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DEPARTMENT OF MENTAL HEALTH

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JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

August 17, 2020

TO: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **CONSOLIDATED REPORT RESPONSE TO THE MOTIONS "CRISIS RESPONSE COORDINATION (ITEM 3, AGENDA OF MARCH 4, 2020)" AND "ALTERNATIVES TO LAW ENFORCEMENT CRISIS RESPONSE (ITEM 40-H, AGENDA OF JUNE 23, 2020)"**

On March 4, 2020, the Los Angeles County Board of Supervisors (Board) approved a motion directing the Department of Mental Health (DMH) and Chief Executive Officer (CEO) to report back with an assessment of Los Angeles (LA) County's current crisis response system and make recommendations for addressing gaps and improving coordination.

On June 23, 2020, the Board approved another motion authorizing DMH to collaborate with the Health and Human Services Crisis Response Coordination Steering Committee (renamed Alternative Crisis Response Steering Committee) to explore ways for LA County residents to call a number that is supported by and provides access to a consolidated health and human services response, consistent with and building off of the recommendations in the Alternatives to Incarceration Workgoup's "Care First, Jail Last" March 2020 report.

The attached report "LA County's Alternative Crisis Response: Preliminary Report and Recommendations" serve as the first phase (Phase 1) to fulfill the directives of the Board.

If you have any question or need additional information, please contact me, or staff may contact Dr. Amanda Ruiz, Mental Health Psychiatrist, at (213) 738-4651 or amaruiz@dmh.lacounty.gov.

JES:tld

Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
Department of Health Services
Alternative Crisis Response Steering Committee

Los Angeles County Alternative Crisis Response

Preliminary Report and Recommendations

Jonathan E. Sherin, M.D., Ph.D.
Director, Los Angeles County Department of Mental Health

Robert Ross, M.D.
President and CEO, The California Endowment

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Preliminary Outline of Recommended One-Time and Ongoing Investments

Crisis System Core Component	Investment Description	Potential Offsets
Component 1: **"**Regional Crisis Call Center Network"	Design, construct, and implement a state-of-the-art Regional Crisis Call Center Network: • Acquire technology platforms equipped to ensure equitable omnichannel access (phone, text, chat) and support coordination (i.e., "air traffic control") of crisis calls, response team activities, and access to care; • Consolidate 911 and other crisis call center functions (requires reconfigurations); • Acquire adequate crisis call center staffing to include peers and clinicians 24/7; • Formalize countywide protocols for crisis and suicide risk evaluation, triage, and dispatch; • Engage ongoing, iterative community member and front-line staff focus groups; • Develop state-of-the-art data collection and analysis infrastructure to assess performance metrics and client as well as community/County outcomes; and • Deliver ongoing training for the system as needed based on indicators.	One-Time: • ATI Fund, Cities • Philanthropy • Private payers • Medi-Cal managed care plans • State/federal grants • DMH/DPH/DHS Ongoing: • ATI Fund, Cities • Private payers • Medi-Cal managed care plans • State/Federal match • DMH/DPH/DHS
Component 2: **"**Crisis Mobile Team Response"	Increase crisis mobile response team and (therapeutic) transport capacity and right-size co-response teams across jurisdictions (including unincorporated County).	
Component 3: **"**Crisis Receiving and Stabilization Facilities"	Increase behavioral health bed capacity including but not limited to urgent care center (UCC), crisis residential treatment program (CRTP), inpatient psychiatry, and peer respite resources.	

NB: As a part of next steps, subcommittees of the Alternative Crisis Response Steering Committee will be created for each of the three core Crisis System components. The subcommittees will be made up of subject matter experts (SMEs) tasked to detail rationale, design, cost, planning, and implementation strategies for these components. Subcommittees will include racial and geographic equity in all planning; throughout each component there is a need to weave in racial equity and measurements to ensure that any gaps identified lead towards improvements that are rooted in racial and geographic equity throughout implementation. Investments will produce a Return on Investment (ROI) via increased access to treatment and a reduction in significant costs of law enforcement responses, emergency room (ER) visits, repeat and extended stay hospitalizations, incarceration and episodes of homelessness across the County. Estimates of ROI will require further research and exploration by subcommittees of the ACR Steering Committee.

A Time for Change in Los Angeles (LA) County's Crisis Response System

Introduction

On March 4, 2020, the Los Angeles County Board of Supervisors (Board) unanimously approved a motion directing the Department of Mental Health (DMH) and Chief Executive Officer (CEO) to report back with an assessment of LA County's current crisis response system and make recommendations for addressing gaps and improving coordination [1].

The following week, the LA County Alternatives to Incarceration (ATI) Work Group released its final report and recommendations [4]. As context, for over a year, the ATI Work Group met and engaged with community members and leaders from throughout the County on how to develop a truly "care first, jails last" system. In response, the Board voted unanimously to establish an office to advance the ATI initiatives, and it was organized into five key strategies including initiative 2., **bolded** below, which has led to the work of the Alternative Crisis Response Steering Committee (ACR):

1. Expand and scale community-based, holistic care and services through sustainable and equitable community capacity building and service coordination.
2. **Utilize behavioral health responses for individuals experiencing mental health and/or substance use disorders, homelessness, unemployment, and other situations caused by unmet needs; avoid and minimize law enforcement responses.**
3. Support and deliver meaningful pre-trial release and diversion services.
4. Provide effective treatment services in alternative placements, instead of jail time.
5. Effectively coordinate the implementation of ATI recommendations, ensuring that strategies eliminate racial disparities and to authentically engage and compensate system-impacted individuals.

Since these prescient Board actions, the tragic murders of Breonna Taylor and George Floyd ignited a mass uprising for Black life that has reshaped the local, state, national, and global conversation on U.S. police practice. Included in this conversation is the urgent need to build new systems for receiving, assessing, triaging, and mounting our non-law enforcement response to crises across our communities. A June 23, 2020, motion from Board [2], and a similar motion from the LA City Council [3] affirmed this demand in Los Angeles and created processes to generate the change we need.

The ACR now charged to review the current state of affairs and develop recommendations for a future state in accordance with Board action, met on July 10, 17, and 24 to discuss a path forward for LA County's crisis system. The ACR is being chaired by Dr. Jonathan Sherin, Director of LA County DMH, and Dr. Bob Ross, President and CEO of The California Endowment and Chair of the ATI Work Group. Among numerous principal committee members is leadership from: County Health and Human Service Departments as well as County Fire and Sheriff's; LA City Fire and Police as well as leaders from other key municipalities; and community leaders from various other organizations across the County. This very preliminary and cursory report represents a consensus framework for how the ACR plans to move forward in developing detailed recommendations.

A Vision for LA County's Crisis System

Values and Principles

In developing a vision and plan for a better crisis system in LA County, it is critical that we adhere to a key set of values and principles that remain intact in deliberation, planning, and implementation efforts:

1. In furtherance of the ATI Work Group's commitment to the robust engagement of community stakeholders and front-line workers, the ongoing reform and transformation of our crisis system must explicitly engage those most impacted to help inform design through firsthand experience.
2. The culture of the rebuilt crisis system must not only meet real-time needs of community but also eliminate racial disparities perpetuated, directly or indirectly, by the current system.
3. A reengineered crisis system must incorporate, at its core, design features and implementation strategies that dramatically reduce and mitigate law enforcement responses wherever and whenever possible.

Crisis System Models and Best Practices

LA County has been an innovator in crisis response for decades. The Didi Hirsch Suicide Prevention Center, founded in 1958 as the first of its kind in the United States, still stands as a beacon of hope and universal access to mental health crisis services on Olympic Boulevard [12, 13]. In addition, the County Sheriff's and Los Angeles Police Department's co-response efforts, in operation for decades, make up one of the first and also largest law enforcement and mental health programs in the nation [14]. By learning from our crisis system experiences to date and best practices from around the country, LA County is once again poised to play a leading role through the further redesign and reengineering of an alternative crisis response system.

