key events (e.g., arrests, charges, jail entries). These data are often used for internal performance measurement and quality improvement.
- **Supportive policy and community environment:** Stakeholders consistently reported substantial community and policymaker interest in solutions, and a willingness among partners to collaborate and innovate.

B. Systemic Challenges

Despite these strengths, the system is constrained by fragmentation and gaps:

1. **Limited coordination across systems and at the individual level**
    - Resources are not systematically aligned across behavioral health, homelessness, and justice systems.
    - Individuals often experience disjointed transitions, duplication of services, or missed opportunities for intervention.
2. **Insufficient data sharing and lack of a unified data hub**
    - Data are siloed within organizations and systems.
    - Cross-system case coordination and system-level outcome analysis are difficult, limiting the ability to know what is working, for whom, and at what cost.

3. **Housing shortages across the continuum**
    - A lack of deeply affordable, transitional, supportive, and permanent housing undermines diversion, treatment, and supervision.
    - Individuals with criminal justice involvement and behavioral health conditions are particularly affected, with criminal records often creating barriers to housing.
4. **Gaps in care coordination, supervision, and diversion**
    - There is no universal screening at jail intake.
    - Transitions (e.g., from jail, hospitals, shelters, or higher-intensity treatment) are especially vulnerable points, often lacking structured supports.
    - Line-level prosecutorial practices vary, and structured post-arrest diversion is not consistently implemented.
5. **Crowded governance space without a unified implementation structure**
    - Multiple committees, councils, and task forces claim some ownership over parts of the behavioral health and justice continuum.
    - Overlapping jurisdictions and inconsistent goals can dilute accountability and impede coherent implementation.

These observations inform the recommendations that follow.

IV. Recommendations by Intercept and System Function

The recommendations below are those that are likely to have the greatest impact on public safety, system efficiency, and behavioral health outcomes. Some are short-term and relatively straightforward; others require new resources, legislative changes, or substantial system redesign. They are generally organized along the Sequential Intercept Model, followed by cross-cutting recommendations related to housing and homelessness, civil processes, and data recommendations, all of which are critical considerations across the intercepts.

Intercept 0–1: Community, Crisis, and Law Enforcement Response

Each of these recommendations are interdependent, and a coordinated continuum of responses is needed to have a significant impact on interrupting the trajectory of crises leading to unnecessary engagement with the justice system.

Recommendation 1: Maintain and expand "upstream" efforts to reduce the prevalence of trauma and behavioral health disorders.

Identifying and appropriately responding to trauma and social determinants of health issues early on is an important strategy in preventing future onset and acuity of behavioral health issues. Strategic attention to and engagement with schools, communities, and families decreases the likelihood of future homelessness and criminal justice entanglement. More specifically, a) working to engage school districts/schools and pediatricians in trauma screenings and trauma informed practices and working on pathways to support children living with trauma; b) preventing substance use by investing in evidence based community, school and family-based strategies to reduce risk factors and increase protective factors; and c) ensuring access to mental health supports for young people.

Recommendation 2: Add "or mental health emergency" to the 911 call taker script.

Proactively offering callers the option to identify an emergency as a mental health episode will promote more appropriate responses and increase opportunities for deflection to behavioral health services rather than default criminal-justice pathways.

Recommendation 3: Increase MCOT and co-responder resources.

Mobile Crisis Outreach Teams (MCOT) and law enforcement co-responder teams should be available, as appropriate, 24/7 across the valley. Expanding these resources will:

- Increase timely access to crisis stabilization
- Reduce law-enforcement-only responses
- Support deflection from jail and emergency departments

Recommendation 4: Coordinate and standardize transportation to crisis services across the valley and create needed alternatives.

Conflicting policies and jurisdictional uncertainties about transport to emergency rooms and the receiving center create delay and conflict, especially when MCOT teams are on scene.

Key steps include:

- Resolving policy conflicts among first responders regarding who transports and how
- Authorizing MCOT teams to transport when appropriate, consistent with practices in other Utah jurisdictions
- Prioritizing non-law-enforcement, non-emergency-vehicle transportation whenever clinically and safely appropriate

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Recommendation 5: Increase law enforcement usage of crisis receiving centers rather than hospitals and jail.

Law enforcement usage of the receiving center is quite low, with significantly less than 50% of admissions coming from police. This represents a significant missed opportunity for stabilization and triage.

- A concerted effort should be undertaken to educate relevant law enforcement personnel about the availability and effectiveness of the receiving center. As data about the successes of the receiving center become more established, those results should be promoted among law enforcement agencies. This should be in addition to the education and training provided as part of the recommended expanded CIT initiative.
- Replication of the current Huntsman Mental Health Institute (HMHI) receiving center in its entirety may be impractical in the South Valley, but a smaller satellite or adjunct facility should be considered. Law enforcement usage of the existing receiving center is lower than expected, perhaps due in part to logistical challenges and the relative ease of jail transport. A more convenient South Valley option may increase utilization and diversion.

Recommendation 6: Develop a law enforcement "behavioral health flag" for law enforcement.

Early identification of individuals with potential mental health conditions is essential, and interactions with law enforcement can provide early clues about potential mental health disorders. A check box or other mechanism for flagging such concerns could be included on the arrest affidavit, or on the citation if the individual is not booked. A simple behavioral health flag would:

- Alert jail and medical staff to possible behavioral health needs
- Trigger further screening or assessment
- Create a data element that can inform analysis and planning

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Recommendation 7: Coordinate Crisis Intervention Team (CIT) implementation across law enforcement entities.

While individual municipal law enforcement agencies retain decision-making authority, a single coordinating entity should standardize CIT training and promote fidelity to the Memphis Model. A robust, well-implemented CIT program has been shown to:

- Decrease arrests of individuals with behavioral health conditions
- Increase appropriate diversion to treatment
- Reduce use of force and law-enforcement injury

Relevant CIT modules should also be regularly provided to:

- 911 and 988 call takers
- Law enforcement CIT coordinators and supervisors
- TRAX and other transit law enforcement

Recommendation 8: Centralize behavioral health services for law enforcement officers in a non-law-enforcement entity.

