



Reframing Health Through **Food Access** and **Social Stability**



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A Mobility-Informed Systems Model Within a Collaborative Statewide Food Equity Ecosystem
Grounded in the Social Determinants of Health

"Where Vision Transcends Boundaries."

Dr. Olivia Johnson

"There is no such thing as a throwaway life."

Dr. John E. Michel

"Every relationship has a purpose, and there is purpose in every relationship."

Dr. Jorey Krawczyn

Abstract

In 2023, the U.S. Department of Agriculture reported that roughly 87% of U.S. households maintained consistent access to adequate food, while about 14% experienced food insecurity—up from 12.8% in 2022. This increase signals a widening gap in stable access to basic nutritional needs. Food insecurity is often mischaracterized as a food shortage problem, when it reflects a structural systems failure rooted in access, equity, and opportunity. It is driven by interconnected barriers such as economic instability, transportation limitations, housing insecurity, fragmented service systems, and uneven geographic distribution of resources; factors that compound rather than occur in isolation.

Within the Social Determinants of Health (SDOH) framework, these pressures intersect across housing, transportation, education, neighborhood conditions, and healthcare access, shaping whether individuals can reliably obtain nutritious food and sustain long-term physical, cognitive, and emotional well-being. Ultimately, food insecurity is not simply about hunger; it is a measure of how effectively systems support or restrict equitable access to the conditions required for health and stability.

This white paper introduces a mobility-informed systems framework that positions food access as a foundational SDOH and a central driver of population health outcomes. Rather than proposing a new standalone service system, this model emphasizes coordination, integration, and amplification of existing community organizations – including food truck apprenticeship programs, commissary kitchens, hydroponic smart farms, and SNAP/EBT-enabled mobile market networks already operating across the Metro East under a dignity-centered food hub framework. Within this model, mobility is treated not as a supporting logistical concern, but as the connective tissue that allows every other Social Determinant of Health to reach the people it is intended to serve.

Illinois C.A.R.E.S.™ (St. Clair County C.A.R.E.S.™ pilot program) seeks to reduce morbidity and mortality and improve quality of life by addressing fundamental upstream SDOH through an integrated systems design methodology (Seligman et al., 2010; Office of Disease Prevention and Health Promotion, 2020). The program serves as the primary access point for individuals and families seeking resources across essential areas of need. It is designed as a centralized, first-stop system—ensuring that before navigating multiple agencies, individuals are connected to the right resources efficiently and accurately. Rather than replacing existing services, this will strengthen coordination within a unified community network, aligning food providers, healthcare systems, transportation services, and community organizations to deliver more seamless, effective support. Illinois C.A.R.E.S.™/St. Clair County C.A.R.E.S.™ tackles system fragmentation by streamlining access, raising awareness, and enhancing connectivity. This approach helps people get support both before crises arise and at their most critical moments.

Illinois C.A.R.E.S.™ is scheduled to launch in St. Clair County in fall 2026 as the inaugural pilot of a comprehensive statewide initiative designed to reach all 102 Illinois counties. The pilot will establish the operational framework, community partnerships, and resource coordination strategies necessary to support a scalable, sustainable model for statewide implementation. To ensure effective expansion, regional collaboration, and consistent oversight, Illinois will be organized into eight designated regions, creating a coordinated network dedicated to identifying risk, reducing barriers, connecting resources, and strengthening communities across the state.

Introduction: Health as a Systems Outcome, Not an Individual Condition

Modern healthcare systems have largely evolved around a reactive model, treating illness after it emerges rather than addressing the conditions that produce it. While clinical care is essential, this approach often overlooks the upstream structural factors that shape health long before a patient enters a clinical setting.

Among the most influential of these upstream drivers are the SDOH. These include income, education, employment, housing, neighborhood conditions, transportation systems, and access to healthcare (Office of Disease Prevention and Health Promotion, 2020). **Within this framework, food access (and nutritious food) emerges as one of the most immediate and measurable indicators of system functioning.**

Food serves not only as a fundamental biological requirement but also as a stabilizing factor that significantly impacts metabolic health, immune response, cognitive functioning, emotional stability, and social interactions. Insufficient or disrupted access to nutrient-rich food can lead to detrimental consequences across multiple aspects of well-being, including a heightened risk for chronic illnesses and mental health disorders (Seligman et al., 2010). Furthermore, food insecurity extends beyond mere availability; it involves whether existing systems provide equitable, consistent, and dignified access to proper nutrition. The first system everyone experiences is the family unit, where it initiates behaviors and dictates the relational purpose of nutrition for the child. This can create developmental issues that impact the child's physical health and mental well-being (Krawczyn, 2025).