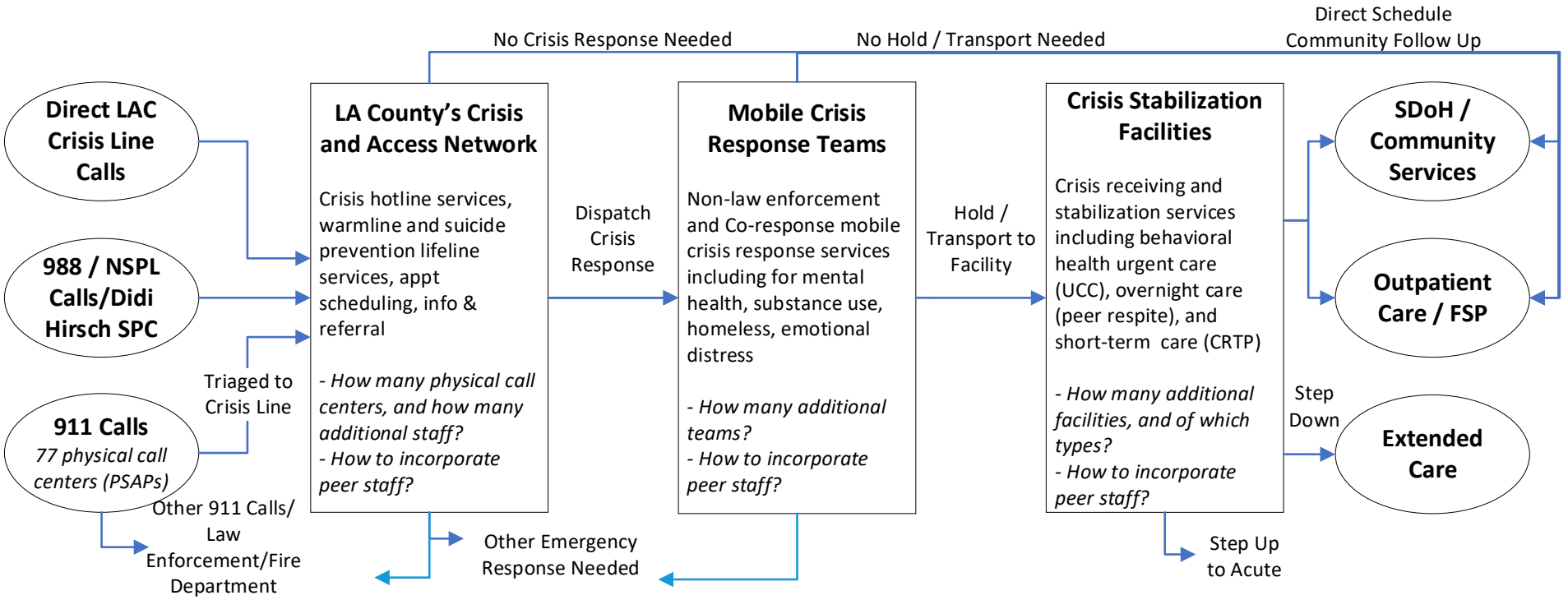
A recent report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers guidance and best practices for developing and improving the three core components of a high-functioning crisis system [7]:

1. Regional Crisis Call Hub Services (Someone to Talk To)
2. Mobile Crisis Team Services (Someone to Respond)
3. Crisis Receiving and Stabilization Services (Somewhere to Go)

A Redesigned Crisis System for LA County

It is important to note that there are jurisdictions in the country that, though smaller, have been able to pull together a variety of the components described in the SAMHSA report including CAHOOTS and Crisis Now, as well as the Georgia Crisis, Sacramento Mental Health First, and Access Line. With lessons and guidance from these models as well as the body of knowledge and experience obtained locally for over 60 years, we as a County have the unique opportunity during this redesign phase to establish a high-level framework, overlaid and built upon LA County's current assets, to determine what we want our crisis system to look like, and how it ought to operate. Although purposefully cursory, like this report, we developed a Proposed Design diagram:

LA County's Crisis System: Proposed Design (Updated 8/5/20)



Technology Platform: Several applications required, must be stitched together into a cohesive system

(1) call/text routing and handling (incl. caller ID); (2) crisis call/case management (incl. disposition status tracking); (3) mobile team dispatch, routing and tracking (incl. GPS); (4) crisis health info exchange (e.g. EDIE, LANES + system interconnections); (5) crisis facility bed registry (e.g. ReddiNet, MHRLN); (6) outpatient care appt scheduling; (7) SDoH / community services referral management; (8) performance dashboards and reporting

Funding Structure: One time and ongoing funds to implement design

(1) one time grant funding for design and implementation projects, including tech platform build out (fed/state/philanthropy); (2) one time capital development funding for new call centers, mobile team offices, and crisis facility builds; (3) ongoing mental health plan / federal, and other health plan reimbursement for crisis services; (4) ongoing funding from local governments

Policy/Legislative Structure: Policy changes needed to realize ideal design

(1) allow EMS providers more flexibility in transport destination; (2) enable proper utilization and funding of peer staff throughout crisis system; (3) all payer case rates for crisis episodes (including for calls, team response, and crisis stabilization care)

Preliminary Gap Analysis of LA County's Crisis System

Regional Crisis Call Centers

Currently, crisis call centers in LA County include 911, DMH ACCESS and the Didi Hirsch Suicide Prevention Center (SPC), wherein DMH ACCESS and the Didi Hirsch SPC serve as behavioral health crisis call centers. The Didi Hirsch SPC currently powers the federal National Suicide Prevention Line (NSPL) for our region as well as the nationally reaching Disaster Distress Helpline, combined serving 130,000 individuals in crisis a year with numbers that have grown significantly during the pandemic. The 911 call center network, which includes 77 public safety answering points (PSAPs), is currently led by law enforcement and manages crisis calls. However, there are variations in screening, triage, handoffs (peers to clinicians) and dispatch processes among the PSAPs as well as the behavioral health call centers.

LA County is in need of a true regional crisis call center network, with shared standards for triage, the ability to dispatch non-law enforcement crisis response teams, and a shared view into available crisis stabilization resources, including treatment beds with an overall goal of minimizing law enforcement response to the maximum extent possible. The ACR considers a reconfigured and appropriately resourced 911 call center network integrated with the behavioral health crisis call center network as one means for all calls to be taken directly and functioning as a regional network to screen, triage, and dispatch crisis calls to a non-law enforcement response at every possible opportunity and law enforcement co-response teams where indicated. A reconfigured 911 call center network would include a re-branding media campaign through a lens of racial equity and in consideration of the communities' current perception of 911.

In terms of this network and its inclusion of 911, it should be noted that other jurisdictions, such as Houston, have 911 networks that are not led by law enforcement and have standard protocols for when to triage a call to law enforcement. This so called "opt-in" framework, whereby the default response is non-law enforcement unless explicitly determined to require law enforcement response during triage, stands in stark contrast to the current "opt-out" framework, where law enforcement response is the default unless otherwise indicated. Preliminary data from Houston shows 51% reduced overall dispatches, 50% reduced time for dispatched professionals in the field, and ~$6:1 ROI. The "opt-in" framework is a model that LA County needs to explore to allow for health and lived experience professionals to facilitate crisis triage options.

Crisis Mobile Response Teams

Reconfiguring the 911 and behavioral health call centers into a regional network is important but will not provide the desired outcomes without also increasing the ability to respond. There is a consensus amongst the ACR that the majority of additional capacity needed for such response ought to focus on interdisciplinary non-law enforcement crisis response with shared response protocols, and there is a strong consensus among the ACR that additional capacity is needed across the County. These teams also need to be better coordinated, more easily dispatched, equipped to manage transportation of clients and staffed with peers. There are also Crisis Mobile Co-Response Teams, including MET, LET, START, and SMART. While there is some consensus that there are an appropriate number of these teams in LA City, there is concern that additional teams are needed elsewhere and in the LA County MET

program in particular. Although these teams include an armed law enforcement officer, they are considered important much more broadly in the crisis response system.

Crisis Receiving and Stabilization Facilities

As indicated in the October 2019 report on addressing the shortage of mental health bed capacity, while LA County has behavioral health urgent care centers (UCCs) and crisis residential treatment programs (CRTPs) as well as inpatient psychiatric treatment and peer respite facilities, there is a significant need to increase these resources as well as facilities for substance use disorders. These facilities are absolutely critical to have a place to take individuals in crisis, other than emergency rooms, hospitals, and jail. There is also a need to evaluate the efficiency, including length of stay, for each of the community based mental health and substance use resources that would support a reimagined alternative crisis response system. There is a strong consensus in the ACR that many more of these facilities are needed and should be geographically distributed around LA County, especially in the outlying areas. Locating these facilities on hospital campuses (key components of our "Restorative Care Village" model) is also important to deal with siting difficulties as well as being conveniently located near public transportation and enriched clinical services. Additionally, the improved alternative crisis response system needs to ensure a better utilization of extant community and non-governmental mental health bed capacity.

Infrastructure: Technology, Funding, Policy

A robust crisis system will need to be supported by an infrastructure that helps to coordinate the various elements, supports the sustainability of the system, and is within a legal/regulatory framework.

