DEPARTMENT OF MENTAL HEALTH

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August 17, 2020

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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

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Table of Contents

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.

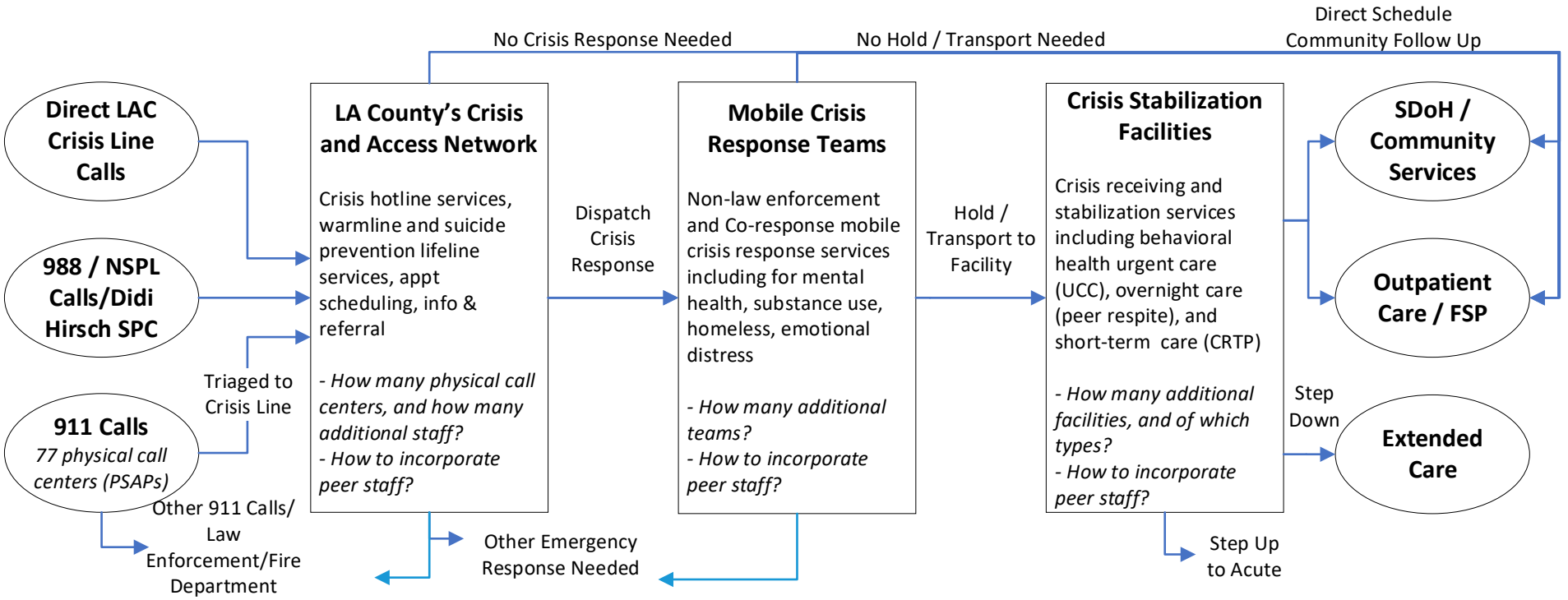
A recent report from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers guidance and best practices for developing and improving the three core components of a high-functioning crisis system [7]:

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.

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    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