Recommendations for Mental Health, Substance Abuse, and Housing Jail Diversion Programs for Los Angeles County

2015

Introduction:

Ever since Dr. Richard Lamb studied the prevalence of mental illness inside the LA county Jail in the 1970's and described the jail as the largest mental hospital in America, it has been a source of shame. Over the generations quite a number of efforts to address this have been undertaken - efforts within the jail (including building a new separate jail for people with mental illnesses and radically increasing the mental health staff treating inmates), diverting people to other institutional programs (including state hospitals, IMDs, locked substance abuse treatment), and community diversion programs (including CONRAP, MIOCR, Prop 63, FSP, Prop 109) as well as court based programs (including mental health court linkage workers and drug court). It seems that all of these efforts help, at least as far as they go, but they are all swamped by the sheer magnitude of people flowing in and out of jail.

Everything that has been built is rapidly filled and yet many more people, new, and returning, are brought to jail daily. Different programs handle being filled in different ways. For example, CRM maintains an incredibly long, first-come first-served unprioritized waiting list for IMDs, while residential drug programs require people keep calling them to check on bed availability every morning for weeks to be admitted, and FSP programs refuse to keep any waiting lists only sending outreach and engagement workers when they have a slot available to enroll the person in. Learning how to navigate around these various gate keepers and advocate for accessibility has replaced any rational sense of triage.

Many people think we just need to build more of the things we have until it's enough to meet the needs. The problem is that with relatively static programs trying to deal with the ongoing dynamic flow of new people in need, the needs can never be met. It's only to the extent that programs help people get out of the system that they can balance the inflow with an outflow. The crucial question isn't, "How many programs do we have to create to meet people's needs?" It is "What programs do we need to create so people will no longer be in need?"

This paper describes the key elements of a full scale jail diversion system of care including triage.

Summary of Key System Elements:

1) **Effective triage by level of dangerousness and public safety risk**

The fundamental goal of our judicial system is public safety – not treatment or punishment, the two goals that are competing now. We have substantially lowered the crime rate and improved public safety partly because of incarcerating and coercing ever larger numbers of people. Just because the cost (both financial and human) of doing so has become prohibitive leading to widespread inmate release doesn't mean that our communities will go along with a substantial decrease our safety and security.

Judicial and treatment staff can collaborate on a triage process for finding places for people that prioritizes public safety, and then incorporates treatment, punishment, and costs. For example, we can divide people into three basic groups: 1) Needing forcible exclusion from the community, (usually this is because they are too dangerous, but they may have other intolerable behaviors or be dangerously self-destructive), 2) Able to be tolerated within the community with active support in the community (may be a combination of voluntary participation and some coercion), 3) Tolerable in the community despite crime, even if not engaged or cooperative with needed/ assigned services.

2) Effective triage by level of growth and recovery the person is currently at (including mental health, substance abuse, and housing)

Instead of determining what services a person needs by a professional assessment of the acuity of their illnesses ("medical necessity" criteria) the services are chosen by what meets the person where they are at – in terms of engagement and cooperativeness, motivation for change, skills and supports, resources, self-responsibility, and community integration. For example, if a person is heavily using drugs and repeatedly jailed as a result and hasn't cooperated in the past, an illness based assessment would put a forced drug treatment program, even though he is unlikely to participate in the program and just wait to get out in exactly the same condition. On the other hand, a community based, housing first, damp housing, with motivational interviewing services might help him begin to create a new life in the community that isn't intolerable to others. As this possible life without repeated incarceration starts to become a realistic possibility for him, he may be more motivated to collaborate with us to make it happen, even considering services and personal changes he initially rejected.

3) Programs need to integrate into "one-stop-shops" an array of condition specific interventions provided within a recovery context (especially mental health, substance abuse, and housing).

Most of the inmates being considered for diversion have issues around mental health, substance abuse, and housing and they are poor at self-coordinating multiple service providers. Therefore, all programs and all program staff, should integrate all three areas of service. That way, if someone happens to need only two, or even one, of the service areas, it's no big deal,

but if they need all three, we're already prepared for that. "We expect you to have multiple needs and goals." Probably the largest challenge in this is getting staff to be competent and compassionate in all three areas so they can create an integrated "counterculture of acceptance". Another major challenge is braiding together siloed funding and accountability systems within every program.