Experience in Miami-Dade County demonstrates that when officers believe behavioral health services are truly anonymous and independent of their employer, utilization rises dramatically. Centralizing officer behavioral health services with a neutral third party (e.g., court or community entity) can:

- Improve officer wellness
- Reduce use of force and officer-involved shootings
- Decrease unnecessary arrests of individuals with behavioral health conditions

Any entity perceived as independent of law enforcement could serve this function.

Recommendation 9: Create homeless outreach teams within relevant law enforcement agencies.

Dedicated homeless outreach teams—ideally with embedded peers or clinicians—can:

- Build trusting relationships with individuals who are unsheltered
- Connect people to appropriate services and housing resources
- Coordinate with downtown Ambassadors and other outreach providers
- Reduce arrests and calls for service related to homelessness

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Intercept 2–3: Arrest, Jail, Courts, and Post-Arrest Diversion

Once an individual is arrested and becomes a part of a criminal justice trajectory it is essential to endeavor to identify the appropriate system response and potential pathway for that individual, whether that be diversion, and if so to what type of treatment and level of supervision, or to the traditional court process.

Recommendation 10: Implement universal jail screening.

The sooner individuals with behavioral health needs are identified, the more effective diversion and treatment responses are, and the individual's criminal charge is a woefully insufficient indicator of those needs. Therefore every person booked into the Salt Lake County Jail should be screened for:

- Mental health disorders
- Substance use disorders
- Criminogenic risk
- Trauma exposure

Validated tools could include:

- Brief Jail Mental Health Screen
- TCU-V substance use screen
- LSI-SV for criminogenic risk
- PCL-5 for trauma

The jail should also use an appropriate suicidality screen for classification and safety.

Screening results should be used as an early triage tool to:

- Inform jail classification and housing
- Identify candidates for diversion and treatment
- Schedule further assessments (mental health, substance use, trauma, or criminogenic needs)

Implementation details:

- Ideally, screens are administered by clinicians; in their absence, specially trained jail or County personnel can administer them (none of these tools requires a clinician).
- Regular checks of inter-rater reliability and implementation fidelity should be conducted.
- Results should be shared promptly with:
    - Jail medical and mental health staff
    - Prosecution and defense
    - Jail in-reach personnel and case managers

Only broad results of the tools should be shared with prosecution and defense (e.g., "strongly recommended for further mental health assessment"); specific responses to individual questions should be treated as protected information to avoid potential use of those responses for incrimination or admissions about illegal conduct.

Eventually a database of arrestee risk-need profiles will be generated, which will enable better forecasting of future resource needs, including jail beds and diversion capacity.

Recommendation 11: Coordinate jail discharge transitions to directly connect individuals with community resources and supports.

Jail releases occur at all hours, and they constitute a period of heightened risk for suicide, overdose, relapse, and treatment disengagement. For individuals identified as high-need—particularly those with serious mental illness—Salt Lake County should:

- Coordinate planned discharge times aligned with service availability
- Provide transportation from jail to a day treatment or similar resource
- Ensure continuity of medications
- Reassess housing and other responsivity needs
- Facilitate warm handoffs to community treatment and supervision providers

Recommendation 12: Create wraparound case management protocols for individuals with behavioral health disorders.

Given the County's complex and somewhat siloed network of behavioral health providers, coordinated case management is critical.

Key elements:

- Contract with a provider (or providers) to respond to individuals flagged through jail screening or assessment as needing significant behavioral health resources.
- Leverage and expand jail in-reach program – ensuring that those in for shorter and long periods of time have access to meet with individuals pre-release, build rapport, and begin planning.
- Coordinate warm handoffs to and among hospitals, community treatment providers, and supervision, including medication continuity and housing supports.
- Provide ongoing and consistent case management for as long as treatment and supervision requirements or needs persist.

Many of these functions are likely Medicaid-reimbursable.

Recommendation 13: Focus intensively on transitions across settings.

Transitions—from shelters, jail, inpatient units, or higher levels of care—are moments of heightened vulnerability. Case managers, peers, and other supports should:

- Provide targeted assistance at all major transition points
- Pay particular attention to step-downs in treatment intensity and supervision level
- Use peers to help sustain engagement and continuity during these transitions

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Recommendation 14: Communicate both primary and behavioral health needs to community providers.

Information about primary and behavioral health conditions, prescriptions, and needed treatments is not consistently transmitted to case managers, community providers, hospitals, or the jail.

The County should:

- Standardize communication at booking and discharge, as well as at transitions between supervision settings and treatment providers
- Integrate these communication expectations into wraparound case management protocols and data-sharing improvements
- Integrate communication expectations for coordinated case management into all provider agreements.

Recommendation 15: Ensure timely access to a range of behavioral health services pre-trial.

The time between jail release and subsequent appearances, when an individual is often subject to pre-trial release conditions, requires robust supports. A full continuum of supervision and treatment supports needs to be available both to those engaged with County pre-trial services and those who are not. Particularly important is ACT team availability. Medium- to low-risk individuals with high behavioral health needs are well-suited for Assertive Community Treatment (ACT)–level supervision, and eligibility criteria for that level of support should be disseminated to relevant stakeholders. Salt Lake County should:

- Inventory available pre-trial supports for misdemeanor and felony level defendants, and develop resources to meet any identified gaps in
- Ensure ACT availability for eligible individuals, to including appropriate pre-trial individuals
- Increase ACT team capacity to serve this population, if necessary

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Recommendation 16: Expand the County's Post-Arrest Diversion System, ensuring it is structured and objective.

Salt Lake County has an existing pre-filing diversion system. The County should build on this foundation by exploring opportunities to divert appropriate cases at other points in the criminal justice process—including at or immediately following arrest. Such an initiative should include:

- Embedding a prosecutor and defense counsel at the SLCO jail to identify and divert appropriate individuals before they are formally booked into custody
- Eligibility determinations based on assessed criminogenic risk and treatment needs, with limited exclusions based on factors such as current charges, criminal history, victim input, program capacity, and public safety considerations
- Matching individuals to levels of supervision and treatment consistent with the risk-needs-responsivity model

To support consistency:

- The process should be clearly defined and systematized so that line prosecutors can apply it uniformly, and the District Attorney must ensure consistent compliance with program fidelity.
- If needed, legislation could define core parameters of the diversion framework.
- Prosecutorial discretion should rarely override risk-needs determinations, absent compelling public safety or victim-based concerns.