Food Insecurity as a Structural Expression of SDOH

Food insecurity is best understood as a visible symptom of deeper structural inequities embedded within the SDOH. People facing food insecurity or access issues often contend with several interrelated challenges, including limited income, insecure housing, inadequate transportation, and both physical and mental health issues. Restricted access to healthcare and education further complicates their situation, resulting in a food environment where nutritious choices are often unattainable, unaffordable, or geographically limited.

Many communities encounter *food-access-constrained environments* in which food is present but often lacks nutritional value, consists primarily of highly processed items, or is economically inefficient (Walker et al., 2010). Reliance on such food sources contributes to metabolic disorders, chronic inflammation, elevated stress and fatigue, and diminished cognitive and emotional well-being, with cumulative effects over time. Within this context, the family functions as a micro-community that both internalizes these constraints and may perpetuate them across generations, potentially resulting in ongoing health and wellness challenges (Krawczyn, 2025).

When people's health worsens, they often find it harder to move around, think clearly, and manage healthcare tasks. This situation can lead to even less access to care, making health problems worse, while poor health itself makes it more difficult to get the help needed. These challenges aren't just due to individual choices—they're also shaped by wider social and structural barriers that limit opportunities and access (Gundersen & Ziliak, 2015). If left unaddressed, these issues can impact not only individuals but also their families and future generations, leading to ongoing problems like unstable nutrition, chronic illnesses, and financial hardship.

Transportation, Technology, and Mobility as Determinants of Food Equity

Transportation is one of the most under-recognized yet critical SDOH, shaping food access and overall food equity outcomes. Access to nutritious food is not determined solely by its availability within a geographic region, but by the ability of individuals to physically reach that food in a consistent, affordable, and dignified manner. When transportation systems are unreliable, fragmented, or inaccessible, food access becomes structurally limited regardless of local supply.

Individuals without reliable transportation often depend on public transit systems that are time-intensive, indirect, and physically burdensome. These barriers disproportionately affect older adults, individuals with disabilities, low-income families, and rural populations, all of whom already experience heightened vulnerability within broader SDOH frameworks (Syed et al., 2013). Proximity often overrides nutrition in food selection, forcing people to rely on nearby options like convenience stores, gas stations, or fast-food outlets that provide mostly processed foods high in fat, sugar, and salt.

Over time, this structural constraint reinforces inequity by making healthier food environments systematically less accessible to populations who would benefit most from improved nutrition and preventive health supports. Modern strategies for food equity understand that simply improving transportation is not enough to overcome deep-rooted barriers. To truly enhance access, it's essential to combine transportation infrastructure with advances in technology and innovative mobility solutions.

Emerging mobility-informed and technology-enabled interventions are beginning to reshape how food systems can function at the community level. These include mobile food distribution

systems; food delivery routed through public transit corridors and strategically located access points that align with existing transportation networks. At the same time, new logistics technologies, including autonomous delivery systems and drones, are opening ways to address geographic isolation and last-mile delivery challenges, especially for rural and underserved urban areas (Choi et al., 2022).

Beyond logistics innovation, food equity is also being influenced by broader systems-level technological integration (e.g., Neighborhood Food Insecurity Index (SocioNeeds Index®, Suite) (Tiwari & Ambinakudige, 2021). Digital infrastructure, data-informed resource mapping, and coordinated service platforms are increasingly being used to identify gaps in food access, optimize distribution networks, and improve real-time responsiveness of food systems. These innovations allow for more adaptive, responsive, and equitable allocation of resources within complex social environments. These innovations include the use of mobile food trucks (Wallace, 2021), drones and unmanned aerial vehicles (UAVs) (Liébana-Cabanillas et al., 2025), and community collaborations and food hub distribution models (U.S. Department of Agriculture, 2012).

At the global systems level, organizations such as the World Economic Forum emphasize the importance of innovation ecosystems and food system transformation hubs for addressing systemic food inequities. These initiatives highlight the need to integrate technological progress, develop robust public-private partnerships, and employ localized innovation strategies to improve food access, sustainability, and resilience within communities (World Economic Forum, 2024). Food innovation hubs increasingly exemplify a model that brings together stakeholders from agriculture, logistics, technology, and community sectors to drive equitable transformation of food systems.