4) Replace as much coercion as possible with voluntary engagement and collaboration

Very few of these inmates have short term, acute conditions that can be involuntarily treated and then they can be released recovered. They almost all have chronic conditions that require ongoing treatment to sustain recovery or even stability. Voluntary treatment is far more likely to be continued after the person's sentence than involuntary treatment and included in their ongoing life. Inmates should be given as much treatment choice and shared decision making as possible to increase their investment in their services over time. This is true whether we're trying to build medication collaboration by giving people meaningful education and choices about their own meds, or building "pride of ownership" in an apartment they helped choose, furnish, and decorate, or taking ownership of the painful emotional work underlying long term sobriety by choosing who to share a "moral inventory" with.

5) Provision of several models of integrated program missions geared for each public safety level

A key engagement strategy is to help people find a program that is a match for their self-image and their personal goals. "This program is designed to serve people like me. They value the same things I do. They help me get what I want." For example, some people may view themselves as having a mental illness or substance abuse issue, while others may think they have a problem with job skills, unemployment, and poverty. Some may want help transitioning for running the streets to having a real life. Some may even want to give back to others to save them from the suffering they've gone through. Note that someone can do any of these things, including giving back to others, even if they are so dangerous they still need to be locked up. We need to have programs and staff branded in all these different ways, and others, to engage as many people as possible.

6) All programs need to be small and relationship based

Most services and treatments, especially mental health and substance abuse services, work better with good personal relationships between staff and clients. There are too many obstacles for good personal relationships to be taken for granted. Many inmates have serious issues with interpersonal relationships, trust, and trauma that make them difficult to connect to and work with. At the same time, many staff seek to distance themselves from inmates both

emotionally and physically. Fear can play a powerful role. Working as a trusting team can be very helpful. Program hiring, culture, and staff support must all emphasize relationships.

Every community will likely try to reject and keep released inmates away from them. Small personal programs have a better chance of creating acceptance and a niche for themselves and their clients in their communities than large, institutional programs do.

7) Programs need to promote growth-oriented flow to lower levels of care both within a given public safety level and to lower levels of public safety to keep opening up capacity for new people. Flow needs to be actively re-triaged and monitored and personally facilitated, including detailed information exchange

Virtually every inmate will be eventually released into the community and even released from coercive oversight. The overarching goal should therefore be, not just to provide them treatment during the current episode of coercion and incarceration, but to prepare them to be reintegrated into the community in as safe, self-responsible, healthy, and productive ways as possible. For the majority of diversion inmates just serving their tie, even with treatment provided, and releasing them will not achieve that. They will need to grow personally to get there.

Growth orientation is best supported by a system that has a series of transitional programs that flow into each other and into graduation and successful release instead of a static service design. Most staff will naturally resist moving people they are succeeding with on to get more new, hard clients, and fear the clients will deteriorate without them. Most clients agree unless moving on means freedom. Therefore, the system design itself has to include structures and incentives for personal flow.

Moving between programs and especially between providers, even for good reasons, tends to involve a loss of valuable information about the person and their services. Communication can also be intentionally misleading and self-serving. Standards and oversight are needed, especially to protect staff safety.

8) Programs need to emphasize engaging people, collaboratively, empowerment, building self-responsibility and community integration by integrating an array of specific recovery based practices to form a growth-oriented, recovery-based core

Relationship based practices are often described as “non-specific” or “something you either have or you don’t. It can’t be taught.” Neither one is true. These practices are only non-specific from an illness-centered point of view. They can be very specific from a person-centered point of view. For example, a medication visit that is designed to build trust, meet someone where they are, and engage them, is very different from a medication visit that is designed to help a person learn by proactively, shared experimenting with their medications,

which is different from a medication visit designed to build enough self-responsibility and knowledge to transfer their medications to a busy PCP, even if the illness and the prescriptions are identical in each case. There are a whole array of specific growth-oriented, recovery-based practices that have been developed within mental health, substance abuse, housing, employment, chronic illness care, rehabilitation, health, hospice, and others. They can be taught and learned and practiced and excelled at. These jail diversion programs will be more successful if they skillfully incorporate a large number of these practices.

