DEPARTMENT OF MENTAL HEALTH

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March 7, 2023

TO: Supervisor Janice Hahn, Chair
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FROM: Lisa H. Wong, Psy.D.
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SUBJECT: **BI-ANNUAL UPDATE ON ALTERNATIVE CRISIS RESPONSE (ITEM 18, AGENDA OF SEPTEMBER 29, 2020)**

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) Alternatives to Incarceration (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. As reported in the August 2022 Alternative Crisis Response (ACR) quarterly report, the ACR reports are now provided on a bi-annual schedule. Effective November 1, 2022, DMH assumed full responsibility of ACR with the transfer of the ATI Office to the new Justice, Care and Opportunities Department (JCOD).

Our previous ACR updates to the Board are available here. This is the sixth report to the Board and serves as the update for 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); the September 2021 and December 2021 reports for Los Angeles County Alternative Crisis Response (Item 18, Agenda of September 29, 2020); Pursue an Agreement with the Los Angeles County Metropolitan Transportation Authority (Metro) to Provide Mental Health Crisis Response (Item 43-E, Agenda of October 19, 2021); and Expand DMH's Mobile Crisis Response Teams to 24/7 (Item 6, Agenda of November 16, 2021).

In May 2021, the Ballmer Group awarded funding to RI International (RI) for RI to analyze Los Angeles County's current crisis system, and to design programs and develop funding and implementation plans to address gaps. In November 2021, RI provided preliminary recommendations regarding ACR which DMH immediately began acting upon, and on December 6, 2022, DMH received the final "Los Angeles County Crisis Response System Implementation Report," from RI which includes a road-map for ACR within Los Angeles County (Attachment I). As the RI report only incorporates the ACR status as of May 2022, DMH has developed a status report on many of the recommendations put forth by RI (Attachment II).

ACR Stakeholders and Partnerships

In September 2022, DMH held its first ACR Providers Meeting. The goal of the ACR Providers Meeting is to bring together mental health providers, along the crisis continuum of care including someone to call (Didi Hirsch [9-8-8], DMH Help Line-ACCESS), someone to respond (FIT[1] providers including PMRT[2] and MCOT[3]), and somewhere to go (crisis stabilization units and crisis residential treatment facilities). The meetings are held monthly to report out on the status of ACR, provide metrics, and discuss standardized procedures across the crisis continuum. In addition to monthly meetings with ACR providers, DMH is developing a contract between DMH and the Los Angeles Network for Enhanced Services *(*LANES*)* to onboard ACR providers to LANES. It will be an amendment to the current contract in which LANES will lead the onboarding efforts to bring the crisis providers onto LANES. As the Health Information Exchange (HIE) in Los Angeles County, LANES will allow ACR providers to appropriately access and securely share vital clinical information electronically—improving the speed, quality, and safety of client care. This contract is paid for by the California Department of Health Care Services Crisis Care Mobile Units (CCMU) grant awarded to DMH.

In addition to these meetings, DMH is working to connect with stakeholders outside of the mental health system to engage communities and other key parties. DMH has developed a monthly ACR Newsletter to be distributed to all ACR stakeholders to provide routine written information such as key dates and data, feature stories, and job postings to keep stakeholders informed. The first issue was released at the end of February 2023. In addition, DMH will be conducting quarterly live stakeholder engagement webinars in conjunction with JCOD. The webinars are an opportunity for stakeholders to interact with the ACR team, discuss quarterly progress, and consult on a rotating set of topics. The first webinar is set for March 15, 2023.

[1] Field Intervention Teams (umbrella term for crisis outreach teams)
[2] Psychiatric Mobile Response Teams (directly operated by DMH)
[3] Mobile Crisis Outreach Teams (contracted providers)

On January 11, 2023, DMH presented on ACR to the Countywide Criminal Justice Coordination Committee (CCJCC) chaired by Supervisor Hahn. After the presentation, Supervisor Hahn motioned, and CCJCC approved a motion to form an ad hoc workgroup to develop best practices for DMH/law enforcement agency partnership in support of ACR. CCJCC, along with DMH, convened a group in coordination with Los Angeles County Sheriff's Department (LASD), Los Angeles Police Department (LAPD), California Highway Patrol (CHP), and the California Police Chiefs Associations, with the first workgroup held on February 9, 2023.

City Partnership

DMH is currently partnering with the City of West Hollywood (City) to develop a pilot to blend city and county capacity and resources by implementing a city-funded low-acuity care team that leverages the DMH crisis continuum of care including 9-8-8 and FIT when needed. The City pilot will develop a West Hollywood (WeHo) Care Team that serves as a rapid mobile responder within city limits that can receive calls for service both from the regional 9-8-8 system and the City's 9-1-1 partners (LASD and Los Angeles County Fire). The WeHo Care Team will respond to calls that may or may not rise to the level of a mental health crisis (e.g., social welfare check, homelessness). If the WeHo Care Team arrives on scene and determines a need for FIT, they will be able to quickly and efficiently request FIT while continuing to provide on-scene support. Through this pilot, DMH and the City will examine how a coordinated city-county partnership supports efficient use of the County's FIT resources, improves the response time to someone in need of rapid support, and creates efficiencies in service delivery and use of resources through this blended, collaborative approach.

The City has identified that many calls going into 9-1-1 could be appropriately served through a rapid, supportive social service intervention in lieu of law enforcement. Additionally, the City has identified that the community is looking for ways to quickly support people in times of need and the advent of 9-8-8 creates a new way for people to connect with help over the phone and be served in-person when appropriate.