Taken together, these developments illustrate a shift away from static, location-bound food distribution models toward dynamic, mobility-informed, and technology-enabled food systems. Within this evolving landscape, transportation, technology, and mobility must be understood as interconnected determinants of food equity rather than isolated logistical concerns. By integrating these domains, food systems can move closer to a model that prioritizes accessibility, responsiveness, and structural equity, ensuring that nutritional health is not determined by geography or transportation status, but supported through coordinated, innovation-driven infrastructure.

The Metro East as a Living Case for Mobility-First Food Access

The Metro East region of Illinois – spanning St. Clair, Madison, Monroe, and portions of Clinton and Randolph counties – offers one of the nation’s clearest illustrations of why mobility belongs at the center of the SDOH framework rather than at its margins. Census tracts across East St. Louis, Cahokia Heights, Centreville, Washington Park, Alorton, and sections of Belleville and Swansea meet the U.S. Department of Agriculture’s definition of low-income, low-access food deserts. These same communities simultaneously rank among the lowest in Illinois for private vehicle ownership and among the highest for residents who depend on public transit, family

networks, or informal rides to reach essential services. In practical terms, a full-service grocery store seven miles away is as inaccessible as one seventy miles away when a household has no car and no safe, timely route to get there.

This dynamic is not regional. Similar access-mobility mismatches define food-insecure environments in cities, small towns, and rural counties across the country. Where fixed-site grocery investment has been pursued as the sole remedy, outcomes have been inconsistent and often short-lived: new stores close within a few years, subsidies lapse, and the underlying mobility gap reasserts itself. A mobility-informed strategy inverts this logic. Rather than asking residents to travel toward food, it brings food to the places where people already live, learn, worship, work, and receive care. In doing so, it treats access not as a geographic problem to be solved once, but as a continuous service to be delivered, measured, and continuously improved.

Mobile Markets: SNAP/EBT-Enabled Grocery Infrastructure

Among the mobility interventions most directly aligned with this framework, SNAP/EBT-authorized mobile markets – fully stocked, choice-based grocery vehicles that route through underserved corridors on a scheduled weekly basis – represent one of the most immediately deployable and evidence-supported. Unlike food pantry distributions, which supplement food budgets with pre-assembled boxes, mobile markets operate as retail: customers select their own produce, proteins, dairy, and pantry staples, and pay with the same benefit they would use at any supermarket. The dignity of choice is preserved; the stigma of need is removed.

The case for mobile markets as public health infrastructure rests on four reinforcing arguments.

Access. A single mobile market operating a structured weekly route can serve six to twelve stops – senior housing complexes, Federally Qualified Health Center clinics, public schools, transit hubs, and faith communities – delivering a consistent supply of fresh, healthy food to populations who might otherwise travel an hour or more by bus to reach a full-service grocer. Routes can be adjusted seasonally and in response to community input, something no fixed-site store can do.

Dignity. SNAP/EBT authorization allows customers to shop rather than receive, restoring the transactional normalcy of a grocery visit. When paired with WIC, the Senior Farmers' Market Nutrition Program (SFMNP), and produce-incentive programs such as Double Up Food Bucks, a mobile market becomes a point of nutritional choice rather than a distribution point of last resort. Users are treated as customers, not recipients.

Economic multiplier effect. Every SNAP dollar redeemed through a locally sourced mobile market circulates into regional supply chains – area farmers, commissary kitchens, small producers, and food-truck operators. USDA Economic Research Service analyses have estimated that SNAP spending generates approximately \$1.50 in GDP for every benefit dollar

redeemed during economic slowdowns (Canning & Stacy, 2019), and mobile markets concentrate that multiplier in precisely the neighborhoods where reinvestment is most urgently needed.

Health integration. Mobile markets are uniquely positioned to serve as the delivery mechanism for emerging Food-as-Medicine and Food Rx programs, in which clinicians prescribe medically tailored groceries and produce prescriptions to patients managing diabetes, hypertension, cardiovascular disease, and other diet-sensitive conditions (Seligman & Berkowitz, 2019). When a mobile market co-locates with a clinic, a prescription can be filled on the same day and at the same address as the patient's appointment, closing a last-mile gap that has historically undermined food-as-medicine pilots.