Recommendation 17: Increase coordinated treatment and supervision options, such as the Justice and Accountability Center concept.

As described in Recommendation 23, the original Justice and Accountability Center proposal was well conceived and would fill a gap in the treatment and supervision continuum. A core gap in the system is a transitional location for people being released from Jail, the State Hospital, HMHI, or residential MH and SUD treatment to stay with wraparound supports until long-term housing or the appropriate treatment become available. This ensures people with behavioral health needs are not released back to homelessness while opening capacity in treatment facilities because folks are not staying past medical necessity. For systemic diversion to be effective, that treatment and supervision continuum must be robust and comprehensive. Any updates and revisions to the proposal and any logistics decisions should be finalized promptly so that the needed resource requests can be advanced.

Recommendation 18: Fully integrate Justice Courts into diversion and treatment-connection initiatives.

Justice Courts handle the highest volume of cases involving individuals with behavioral health needs, yet they often have the fewest resources and the least access to comprehensive information. In Salt Lake County, the Justice Court System is highly decentralized, consisting of 16 separate jurisdictions. Additionally, opportunities for prefiling diversion are limited because most cases are directly filed in justice court upon issuance of a citation by law enforcement.

To address these challenges, Salt Lake County should pursue a more integrated, system-wide diversion strategy that fully includes Justice Courts. As part of that effort, the Third District Court must be an active participant in information sharing and coordinated diversion planning.

Salt Lake County should:

- Consider a robust post-filing diversion model in justice courts. Currently, most justice court cases begin with a citation issued by law enforcement, which is filed directly with the court without a review by a prosecutor. This practice limits the opportunity for prosecutors to divert appropriate cases before formal court involvement. Absent a wholesale restructuring of the filing system in justice court, a robust post-filing diversion program is the best way to divert appropriate cases once a citation is issued. And, as mentioned in Recommendation 16, having an embedded prosecutor and defense counsel at the SLCO jail will increase the likelihood of diverting appropriate cases as soon as possible after arrest.
- Increase pretrial resources for misdemeanor defendants.
- Without a complete view of a defendant's risks, needs, and criminal history, supervision decisions tend to rely too heavily on charge type and indicators of violence or aggravation. Decisions should also incorporate the PSA, validated risk-needs and trauma screenings and assessments, and appropriate consideration of victim input and public safety.
- Provide Justice Courts with real time, reliable, user-friendly information regarding treatment resources, eligibility criteria, and service availability, enabling courts to more effectively connect individuals with appropriate services.

- Create a targeted pilot for high-volume Justice Courts located along TRAX lines. These courts handle a disproportionate number of minor offenses involving individuals experiencing homelessness and behavioral health conditions and are well suited for piloting enhanced treatment, supervision, and support responses.

Assisted Outpatient Treatment and Civil Commitment

Recommendation 19: Promote diversion to Assisted Outpatient Treatment (AOT) at multiple points in the system.

Assisted Outpatient Treatment is a valuable tool for medium- to low-risk individuals with significant behavioral health needs. Recent legislative enactments have improved the criteria for AOT eligibility, but there remain attitudinal and pragmatic obstacles to meaningful levels of usage. The District Court filing and adjudicative process is not currently a practical or quick enough process. When implemented with fidelity, AOT has been associated with:

- Increased treatment engagement
- Reductions in non-compliance with supervision requirements
- Decreases in criminal behavior

AOT should be considered:

- As an early intervention for families, behavioral health providers, and others when a person may meet the definition in U.C.A. § 26B-5-351(14)
- As an alternative to arrest (law enforcement officers are permitted petitioners)
- In prosecutorial charging decisions as a diversion option
- As a disposition option for criminal charges
- As a sentencing alternative
- As a response to pre-trial and post-sentence non-compliance by eligible defendants
- As a step-down option from inpatient civil commitment or inpatient competency restoration

Several jurisdictions in other states successfully use AOT at various stages of misdemeanor court involvement. However, Utah Justice Court judges currently lack civil case authority. Options to solve this include:

- Legislation granting Justice Court judges jurisdiction to monitor defendants in a civil AOT context; or
- A streamlined process for transferring eligible cases to District Court.

Whatever the mechanism, conversion from criminal proceedings to AOT should be quick and simple for stakeholders to embrace.

Additional ACT and related community resources will likely be necessary to support expanded AOT use.

Recommendation 20: Increase inpatient civil commitment resources and improve processes.

Civil commitment in Utah is often described as "a status, not a placement," reflecting bed shortages and the prioritization of forensic patients at the Utah State Hospital. This leaves counties to address civil bed shortfalls.

Key points:

- While statutory improvements to civil commitment standards may be helpful, the more pressing challenge is the lack of staffed inpatient beds.
- Reducing the number of individuals entering the competency restoration pipeline would free forensic beds and increase civil bed capacity.
- In the near term, SLCo's options are limited to contracting with local private psychiatric and acute mental health providers while broader system reforms take hold.

If upstream interventions and diversion are successfully implemented, the need for long-term inpatient care should narrow to the most acute individuals.

Procedurally:

- Pink-sheet/civil commitment evaluation petitions are still largely paper-based.
- The process should be automated.
- Law enforcement should receive training on involuntary examination criteria and documentation to ensure appropriate, timely use of civil commitment tools.

Housing, Risk-Mixing, and Facility Planning

Recommendation 21: Increase housing resources across the continuum of housing options and avoid harmful risk-mixing.

Diversion, treatment, and effective supervision are undermined when fundamental responsivity needs—especially housing—are unmet. Individuals experiencing homelessness have disproportionately high behavioral health needs, and unsheltered individuals face particularly poor prognoses. While there have been laudable efforts to address some aspects of the housing shortage, sustained investment in the full continuum of housing options and resources is essential to the success of these broader recommendations.