Data Analytics and Expansion of FIT

An internal ACR Dashboard prototype to routinely track and report out on key data metrics was implemented in November 2022. While DMH is continuing to add data metrics to the dashboard, it currently includes an initial set of metrics broken out by age, ethnicity, and service area, such as:

- Number of Crisis Calls to the DMH Help Line-ACCESS and speed to answer;
- Number of Crisis Calls transferred from Didi Hirsch 9-8-8 and speed to answer;
- Number of FIT dispatches, including break out of calls dispatched within one (1)

hour, two (2) hours, three (3) hours, and over four (4) hours and number of crisis contacts resulting in an involuntary hold.

In addition to the above metrics, DMH receives monthly reports from Didi Hirsch Mental Health Services related to 9-8-8 key performance indicators and is closely monitoring the hiring of additional peers for Psychiatric Mobile Response Team (PMRT) and contracting of MCOT. DMH reported these metrics to the Board in the January 24, 2023, report, "Report Response on 9-8-8 Suicide and Crisis Hotline Rollout Update."

Metro Partnership

Per the Board's direction in the October 19, 2021, motion, "Pursue an Agreement with Metro to Provide Mental Health Crisis Response," DMH negotiated and finalized an agreement with Metro to establish dedicated, contracted ACR services for Metro service areas. DMH issued a solicitation for MCOT providers on August 3, 2022, to cover the Metro high need areas. Due to a lack of response for the solicitation, DMH and Metro have agreed upon a one-time incentive payment of $5,000 per MCOT team (maximum of ten teams) and a telehealth option (with DMH approval) for the clinical team member to be added to the solicitation to hopefully increase interest. DMH is finalizing the modification to the solicitation and will issue the amended solicitation in March 2023.

Expansion of Crisis Stabilization Units and Receiving Centers

DMH continues the process of adding Crisis Stabilization Units (CSUs) in underserved areas throughout Los Angeles County, as well as adding Crisis Residential Treatment Programs (CRTPs) on its four County Hospital Restorative Care Village (RCV) campuses: Los Angeles County-University of Southern California, Rancho Los Amigos Rehabilitation Center, Olive View Hospital, and Martin Luther King, Jr. Behavioral Health Center. DMH is in the early planning phases of adding CSU chairs in Norwalk and Hollywood, both areas that have no CSUs at this time, and expanding CSU chairs on the Westside. CRTPs will be open and operational in the next six to nine months at each of the RCVs, adding 240 beds to the crisis care network.

Dispatch Board

The implementation of a FIT Dispatch Board to provide a standardized, coordinated, and efficient dispatch process 24/7 is critical to triaging crisis calls, maximizing capacity of FIT teams across the County, and ensuring all crisis calls are responded to as quickly as possible. DMH finalized standardized procedures for dispatching teams as well as creating a Microsoft Dynamics Dispatch Board that prioritizes all crisis calls awaiting dispatch into high, medium and low priority; track how long calls have been waiting; and record dispositions of the calls. The Dispatch Board is currently live 24/7 and is utilized

by the DMH Help Line-ACCESS and PMRT. The second phase will begin in April which includes giving direct access to MCOT providers, as well as identifying FIT team availability. DMH is also planning to issue a Request for Information (RFI) to determine the best long-term dispatching technology.

9-8-8 Transfers and Staff Training

While the goal is ultimately for 9-8-8 to dispatch FIT directly, currently all FIT is dispatched by the DMH Help Line-ACCESS and PMRT. To ensure callers contacting 9-8-8 can access a FIT dispatch without making another call, DMH set-up a Priority Line for 9-8-8 agents to warm transfer third-party callers requesting FIT dispatch. This priority line was set up in September 2022, and 9-8-8 agents were instructed on October 3, 2022, to begin using the line to warm transfer third party callers needing FIT dispatch. Effective February 1, 2023, 9-8-8 agents may also warm transfer first party callers needing FIT dispatch to the Priority Line. DMH has been working closely with Didi Hirsch Mental Health Services to develop a training to ensure its over 200 9-8-8 agents are aware of ACR efforts within LA County, new transfer protocols between 9-8-8 and the DMH Help Line-ACCESS, and how to handle new types of calls they may receive. The first training occurred on February 7, 2023, with additional trainings occurring in March 2023. A recording of the training will be made available to all agents, including volunteers, and viewing of the training will be tracked.

Resources and Marketing

DMH has developed several useful documents to spread information about 9-8-8. In late July 2022, DMH issued a 9-8-8 Frequently Asked Questions (FAQ) document as well as a 9-8-8 Call Comparison Chart. Both documents, as well as other marketing materials related to 9-8-8 and ACR, can be found at www.dmh.lacounty.gov/988. Currently, DMH is finalizing a resources flyer that can be made available in lobbies and other public locations. In addition, through the use of CCMU funds, DMH is in the planning phase to develop marketing campaigns related to FIT in order to increase awareness of the team's availability as well as recruit potential providers and practitioners.