9) Programs need to actively include and collaborate with public safety staff

Just because an inmate is diverted to a more positive treatment setting doesn't mean that public safety staff should withdraw. As long as public safety is a concern for a diverted inmate, public safety staff (whether jail guards, probation officers, police, or judges) need to be actively included. Treatment staff cannot always keep ourselves or our communities safe. We need active help and collaboration. This collaboration is most likely to be effective when there is mutual respect, overlapping shared missions, bidirectional trainings, lots of personal contact and relationships, and collaborating leaders. One effective approach is to have specialized collaborative staff on both sides working together (for example, emergency response teams with a police officer and a mental health worker, and probation officers with specialty mental health training and caseloads sharing plans and resources with jail diversion mental health workers).

Discussion:

Why pursue jail diversion?

Our current legal system is based upon an old premise that people should be found guilty or admit their guilt and then be punished to pay their debt to society for their transgression and then return to their lives. Unfortunately, the courts are far too busy to actually assess guilt and punishment so a plea bargaining process has been substituted for it. Most inmates do not admit their wrong doing (except as a negotiating strategy) and do not think their punishment fits their crime. Also instead of clearing their record by paying their debt to society, people who are convicted are permanently identified and restricted from private and public housing, education scholarships, and jobs. Overall, our current system's erratic, punitive discipline seems to produces very little positive behavioral change, personal growth, or community reintegration.

Even though there are many people in jail and prison serving their sentences, there are far more people under judicial orders in the community – either awaiting trial, with a warrant for failure to appear, on probation or parole, or serving community sentences. In fact the majority of the coercive power of incarcerating people in jail is not being used to punish for crimes, but

to uphold the power of the judicial system itself. Most people are sent to jail for not complying with their probation or sentencing or returning to court, rather than for committing another crime.

Also, the system is not geared to support the police in their primary objective – to protect public safety, since most of re-incarceration isn't directly linked to assessments of dangerousness to society. "Getting someone off the streets" to keep the public safe isn't a directive of the judicial system. This has forced police to move more towards community policing and to look for non-judicial partners to try to increase public safety.

This whole system seems incredibly unfair, inhumane, destructive, and costly to almost any observer, yet change is difficult, at least partly because of the scale of the system. Small programs and dedicated individuals of all kinds scarcely seem to make a dent in the problem.

From a treatment perspective, jailing intended primarily to punish people, is a terrible setting in which to try to help people with treatment. Moving them to other locked treatment facilities seems a more humane alternative. We can try to move forwards with that logic and transfer funds and coercive powers from punitive forensic institutions to treatment oriented psychiatric and drug treatment institutions.