Technology

- The current crisis system does not have a holistic technology platform to support it, similar to the proposed LA County's Crisis System proposed design diagram.
- The current crisis system components do not communicate efficiently to coordinate crises and share information in real-time as needed.
- Achieving true "air traffic control" of crisis cases will require a big technological overhaul, but given the ROI and likely human harms we could avoid, this would be worthwhile investment.
- Increase mobility by exploring the use of mobile device applications to directly connect health and human services workers to the appropriate crisis response teams

Funding

- Initial investments will require significant one-time funding, including leveraging grants, local health plans, and philanthropy in addition to various public funds.
- Sustaining investments will require significant ongoing funding and a structure that leverages those funds efficiently and effectively.
- DMH as the mental health plan, DPH SAPC, and the managed care plans (LA Care and HealthNet) can be used to draw down federal Medicaid funds for services provided in the Crisis Mobile Team Response and Crisis Receiving and Stabilization Facility components of the crisis response system provided all applicable federal and state requirements are met. Claiming to Medicaid for the Regional Crisis Call Center component is also possible limited.
- Proper reimbursement will be required from private/commercial health plans.

- States like Arizona and Washington have models for crisis call centers identifying and billing callers' public and private insurance plans.
- Explore partnerships with major telecom partners like Verizon or IBM which are funding communication systems in other parts of the country.

Policy

- Peers are a key element in a high-functioning crisis response system, at every step from the initial call all the way through to the crisis receiving and stabilization facilities. It is important to ensure they can receive compensation, and we await legislative action on Senate Bill (SB) 803, which would allow Medi-Cal billing for Peer Support Specialist Services to start in three or more years.
- We need more flexibility for EMS providers to transport clients to destinations by expanding the current waiver for paramedics (LAFD has a current waiver per discussion).
- An increase from 24 hours to 72 hours for reimbursable services in behavioral health urgent care centers will improve both the urgent care program and client outcomes but also assist with bringing in federal dollars.

Next Steps

1. **Continue the work.**
   Identify and implement changes that can begin immediately to improve the current system while addressing current barriers that exist and developing remedies to resolve those issues, including but not limited to, creating a direct line to DMH ACCESS for law enforcement.

   Develop the three alternative crisis system core components referenced in this report with input from the following principals and stakeholders to focus on the following areas:
   a. Representation across key public health, public safety, technology, capital, finance, labor and marketing fields with both public and private sector involvement;
   b. Clients previously exposed to the current system and community advocates as well as front-line workers to develop racial, ethnic and geographic equity measurements, and facilitate planning to ensure that any identified gaps guide efforts towards system improvement rooted in equity from design to implementation;
   c. Operations, finance structures, and relevant policy advocacy to ensure the sustainability of each component; and
   d. Granular, feasible and actionable recommendations for design, development, funding and implementation.

   Map the current, in development and potential assets within each supervisorial jurisdiction in Los Angeles, prioritizing those to whom response is most impacted by behavioral health crisis and issues relating to social determinants as well as incarceration

2. **Design a system for LA County.**
   Secure a consultant who, in coordination with the three subcommittees, a full range of community stakeholders, and front-line workers, will help:
   a. Analyze LA County's existing crisis system and gaps in more detail.
   b. Develop focused recommendations and an implementation plan to optimize the existing system and identify "early wins." These "early wins" need to address the current barriers that exist and develop remedies to resolve those issues to create an existing system that is fully functional.
   c. Design a new, scalable system structure in which the County can allocate additional needed resources in a way that will maximize a return on investment, both in terms of fiscal savings from reduced ER visits, hospitalizations, and law enforcement response and incarcerations, but even more importantly the elimination of racial disparities and preventable harms done to individuals and communities by the current system.
   d. Develop a long-term implementation plan for the new system design and work with County leaders to develop a funding plan for it.
   e. Establish performance metrics by which the system can measure and hold itself accountable for high quality outcomes.

3. **Don't reinvent the wheel.**
   Continue to leverage research and best practices of over 60 years in LA County as well as from around the country (e.g., Crisis Now, CAHOOTS, and the Mental Health First team) to inform the

vision for and implementation of a 21st century crisis system in LA County. Dr. Sherin kicked off the effort with a visit to Arizona to tour its crisis system and see firsthand implementation of the Crisis Now model.

4. **Be a model for the rest of the nation.**
   Work with local experts and research institutions to ensure this change process is documented and key outcomes are monitored according to high quality research principles. Leave no doubt about the impact of this new crisis system on LA County and show other jurisdictions throughout the country how they, too, can build a better crisis system.

References

1. LA County Board of Supervisors Motion (Hahn/Barger). March 4, 2020. "Crisis Response Coordination"
2. LA County Board of Supervisors Motion (Hahn). June 23, 2020. "Alternatives to Law Enforcement for Crisis Response"
3. LA City Council Motion, Council File 20-0769. June 16, 2020. "Unarmed Model of Crisis Response / Non-Violent Calls for Service / Non-Law Enforcement Agencies"
4. LA County Alternatives to Incarceration Work Group. March 2020. Final Report – "Care First, Jails Last: Health and Racial Justice Strategies for Safer Communities"
5. LA County Alternatives to Incarceration Work Group. February 2020. Preliminary Implementation Plans
6. LA County Department of Mental Health (DMH). October 29, 2019. "Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response" + "Countywide Mental Health and Substance Use Disorder Needs Assessment" reports
7. Substance Abuse and Mental Health Services Administration (SAMHSA). February 2020. "National Guidelines for Behavioral Health Crisis Care"
8. National Association of State Mental Health Program Directors (NASMHPD). Crisis Now Model
9. National Action Alliance for Suicide Prevention: Crisis Services Task Force. 2016. "Crisis Now: Transforming Services is Within Our Reach"
10. Crisis Now Videos:
    a. The Promise of 988: Crisis Care for Everyone, Everywhere, Every Time
    b. Crisis Now: Crisis Call Center Hub
    c. Crisis Now: Transforming Crisis Services in Arizona
11. LA County Emergency Medical Services Commission (EMSC): Ad Hoc Committee on the Pre-Hospital Care of MH and Substance Abuse Emergencies. September 2016. Final Report.
12. Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US); 2012 Sep. Appendix C, Brief History of Suicide Prevention in the United States.
13. Didi Hirsch Mental Health Services, Suicide Prevention Center
14. Los Angeles Police Department. Mental Evaluation Unit.
15. Regional Models and Best Practices:
    a. White Bird Clinic, Eugene, Oregon. Crisis Assistance Helping Out On The Streets (CAHOOTS) Model
    b. Georgia Crisis and Access Line (GCAL)
    c. New Mexico Crisis and Access Line and Peer-to-Peer Warmline
    d. Colorado Crisis Services
    e. Pima County, Arizona. Crisis Response Center: Main Website, Case Study, and Presentation
    f. Sacramento, The Mental Health First Team
16. Relevant Pending Legislation:
    a. US Senate Bill S.2661. National Suicide Hotline Designation Act of 2020

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July 21, 2021

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director, Department of Mental Health

Judge Songhai Armstead (Ret.)
Executive Director, Alternatives to Incarceration Office S. Armstead
Chief Executive Office

SUBJECT: **CONSOLIDATED REPORT RESPONSE TO THE MOTIONS "CRISIS RESPONSE COORDINATION (ITEM 3, AGENDA OF MARCH 4, 2020)," "ALTERNATIVES TO LAW ENFORCEMENT CRISIS RESPONSE (ITEM 40-H, AGENDA OF JUNE 23, 2020)," AND "LOS ANGELES COUNTY ALTERNATIVE CRISIS RESPONSE (ITEM 18, AGENDA OF SEPTEMBER 29, 2020)"**

On March 4, 2020 and June 23, 2020, the Los Angeles County (LA County) Board of Supervisors (Board) approved motions which led to the creation of the Alternative Crisis Response (ACR) Initiative to explore ways for LA County to provide access to a consolidated health and human services response, consistent with and building off of the recommendations in the Alternatives to Incarceration (ATI) Workgroup's "Care First, Jails Last" March 2020 report.

On September 29, 2020, the Board approved the motion, "Los Angeles County Alternative Crisis Response" directing the Department of Mental Health (DMH), in coordination with the Chief Executive Office's (CEO) ATI Office, to move forward with the recommended "Next Steps" in the August 17, 2020 report, "LA County Alternative Crisis Response: Preliminary Report and Recommendations," and provide the Board with a progress report in sixty (60) days and quarterly thereafter.

The initial sixty (60) day report was submitted to the Board on December 7, 2020, and the first quarterly progress report was submitted to the Board on March 9, 2021, (both available here). The following is the second quarterly progress report. As the goals of these motions are related, this report serves as a consolidated quarterly report response.