Equitable Outcomes Team (EOT)

DMH has entered into a Memorandum of Understanding (MOU) with Delivery Associates, funded by the Ballmer Group, to set up an Equitable Outcomes Team (EOT). The EOT will consist of three (3) staff that will be hired by Delivery Associates, become DMH volunteers, and embedded within DMH to assist in leading key priorities for ACR. DMH, the Ballmer Group, Delivery Associates and the EOT, have the common overall objective of ensuring individuals experiencing a mental health crisis in Los Angeles County are treated quickly, effectively, and with empathy at the least restrictive level of care by mental

health professionals by reducing reliance on law enforcement for mental health crises, reducing overall average response time by mental health field intervention teams, increasing availability and use of crisis stabilization units; and equitable service experience based on race, gender, ability, geography, sexual orientation, and veteran status when experiencing a mental health crisis. Delivery Associates, in partnership with DMH, is in the final stages of hiring the three EOT staff and will be assisting DMH in its key priorities for 2023.

Key Priorities for 2023

DMH has set several priorities for ACR for this year, including:

1. Development of a Standardized Screening Tool to appropriately triage mental health crisis and ensure individuals are served at the least restrictive level of care;
2. Continued expansion of FIT to reduce FIT response time and operate 24/7 by the end of 2023, with a priority focus on underserved communities such as those at risk of incarceration and/or homelessness; and
3. Partner with Law Enforcement to develop best practices in law enforcement/mental health response and expand 9-1-1 diversion to the mental health crisis continuum of care.

The next report on ACR is to be submitted on August 31, 2023. Should you have any questions concerning this matter, please contact me, or staff can contact Jennifer Hallman, Alternative Crisis Response (ACR) Unit Program Manager, at (213) 943-8289 or via email at jhallman@dmh.lacounty.gov.

LHW:JH:lm

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Justice, Care and Opportunities Department

Category	Recommendation Detail	Summary of Progress to Date
Someone to Call	Continue expansion, monitor demand and service quality, establish long-term funding	✓ Contracted with Didi Hirsch for 9-8-8 ✓ Receive monthly data metrics from Didi Hirsch ✓ Monitoring Federal and State legislation
Someone to Call	Build technological capabilities (+dispatching) to make 9-8-8 a crisis contact center hub	✓ Built Microsoft Dynamics Dispatch Board for release Feb 2023 ✓ Finalizing RFI to evaluate long-term dispatch technology
Someone to Call	Monitor system outcomes and be ready to make adjustments	✓ Gathering data from law enforcement to better analyze potential calls to divert to 9-8-8 ✓ Closely tracking calls unable to be resolved by 9-8-8 and where they are diverted to
Someone to Call	Create and implement 9-8-8 marketing plan	✓ Finalizing resource flyer for public use ✓ Developing SOW for marketing campaign
Someone to Respond	Reduce reliance on law enforcement	✓ Law enforcement/mental health workgroup began Feb 2023 to plan for diverting calls from 9-1-1
Someone to Respond	Continue with phased expansion, monitoring demand, utilization, and performance metrics, while establishing sustainable funding	✓ Contracted with Sycamores and Vista del Mar MCOT ✓ Open continuous MCOT solicitation ✓ Added 30 new Community Health Worker positions to PMRT to expand peers within PMRT ✓ Set up internal dashboard for monitoring FIT services
Someone to Respond	Continue to improve PMRT operations and efficiency	✓ Analyzing staffing and service demand patterns and using MCOTs to fill in the gaps ✓ Developed and implemented standardized dispatch procedures ✓ Meeting regularly with MCOT providers to discuss and develop written procedures
Someone to Respond	Offer incorporated cities a leadership role in MCR (like EMS/Fire/Police)	✓ Partnering with City of West Hollywood for a sub-acute field response team
Someone to Respond	Resolve client transport barriers	✓ Preparing vehicle requests for PMRT under the CCMU contract to address ambulance response times ✓ Developing protocols for client transport by PMRT/MCOT
Somewhere Safe to Go	Expand capacity of psych. Urgent Care Centers (i.e., Crisis Stabilization Unit) and establish Short-Term Acute Crisis Center beds (i.e., Psychiatric Health Facilities)	✓ Planning to implement priority access to beds for law enforcement/PMRTs at participating hospitals ✓ Planning to add and expand CSU chairs in areas of need

Category	Recommendation Detail	Summary of Progress to Date
Somewhere Safe to Go	Manage alignment to national best practices	✓ Exploring contracts with participating hospitals to provide priority access to beds for crisis response and law enforcement ✓ Incorporated peer workers into PMRT ✓ Including peers as a core component of Crisis Academy training
Infrastructure and Capacity	Implement DMH entity with authority/accountability over crisis response system	✓ Recognized DMH ownership of ACR implementation per November 2022 CEO letter ✓ Established ACR Unit within DMH by identifying temporary program manager in June 2023 ✓ Pulling together permanent ACR staffing request, to be submitted by March 2023
Infrastructure and Capacity	Develop crisis response provider workforce	✓ Meeting monthly with all ACR providers ✓ Finalizing SOW for crisis academy training based on finalized curriculum
Infrastructure and Capacity	Advocate for legislative and regulatory change to support optimized crisis response system	✓ Met with Substance Abuse and Mental Health Services Administration (SAMHSA), Federal Communications Commission, and other key parties to advocate for geo-routing of 9-8-8 calls
Infrastructure and Capacity	Establish process and measurement system for core service components of the system; report on performance and outcomes	✓ Developing data dictionary for Key Performance Indicators ✓ Developed internal ACR Dashboard
Infrastructure and Capacity	Adopt use of HIE as standard of practice	✓ Finalizing SOW to integrate all crisis providers into LANES
Infrastructure and Capacity	Use existing data to illuminate inequities	✓ Working with EOT to analyze equity data to implement targeted interventions
Infrastructure and Capacity	Align data collection with stakeholder and consumer priorities and values	✓ Planning to engage community members using quarterly ACR public convenings starting March 2023
Infrastructure and Capacity	Establish regular touchpoints with first responders, healthcare facilities, BH agencies, and crisis servicers/advocates to promote consistent communication and identify channels to address challenges	✓ Developed ACR Newsletter to be sent to all stakeholders on a monthly basis ✓ Implemented regular ACR providers monthly meeting
Infrastructure and Capacity	Gauge target population's knowledge, biases, and beliefs	✓ Planning to engage community members using quarterly ACR public convenings starting March 2023

