LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
Community Planning Process - MHSA Three-Year Plan
Community Planning Team Session

BACKGROUND

FOCUS

- The MHSA Three-Year Plan contains the goals and recommendations to be implemented over the course of two years from July 1, 2024, through June 30, 2026.

COMMUNITY PLANNING STEPS

- Members of the Community Planning Team and/or community stakeholder groups identified critical issues from August through October across four areas:
    - Prevention and Early Intervention (PEI)
    - Community Supports Continuum (CSC)
    - Homeless Services and Housing Resources (HSHR)
    - Workforce, Education, and Training (WET)

- Consultants turned all the 'critical issues' into a list of 'recommendations' (i.e., proposals to address the critical issues) and confirmed this list with CPT members on October 3, 2023.

- DMH staff and consultants clustered all the recommendations based on similarities, created categories, and confirmed the categories with Workgroup members on October 27, 2023.
    - DMH staff identify if the program or service already exists or not.
    - If already exists, if its expand and/or improve

- On November 7, CPT members review and confirm recommendations for specific categories.

    - Clarification: The act of listing the services, programs, interventions does not mean they are endorsed. These will need to be ranked later on.

- On November 17, CPT members review and confirm recommendations for remaining categories.

- On December 5, CPT members review all the recommendations from Workgroups and provide initial ranking.

- On December 15, CPT members build consensus on key recommendations.

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GLOSSARY

1. Goal: Desired change (what we want)

2. Implementation: Action plan (how)

3. Critical Issues: Refers to unmet needs or service gaps.

4. Recommendations: Refers to proposals for action(s) that address unmet needs and/or service gaps.

5. Services: Refers to specific resources and/or support(s) for individuals and/or groups.

6. Programs: Refers to a set of services.

7. Policies: Refers to rules, protocols, standards, and/or criteria that guide and/or structure the delivery of programs, services, and/or interventions.

8. Practice(s): Refers to the specific ways that services are provided and/or delivered.

9. Advocacy: Refers to action that seeks to produce a change in practice, policies, programs, and/or services.

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COMMUNITY SUPPORTS CONTINUUM (CSC)

CATEGORIES

Category 1: Emergency Response
Category 2: Psychiatric Beds
Category 3: Full Service Partnerships - Access and Efficacy
Category 4: Increase Access to Quality Care

CSC CATEGORY 1: EMERGENCY RESPONSE

GOAL: Improve Emergency Response

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS

1. Improve and/or Expand Existing Programs (Exists Already)

Existing Program	Description	Expand &/or Improve	CPT Recs
PMRT	1. Expand PMRT service and focus on hiring individuals who come underserved communities.	Expand & Improve	1,3,9
PMRT	2. Provide cultural competence training to existing PMRT.	Expand	2
Therapeutic Transport	3. Current Innovations program in partnership with Fire Department, combines Peers, mental health specialists, and Fire Dept. to provide response for mental health calls.	Expand	6
Mental Health Training for Law Enforcement	4. LADMH to provide sensitivity training to Law Enforcement on working with individuals with mental illness.	Expand	10

2. Add New Programs and/or Interventions (Do Not Exist)

Program or Service Recommendation	DMH &/or Partner	CPT Recs
1. Develop a media campaign to raise awareness about available crisis services including urgent care and mental health crisis teams.	DMH	5

B. ACTION RECOMMENDATIONS: POLICY, PRACTICE, AND/OR ADVOCACY

1. Prioritize hiring of culturally competent individuals reflective of their communities and provide cultural competence training to existing PMRT. [2]
2. Prohibit armed law enforcement in emergency responses. [9]
3. Expand use of unarmed teams. [9]
4. Create greater accountability law enforcement in emergency. [11]
5. Incorporate more community-based organizations as part of emergency response. [4,12]

CPT RECOMMENDATIONS (through 10/27/23)