There are several ACR projects in discussion and in progress. Many of these are also aligned with recommendations from the ATI Workgroup's final report as indicated. The following is an updated table of these projects and the status of each:

Project	Status
(0): Infrastructure/Technology Projects	
(0A): Funding Efforts. Identifying and leveraging myriad funding sources to build and sustain adequate crisis services throughout the County, especially in response to 9-8-8 calls.	**Design/Discussion.** Discussing how to obtain and braid together several possible funding streams for crisis system capacity expansion and ongoing services. The ACR consultant will play a vital role in forming our funding plans, and we are also forming a specific group of stakeholders to develop a funding and advocacy strategy. Possible new funding streams identified so far include: • Care First and Community Investment (CFCI) (formerly Measure J) funding; • AB 988, proposed legislation which would include a surcharge on phone bills for 9-8-8 and connected services; • Utilizing Medi-Cal administration (admin) match for 9-8-8 call center services; • Increased Medi-Cal Federal Medical Assistance Percentages for mobile crisis services as part of the American Rescue Plan Act (ARPA), to 85 percent starting in early 2022; • Improving private health plan reimbursement; • One-time funding via the ARPA and Coronavirus Relief Act; • Medi-Cal enhanced admin match for information technology (IT) development and maintenance; • Some cities are considering using municipal funds to help develop their own mobile crisis response programs; and

Project	Status
	• HR 2611, which would repeal the Institutions for Mental Disease (IMD) Exclusion, resulting in a potentially significant increase in federal funds available for residential crisis facility care.
(0B): ACR Consultant. Contracting with a consultant, in partnership with our stakeholders, to develop program and system designs, funding plans, and an implementation plan for expansion of ACR services throughout the County.	**Onboarding.** We have finalized the scope and budget for the consultant's work and are now finalizing the contract needed to onboard them. The previous quarterly progress report included a high-level analysis of current crisis response assets in LA County. As part of the ACR consultant's scope of work, they will be doing a more in-depth analysis of these assets to assess gaps in the system and recommend specific expansions in capacity needed to address them.
(0C): Crisis Facility Bed Registries. Refining applications for tracking and sharing the availability of crisis beds with first responders and crisis care providers. *ATI Recommendation #40*	**Implementation.** There are three existing relevant bed registries: ReddiNet, DMH's Mental Health Resource Locator and Navigator app, and DPH-Substance Abuse Prevention and Control's Service & Bed Availability Tool. We are reviewing existing crisis facility participation in these registries and any needs for promoting more provider engagement. CEO is also working to develop an application capable of integrating information from these and other bed registry applications to further ATI efforts around the County.
(0D): Crisis Information Exchange. Developing solutions for exchanging key information about individuals in crisis between care providers, such as service history, "hooks" and "triggers," crisis care plans, and/or psychiatric advance directives.	**Design/Discussion.** A small working group consisting of representatives from DMH, Didi Hirsch, Los Angeles Police Department (LAPD), Los Angeles County Sheriff's Department (LASD), Emergency Medical Services (EMS) Commission, CEO-Chief Information Office (CIO), and County Counsel met several times to formulate a project write-up, laying out the needed project scope and next steps.

Project	Status
ATI Foundational Recommendation #110	Now we are formulating subject matter expert focus groups to work with the Los Angeles Network for Enhanced Services (LANES), LA County's regional health information exchange, to develop specific LANES data views/dashboards most relevant to crisis care providers.
(0E): ACR Dashboard: Data and Outcomes. Assessing the landscape of data in LA County relevant to our crisis system and developing plans to regularly gather and analyze it to inform system changes. *ATI Foundational Recommendations #87 and #110*	**Design/Discussion.** Currently in discussion with the CEO-CIO to ensure alignment of ACR data strategy with the overall ATI Initiative. Once onboarded, the ACR consultant will help inform data strategy for ACR specifically, including key metrics and ongoing analysis needs. We are particularly interested in ensuring the ability to disaggregate this data to show differences in outcomes by race/ethnicity, geography, and other cultural characteristics, so that we can develop focused projects to address inequities in the system up front.
(0F): Legislative Advocacy. Advocacy efforts for State and federal legislation that would help advance ACR in LA County.	**Ongoing.** There two (2) primary legislative advocacy efforts relevant to ACR in which the County is engaged: • AB 988, a State bill which would establish a governance structure and a new surcharge to help fund and provide oversight of 9-8-8 call centers and connected crisis services; and • HR 2611, a federal bill which would eliminate the Medicaid IMD Exclusion for States, which have an approved plan for sufficient outpatient and crisis behavioral health care services.
(1): Crisis Call Center Network Projects	
(1A): 9-1-1 Diversion. Establishing standards, developing trainings, and implementing protocols to reliably divert crisis calls from	**Pilot.** There are several related 9-1-1 diversion efforts being stitched together: • Development of a standard behavioral health crisis call assessment matrix as well as a Countywide call diversion model. See

Project	Status
9-1-1 to 9-8-8 and connected services. *ATI Foundational Recommendation #43*	Appendix A for the current iteration of the assessment matrix and Appendix C for the proposed Countywide call diversion model. We are continuing to gather feedback on these from system stakeholders and the community; • LAPD 9-1-1 to Didi Hirsch Pilot. Recently expanded to 24 hrs/day, this pilot is actively diverting 9-1-1 behavioral health crisis calls to the Didi Hirsch Suicide Prevention Center, the same call center which will answer calls to 9-8-8 from individuals in LA County beginning in July 2022; • Discussions between LASD, DMH, and Didi Hirsch of how to move the LASD 9-1-1 call centers toward the LAPD/Didi Hirsch pilot model. This is a change from the original proposal of diverting LASD 9-1-1 calls to the DMH Help Line; and • Discussions on implementation/rollout plans for 9-1-1 diversion that would work for the rest of the law enforcement agencies in the County and their 9-1-1 call centers.
(1B): 9-8-8 and Mobile Crisis Response Coordination. Establishing standards, developing trainings, and implementing protocols to ensure Didi Hirsch/9-8-8 can quickly connect with a mobile crisis response program (e.g., DMH Psychiatric Mobile Response Team [PMRT]) for an in-person civilian response, when needed.	**Design/Discussion.** There are several components under discussion to better coordinate crisis response between Didi Hirsch and the DMH PMRT program, including: • The development of standards and protocols for coordinating PMRT dispatch to Didi Hirsch/9-8-8 calls that require an in-person response (but not a law enforcement or EMS response); • PMRT dispatch centralization/process improvements, along with general DMH Help Line (ACCESS) call center modernization improvements; and • Gathering lessons learned to inform the interface between 9-8-8 and other mobile crisis response programs forming in the County.

Project	Status
	Report back to the Board of Supervisors on March 24, 2021.
(2): Mobile Crisis Response Projects	
(2A): Mobile Crisis Response Programs Expansion. Expanding the capacity of mobile crisis response programs throughout the County, especially civilian mobile crisis response, including co-response programs for the highest risk crises. Includes expansion of peer staff as part of the mobile crisis response teams. *ATI Foundational Recommendations #35, #48, and #108, and Recommendations #36 and #45*	**Pilot.** There are several program expansion efforts in discussion and one piloting, including: • DMH Therapeutic Transportation pilot with the City of LA. This is a civilian mobile crisis response program which will be dispatched by the LA City Fire Department (LAFD). It includes peer staff with lived experience on the teams and will be capable of transporting clients, as needed, to follow-up care; • Discussion of DMH PMRT program expansion, especially with increased federal reimbursement for mobile crisis response starting in early 2022; • Several cities are pursuing development of their own civilian mobile crisis response programs, and DMH is working with those cities to provide access to the upcoming increased federal reimbursement for Medi-Cal mobile crisis response services; and • Discussion of co-response team program expansion, including the LASD Mental Evaluation Team program.
(2B): PMRT Program Improvements. Examining opportunities to improve the PMRT service alongside program capacity expansion. *ATI Foundational Recommendations #35 and #108, and Recommendation #36*	**Design/Discussion.** There are several PMRT program enhancements in discussion, most prompted by stakeholder feedback, including: • Streamlining the PMRT dispatch process to reduce response times; • Incorporation of peer staff on teams; • Moving to a truly 24/7/365 service; • Adding public safety radios to teams; • Revising field triage criteria to improve linkage to follow-up care; and • Equipping teams to be capable of transporting clients most of the time.