A sustainable response requires:

- A full continuum of housing, from shelters to transitional and supported housing to permanent housing units
- Dedicated funding streams for this continuum (e.g., taxes or other earmarked funds as seen in Miami-Dade and other jurisdictions)
- Data-informed planning to ensure new housing resources are targeted to actual system needs
- Reduced entanglement with the criminal justice system where possible (e.g., avoiding criminalization of public urination that can lead to sex offender registration and long-term housing exclusion)

Regarding the potential large campus in northwest Salt Lake City, the proposed resource investment provides a unique opportunity to effect significant change. While details are not yet clear, policymakers should consider the following as specifics are filled in:

- Risk-mixing is a serious concern. Large congregate settings that co-locate criminogenically low- and high-risk individuals will likely increase recidivism, victimization, and crime. This risk is heightened if individuals are compelled to be there or if the campus is relatively isolated.
- Preliminary descriptions suggest the inclusion of involuntary civil commitment beds within a CCBHC-like framework. While CCBHCs are a promising model, they typically do not include locked long term civil beds. Integrating such beds raises complex licensure, staffing, and design issues.
- Best practice is to use data to identify specific gaps in the current resources, then design new facilities (including size, function, and population served) to fill identified gaps. Without such analysis, there is a risk of designing a resource that people are connected or compelled to use because it exists—not because it is what they need.

The cornerstone of the risk-needs-responsivity model is providing targeted responses to the assessed risks and needs of individuals, not to the legacy configuration of available resources.

Data, Analytics, and System Learning

Recommendation 22: Reliably and appropriately communicate behavioral health needs among justice system partners.

Supervision entities are currently siloed with respect to behavioral health needs and treatment requirements. Law enforcement, jail staff, County pre-trial and probation, and Adult Probation and Parole (AP&P) must proactively and promptly share relevant information as individuals move between systems.

This may require:

- A single unique identifier across systems
- Memoranda of understanding (MOUs) and/or legislation authorizing data sharing for care coordination and public-safety purposes, including outlining guardrails to ensure data are utilized appropriately and for intended purposes without causing harm for individuals engagement in the criminal justice system.

Recommendation 23: Use existing data to determine the type(s) of facilities and services needed.

The County should first define its target population(s) and then use existing data systems to locate and characterize those individuals.

The original Justice and Accountability Center (JAC) proposal provides an illustrative example of data utilization (given a new mental health/substance use subacute is now opening in early 2026, there may be shifts in population and service model):

- The key population was originally defined as:
    - Frequent criminal justice contact
    - Unmet behavioral health needs, including substance use and/or other mental health disorders
    - Unsheltered

- Data from:
    - Offender Management System (OMS) (bookings, including a serious and persistent mental illness [SPMI] flag)
    - Homeless Management Information System (HMIS) (homeless service utilization, chronic homelessness flag)
      were merged to identify individuals with:
    - Frequent bookings
    - SPMI flags
    - Frequent homeless service use and chronic homelessness flags

This merged dataset allowed the County to:

- Estimate the size of the key population
- Determine needed facility capacity
- Identify the types of services most appropriate to address their specific needs

Using data in this way supports:

- Precision in resource allocation
- Avoidance of misallocating funds to low-need areas
- Identification of areas where additional investment is required

Given current and future decisions around jail programming, facility design, and related infrastructure, this type of analysis is both timely and essential. It is equally important to:

- Involve experts with local knowledge and analytic experience
- Routinely refresh analyses to reflect changes in drug trends, mental health prevalence, and system utilization

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Recommendation 24: Create a data warehouse or "data hub" to combine cross-organizational data for care coordination, performance measurement, and outcomes analysis.

Most organizations interviewed:

- Collect individual-level data (demographics, assessments, service dates, service types, key events such as arrests or jail entries)
- Use these data to produce performance measures and internal statistics

However, it is less common for organizations to:

- Link service data to outcomes (e.g., improved health, reduced justice involvement)
- Share data robustly across agencies for coordinated case management or system-level evaluation

Barriers include siloed systems, privacy concerns and potential for associate harm, and the absence of shared infrastructure.

Consequences of limited data sharing:

- Limited visibility into available services
- Fragmented service coordination
- Case managers lack full information about client needs and prior services
- Difficulty connecting services to outcomes
- Duplication of services, missed needs, and unnecessary or ineffective interventions
- Higher costs and poorer outcomes

Lessons from other jurisdictions:
Allegheny County (PA) and others have demonstrated the benefits of cross-system data hubs. Uses have included:

- Real-time service inventories
- Predict adverse outcomes for individuals and to use those predictions to inform worker decision-making at the time of child welfare call screening (Allegheny Family Screening Tool)
- Allow the ability to do outreach and proactively offer supportive services to high-need new parents (Hello Baby),
- Analyze service outcomes including housing, employment, criminal justice and use the results to improve service effectiveness
- Housing resource allocation tools

The U.S. Government Accountability Office has documented benefits of data warehouses in:

- **Eligibility and enrollment:**
    - Sharing assessments across agencies
    - Pre-populating forms and reducing client burden
    - Providing timely updates to reduce overpayments and recoupment

- **Case management and care coordination:**
    - Ensuring caseworkers have comprehensive information
    - Improving contact information accuracy
    - Reducing staff time spent on manual data lookups
    - Supporting integrated services for families with complex needs

- **Program oversight and effectiveness:**
    - Providing a fuller picture of service delivery and outcomes
    - Understanding multi-system service utilization
    - Identifying program integrity issues and improving payment accuracy
    - Monitoring outcomes across domains (education, employment, health)

Recommendations for building the SLCo Data Hub:

1. **Implement cross-organization data-sharing protocols and guardrails.**
    - Develop MOUs that:
        - Address privacy and potential harms
        - Follow privacy regulations including 42 CFR, HIPAA
        - Define duties, responsibilities, data safeguards, and data-sharing rules
    - Create protocols for adding data sources that involve developing trust, shared vision, and legal review

2. **Create a cross-system/cross-organization Data Hub Task Force.**
   The task force should include:
    - A high-level County leader with statewide stature to champion the effort
    - Representatives from agencies already integrating data (e.g., Office of Homelessness and Criminal Justice Reform working with OMS, HMIS, and Versaterm)
    - Individuals involved in previous unsuccessful data centralization efforts, to capture lessons learned
    - IT experts skilled in data systems and current technology
    - Agency directors authorized to approve data sharing
    - Service providers who understand what information is needed for effective coordination
    - Research and evaluation experts (including local universities) to define performance and outcome metrics