Attachment II



Los Angeles County Crisis Response System Implementation Report

Submitted by RI International
May 31, 2022

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RI INTERNATIONAL

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Table of Contents

Acknowledgements..... 3

Executive Summary..... 6

Introduction and Background..... 11

Someone to Call: A 988 Crisis Call Center for LA County..... 15

Someone to Respond: Mobile Crisis Teams in LA County..... 26

Somewhere Safe to Go: Crisis Care Facilities in LA County..... 41

Cross-Cutting Concerns: A Robust Infrastructure to Support the Crisis Response System in LA County 58

Key Takeaways..... 102

Appendices

A. Acronyms

B. References

C. The National and California Context for 988 Implementation

D. Erlang C Workforce Calculations (2023-2027)

E. Los Angeles County Crisis Capacity Modeling

F. Listing of Stakeholder Inputs

G. Key Performance Indicators

H. Crisis Academy Syllabus

I. *SAMHA's National Guidelines for Behavioral Health Crisis Care*

J. Crisis Care Guidelines for Serving Children, Youth, and Families

K. Guidelines for Serving Persons with Intellectual and Developmental Disabilities

L. Crisis Adjacent Services

Acknowledgements



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The RI International (RI) consulting team thanks the many Los Angeles County contributors to this crisis response system assessment including the Alternative Crisis Response (ACR) Steering Committee for their time, candor, and willingness to participate in a process to design and establish a sustainable ACR and a robust crisis response system: crisis contact centers, mobile teams, and receiving centers. These contributors consistently demonstrated a passionate commitment to meet the needs of County residents and they respectively shared their perspectives regarding the strengths and weaknesses of the current crisis response system and suggestions on how to improve it.

This crisis response system assessment and ACR implementation plan and this final report is the result of a contract between the County of Los Angeles through the Office of the CEO and RI. We would like to extend our appreciation to the following individuals whose collaboration and support were essential to the entire project:

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Executive Summary



Executive Summary

The Los Angeles County Crisis Response System Implementation Report

In support of the Los Angeles County (LAC) Board of Supervisors' (BOS) efforts to strengthen and expand the County's current crisis response system, RI International (RI) was contracted on July 20, 2021 to develop designs, plans, and relevant analyses needed to build an improved Alternative Crisis Response (ACR) System of Care. This improved system is meant to create low-barrier access to care and divert away from criminal justice and emergency medical systems. As a result, this project will also support the County's overall Alternatives to Incarcerations (ATI) Initiative.

Timeline and Background:

- **June 2020:** Alternative Crisis Response (ACR) initiative created by Board of Supervisors (BOS) as partnership between DMH and CEO-ATI
- **September 29, 2020:** The BOS approved a motion that authorized the DMH and the Chief Executive Office's (CEO's) ATI to partner with a Consultant to
    - Analyze LAC's existing crisis system and gaps in detail;
    - Develop focused recommendations and implementation plan(s) to improve the existing system;
    - Design a new system structure;
    - Develop long term implementation plan for new system; and
    - Establish performance metrics to measure and obtain high quality outcomes.
- **October 2020:** Federal bill establishes 988 as national number for behavioral health crisis calls, to go live in July 2022
- **May 2021:** Ballmer Group awards funding to RI International for consulting engagement with LA County on ACR
- **November 2021:** RI International provides preliminary recommendations for LA County ACR, which were incorporated into the County's ACR Strategic Project Portfolio and instigated immediate actions
- **September 2022:** RI International finalizes the Report, providing a long-term roadmap for the County
- **July 2022:** 988 officially launches nationwide, and LA County is targeting several ACR expansion efforts by this date

This *Los Angeles County Crisis Response System Implementation Report* is the culmination of RI's engagement over most of the last year to analyze LAC's existing crisis response system, design a new system structure, develop a long term implementation plan for the new system, and establish performance metrics to measure and obtain high quality outcomes.

All three core service components of the *Crisis Now* model and the *National Guidelines for Behavioral Crisis Care* are represented and functioning within LA County: a crisis call center, mobile crisis teams, and facility-based crisis services in the form of mental health Urgent Care Centers. Overall LAC's crisis response system operates at a "Basic Level" of alignment with national best practices. The Crisis Now System Scoring Tool was used to make this determination and the results appear on page 60.

With the priorities associated with CalAIM, ATI, and ACR, LAC's crisis response system is rapidly progressing toward national best practices for crisis care. However, one of its major drawbacks is the general absence of the peer support specialty having been integrated within each core service component of the crisis response system. Fortunately, given recent legislation, this deficit will soon be comprehensively addressed. An even larger hurdle to optimizing the crisis response system is the need to establish crisis facilities with beds, throughout the County. These centers will each need to be appropriately licensed to provide acute psychiatric care and be Lanterman-Petris-Short (LPS) designated, with stays of under fourteen (14) days.