Project	Status
(2C): EMS Alternate Destination Program (ADP). Enabling Fire/EMS first responders to transport clients to alternative destinations, such as behavioral health urgent care centers (UCCs) and sobering centers.	**Pilot.** There are several components of this project, including: • Drafting policies and procedures to allow EMS providers to transport to behavioral health UCCs and sobering centers, as well as designation requirements for these facilities to receive patients transported via the 9-1-1 system; • Designating the sobering center downtown, as well as six UCCs under these new protocols; • Approving personnel from the LAFD, LA County Fire Department, and Santa Monica Fire Department to participate in the ADP; • Encouraging participation from other fire departments around the County; and • DMH is evaluating Lanterman-Petris-Short certification policy changes that could support the ADP project. Report back to the Board of Supervisors on May 26, 2021.
(2D): Family Urgent Response System (FURS). Responding to current and former foster children, youth, and non-minor dependents who are experiencing a crisis and requesting in-person support, to reduce placement disruptions and other crisis risks.	**Design/Discussion.** There are several components of this project, including: • Working with the State to design workflows for receiving urgent response referrals from the FURS State Hotline; • Developing a decision tree to assess referrals and route to an appropriate provider within DMH's network of care for a 24/7/365 response, within one (1) hour or up to three (3) hours in extenuating circumstances, unless a different timeframe is agreed upon with the family; • Developing FURS Placement Stabilization Teams to provide additional short-term guidance, in-person support, and/or linkages/referrals for the family for up to 72 hours from the in-person contact; and

Project	Status
	• Developing protocols to transition youth and families from mobile response to ongoing services, as appropriate.
(2E): California-Systemic, Therapeutic, Assessment, Resources and Treatment Program. Providing prevention and intervention services to individuals with intellectual/developmental disabilities and complex behavioral health needs through crisis planning and response, education, consultation, and coaching.	**Pilot.** Exodus Recovery is working with the Westside and South Central Regional Centers to provide specialized crisis response services to regional center clients experiencing a behavioral health crisis, with the goal of reducing placement disruptions, hospitalizations, and any loss of school services.
(3): Crisis Facility Projects	
(3A): Crisis Receiving Facilities Expansion. Expanding the capacity of facilities which can receive individuals in crisis 24/7/365, including behavioral health UCCs and sobering centers. *ATI Foundational Recommendation #2*	**In Development.** There are several new crisis receiving facilities in the pipeline, including: • New Antelope Valley UCC opening imminently (18 beds; 12 adult and 6 adolescent); • New Olive View UCC opening fall/winter; • Two (2) UCCs for children (ages 5 to 12), no opening date yet; • Sobering center in West Athens (Safe Landings) opening in October 2021 (20 beds); and • Sobering center located at the Mark Ridley-Thomas Behavioral Health Center opening in December 2021 (15 beds). There are maps of our current UCCs and sobering centers located in Appendices D and E, respectively.

Project	Status
(3B): Residential Crisis Facilities Expansion. Expanding the capacity of facilities which provide multi-day overnight/residential crisis care, and often serve as an important step down from crisis receiving facilities, including crisis residential treatment programs (CRTPs), peer respite programs, and residential substance use treatment programs (American Society of Addiction Medicine levels 3.1 and 3.2). *ATI Foundational Recommendation #2*	**In Development.** Several new facilities in the pipeline, including: • Two (2) privately-owned CRTPs serving Medi-Cal clients (16 beds each) opening by the end of the year; and • Several CRTPs across four County medical campuses (240 beds total), facility development to be completed by the end of the year. There is a map of our current CRTPs and peer respite programs in Appendix F, as well as a map of our psychiatric acute inpatient facilities in Appendix G. Reports back to the Board of Supervisors about shortages in our network of mental health treatment beds.
(3C): Client Flow Process Improvements. Examining opportunities to streamline and improve the admitting criteria/process for admission to UCCs and CRTPs, as well as to improve client flow into and out of crisis facilities more generally.	**Design/Discussion.** We are reviewing existing admitting criteria and the process for admission to UCCs and CRTPs to evaluate any gaps in comparison to national best practices and formulate plans to address, as needed. We are also working with our crisis facility partners to examine data representative of client flow barriers both into and out of our crisis facility network, in order to develop focused projects to address specific client flow problems.

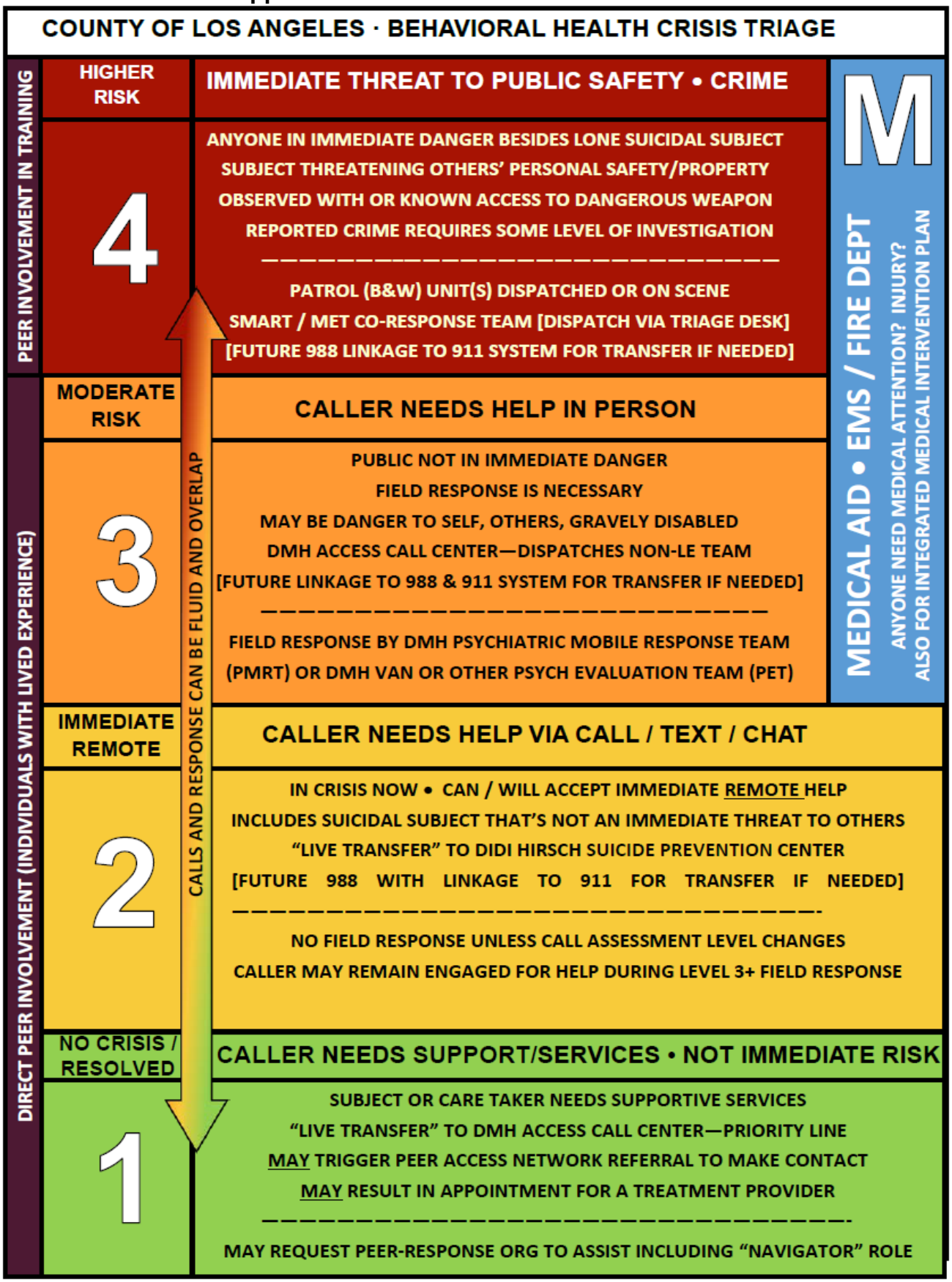
This report is issued on a quarterly basis with the next report to be submitted on September 24, 2021. If you have any questions or need additional information, please contact me, or staff may contact Dr. Amanda Ruiz, Supervising Psychiatrist, at (213) 738-4651 or amaruiz@dmh.lacounty.gov.