1. Provide sufficient crisis response teams.
2. Mobile response teams culturally competent.
3. Reduce response times to emergency situations (particularly SA 6).
4. Community organizations be able to qualify for RFPs
    a. Examples: services that provide de-escalation services working with PD
    b. Mental health crisis responses – fund more peer respite
    c. More community-based orgs providing those resources in the community (specifically de-escalation services) – support comm based orgs be a legal entities
    d. Lack of community organizations who qualify for RFP to provide needed services/programs
5. Increase information about emergency services.
6. Improve integration between firefighters, EMS, DMH and other community stakeholders to ensure that frontline staff are able to be more efficient with referrals and get folks into care.
7. When emergency responses end up in hospitalization, individuals end up in hospital beds. Improve coordination of support at this level.
8. Improve emergency response for individuals in interim housing programs and Permanent Supportive Housing programs.
9. Use psychiatric medical response to respond to emergency psychiatric situations, with no armed law enforcement. [Background: Law enforcement is doing welfare checks and that is traumatizing not just to the individual but to families. There are very minimal situations in which armed law enforcement is necessary for the safety of the community. Yet the majority of responses with Blacks and Latinos involves armed law enforcement, with is linked to significant health inequities equities and racial trauma. The law enforcement system used currently criminalizes populations, particularly Latino and Black communities. So, use a model that includes fire department and medical staff to deal with medical emergencies. It is safer, more therapeutic, and beneficial given the significant mental health stigma that law enforcement has. If DMH is collaborating with armed law enforcement, this causes further harm.]
10. Incorporate sensitivity trainings as part of the Los Angeles Police Department and Los Angeles County Sheriff's Department so that they can handle emergency psychiatric situations effectively.
11. Strengthen accountability for LAPD and LA County Sheriff's for their approach to psychiatric emergency situations.
12. Provide opportunities for community-based organizations to apply for Requests for Proposals to obtain resources and build the capacity to be part of this emergency response system.

CSC CATEGORY 2: PSYCHIATRIC BEDS

GOAL: Increase Number of Psychiatric Beds

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS

1. *Improve and/or Expand Existing Programs (Exists Already)*

Existing Program	Description	Expand or Add	CPT Recs
Peer Respite Care Homes	DMH contracts for 2 Peer run crisis residential homes offering short term respite	Expand	5
Crisis Residential Treatment Programs	Serves individuals experiencing a mental health crisis and are need of support but not hospitalization. Provides short term intensive residential services in a home like environment. DMH is currently expanding CRTPs to serve youth.	Expand	4

2. Add New Programs and/or Interventions (Do Not Exist)

Program or Service Recommendation	DMH or Partner	CPT Recs
Provide funding for community based organizations to provide wraparound supports and warm hand offs for individuals being discharged from hospitals through a full referral system with case notes and coordination in real time of beds available across the system.	DMH	9

B. ACTION RECOMMENDATIONS: POLICY, PRACTICE, AND/OR ADVOCACY

1. Identify funding resources to increase number of psychiatric beds (Psychiatric beds cannot be paid for with MHSA funds) [1]
2. When funding psychiatric beds consider need for services for minor to moderate medical issues as well, like basic diabetes, basic hypertension, so that we're not wasting that space and that resource. [3]
3. Ensure hospital discharge planners are aware of all housing and support options, specifically the availability of Peer Run respite homes. [5, 7]
4. Take steps to make sure the full spectrum of crisis response services from field teams to respite homes, to hospitals are culturally competent. [2, 6]

CPT RECOMMENDATIONS (through 10/27)

1. Provide sufficient psychiatric beds.
2. Ensure that people utilizing psychiatric beds experience effective supports and avoid being traumatized by their experience being in psychiatric bed.
3. Ensure that the funding for these psychiatric beds does not needlessly narrow the eligibility to only include people with one single psychiatric issue and that we accommodate at least some minor to moderate medical issues as well, like basic diabetes, basic hypertension, so that we're not wasting that space and that resource.
4. Ensure that there is a range of different types of psychiatric beds available, with different options including peer respites.
5. Encourage referrals from hospitals to peer respites, which happens now and can be very effective.
6. Increase the number of respite homes that are accessible across the county (e.g., Chatsworth) and ensure these are culturally and linguistically competent (e.g., Korean, Native American, Latino, etc.), including using a harm reduction model (e.g., substance use disorder). [Background: Many people with mental health issues cannot stay with family and the cost of rents is too high. So, sometimes we just to go for a couple of days and calm down in places with therapeutic beds or cool-down centers—i.e., respite care—to de-escalate situations at home. It's important to avoid individuals with psychiatric emergencies from becoming homeless, because exposure to the streets makes it much more likely for individuals to die.]
7. Improve the discharge process from hospitals when they do discharge the 5150s. [Background: They are being discharged from hospital with drug addictions yet coming back to homes that do not have resources to support them. Some migrants who are coming from other areas who have nowhere to go.
8. Partner with housing developers and property owners and offer an incentives.
9. Provide funding for community based organizations to provide wraparound supports and warm hand offs for individuals being discharged from hospitals through a full referral system with case notes and coordination in real time of beds available across the system.