While PMRT as a mobile crisis service is well-established and growing, it continues to provide unacceptably low crisis response times. To overcome this, Psychiatric Mobile Response Teams (PMRT) require management under a system of accountability to assure that this service meets the newly developed PMRT Policies and Procedures and PMRT Key Performance Indicators. Lastly, the application of technology to crisis care has been lacking. However, this deficit too is rapidly being addressed through a procurement of a technology enabled 988 crisis call center hub and through a variety of DMH technological advancements. When combined, these initiatives will substantially move LAC into full alignment with national best practice crisis care.

Below are general recommendations to optimize LAC's crisis response system and each of these recommendations have additional elaborations within the body of this Report:

988 Crisis Contact Center Recommendations: *Where LA County needs to go with crisis call center services over the next 3-5 years.*

A. Continue expansion, monitor demand and service quality, establish long-term funding.
B. Build out the technological capabilities (in addition to dispatching) to make LA County 988, a true "crisis contact center hub"
C. Monitor system outcomes and be ready to make adjustments
D. Create and implement a 988 marketing plan.
E. Conduct a cost benefit analysis of the multiple other LAC crisis helplines that are currently operating such as rape crisis and domestic violence, and determine the degree to which these resources should be consolidated with the 988 crisis contact center or remain a customized resource.

Mobile Crisis Team Recommendations: *Where LA County needs to go with mobile crisis services over the next 3-5 years.*

A. Reduce the reliance on law enforcement for this service.
B. Continue with phased expansion, monitoring demand, utilization, and performance metrics, while establishing sustainable funding.
C. Continue to improve PMRT operations and efficiency.
D. Offer incorporated cities a leadership role in mobile crisis response, just as they have in police and fire/Emergency Medical Services (EMS) services.

E. Resolve client transport barriers.

Facility-based Crisis Services Recommendations: ***Where LA County needs to go with facility-based crisis services over the next 3-5 years.***

A. Solidify the County plan for the expansion of psychiatric Urgent Care Centers (UCC) and for Short Term Acute Crisis Centers (STACC).
B. Determine a sustainable financing strategy for ongoing facility-based crisis services, and launch phased expansions.
C. Continue to pursue process and quality improvements.

Cross-Cutting Recommendations: ***Where LA County needs to go to establish a robust infrastructure to support the crisis response system in LA County over the next 3-5 years.***

A. Follow the proposed financial plan on pages 63-68 of this Report to finance the staged development of each core service component over the course of the next 3-5 years.
B. Implement a DMH organizational entity with the authority, responsibility, and accountability for the entire crisis response system.
C. Develop the crisis response provider workforce.
D. Advocate for legislative and regulatory change to support an optimized crisis response system.
E. Establish a process and outcome measurement system for the core service components of the crisis response system and provide transparent reporting of the performance and outcome achievements over time.
F. Create and monitor utilization benchmarks to support an increase in capacity, if existing crisis services are failing to meet anticipated growth projections (phased growth).
G. Adopt the use of a Health Information Exchange (HIE) as a standard of practice to assure crisis care follow-up and care coordination.
H. Focus on the efficient operation of all core service components in the crisis response system, which will yield significant cost savings and contribute to ongoing sustainability.
I. Continue to buildout LACs Behavioral Health (BH) care continuum and the services that address the social determinants of health to both prevent BH-related crises and to provide community-based services and supports for those recently stabilized from a crisis episode.
J. Adopt the Plan-Do-Study-Act model, coupled with applying a standardized health equity framework, to measure community impact.
K. Develop a Quality Metric Workgroup that meets with stakeholders in the community and utilizers of the programs to evaluate the LAC crisis response system and determine which data points to collect and which metrics to include for monitoring and accountability.
L. Utilize Substance Abuse and Mental Health Services Administration's (SAMHSA) 988 Partner Toolkit, which is referenced in this Report, to develop and implement an ongoing 988 marketing plan.

Financial Planning Recommendations: ***How LA County needs to fund capital costs for a sustainable crisis system for the next 5 years.***

A. Allocate $5.3 million in funding that has already been awarded for MCT one-time costs to cover the capital resources associated with purchasing 62 new vans and execute the purchase of these vehicles.
B. Support the DMH application to DHCS for BH CIP – Continuation Grant for Facilities - $3 Billion – CCMU. These funds should be used for the $614 million in capital costs associated with 244 new UCC chairs, 256 new PHFs beds and the conversion of 233 existing psychiatric inpatient beds – all of which should be phased in over the course of three years.
C. Pursue other capital funds that may be used if the DHCS grants are insufficient. These options may include additional ARPA funds or Prevention and Early Intervention one-time carry forward funds.
D. Support DMH in the procurement of the new facilities that are established as part of the 5-year plan.
E. Support DMH in completing any necessary grant reporting that may be required from DHCS.