JES:JSA:jfs

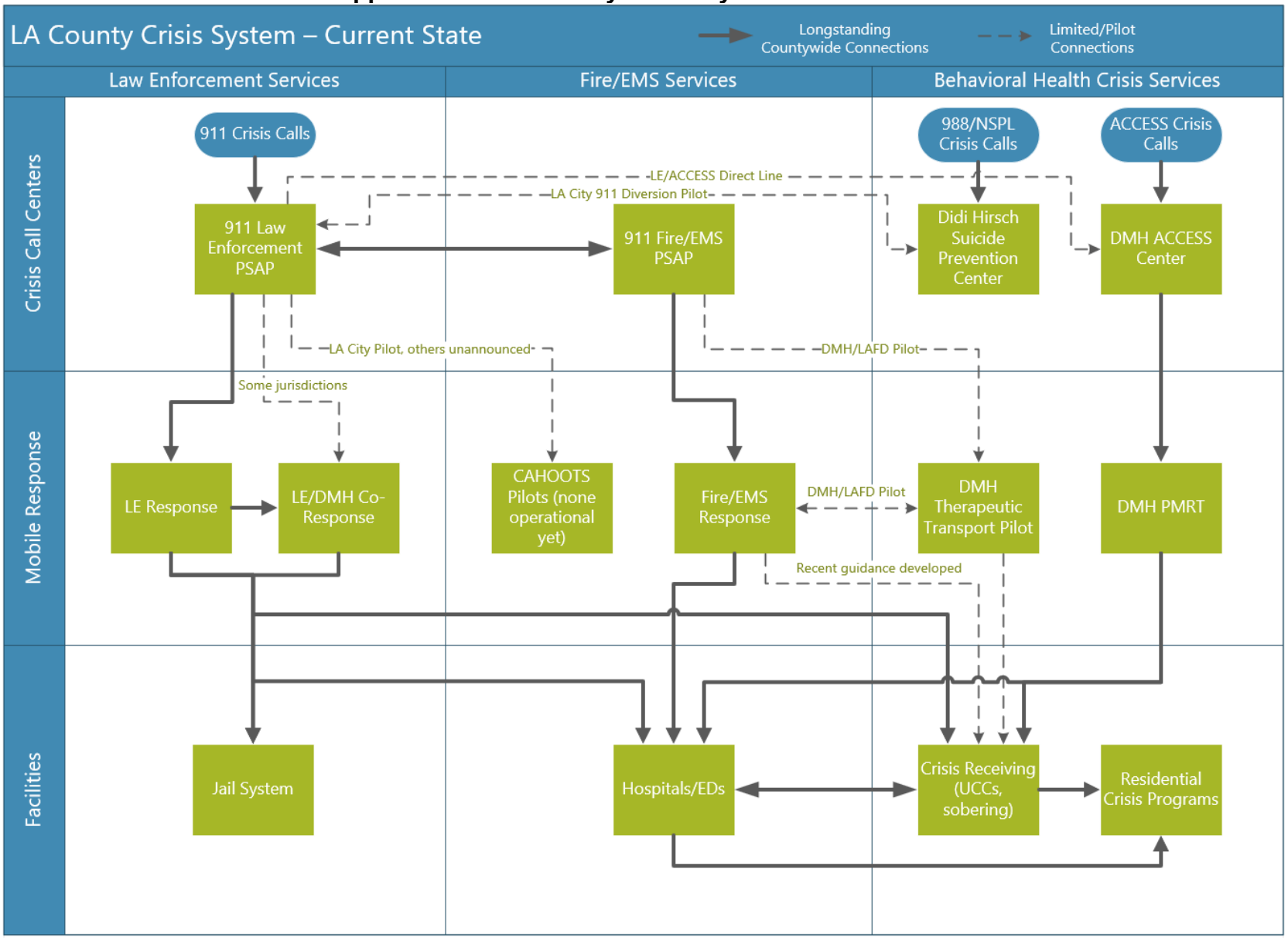
Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

Appendix A: Crisis Call Assessment Matrix

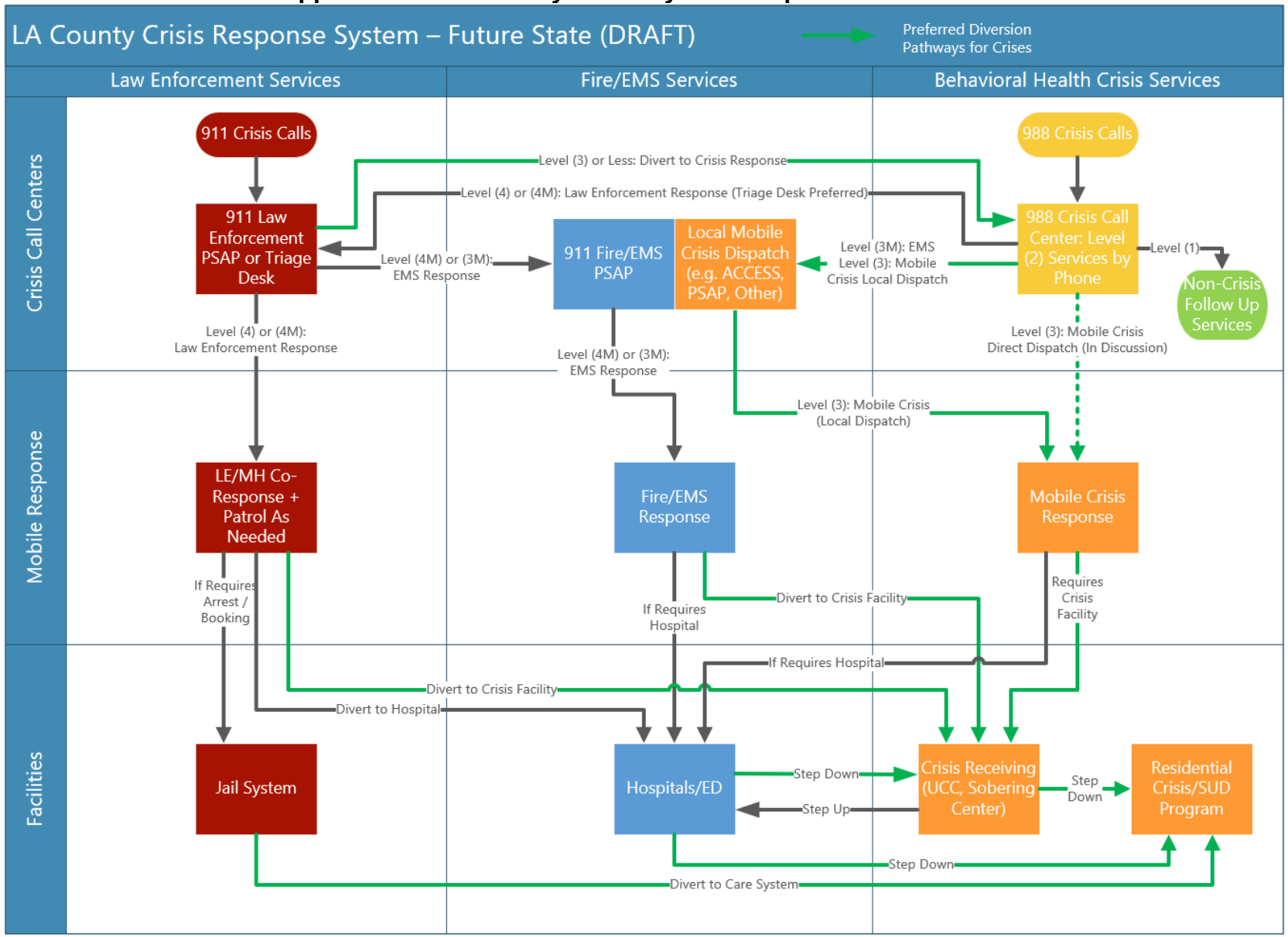


Appendix B: LA County Crisis System Current State



Acronyms: CAHOOTS = Crisis Assistance Helping Out On The Streets Program (Eugene, OR); DMH = LA County Department of Mental Health; ED = Emergency Department; EMS = Emergency Medical Services; NSPL = National Suicide Prevention Lifeline; PSAP = Public Safety Answering Point (911 Call Center); UCC = Behavioral Health Urgent Care Centers