3. **Create data-hub-specific legislation.**
    - Mandate use of the data hub and specify participating organizations
    - Define data-protection requirements, permissible uses, and access controls
    - Ensure ongoing compliance with privacy regulations, including 42 CFR and HIPAA

4. **Develop a flexible, web-based hub architecture.**
    - Enable upload and integration from diverse existing case management systems and databases
    - Allow smaller providers without established systems to use the hub directly as a case management or data-entry platform
    - Ensure secure, role-based access from any location

5. **Include data across multiple systems.**
   The data hub should ultimately integrate data from:
   - Behavioral health
   - Homelessness services
   - Child welfare
   - Intellectual and developmental disability services
   - Aging services
   - Police and law enforcement
   - Corrections, jails, and courts
   - Public schools and community colleges
   - Other relevant human services and community providers

Recommendation 25: Evaluate the implementation and effectiveness of the new system

Engage with research partners including local universities and other researchers with appropriate expertise to evaluate the implementation and effectiveness of all aspects of the new system changes.

The evaluation should encompass:

1. The process of implementation itself including the stakeholders involved, the activies, challenges and lessons learned at every intercept as well as the development of the data hub, etc. This information can be used to develop a how-to manual for other counties and states to implement their own system change.

2. Implementation effectivess: Were the system improvements implemented as intended (e.g., Did new services and number of slots address the actual population in need?; Was a functional and accessible data hub created? Did key partners share necessary data in the new data hub?)?

3. System effectiveness – Did the improvements to the system have the intended impact – increased communication and data sharing across partners, better coordination of care, increased public safety (lower recidivism), decreased numbers of houseless individuals, improved behavioral health outcomes.

The evaluations should begin as early in the implementation process as possible to ensure that all activities are documented and that systems for tracking and collecting data are in place as soon as

they are needed (e.g., when new services are being provided). Evaluation results should be used for feedback and continuous system improvement as well as to demonstrate effectiveness to commuity stakeholders, and to support any need for additional resources.

V. Implementation Framework

The City, County, and State all have a stake in these issues and must unify and coordinate their responses. Achieving the recommendations in this report requires a structured, durable, and inclusive implementation framework.

A. Overall Coordinating Stakeholder Group

Salt Lake County is the logical locus for system coordination, as it is responsible for organizing and delivering treatment services. Cities, state and local courts, and multiple state agencies also play essential roles. All must be meaningfully engaged.

TLG recommends that the County:

1. **Propose and jointly convene an overall coordinating stakeholder group.**
    - Leadership should be shared by major stakeholders (County, City, State, justice system, behavioral health, housing/homelessness, etc.).
    - Membership should include public and private partners essential to comprehensive reform, as well as individuals with lived experience and community representatives.

2. **Clarify and memorialize shared goals.**
    - The group's first task should be to agree on overarching goals (e.g., public safety, reduced recidivism, improved health, efficient use of resources).
    - These goals should be formally documented to sustain focus over time.

3. **Prioritize recommendations.**
    - Review this report and identify which recommendations to pursue and in what order.
    - Distinguish between short-term "early win" actions and longer-term, resource-intensive initiatives.
    - Implement a small number of early wins promptly to demonstrate progress and maintain stakeholder engagement.

4. **Establish subcommittees aligned with the Sequential Intercept Model and cross-cutting themes.**
   Potential structure:
   - Intercept 0–1 (community, crisis, and law enforcement)
   - Intercept 2–3 (arrest, jail, courts, and diversion)
   - Intercept 4–5 (reentry and community corrections)
   - Data and Analytics
   - Cross-Intercept / Housing and Supportive Services

   Membership should include professionals directly engaged in front-line work to ensure that implementation plans are realistic and grounded.

5. **Identify and prioritize resource needs collaboratively.**
   - The stakeholder group should define key resource requirements for long-term goals (e.g., housing, ACT teams, data infrastructure, workforce).
   - A unified voice is critical for making effective resource requests to local, state, and philanthropic funders.

6. **Move quickly to maintain momentum.** The implementation phase should start promptly, i.e. within weeks, not months, at least for the organizational process. The current energy and focus on these issues is impressive, and the County should take advantage of this moment of consensus and purpose to move forward with implementation.

B. Role of Neutral Facilitation and Technical Assistance

Implementation will inevitably intersect with political interests and competing priorities. While local leaders are best positioned to navigate those dynamics, a neutral third-party subject-matter expert and facilitator can:

- Help maintain focus on agreed-upon goals
- Provide technical assistance and evidence-based guidance
- Reduce the impact of jurisdictional or political tensions on system design

TLG or another entity could serve this role.

C. Leadership and Sustainability

As noted at the outset, Salt Lake County is fortunate to have assets that many jurisdictions lack, including strong leadership from the County Mayor and other elected officials. Successful initiatives in this field consistently share:

- Persistent, energetic leadership
- A clear vision
- Willingness to sustain reforms beyond political cycles

With a unified implementation structure and sustained leadership, Salt Lake County and its partners can substantially:

- Increase public safety
- Use public resources more effectively
- Improve the health and stability of residents with behavioral health disorders

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VI. Conclusion

Salt Lake County has already done much of the hardest work: building resources, cultivating partnerships, and recognizing the urgency of reform at the intersection of behavioral health, homelessness, and the justice system. The recommendations in this report are intended to harness those strengths, address known gaps, and provide a roadmap for coordinated, data-driven, and humane system transformation.

By:

- Enhancing crisis response and deflection
- Implementing universal screening and wraparound case management
- Building structured diversion pathways (including through Justice Courts)
- Expanding AOT and civil resources
- Increasing housing across the continuum
- Creating a robust data hub
- And establishing a clear implementation structure

Salt Lake County can become a national model for how communities respond to individuals with behavioral health needs in a way that promotes public safety, fiscal responsibility, and human dignity.