Taken as a whole, mobile markets are not a charitable work around for a broken food system. They are scalable, revenue-generating, dignity-preserving public health infrastructure that connects agriculture, commerce, transportation, and clinical care inside a single mobile footprint.

Mobility Across the Broader Food Ecosystem

Mobile markets are one expression of a broader principle. The same mobility-informed logic applies across the food ecosystem: food truck fleets that rotate through transit-dependent neighborhoods; mobile commissary-prepared meal delivery for homebound seniors and post-discharge patients; mobile cold-chain distribution from regional food hubs to last-mile drop points; and workforce-development programs that train apprentices to operate, maintain, and grow this infrastructure as a credentialed career pathway rather than a temporary employment stop. The same vehicle that delivers dignity-preserving food access can, with intentional design, also deliver a living wage, a credential, and a durable entry point into the hospitality and food industries. Mobility, in other words, is how food equity reaches people – and how people reach careers.

Food, Health, and the Cycle of Systemic Instability

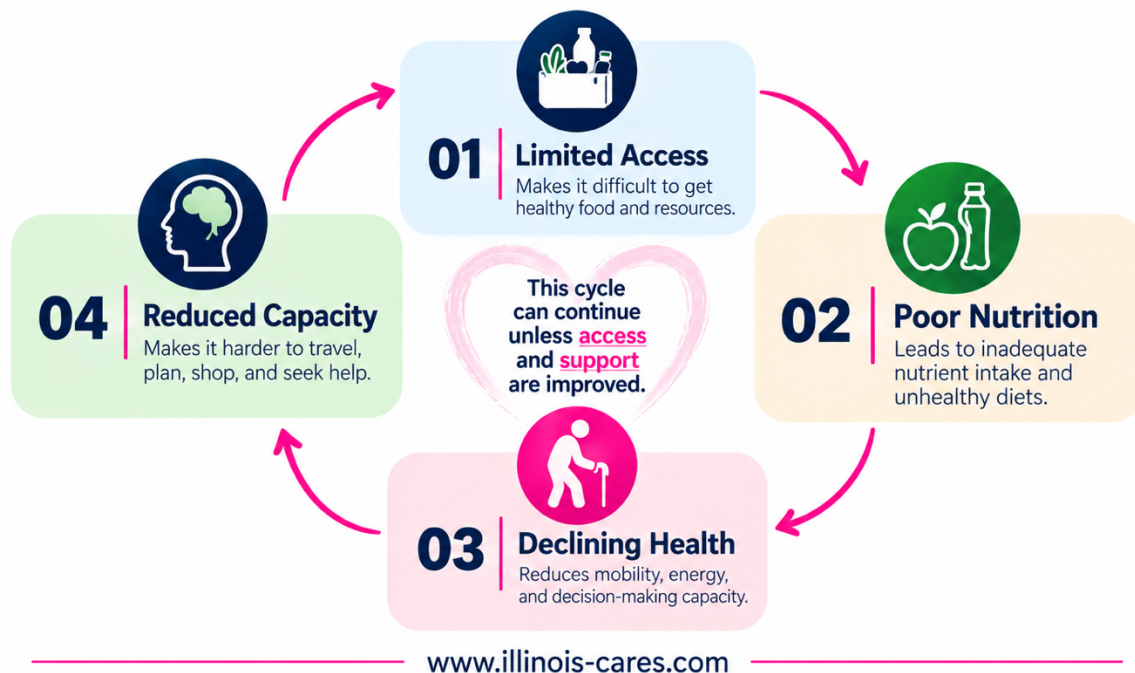
Food insecurity directly and measurably affects physical, psychological, and emotional health. Poor nutrition is associated with increased risk of cardiovascular disease, diabetes, obesity, depression, anxiety, and cognitive impairment (Firth et al., 2020; Krawczyn, 2025). These outcomes are not isolated; they interact to reduce overall functioning, including energy levels, executive functioning, and emotional regulation.

As these health impacts accumulate, individuals have less capacity to work, travel, plan, and access available resources. This further reinforces dependence on limited food environments and deepens systemic instability.

Breaking this cycle requires coordinated interventions that address infrastructure, education, mobility, and system navigation simultaneously.