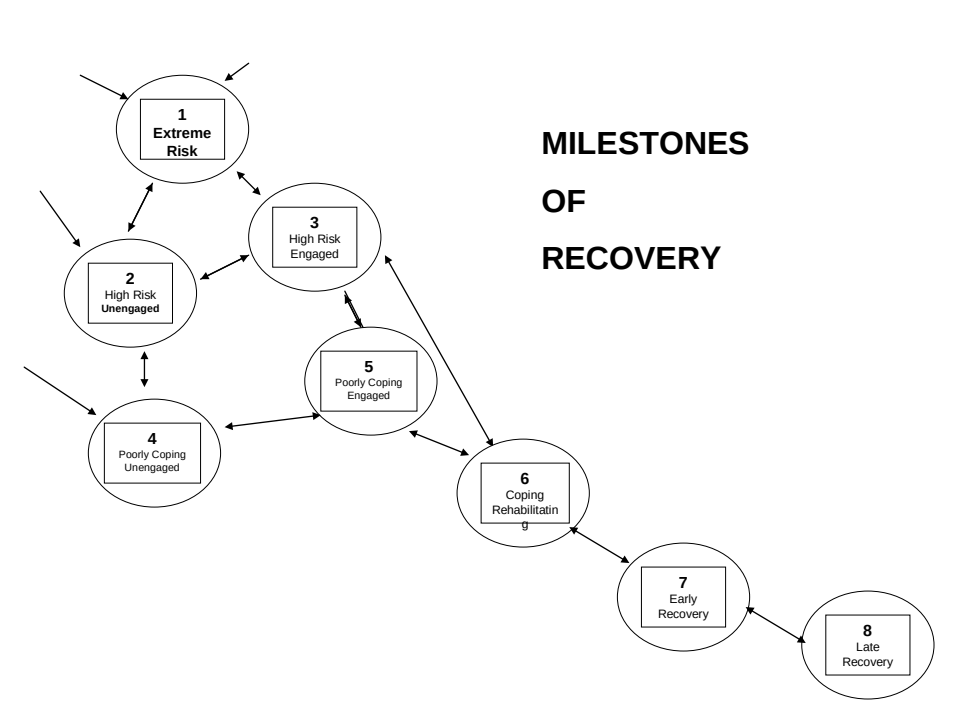
There is the issue of who deserves more humane treatment instead of punishment. Treatment staff and judicial staff tend to have different approaches to this triage task. Marv Southard, the director of LA county DMH articulated this triage system at a conference speech a couple years ago: "People whose mental illnesses influenced their criminal behavior, people who make bad decisions, people whose use of substances directly or indirectly led to their charges, "morally evil" people, and people with various brain damage / neurological conditions that aren't traditionally considered part of mental health." His stated reason for dividing people up like this is to proscribe different treatment approaches for each set, regardless of their crime or dangerousness. Illness based triage schemas like this are difficult to implement when almost everyone In jail is focused on avoiding getting punished and getting out of jail at any cost.

Why growth-oriented, recovery based programs instead of treatment programs?

Mental health programs, especially institutions like state hospitals, IMDs and Board-and-Cares tend to come from a caretaking, stabilizing perspective instead of an empowering, growth-oriented perspective. While either approach can be humane, only growth-oriented practices and programs are likely to produce flow to lower levels of care and positive graduates to voluntary community based services. (Acute public hospitals are only funded to reduce acute dangerousness – to self or others – for involuntary patients, not to treat illnesses successfully. Their funding is limited to very short stays and rarely produces growth.) While these danger reduction and long term stabilization approaches are actually a good match for the judicial

system's perspectives, they cannot meet the volume of need from the jail. So long as people stagnate in these programs, while jail has a very dynamic flow of numerous new and returning people every day, almost no matter how much money is spent and how many programs are built their beds will always be full and they will not be able to open the large numbers of new beds daily that are needed. Only a growth-oriented programs have the potential to do that.

To provide growth oriented services, we need to know how far the person has grown so far, rather than assuming everyone is at the same point. For example, MHALA has developed the Milestones of Recovery Scale (MORS) to assess someone's mental health recovery based on their level of engagement, risk, skills and supports, and meaningful community roles:



Substance abuse has a growth tracking tool developed within the Motivational Interviewing practice: Precontemplation, Contemplation, Planning, Action, and Sustaining. There are also supported housing tools to measure level of housing maturity and need for support (ranging, for example, from needing intensive, even daily support and skills training to be able to manage their own apartment, meet their responsibilities, and get along with neighbors and landlords all the way to people who need just deposit assistance and then can handle everything on their own.)

Here is a contrast between caretaking and growth-oriented mental health programs at several levels of growth:

Stage of Recovery	Care taking services	Growth oriented services
Stage 0: Extreme Risk (MORS 1)	• External controls – locked environment, seclusion, restraints, 1:1 monitoring • Forced sedation • Reduce external interactions and stress	• Support to increase internal controls and self-responsible problem solving • Help to reduce internal sources of distress and loss of control • Trauma sensitive interactions
Stage 1: Unengaged (MORS 2,4)	• Forced treatment • Protection • Benefits establishment • Acute stabilization	• Outreach and engagement • Peer bridging • Concrete quality of life goals • Relationship building
Stage 2: Engaged, but poorly self-coordinating (MORS 3,5,6)	• Structure • Making decisions for people • Case management • Chronic stabilization	• Supportive services • Skill building • Personal service coordination • Collaboration building
Stage 3: Self-responsible MORS (6,7,8)	• Benefits retention • Maintenance therapy and medication	• Community integration • Self-help • Peer support • Wellness activities • Growth promoting therapies

From the inmates' perspective, they see both incarceration and forced treatment as punishment, not as a collaborative effort to help them. They may well prefer the humanity of the treatment institutions to the jails (though not always), but both are punishments to be avoided. We already know that the vast majority of these people do not voluntarily engage with and collaborate well with our current community based mental health or substance abuse programs (or health care, education, employment, family services, or housing). There are problems throughout the process – including self-identification, engagement, trust, self-responsibility, shared goal setting, socially considerate behavior, health promotion, etc.