Financial Planning Recommendations: ***How LA County needs to fund operational costs for a sustainable crisis system for the next 5 years.***

A. Over the course of the 5-year funding plan, operational costs will grow approximately $300 million. Medi-Cal total funding accounts for about $190 million of the increase. Uninsured/Underinsured represents $80 million. Medicare and Commercial are $29 million of the increase but may be even higher as noted in the modeling that suggests these two "underinsured" groups represent nearly half of the other/uninsured bucket of individuals receiving crisis care.
B. Over the next 5 years, the finance team will need to budget the projected Medi-Cal increases in local county match funds that are necessary to support the annual incremental growth associated with the operating plan. The net annual increases are delineated in the table 11, on page 72. Annual increases over the FY 23 baseline are detailed in table I2, on page 72.
C. The finance team will need to develop budget estimates that identifies and secures funding to cover the anticipated growth in resources needed to cover the uninsured and underinsured populations. These amounts are delineated in the tables on pages 66-67.
D. On an annual basis, the finance team should evaluate some of the potential savings options described above to determine what resources may be available to offset the new local costs for crisis care. Realized offsets may include decrease in hospital ED utilization, lower inpatient psychiatric care utilization and reduction ambulance transport for individuals in mental health and/or substance use distress.

Introduction and Background



Introduction and Background

In support of the Los Angeles County (LAC) Board of Supervisors' (BOS) efforts to strengthen and expand the County's current crisis response system, RI International (RI) was contracted on July 20, 2021 to develop designs, plans, and relevant analyses needed to build an improved Alternative Crisis Response (ACR) System of Care. This improved system is meant to create low-barrier access to care and divert away from criminal justice and emergency medical systems. As a result, this project will also support the County's overall Alternatives to Incarcerations (ATI) Initiative.

Prior to this, on March 4, 2020, the LAC BOS approved the Crisis Response Coordination motion that authorized the LAC Department of Mental Health (DMH) to create the ACR Steering Committee composed of various health, fire, law enforcement, legal, and social services agencies to advise LAC DMH on the development, expansion, coordination, and utilization of health and human services crisis response resources throughout the County.

The following week, the LA County Alternatives to Incarceration (ATI) Work Group released its final report and recommendations. 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 the following initiative, which has led to the work of the Alternative Crisis Response Steering Committee (ACR):

> *Utilize behavioral health (BH) 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.*

The ACR was charged to review the current state of affairs and develop recommendations for a future state in accordance with Board action, to establish a path forward for LA County's crisis system. The initial ACR Steering Committee was chaired by Dr. Jonathan Sherin, former Director of LA County DMH, and Dr. Bob Ross, President and CEO of The California Endowment and Chair of the ATI Workgroup. Numerous principal committee members had leadership roles from entities such as: County Health and Human Service Departments, County Fire and Sheriff; LA City Fire and Police, leaders from other key municipalities; and various other organizations across the County. On August 17, 2020 a report was issued, representing a consensus framework for how the ACR planned to move forward in developing detailed recommendations.

This Report entitled, *Los Angeles County Alternative Crisis Response Preliminary Report and Recommendations*, established the following vision for LAC's crisis system:

> 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:

- 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.
- The culture of the rebuilt crisis system must not only meet the real-time needs of the community, but it also must eliminate racial disparities perpetuated, directly or indirectly, by the current system.
- A re-engineered crisis system must incorporate, at its core, design features and implementation strategies that dramatically reduce and mitigate law enforcement responses wherever and whenever possible.

In response to one of this Report's delineated next steps to secure a Consultant, on September 29, 2020, the LAC BOS approved a motion that authorized the LAC DMH and the LAC Chief Executive Office's (CEO's) ATI to partner with a Consultant. When RI was awarded the LAC Consultant Contract, it was expected that RI would, in partnership with LAC, study and learn from the innovations in other jurisdictions to build upon LAC's several decades of crisis services innovation, in order to reform and further modernize LAC's crisis system. In addition, RI was expected to utilize the Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (2020) to build an improved ACR System of Care for LAC to include the following:

1. A modernized regional crisis contact center network, including properly aligned and integrated emergency telephone number (9-1-1) and the upcoming National Suicide Prevention Hotline (988) services;
2. Crisis mobile response teams, with a particular focus on unarmed crisis response services, but also including behavioral health and law enforcement co-response team services, as indicated; *and*
3. Crisis receiving and stabilization facilities, including psychiatric urgent care centers, peer respites, and crisis residential treatment programs.

The purpose of this project has been to create an ACR implementation plan and determine how to align current crisis practices within LA County to the practice standards for BH crises care as defined within the *National Guidelines*. In addition, the intention of this project is to optimize crisis resource design and allocations to meet LA County needs; and to find opportunities to reduce overall health care costs and those costs associated with psychiatric boarding, law enforcement interventions, and incarceration. In order to implement and sustain a comprehensive ACR system with fidelity to the *National Guidelines*, RI examined available information regarding LA County's current policy alignment with these expectations.

RI applied the pertinent data that was gleaned throughout the assessment process to its algorithmic formulations to determine the general capacity needs for LA County. The results of these calculations were subsequently modified to accommodate the unique permutations of client flows within LA County's crisis

response system and the anticipated impact to the system based on 988 demand calculations. RI analyzed the assessment results to identify gaps and opportunities. This was followed by an analysis of service demand, crisis system optimization, costs, feasibility, and a review of financing methodologies and rates. Subsequently, RI developed an implementation plan, balancing all of these elements and reviewed it with DMH. The results were then analyzed against the current crisis service assets and strengths to develop a set of concrete recommendations on how to best develop and implement a staged approach to an optimized and fully integrated ACR system. The culmination of this work is embodied within this Report. In the Appendices the reader will find supporting documentation to include the literature reviewed, key performance indicators, stakeholder contributions, best practices, and other supporting documentation.