Appendix A: Priorities and Opportunities Identified at the November Convening

(Unedited list submitted by attendees; minor formatting applied)

- Coordinate CIT communication across all Salt Lake County agencies.
- Collaborate with city, County, state, and federal partners.
- Use data metrics and weekly dashboards.
- Ensure willingness and commitment from various organizations—both public and private.
- Provide wraparound care.
- Streamline pink-sheeting and include independent ambulance services (Gold Cross).
- Develop deeply affordable housing and supports.
- Expand pre- and post-diversion opportunities, programs, services, and incentives for law enforcement to use these services.
- Invest in upstream prevention opportunities for at-risk children and youth.
- Repurpose dollars currently devoted to overused competency restoration processes toward solutions that work.
- Improve Justice Court–District Court case coordination.
- Increase housing support and availability of housing options.
- Expand case management services.
- Prioritize funding for this type of work.
- Identify available facilities.
- Coordinate with local, county, and state entities.
- Address technical and software needs.
- Improve coordination.
- Pursue creative funding.
- Ensure staff are available to dedicate themselves to this process.
- Fix the 70% capacity issue, then lean into supports for the 20–30% with serious mental illnesses and co-morbid conditions for the long term.
- Explore opportunities with the 2100 South facility as the County moves to create or build out capacity for those with serious mental health issues.

- Acknowledge that current system capacity is insufficient.
- Create a Power BI dashboard demonstrating “collective” touch points.
- Implement bed management across the system.
- Streamline access points.
- Reduce or release supervision when risk decreases.
- Increase tolerance for non-punitive responses to crime and other social problems related to substance use and homelessness.
- Ensure housing so that individuals do not get “stuck” in resource centers due to lack of housing opportunities.
- Expand homeless resource center connections to supportive housing.
- Increase peer outreach.
- Develop non-law-enforcement crisis response options.
- Expand the use of non-clinical peer support in the community.
- Improve diversion and case coordination between Justice and District Courts, with peers as solutions and a single courtroom to help people.
- Implement consistent, centralized case management with peers for pre- and post-arrest diversion.
- Revisit police department reporting requirements and alignment.
- Promote shared responses when exposed to trauma in smaller jurisdictions.
- Incentivize municipal zoning for needed housing types.
- Prioritize funding.
- Leverage County resources such as libraries, parks, and recreation centers.
- Develop hub-and-spoke resources countywide to keep people near their communities of origin and support centers.
- Implement best practices for police departments when responding to mental health, homelessness, and diversion opportunities.
- Maintain the willingness of stakeholders to identify solutions.
- Provide pink-sheet training for officers.
- Improve transportation to HMHI.
- Define “ownership” of gaps.
- Enhance case management.
- Improve coordination with stakeholders.
- Expand diversion systems for low-level offenses, including pre-filing, felony, and misdemeanor diversion programs.
- Increase high-risk Justice Court treatment and supervision options.
- Ensure real-time availability of placements for legally competent individuals with SPMI.

- Engage providers who can bill Medicaid to provide treatment.
- Develop data systems allowing for systemic coordination.
- Establish robust screening prior to booking.
- Leverage Medicaid expansion and willing providers.
- Align on a common focus and create infrastructure to lead and grow other priorities.
- Improve data coordination systems across sectors.
- Implement systemic diversion processes using screening tools.
- Leverage CCBHC planning grants and grantees at Valley Behavioral Health.
- Strengthen behavioral health provider voices.
- Enhance post-arrest diversion to more community-based services and long-term treatment.
- Adopt a co-occurring approach to planning releases.
- Ensure warm handoffs at intercepts.
- Screen for possible needs of families and children and use family peer support.
- Clarify definitions, processes, and the impact of civil commitment in the short and long term; identify alternatives.
- Expand permanent housing options.
- Implement electronic civil commitment systems.
- Implement the Justice Reinvestment waiver.
- Share resources.
- Address situations where the same clients receive different treatment from different providers at the same time; integrate efforts.
- Consider a non-refusal center.
- Prioritize a range of community-based housing options.
- Prioritize financial resources for case management and peer support services.
- Expand ACT teams.
- Assign a single caseworker to specific individuals in the criminal justice system for continuity.
- Develop uniform programs as alternatives to incarceration.
- Intervene early in an individual's criminal justice journey.
- Identify at-risk individuals and work with them proactively.
- Facilitate transfer of inmates so they can continue education and other programs.
- Improve physical and mental health treatment in jails with sufficient transition planning.
- Avoid discharging people from jails, hospitals, or treatment directly to the street.
- Re-examine the "Home Court" move from criminal to civil court; consider opportunities.
- Shift street outreach leadership from police to social services where appropriate.
- Explore creation of a jail diversion desk.
- Utilize LDA social workers' screening tools and willingness to share information.

- Emphasize planning and care coordination.
- Work together to create comprehensive plans.
- Recognize and learn from homeless resource officers and their work.
- Align coalitions.
- Address transportation issues.
- Clarify pink-sheet processes.
- Coordinate existing data sources.
- Implement peer specialists to fidelity across systems.
- Integrate referrals to non-treatment supports into diversion processes.
- Expand housing with wraparound services.
- Build stronger partnerships with religious organizations.
- Ensure surrounding counties provide services to their populations so Salt Lake County retains capacity within its own system.
- Increase outreach teams.
- Ensure peers and supports are tied to the individual, not just the program.
- Enhance coordination with stakeholders.
- Strengthen data coordination.
- Support all types of housing.
- Align Medicaid payments to support the overall vision.
- Improve discharge data sharing—medical and behavioral health—to community providers.
- Expand reentry resources, including stabilization, transitional, and permanent housing.
- Increase law enforcement training.
- Develop pre-arrest diversion programs.
- Ask: If we can spend $75 million on our system, where and how should we spend it (campus, housing, ACT teams, jail beds, resource centers, etc.)?
- Adopt HMHI's "Call Up" service for clinical consultation.
- Improve transportation options to the receiving center beyond EMS and law enforcement.
- Expand peer outreach on the streets and pre-release.
- Build on Salt Lake City Police Department's 100% CIT training by allowing elective specialization.
- Position Salt Lake County as the nexus for city and state policies and functions.
- Invest in youth prevention and pre-criminal involvement strategies.
- Emphasize housing—permanent supportive housing, apartments, group homes.
- Invest in workforce development.
- Increase resources for mental health needs, including medication, treatment beds, and housing beds.