Therefore, transferring people from jail to coercive mental health and substance abuse programs as usually provided may well achieve a beneficial trans-institutionalization and better treatment, for those who can access long term beds, but it is unlikely to lead to significantly more ongoing treatment or reintegration in the community after their sentence is served.

There is also the issue of the dark past history of mental health and coercion. If people are transferred from the justice system to the mental health system, most of the coercive powers would go into upholding the power of the mental health system rather than directly forcing treatment. Mental health has severe scars, trauma, guilt, and resentments around our past use of coercion to uphold our power. The contentious Assisted Outpatient Treatment (AOT) argument, raging across the country gives a sense of what might happen if large numbers of people were transferred to coercive mental health and substance abuse treatment, either in institutions or in the community.

If we're going to try to make a large scale change, do we want it to achieve beneficial trans-institutionalization or community re-integration?

To have a chance at community re-integration as a goal, we have to provide services that both specifically target that goal and that actively engage the inmates "meeting them where they are", building collaboration instead of coercion.

For example, if we master lease an apartment for inmates with mental health and substance abuse needs to live in while supervised in the community, do we expect the inmates to see this as an involuntary treatment facility that is a better place to serve their sentence and to work to be released form than jail, or their new home to build a more successful community life in that they may want to stay living in after their sentence or at least use it as a transitional stepping stone to getting their own home? Will it include the basics of a home – a place to cook a meal giving scraps to their pet, come home from work and watch a ball game, have sex with their girlfriend, pray, have their kids visit and share Christmas gifts?

For the most part, inmates don't view themselves as bad people deserving of their punishments. They're more likely to view themselves as wounded, traumatized, damaged, isolated and rejected, worthless to society, discarded, and cheated of an opportunity for a good life. Collaborative, recovery and community integration focused services would have to meet them there, seeing them that way as well.

There are three basic domains for rebuilding lives that would have to infuse these programs:

1) **Personal:** Helping people understand their own stories, come to terms with their lives, reconnect to their emotions and their goals, heal and adapt, grieve and forgive, rebuild their self-confidence and sense of personal power, to be whole

2) **Relationships**: Helping people to feel listened to , cared about, and no longer isolated, connecting to others in compassionate, mutually beneficial ways, sharing their own strengths and gifts with others instead of acting out of deprivation and pure self-interest, trusting others and being trustworthy, building self-responsibility
3) **Meaningful roles:** Helping people feel welcomed by and connected to their communities, belonging, having positive, useful roles, being good citizens with a share in our society

Clearly jail based, and even most community based coercive forensic programs do an enormous amount to destroy people in all of three of these areas, rather than helping them to rebuild. They intentionally degrade people instead of empower them, isolate them and create primitive fear and power based relationships, disconnect them form meaningful roles. To be fair, coercive mental health and substance abuse programs are likely to be more destructive than rebuilding in these areas too. Even if we do better treatment though trans-institutionalization, we won't likely increase community integration, public safety or decrease future criminal offenses that way.