A SELF-PERPETUATING CYCLE

Barriers to Access and Their Impact on Health



Illinois C.A.R.E.S.™: A Collaborative Ecosystem Hub Within the SDOH Framework

Illinois C.A.R.E.S.™ operates as a *collaborative infrastructure hub* embedded within a larger ecosystem of organizations addressing SDOH. It is not a direct service provider, nor does it replace or duplicate existing food systems, healthcare programs, transportation services, or nonprofit initiatives. Instead, it functions as a coordination and amplification layer designed to strengthen the effectiveness of existing systems.

Rather than duplicating services, Illinois C.A.R.E.S.™ enhances the systems already in place by improving coordination, education, and communication across sectors. It increases system effectiveness by reducing fragmentation and strengthening alignment among organizations already doing critical work in food access, healthcare, transportation, housing, and social services.

Illinois C.A.R.E.S. operates as a centralized coordination and engagement infrastructure focused on:

- Community advocacy and engagement across local and regional systems
- Resource navigation and connection to existing services and programs
- Education addressing mortality, morbidity, and preventable health disparities across Illinois
- Education on SDOH and their real-world impacts on communities
- Bridging gaps in access, awareness, and service utilization across fragmented systems
- Strengthening collaboration, communication, and network-building among existing providers and organizations

This framework positions Illinois C.A.R.E.S.™ as a *spoke within a larger wheel of care*, where each organization contributes essential services and enhances the connectivity, visibility, and coherence of the entire system. The goal is not consolidation or control, but integration, amplification, and improved system flow.

St. Clair County C.A.R.E.S.™: Pilot for Systems Integration

St. Clair County serves as the initial pilot region for implementing this collaborative framework. The pilot will evaluate how enhanced coordination within the SDOH ecosystem improves access to food, healthcare, transportation, and social services without duplicating or replacing existing programs.

This pilot emphasizes:

- Strengthening awareness of existing resources
- Improving navigation across fragmented service systems
- Enhancing education on nutrition, health, and SDOH
- Identifying structural gaps in access and coordination
- Building stronger collaboration between community organizations

Findings from St. Clair County will guide the strategic, scalable implementation of eight regional infrastructure models throughout Illinois's 102 counties.

Empowerment Through Access, Choice, and Education

A foundational principle of this model is that access alone is insufficient to achieve sustainable change.

Meaningful improvement occurs when individuals are provided with:

1. Reliable access to nutritious food
2. Education about health, nutrition, and system navigation
3. The ability to make informed choices within their environment

When these conditions are present, individuals are more likely to engage in behaviors that improve long-term health outcomes. Conversely, when access is limited and education is absent, behavior is shaped primarily by environmental constraints rather than informed decision-making. Empowerment in this model is defined not as individual responsibility alone, but as the intersection of access, knowledge, system design, and social connection and support.

From Reactive Healthcare to Coordinated Health Infrastructure

This framework represents a shift from reactive healthcare delivery toward proactive, coordinated health infrastructure grounded in SDOH. Instead of intervening only after disease develops, this model emphasizes stabilizing upstream conditions such as food access, transportation, housing, and education.

Food, within this context, is not a supplemental service but a foundational health intervention. Strengthening food systems has measurable impacts on chronic disease prevention, mental health outcomes, and overall population stability (Seligman et al., 2010; Firth et al., 2020; Krawczyn, 2025). Coordinating existing systems rather than replacing them allows for more efficient use of resources, reduced duplication, and improved outcomes across sectors.

Conclusion: Building a Connected Ecosystem for Health Equity

Food access represents one of the most powerful and actionable entry points for addressing the SDOH. It intersects with nearly every major determinant: transportation, income, housing, education, and healthcare, making it a central leverage point for systemic change.

Illinois C.A.R.E.S.™ operates within this ecosystem as a collaborative coordination hub that strengthens existing organizations rather than replacing them. Beginning with the St. Clair County pilot, this model demonstrates how systems alignment, mobility-informed design, and education can improve access and reduce fragmentation across care networks.

By addressing food insecurity through the lens of SDOH, this framework supports a transformation from fragmented, reactive systems to integrated, proactive infrastructure. Ultimately, the goal is not only to reduce food insecurity, but to strengthen the conditions that allow individuals, families, and communities to thrive in all areas of their lives.