II. Someone to Call: A Crisis Call Center for LA County



The "front door" of a modern crisis system is a crisis call center that meets National Suicide Prevention Line (NSPL) standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 180 call centers have met the standards of and participated in the NSPL. Such a crisis call center is equipped to connect individuals in a BH crisis to needed care. These programs use Global Positioning System (GPS) technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day.

That real-time care coordination requires electronic linkage with every BH inpatient and residential bed and with every outpatient treatment slot in the service area. At the same time, they provide high-touch support to individuals and families in crisis that adheres to NSPL standards. In order for crisis call centers to be accessible to youth, it is critical that they include the technology and the staffing to support both texting and chat capabilities. The crisis call function can be further complemented by a Peer-to-Peer Warm Line, which is staffed by Certified Peer Support Specialists. This service can provide 24/7 readily accessible support, outreach, and post-vention which can prevent the emergence of future crises or re-stabilize an individual who is beginning to feel over-stressed, overcome with drug cravings, or feelings of loneliness, hopelessness, and burdensomeness.

The new national crisis call number, 988, holds the promise of an equitable healthcare response to a healthcare issue that provides better outcomes as people receive the services and supports they need to remain in their communities and thrive. This promise will only be fulfilled if adequate resources are available to accommodate increased call/chat/text volume, as well as the continuum of crisis care services that can respond as appropriate. Crisis care services are more impactful when they include and are informed by individuals with diverse backgrounds, including lived experience, who are trained to respond in an empowering and culturally responsive manner.

Vibrant Emotional Health (Vibrant), the administrator of the National Suicide Prevention Lifeline, has provided recommendations and defined the vision and mission of 988 as follows:

- Vision: 988 serves as America's mental health safety net. It will reduce suicides and mental health crises and provide a pathway to well-being.
- Mission: Everyone in the U.S. and its territories will have immediate access to effective suicide prevention, crisis services and behavioral healthcare through 988.

The key features of 988 include:

a. Universal and Convenient Access, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication;
b. High Quality and Personalized Experience that is tailored to the unique needs of the individual while also in line with identified best practices;
c. Connection to Resources and Follow Up to ensure all persons contacting 988 receive additional local community resources as needed.

Learning from Air Traffic Control Safety

The keys to advancements in aviation safety are simple. Two vitally important objectives make it impossible to avoid tragedy:

1. Always know where the aircraft is – in time and space – and never lose contact; and
2. Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

Air Traffic Control's technological systems and clear protocols ensure that there is absolute accountability at all times, without fail. When an air traffic controller has the responsibility for any given plane… unless and until they seamlessly hand the responsibility to someone else, who then assumes the same level of care and attention. They simply do not allow an airplane to be unsupported and left on its own. These objectives easily translate to BH. We should always know where the individual in crisis is, and verify that the appropriate hand-off has occurred. Yet these seemingly simple objectives are missing from most public sector BH crisis systems. Individuals and families attempting to navigate the BH system, typically in the midst of a BH crisis, should have the same diligent standard of care that air controllers provide.

In 2006, the Georgia Crisis and Access Line (GCAL) was launched. The goal was to have an "air traffic controller's view" of individuals currently navigating the crisis system. This goal was accomplished through state-of-the-art technology, including an integrated software infrastructure that tracks individuals at a statewide level, with built-in assurance of consistent triage, level of care protocols, and warm hand-offs to the appropriate Mobile Crisis Teams (MCTs) across the state. This is very different from traditional systems and can reduce the number of failures facing current crisis response systems across the country. This approach does not imply a belief that human beings can be routed like objects, nor is it an effort to force a one-size-fits-all approach on unique geographies, demographics, funding streams, and BH care systems. Rather, it ensures no individual gets "lost" in the system.

A BH crisis needs a BH response. Increased collaboration between 911 and 988 would provide more options for those in crisis, such as transferring BH crisis calls to 988 call centers, dispatching MCTs to individuals in BH or suicidal crises rather than police or Emergency Medical Services (EMS), and greater coordination around access to care options. The 988 implementation should be designed to provide an empowering, personalized, high quality and culturally responsive experience for individuals in crisis. The system should be designed to optimize and support services that ensure access and inclusion within the 988 crisis response to meet the unique needs of at-risk groups, including youth, rural populations, black, indigenous, people

of color (BIPOC) communities, and lesbian, gay, bisexual, transgender, queer (LGBTQ+) individuals. Multiple modalities such as text and chat should be available in addition to phone support. Crisis staff should reflect the communities served and engage people with lived experience at all levels of response. Individuals providing those services should be trained to be culturally responsive in order to ensure dignity for the person being served. Services should also be linguistically appropriate for the communities served. Data driven metrics, including performance and user experience by race and ethnicity, are needed to ensure quality service and positive outcomes for all members of the community.

On September 4, 2021 the Department of Health Care Services (DHCS) announced that it would invest $20 million in California's network of emergency call centers to support the launch of 988. On March 7, 2022, this allocation was made from the SAMHSA Mental Health Services Block Grant. This allocation was the basis for the signing of a contract between DHCS and Didi Hirsch to support California's network of thirteen (13) local and regional crisis contact centers, to expand their respective capacity for the launch of 988. With this funding, additional infrastructure is being developed and deployed at these 988 crisis centers to meet the anticipated increase in service demand. Aligned with the realities of disproportionate need, a special focus in the use of this funding is on serving several populations: the young; Black, Indigenous, and people of color (BIPOC); and LGBTQ+ identifying individuals.