There are mental health and substance abuse programs and "countercultures" that do engage people in rebuilding themselves in precisely those three ways. For example:

- 12-step AA meetings accept the person as they are, help them deal with their internal shame, make amends to others, reconnect to a higher spiritual power and give back to others. Those features are what makes AA a recovery program instead of just a treatment program.
- Mental health clubhouses and psychosocial rehabilitation programs like the MHALA Village and others – welcome people who our community routinely rejects, help them feel understood and respected, empowered and making goals again, and have purpose and usefulness through a network of relationship based services. Those features are what make us recovery programs instead of just a treatment programs
- Motivational interviewing avoids direct confrontation of destructive and unhealthy behaviors, instead working to understand how the person sees their own life and choices, how their ambivalence can be exploited, and how they can be supported to gradually find the will and tools to change and sustain change within them
- Trauma informed approaches, help inpatient staff view their violent patients as traumatized and frightened, needing caring and reassurance rather than as enemies needing to be sedated and controlled. They are able to avoid using seclusion and restraints and rebuild people's self-control instead.
- Peer support breaks down the "us vs. them" walls and stereotypes that separate and segregate us. Other people who have overcome similar experiences and conditions and successfully returned to the community, create a "counterculture" of acceptance and

hope. The best, like Homeboy Industries, then spread their counterculture to the community around them.

- Other specific examples of person centered, growth oriented recovery based practices include: exposure to new activities and values, harm reduction, housing-first, supported housing, education, employment and health care, Critical Time intervention (CTI) housing programs, mentoring (like Big Brother-Big Sister), narrative therapy, moral and other Cognitive Behavioral Therapies (CBT), open dialogue, Wellness Recovery Action Plans (WRAP), advanced directives, Dialectic Behavioral Therapy (DBT), shared decision making / collaborative medication, core gift,

If we want to try to have these jail diversion programs do more than temporary treatment, to have them help people rebuild their lives, we must insist that, despite the forensic context, they be growth-oriented, recovery based programs.

Keeping programs small and relationship based.

Recovery based programs are invariably relationship based programs. The work of rebuilding occurs within genuine emotional caring relationships. Relationships can only be sustained within groups of 150 or less. Beyond that point, few of us can individualize our emotions and we turn instead to habits and policies and professional standards to guide our interactions. This means that for jail diversion programs to be brought up to a useful scale there has to be many local small programs instead of a few big, institutional programs. It's far better to have 50 transitional homes of 10 apartments each, than one 500 bed institution. (Also, communities are more likely to accept and relate to and include local small programs that are serving their family members, friends and neighbors than large institutions.)

Integrating Services:

Many people will be initially engaged by relationship based recovery services rather than treatment services. Initial goals will far more often be things like getting to talk to family again, or getting an apartment, or a job, or even just to go to a movie or have a hamburger, than they will be illness driven goals. But over time, they will build collaborative relationships, and even treatment goals, within that context. Then is when we must have condition specific services integrated within these programs and accessible, without needing to switch paradigms. They will likely need psychiatric medications and substance abuse treatment, housing and employment training, anger management and parenting skills all provided within recovery based relationships and program cultures.

Key among needed services are mental health, substance abuse, housing, and public safety. Too often, however, the issue is seen as one of diverting people from incarceration to other service systems, rather than a need to integrate all four sets of services. Regardless of who has

lead responsibility, virtually all of these people need all four of these services. It's not a question of just providing money for community mental health services for released inmates, for example. They'll need housing, substance abuse services, and even community public safety services if staff and community members aren't going to be hurt or otherwise victimized.

Historically, each system has tried to define its responsibility to exclude the other three sets of needs, not to integrate them. Mental health programs excluded people who were actively abusing drugs and alcohol for years and vice versa. Police and jails resent having to serve people with mental illnesses and want us to take these people off their hands. Housing programs exclude people with criminal records, substance abuse and disruptive mentally ill behaviors. Nonetheless, most people have multiple challenges and needs and need all of us to work together.

Since inmates are generally poorly engaged and self-coordinating the four sets of services need to be integrated into every service location as "one-stop-shops" to be effectively used. Just having a probation officer or a HUD housing office somewhere in the same city, isn't enough for even an intensive mental health Full Service Partnership (FSP) program to be effective. A common successful partnership are the MET and SMART teams pairing mental health and police directly in the same car.