Additionally, addressing food insecurity through mobility acknowledges a principle that guides this work at every level: there is no such thing as a throwaway life. Every household that gains reliable, dignified access to nutritious food represents a life the system chose to reach rather than leave behind. When a region commits to moving food the last mile – rather than requiring its most vulnerable residents to travel the first seven – it makes a measurable statement about whose health, time, and stability are worth the coordination effort. Illinois C.A.R.E.S.™ and its partners are an expression of that commitment.

Recommendations for Additional Research

While this white paper establishes the conceptual framework and operational case for a mobility-informed, collaboratively coordinated food equity ecosystem, several areas warrant focused further inquiry.

The following recommendations are offered as priorities for academic researchers, health systems, philanthropic funders, and public agencies seeking to strengthen the evidence base for mobility-centered SDOH interventions.

1. Longitudinal health outcome studies tied to mobile market coverage. Multi-year tracking of clinical indicators (e.g., HbA1c, blood pressure, BMI, and emergency department utilization) for populations residing within active mobile market service corridors, compared with demographically similar populations outside those corridors, would substantially strengthen the causal evidence base for mobile grocery as a population health intervention.

2. Transit-integrated food access modeling in the Metro East. Geospatial analysis combining USDA food access data, public transit routing, vehicle ownership rates, and SNAP redemption patterns would identify the highest leverage stop locations for mobile market expansion and pinpoint census tracts where current coordination is failing.

3. Cost-benefit comparisons of mobile market infrastructure versus fixed-site grocery incentives. Public investment in food deserts has historically favored grocery subsidies, new-store tax credits, and developer incentives. Comparative analysis of cost per household served, persistence of access, and long-term community health outcomes would inform more efficient public-private capital deployment.

4. SNAP redemption behavior and clinical outcomes at co-located Food Rx points of care. Studies evaluating patient adherence, clinical outcomes, and sustained dietary change when mobile markets are integrated with clinician-issued produce prescriptions and medically tailored grocery programs would clarify the return on investment for Food-as-Medicine at scale.

5. Workforce development outcomes linked to food-mobility infrastructure. Longitudinal tracking of apprentices and credentialed workers operating within mobile food systems – including wage progression, credential stacking, small-business formation, and multi-year career retention – would clarify the economic mobility dividend of food-access mobility.

6. Comparative rural, suburban, and urban mobility strategies. A cross-geography evaluation of mobile markets, food trucks, transit-integrated pickup points, and emerging autonomous and aerial delivery systems would help match intervention types to community context rather than apply a single model universally.

7. Measurement of the dignity dimension. Food access research has historically centered on caloric and nutritional adequacy. Validated instruments that systematically measure perceived dignity, choice, stigma, and community belonging in food access settings would allow the field to evaluate interventions against the full set of outcomes that matter to the communities being serv

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Author Biographies

Dr. Olivia Johnson

Dr. Johnson is the Founder and President of Illinois C.A.R.E.S.™, a nonprofit organization that uses a predictive public health model designed to lower mortality and morbidity and enhance quality of life. She is a United States Air Force veteran and former law enforcement officer with experience spanning operations, applied practice, and research. She holds a Doctorate in Management and Organizational Leadership, a master's in criminology and criminal justice, and a Bachelor's in Workforce Education and Development.

For nearly two decades, Dr. Johnson has led national work in first responder wellness, suicide prevention, and organizational health, training thousands of military members, law enforcement, and frontline professionals. She is a suicidology researcher, a certified Law Enforcement Psychological Autopsy Investigator, and nationally certified Medicolegal Death Investigator. Through this work, she has identified critical gaps in early risk detection and coordinated intervention—gaps that informed the development of Illinois C.A.R.E.S.

Dr. Johnson developed a specialized national research database encompassing more than 3,500 cases of completed suicide, murder-suicide, and nonfatal suicide attempts of law enforcement and correctional officers, examining over 220 individual, behavioral, relational, occupational, and organizational variables. Through systematic analysis and psychological autopsy methodologies, her research examines patterns, vulnerabilities, and circumstances associated with suicidal behavior. This work informed the development of the FATAL 10™ framework and, in collaboration with Dr. Jorey Krawczyn, the Suicide Inoculation™ paradigm—a systems-oriented approach that shifts prevention beyond crisis intervention toward earlier risk recognition. By examining behavioral “infection points,” cumulative vulnerabilities, relational dynamics, and protective factors, these frameworks emphasize strengthening adaptive traits, coping skills, and resilience throughout the lifespan, before a crisis develops.