Appendix C: LA County Crisis System Proposed Future State

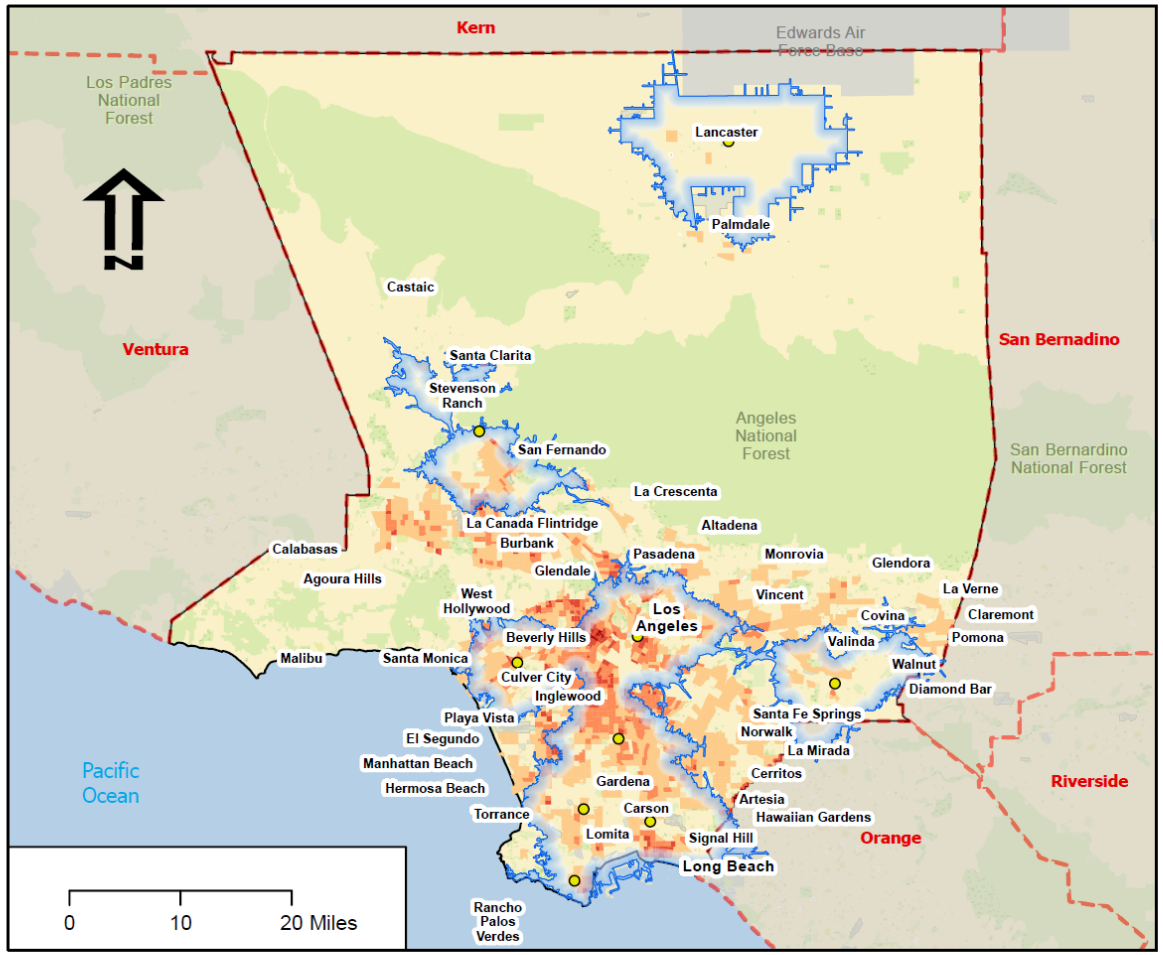


Acronyms: ACCESS = LA County Department of Mental Health's 24hr Call Center; ED = Emergency Department; EMS = Emergency Medical Services; LE = Law Enforcement; MH = Mental Health; PSAP = Public Safety Answering Point (911 Call Center); UCC = Behavioral Health Urgent Care Center

Appendix D: LA County Behavioral Health Urgent Care Centers (UCCs)

Los Angeles County Mental Health Urgent Care Centers

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.



LAC Mental Health Urgent Care Centers

Census Tract Population Density

Sparse

Dense

Drive Time Boundary

15min

Map Created: JAN 2021
By: LACDMH-CIOB (K.T. Williams)
Contact: KyWilliams@dmh.lacounty.gov

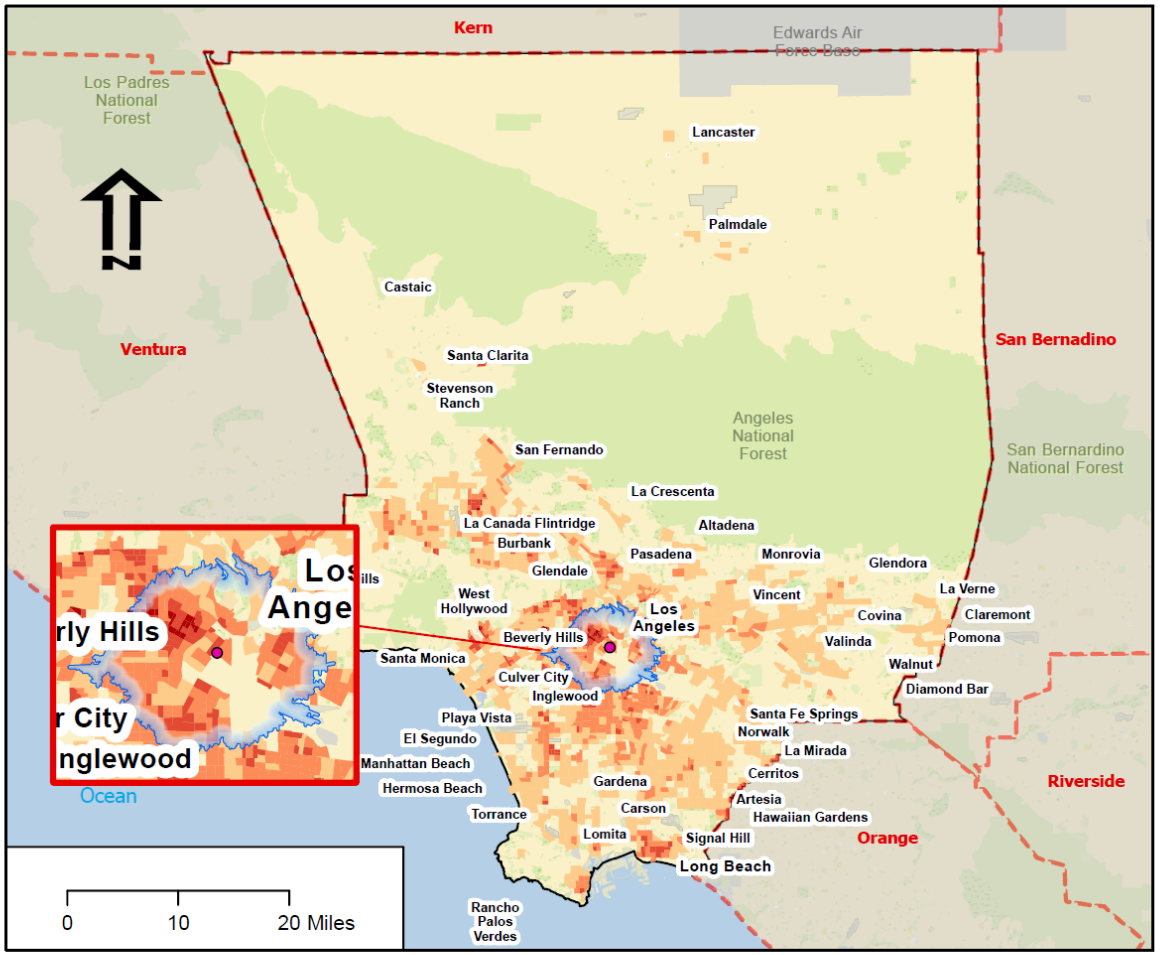
Disclaimer: This product is for informational purposes only and may not be suitable for legal, engineering, or survey purposes. Users of this information should review or consult the primary data and information sources to ascertain the usability of the information.

Sources: U.S. Census Bureau American Community Survey 2015-2019 5-year estimates; California Public Utilities Commission; and 2020 Planning Database
Pop Density = (Total Estimated Pop / Census Tract Area in SQMI)
Drive Time Calculated for Tues 01/12/2021 @ 9:15AM

Appendix E: LA County Sobering Centers

Los Angeles County Sobering Center

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.