- Fund programs that work and pilot new evidence-based practices.
- Expand homeless outreach by social workers rather than law enforcement.
- Implement pre-arrest diversion to residential detoxification.
- Support VOA's 19-bed subacute residential stabilization unit (60-day maximum).
- Maintain a youth focus for diversion.
- Push development of more affordable housing, group homes, boarding homes, and permanent supportive housing at ≤50% AMI.

Appendix B: Assets and Gaps by Intercept

(Based on observations by TLG and unedited participant input; formatting refined for readability)

Intercepts 0–1 (Community and Crisis)

Assets

HMHI Receiving Center; MCOT; crisis lines; detox; CIT-trained officers; local police social work programs; Downtown Ambassadors; VA/VOA outreach; 4th Street Clinic; CCBHCs; 988; 211; co-responders; coalitions; family-responsive culture; harm-reduction programs; motivated business community; Chamber of Commerce; Park Rangers; pressure of 2034 Olympics; "Call Up" medical/behavioral health support; homeless resource centers; engaged leadership; SUD treatment beds; LDA Project RIO; ER services; passionate legislators; gun-safe distribution grant; homeless outreach at the main library; Targeted Adult Medicaid; UDC CCC-TRC drop-in center; warmline; behavioral health transport; new ACT team; resource lists; Optum recovery and receiving team training; Wellness Recovery Center; 211 navigators; school- and community-based prevention; multiple fidelity ACT teams; housing investments for persons with mental illness; good 988 capacity; law enforcement wellness program; CJAC and workgroups; 911–988 collaboration; crisis care center; shelters; street outreach; libraries; Utah Community Action; homeless diversion team; coordinated local government planning; pre-filing diversion programs; strong volunteer culture; Road Home outreach; strong LE–homeless service partnerships; community groups; NOMAD Alliance; "Code Blue" winter sites; LDS Church mission assignments; civil commitment law framework; behavioral health providers with open beds.]

Gaps

South Valley CRC gap; limited MCOT and co-responders; siloed CIT resources; few stabilization options

beyond receiving center; ED overuse and psychiatric boarding; insufficient ACT access; limited non-law-enforcement transport; first-responder coordination challenges; lack of early behavioral health information sharing; limited initial peer support; no countywide deflection or pre-arrest diversion system; limited awareness of resource availability; insufficient inpatient capacity linked to housing deficits; acute affordable housing shortage; barriers to telehealth; limited primary care access; restrictive Medicaid policies; lack of permanent supportive housing; regional coordination gaps; transportation barriers; limited data to guide decisions; unclear ambulance/EMT availability; need for red-flag systems and peer response; threats to continuous Medicaid eligibility; lack of centralized cross-sector communication; data-sharing issues; perverse incentives to arrest low-level homeless populations; long-term residential treatment gaps; limited family support for homeless individuals; insufficient funding and administrative flexibility; lack of civil-commitment tracking; politics favoring jail over alternatives; lack of services outside Salt Lake City.

Intercepts 2–3 (Arrest, Jail, Courts, and Pretrial)

Assets

Medicaid-funded jail in-reach; jail mental health and SUD services (including CATS); Community Response Team; jail MAT program (three FDA-approved medications); Criminal Justice Services Pretrial; PSA tool; County Pre-file Intervention Program; 4th Street transition and targeted case management; mental health, veterans, drug, Familiar Faces, and homeless courts; South Salt Lake Justice Court diversion and coordination; Legal Defender mental health liaison and social services; case resolution coordinator; civil commitment/AOT statutes; homeless resources and coordination; Project RIO and Project Connect; Medicaid expansion; prison/jail peer support; ACT/FACT teams; “Guilty with Mental Condition” statute; Utah State Hospital campus; reentry diversion programs; HRC-embedded behavioral health providers; Justice Reinvestment waiver; peer screening opportunities in jail; robust 24-hour pretrial screening team using PSA; peers in the jail and in treatment courts; UBH Core; trauma-informed training; electronic probable cause system; grants for care management with peers; prison intergenerational director; 211 data; legal sandbox; lessons from neighboring counties; HRSN waiver; 1115 justice-involved waiver; “Divert! Don’t file charges” philosophy.

Gaps

Lack of universal jail screening; inconsistent prosecution practices; limited diversion buy-in from line prosecutors; limited access to AOT as misdemeanor-level diversion; challenges in jail transitions (medications, housing, release times); insufficient LAI access; poor communication of primary and

behavioral health information; uncoordinated embedded case managers; overreliance on CATS; lack of BH-specific probation; limited case-management coordination; weak individualized RNR-based planning; limited District Court engagement beyond problem-solving courts; Justice Court–District Court communication gaps; lack of routinized diversion processes; overuse of competency to stand trial; lack of seamless transitions from inpatient/restoration; absence of DSPD services/funding; limited subacute housing/treatment/supervision; insufficient co-occurring treatment options; inconsistent Justice Court practices; data-sharing challenges; insufficient support for peer specialists; limited housing/boarding homes; lack of meaningful diversion for non-competent, non-restorable individuals; limited primary care access; gaps in post-arrest diversion programs; various logistical and financial barriers (impound fees, cell phones, medication); ownership gaps for pre-justice case management; limited community-based residential mental health treatment beds; outdated AOT statutes; no statewide civil commitment database; funding limitations for pre-assessment care management; lack of jail population reviews; insufficient CPSS supervisor training; constrained ACT capacity; limited reentry planning; insufficient person-centered data and unique identifiers; limited ACT teams and family support; regulatory misalignment; inadequate judicial resources; lack of early, high-quality risk/needs information for judges; inadequate post-release case management and peer support; limited transitional housing; bail reform needs; ongoing discharges to street; non-existent step-down continuum; housing shortages; fragmented prosecution policies; limited contingency-management resources; gaps in judicial and prosecutorial education on treatment.