When services are integrated, new integrated recovery based program descriptions like these emerge:

1) **Welcoming center**: outreach and engagement, "no wrong door", connecting and building therapeutic relationships, drop-in, urgent care, charity services
2) **Sanctuary**: a safe place of acceptance, where one can lower defenses and vulnerably look at what needs to change, to get hope, physical safety through shared community, there are consequences for behavior but people aren't rejection and there are "no fail" policies
3) **Refugee center**: many people have lost their roots and connections, drifting or excluded as refugees in their own country. They need charity, re-documentation, benefits assistance, treatment, danger reduction, "good citizenship" training, developing a community "niche" and belonging, and social advocacy.
4) **Healing and Wellness center**: True healing requires work on many levels: biological, cognitive, emotional, and spiritual and a great deal of collaboration and self-responsibility.
5) **Opportunity center**: Access to opportunities to rebuild your life despite past record and history in key quality of life areas – housing, education, employment, family reunification. "We'll open a door to a new life, but you have to walk through it."

While there is overlap between these centers' missions, they are more likely to match the person's self-perception of their needs more than our current program missions.

Programs predictably fail in the areas that aren't robustly included. FSPs have attracted a great deal of positive attention because of considerable integration of mental health, housing, and substance abuse services. Their failure to integrate public safety (for example by having a mental health court, a mental health specialty probation officer, and a quality of life police team included in the FSP) is being exposed as a crucial weakness as more people with criminal and dangerous lives are enrolled. We must especially focus on bridging the divides between public safety and treatment staff and systems to actively collaborate (for example a co-located police outreach worker can help keep treatment staff safe and an mental health Nurse Practitioner can give street based consultations to the Quality of Life police).

Triage focused on reducing risk of dangerousness and increasing public safety.

If we begin by triaging people by their risk to public safety, rather than by their diagnosis (and treatment need) or by their current offense (and need for punishment) , almost regardless of what services the person is receiving, we can divide people into three basic groups: 1) Needing forcible exclusion from the community, (usually this is because they are too dangerous, but they may have other intolerable behaviors or be dangerously self-destructive), 2) Able to be tolerated within the community with active support in the community (may be a combination of voluntary participation and some coercion), 3) Tolerable in the community despite crime, even if not engaged or cooperative with needed/ assigned services.

Here is a grid of our current fragmented system:

Triage by public safety level			
	Level 1: Involuntary , excluded from society	Level 2: Actively supported in the community	Level 3: Unengaged, living in the community
Housing	institutional living	Housing subsidies	Shelters Self-supporting – often homeless
Substance abuse	Locked drug rehab, Substance abuse treatment while incarcerated, Voluntary detox and inpatient treatment	Residential treatment Sober living Outpatient services Self-help groups Drug court – prop 36	"harm reduction" "housing first"
Mental Health	Hospitals – acute and long term IMDs Jail and prison mental health programs	FSPs Board and Cares Outpatient clinics and case management Housing subsidies	Psych ER Crisis, urgent care, walk-in services MET / SMART PET

		AB109 POC AOT	Outreach 'housing first" "collocated services"
Public Safety	Jail Prison	Probation Parole Community policing / "wellness checks" "Quality of life" police	Police dispatch /patrol Court warrants MET / SMART Restraining orders

Looking back at our previous four integrated service missions, we'd expect people in level 1 to need incarceration and refugee centers, people in level 2 to need sanctuaries, opportunity centers, and healing / wellness centers, and people in level 3 to need welcoming centers.

There is an important difference between community services who see their primary purpose as triaging and evaluating people for community exclusion (like MET / SMART) and those who see their primary purpose as providing support within the community (like the Quality of life police teams in Long Beach). Even within a given office (like probation or parole) some officers may see their primary role as assessing for reincarceration and some may see their primary role as providing support, advocacy, and services to help people live successfully in the community. Similarly some Psychiatric ER staff may see their primary role as evaluating for involuntary hospitalization and some may see their role as supporting engagement with and effective usage of community services

Too often, moving from one "lead responsibility" to another also inadvertently leads to changing levels of care. For example, when a public defender trying to keep their client out of jail (level 1) can't find a locked drug rehabilitation program for them (also level 1), they will refer them to a mental health FSP program in the community (level 2). When the person turns out to be level 3 and won't cooperate, uses drugs, and is abusive in the community the FSP program can neither move them up to level 1 mental health services (since they aren't on a mental health LPS conservatorship) or return them to level 1 public safety or substance abuse services without getting a court order and a warrant for their arrest. Almost all agencies only have access to a limited number of triage choices – by either level or lead responsibility – and mismatches are the too frequent outcome.