LAC Sobering Center

Census Tract Population Density

Sparse

Dense

Drive Time Boundary

15min

Map Created: JAN 2021
By: LACDMH-CIOB (K.T. Williams)
Contact: KyWilliams@dmh.lacounty.gov

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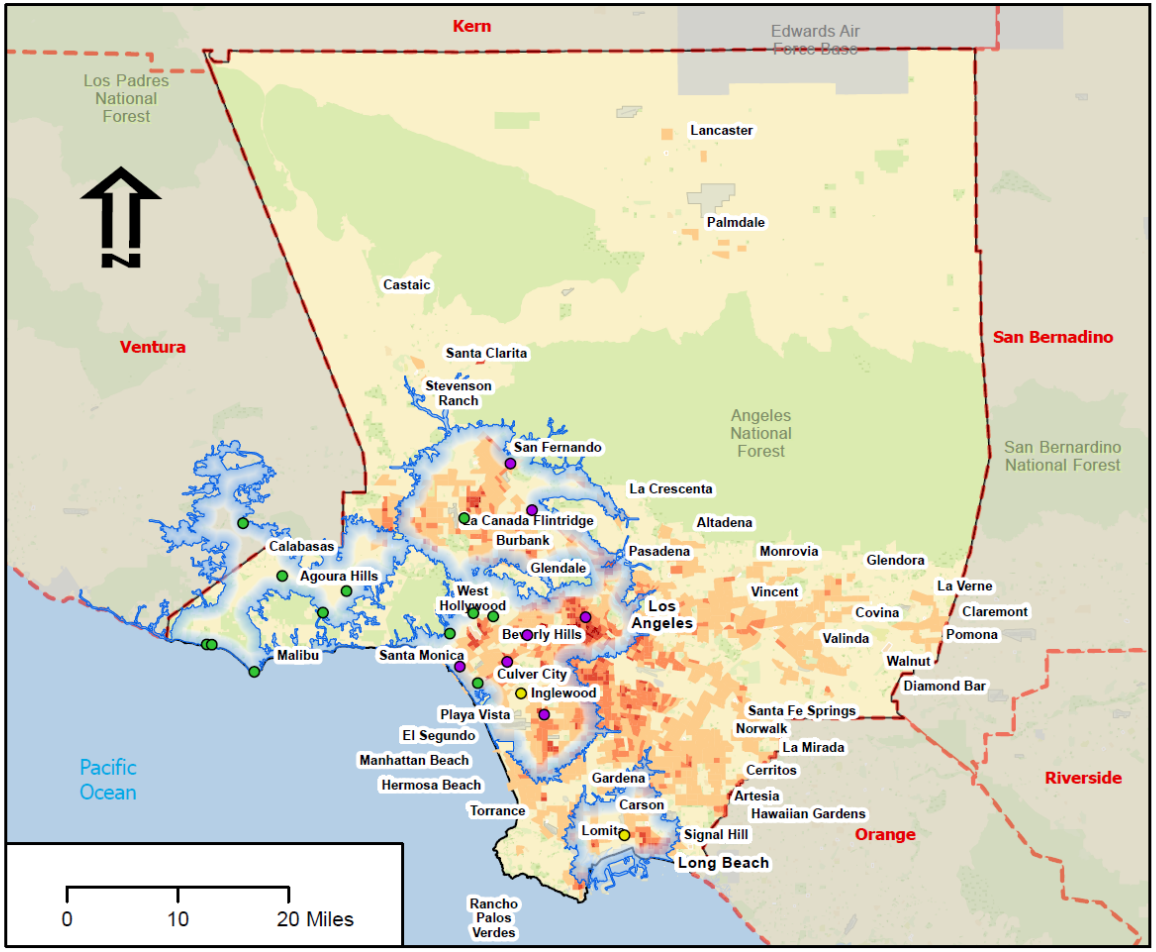
Sources: U.S. Census Bureau American Community Survey 2015-2019 5-year estimates; California Public Utilities Commission; and 2020 Planning Database
Pop Density = (Total Estimated Pop / Census Tract Area in SQMI)
Drive Time Calculated for Tues 01/12/2021 @ 9:15AM

Appendix F: LA County Residential Crisis Facilities

Los Angeles County Crisis Residential Facilities

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.



CR Facility Types

- Crisis Residential - DMH In-Network
- Crisis Residential - Out-of-Network
- Peer Respite

Census Tract Population Density

Sparse — Dense

Drive Time Boundary

15min

Map Created: JAN 2021
By: LACDMH-CIOB (K.T. Williams)
Contact: KyWilliams@dmh.lacounty.gov

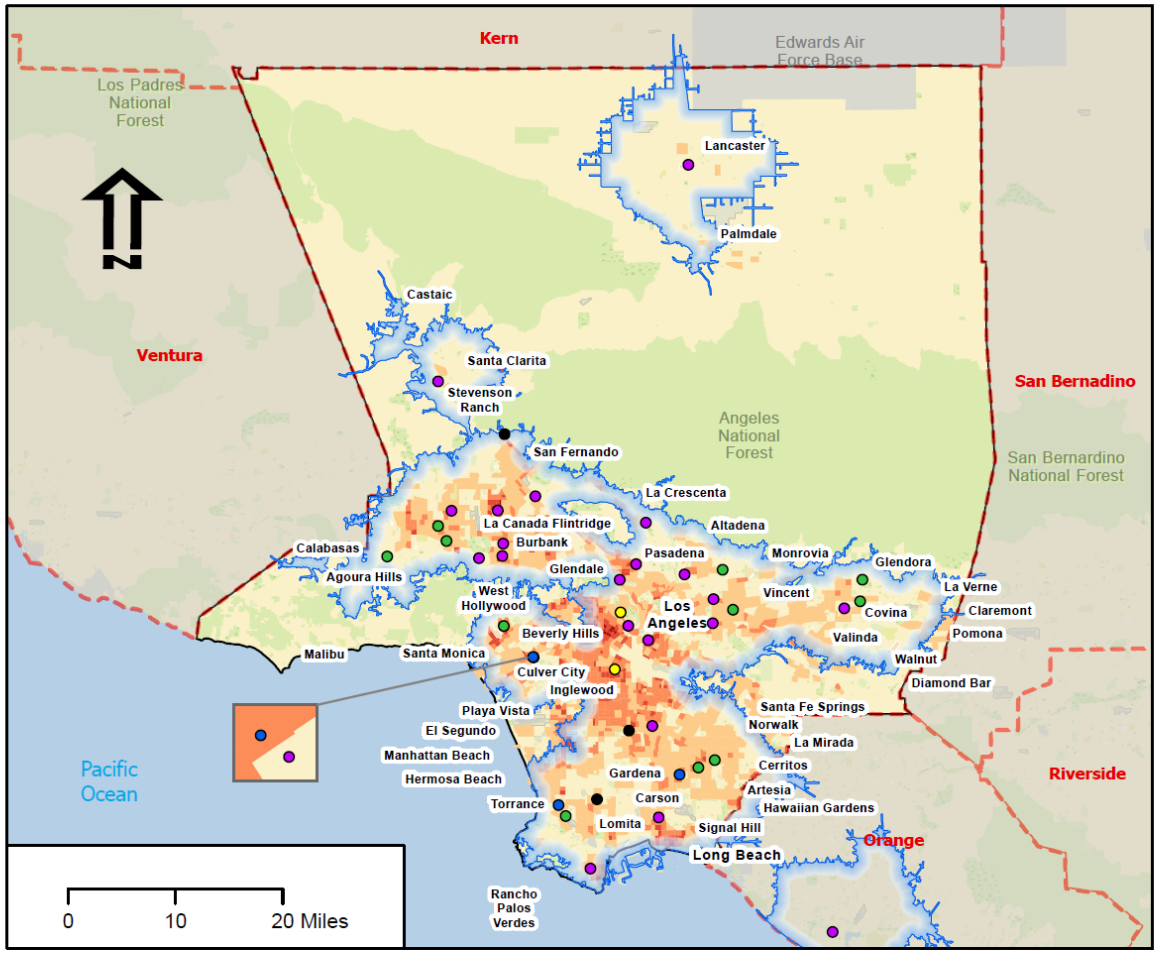
Disclaimer: This product is for informational purposes only and may not be suitable for legal, engineering, or survey purposes. Users of this information should review or consult the primary data and information sources to ascertain the usability of the information.

Sources: U.S. Census Bureau American Community Survey 2015-2019 5-year estimates; California Public Utilities Commission; and 2020 Planning Database
Pop Density = (Total Estimated Pop / Census Tract Area in SQMI)
Drive Time Calculated for Tues 01/12/2021 @ 9:15AM

Appendix G: LA County Acute Inpatient Psychiatric Facilities

Los Angeles County
Inpatient Acute Psychiatric Facilities

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.



IAP Facility Types

- County Hospital (DHS)
- FFS Hospital - APH
- FFS Hospital - GACH
- Psychiatric Health Facility
- Short Doyle Hospital - APH

Census Tract Population Density

Sparse — Dense

Drive Time Boundary

15min

Map Created: JAN 2021
By: LACDMH-CIOB (K.T. Williams)
Contact: KyWilliams@dmh.lacounty.gov

Disclaimer: This product is for informational purposes only and may not be suitable for legal, engineering, or survey purposes. Users of this information should review or consult the primary data and information sources to ascertain the usability of the information.

Sources: U.S. Census Bureau American Community Survey 2015-2019 5-year estimates; California Public Utilities Commission; and 2020 Planning Database
Pop Density = (Total Estimated Pop / Census Tract Area in SQMI)
Drive Time Calculated for Tues 01/12/2021 @ 9:15AM