Intercepts 4–5 (Reentry and Community Corrections)

Assets

JDOT, Alternatives to Incarceration Transport, CCBHCs (Odyssey House, VOA, VBH), jail reentry programs, 4th Street Clinic, Medicaid-eligible specialized providers, ACT/FACT teams, Criminal Justice Services case managers and peers, AP&P MIO, VA outreach, USARA, County Intensive Supervision Program, HRCs, Alliance House, robust recovery housing, supported housing initiatives, funding instruments, LDS transition programs, housing stability services, Medicaid waivers, philanthropic partners, and a strong culture of volunteerism.

Gaps

Gaps in universal screening, diversion consistency, AOT access, jail transitions, LAIs, case management coordination, BH-specific supervision teams, housing continuum and capacity, supported employment, transportation, data-sharing, coordinated exits, aftercare, early treatment in

prison.

Across All Intercepts

Assets

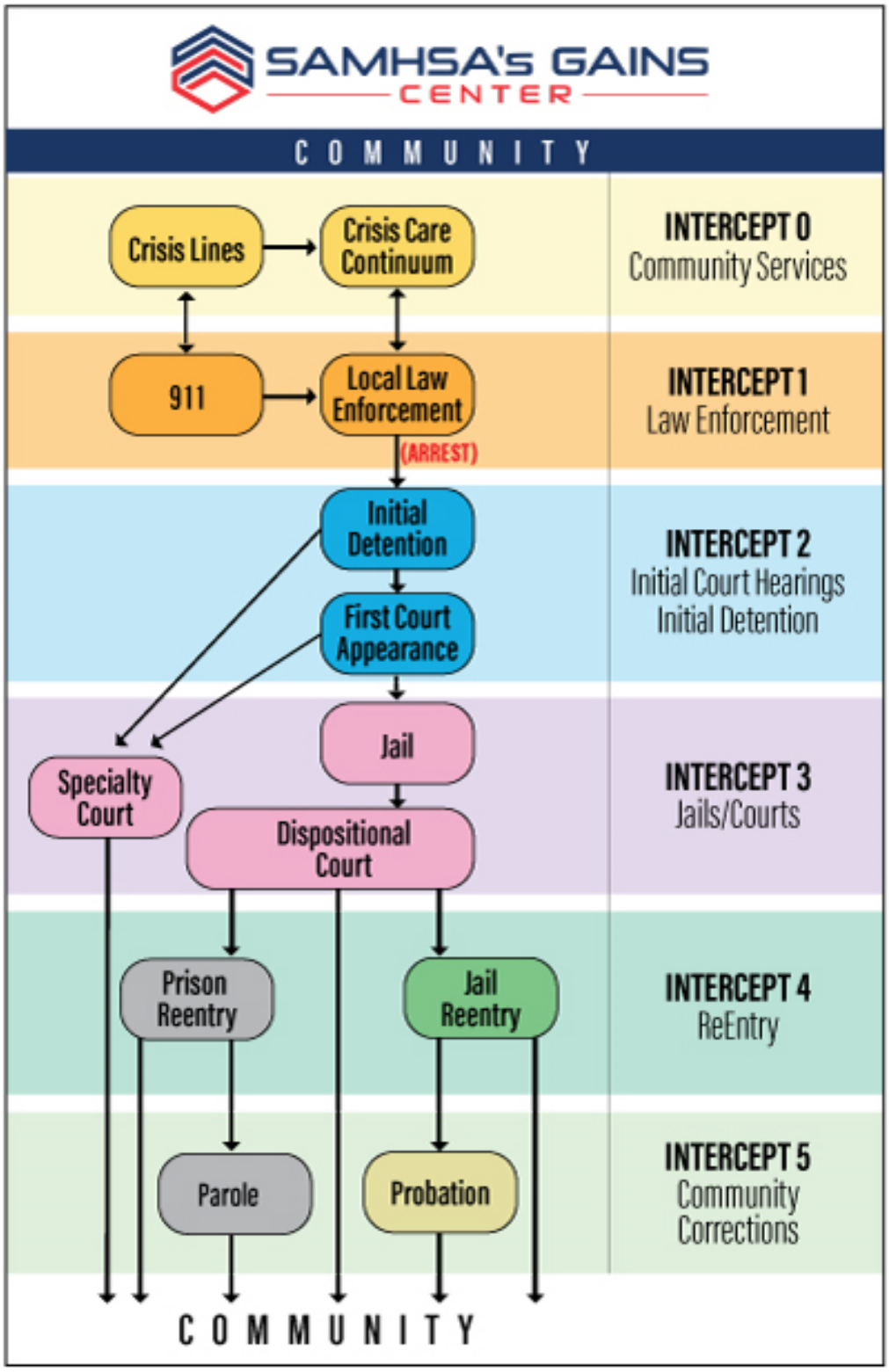
- Numerous resources, though not always accessible to all.
- Strong commitment by stakeholders to improve processes and center the individual experience.
- CCBHC State Planning Grant and active grantees.
- Committed partners willing to step into gaps and ask how to help.
- Rich community supports and strong relationships.

Gaps

- Medicare/Medicaid spend-down challenges.
- Restrictive housing voucher eligibility (warrants, open cases, eviction records).
- Need for better coordination and communication among stakeholders.
- Variability in programs and alternatives to incarceration.
- Fatigue across sectors and levels of government; unclear responsibility.
- Lack of coordinated, longitudinal case management.
- Need for more peers and mentors.
- Insufficient housing and prevention resources.
- Funding and capacity constraints.
- Need to integrate new technologies (including AI) to support system needs.
- Too many “dead ends” in the system.
- Need for improved wraparound case management and long-term support.

Appendix C: Sequential Intercept Model

The Sequential Intercept Model (SIM) details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system. The SIM helps communities identify resources and gaps in services at each intercept and develop local strategic action plans. The intercepts are illustrated by the following graphic:


SAMHSA's GAINS CENTER
COMMUNITY
Crisis Lines
Crisis Care Continuum
911
Local Law Enforcement
(ARREST)
Initial Detention
First Court Appearance
Jail
Specialty Court
Dispositional Court
Prison Reentry
Jail Reentry
Parole
Probation
COMMUNITY
INTERCEPT 0
Community Services
INTERCEPT 1
Law Enforcement
INTERCEPT 2
Initial Court Hearings
Initial Detention
INTERCEPT 3
Jails/Courts
INTERCEPT 4
ReEntry
INTERCEPT 5
Community Corrections