Dr. John E. Michel

Brigadier General (U.S. Air Force, Ret.) John E. Michel is a nationally recognized social entrepreneur whose work is redefining community-based responses to food insecurity through innovation, dignity-centered service, and workforce development. As the Founder of *Soulcial Kitchen* and *The Soulcial Solutions Foundation*, Michel has led efforts that have delivered more than 383,000 free, chef-prepared meals through restaurant and food truck models over a four-year period. His approach demonstrates that access to nutritious, high-quality meals—delivered with dignity—can serve as a powerful intervention point for improving individual and community well-being.

Central to his model is the integration of food access with economic mobility. Michel developed the first U.S. Department of Labor-recognized Food Truck Apprenticeship

Program, a pioneering initiative designed to cultivate a new generation of culinary and hospitality entrepreneurs while simultaneously expanding access to nutritious food in underserved communities. This dual-impact framework reflects a broader systems approach, addressing both immediate food needs and long-term economic sustainability.

In recognition of this work, *Soulcial Kitchen* was named the recipient of the 2025 Community Champion Leadership Award by American Express and the National Restaurant Association, highlighting its role as a leading national model for community impact within the hospitality sector.

Prior to his transition into social entrepreneurship, Michel served 26 years in the United States Air Force, retiring at the rank of Brigadier General. During his military career, he led complex, large-scale international initiatives, including a 14-nation NATO effort to establish Afghanistan's \$6.7 billion Air Force. His leadership experience reflects a deep capacity for systems-level thinking, cross-sector collaboration, and operational execution in high-stakes environments.

Michel holds advanced degrees from Embry-Riddle Aeronautical University, Air University, and Bakke Graduate University, and has completed executive education programs at Stanford University and Harvard University.

His leadership philosophy centers on long-term impact and empowerment. He emphasizes building sustainable pathways for others, grounded in the belief that effective leadership is measured not by followers, but by the futures it helps create.

Dr. Jorey Krawczyn

Dr. Jorey L. Krawczyn has an extensive career extending over 55 years in law enforcement, forensic psychology, and teaching. His law enforcement experience ranges from undercover narcotics investigations to the administrative duties of Chief of Police (Retired). He was in private practice for twelve years with psychiatrist A. Mohamed, MD, where he authored over 400 court-ordered comprehensive forensic evaluations.

Dr. Krawczyn served three years as a Senior Police Psychologist for the US Department of Justice: International Criminal Investigative Training Assistance Program (ICITAP) assigned to Kyrgyzstan, Kosovo, and Tanzania. He served an additional three years as the Academic Director for the US Department of State's International Law Enforcement Academy and two years with the Bureau of International Narcotics and Law Enforcement Affairs as a Psychological Advisor to foreign judges, prosecutors, and senior law enforcement officials on matters of Transnational Organized Crime and Radicalized Violent Extremists.

Dr. Krawczyn was contracted as a Subject Matter Expert, Instructional Designer, and lecturer for the Naval Chaplaincy 27th Professional Development and Training Course (PDTC) "The Role of Chaplaincy in the Aftermath of Targeted Violence. He also functioned as an advisor to four

Commanders, five Admirals, and three Vice-Admirals on effective resolutions and behavioral insights regarding chaplains' confidentiality and the mass shootings at the DC Naval Yard and Chattanooga Recruitment Center.

Dr. Krawczyn is a faculty member in the Department of Criminal Justice Graduate Studies at Saint Leo University, where he teaches Forensic Interviews, Methodologies of Violence, and Quantitative Research Methods. He also Chairs Dissertation Committees and doctoral research. He has been a psychological consultant and contributor to Nancy Grace's Crime-Line broadcasts, having appeared on over 65 episodes. Dr. Krawczyn provides analytical research and analysis to the Blue Wall Institute's National Law Enforcement Suicide Mortality Database and has developed the research-based alteration in treatment practice from the Disease Model (Pathogenic) to the Health Model (Salutogenic) to the Suicide Inoculation Protocols.

He has testified as an Expert Witness in twenty-two State and Federal Court cases on police behaviors, police testing methodologies, and violent offenders. He holds a Bachelor's in Criminal Justice Administration, a Master's in Human Development, a second Master's in Instructional Design, and a Doctorate in Counseling Psychology. Dr. Krawczyn also maintains his Florida State Law Enforcement Officer and Police Instructor certifications.

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