The different lead responsibility systems have very different levels of resources and services allocated to them and to their different levels. Also different service delivery strategies have evolved within the different systems. Sometimes that historical development leads to triaging to a different lead responsibility system even if it's not really their primary need. For example, Assertive Community Treatment (ACT) teams have existed within mental health for 40 years, but none of the other systems have them. That has led to mental health being the major

provider of intensive level 2 services and some "subcontracting partnerships" – like shelter-plus vouchers or AB109 but also to strange diversions (for example drug addicts or repeated domestic violence perpetrators being referred to mental health FSPs.) On the other hand, substance abuse never developed involuntary civil commitment treatment facilities and mental health has closed most of their institutions leaving public safety as the major providers of level 1 services even though they have limited therapeutic effectiveness.

Transitioning between levels presents special challenges. For example, housing subsidies and SSI disappear when someone is incarcerated and it's difficult to restart rapidly upon release as a coordinated part of a community integration plan. Mental health has had to divert treatment money into housing subsidies as a result.

With such a complex system effective, integrated, well informed triage becomes a necessity. Unfortunately, the triage we use is incredibly fragmented and poorly informed and is too often guided by accessibility and familiarity more than by meeting people's needs.

By far the most extensive and expensive component of the triage system is the criminal courts. They can spend incredible efforts determining whether someone who requires exclusion from the community goes to a prison with mental health services or a forensic mental hospital with public safety guard services. Decisions about "conditions of probation" or "conditional release" which may be crucial to the person succeeding in the community are often buried in the plea bargain process or assigned by rote. Crucial innovations in legal procedures to facilitate triage, like drug court, mental health court, and homeless court would need to become the normal procedures for effective deincarceration to occur.

There is very limited sharing of information between the systems of either the people's characteristics (including dangerousness) or the system's service availability. Individual lawyers and judges, police and ER psychiatrists, HUD eligibility workers and substance abuse program intake workers, Board and Care staff and shelter staff make fragmented, poorly informed triage decisions daily.

When someone agrees to and is assigned to a level 2 program (for example by the AB109 hubs) and then doesn't engage or cooperate, there needs to be a way to re-triage them, either to find a better matched level 2 program or to determine if they are too dangerous or destructive to be allowed to continue in level 1 services and must be moved to a level 3 service. Within our present system – except for some parole officers and some drug and mental health courts – that re-triage generally doesn't occur unless some new bad thing happens like getting psychotic enough to be taken to a psychiatric ER or being arrested for a new offense.

Implementation challenges.

Individual agencies, programs, and communities can approach providing for these needs in individualized, creative ways building on their current strengths. Transforming existing programs and creating new programs engaging new or expanded populations is a serious leadership challenge. Here are some key implementation domains:

1) **Agency vision and mission**: Does this new project reinforce the agency's identity or change it in ways that add meaning to the work being done?
2) **Staff compassion**: Can the agency put together a "critical mass" of staff who are compassionate towards these people to build a cohesive "counterculture of acceptance"?
3) **Staff skills and competencies**: Can the agency find staff "champions" to get needed "specific skills" integrated into everyone's competencies so staff can feel hopeful and effective?
4) **Community resources and partners**: Can the agency find enough community partners accepting of these people and fend off community intolerance and rejection so that the program and the people they serve have opportunities to be included in the community in meaningful roles and avoid "going it alone"?
5) **Containing fear**: Do the staff have enough cohesiveness, relationships with the people being served, skills, and active collaboration with public safety providers, to feel safe and secure and avoid working in an atmosphere of fear?
6) **Sustaining emotional relationships**: Do staff have the ability to overcome serious barriers to engage with the people they're serving, in mutually trustworthy relationships and avoid people being "unreachable" or "untouchable"?

As a comprehensive system unfolds there will likely be less need for the most coercive, risk averse programs than at first because some people will be getting more collaborative, community based services that stop their deterioration and because some people in the most coercive, risk averse programs will be able to grow enough to go to more collaborative, community based programs that previously didn't exist. It takes trust to allow this to unfold.