- Goal 1: Recruit, hire, and train the BH workforce to staff CA's crisis call centers to respond, intervene, and provide follow-up to individuals experiencing a BH crisis.
    - Objective 1.1: DHCS will directly support the workforce of state selected crisis call centers via subcontracts to ensure 100% coverage of calls and greater than 90% answer rate by end of grant.
    - Objective 1.2: By June 2023, staff and volunteers at each 988 crisis call center will have access to a statewide directory of BH resources (e.g. BH Access lines, crisis lines, warm lines, BH urgent care Centers (UCC), Psychiatric Health Facilities (PHF), peer warm lines, and health plans) for information, linkage, and referrals when appropriate.
- Goal 2: Engage crisis call centers to unify 988 response across CA.
    - Objective 2.1 By April 2022, DHCS committed to develop and disseminate a standard data collection and analysis protocol among the 988 call centers.
- Goal 3: Expand CA's crisis call center staffing and response structure needed for the successful implementation of 988.
    - Objective 3.1 By July 2022, all 988 crisis call centers will answer at least 90% of in state calls.
    - Objective 3.2 By July 2023, all 988 crisis call centers will provide at least eight (8) hours of chat/ text services.

To learn more specifics regarding 988 implementation within a National and California context, the reader is encouraged to refer to Appendix C of this Report.

There has been one crisis call center active within LAC. The Didi Hirsch Suicide Prevention Center (DH) has been fielding suicide prevention calls in LAC since the opening of their doors in 1958. DH has been operating as an inaugural affiliate of the National Suicide Prevention Lifeline (NSPL), and serves as one of

three Spanish-speaking crisis contact centers in the country and one of three national Disaster Distress Helplines.

LA COUNTY STATE OF CRISIS CALL SERVICES TABLE

CRISIS SERVICE	INDIVIDUALS SERVED AND CONTRACT AMOUNT		
	FY 18-19	FY 19-20	FY 20-21
DH Call Center	130,154 calls, texts, & chats	133,837 calls, texts, & chats	129,328 calls, texts, & chats

DH's crisis counselors answer the Teen Line (310-855-4673) outside of the Teen Line's operating hours of 6pm – 10pm PT. In addition, DH offers follow-up services to high-risk callers and those recently discharged from local hospitals after a suicide attempt. In partnership with the Los Angeles Mayor's Crisis Response Team, DH's Suicide Response Team will go to the scene of a suicide to provide immediate comfort or support. DH serves, in addition to LAC, the counties of Imperial, Inyo, Orange, Riverside, San Bernardino, and Ventura, while also providing back-up coverage for all of California's fifty-eight (58) counties. In terms of performance metrics, the contract between DH and LAC has required that 90% of calls are answered within one-minute.

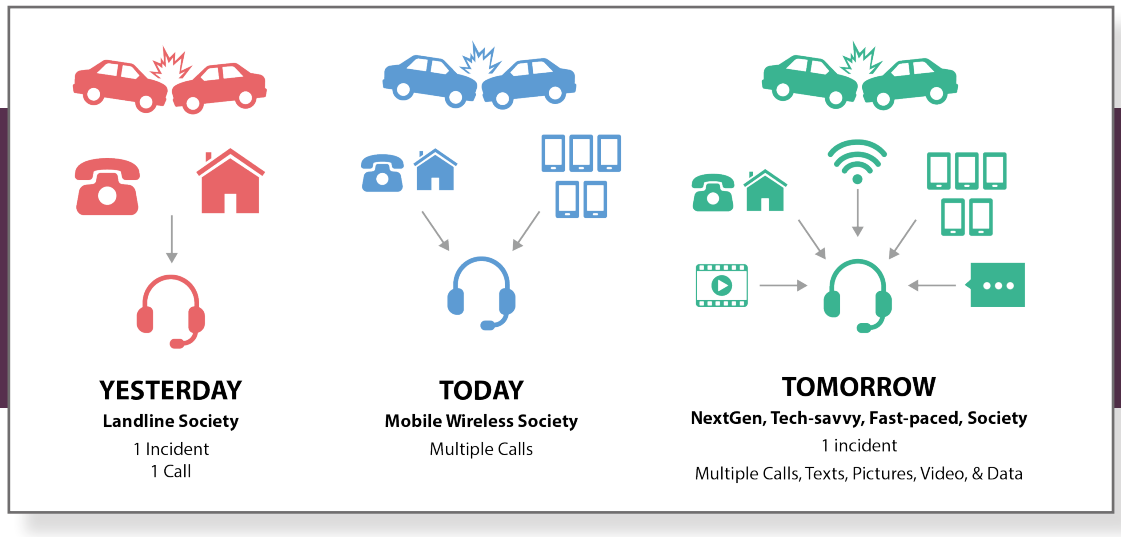
The DH work force has been comprised of three-hundred (300) volunteers and seventy-five (75) staff. DH utilizes a combination of licensed professionals and para-professionals on the crisis line. It also employs supervisors on each shift and the ratio is approximately four (4) to six (6) volunteers per supervisor. An on-call system 24/7 is readily available that is comprised of contingent clinicians for additional support as needed.

Volunteers are incorporated into answering calls, chats, and texts. Each volunteer is required to complete a six (6) week part-time training, with eighty (80) hours of content, that is conveyed via lectures, role-plays, training videos, mentor calls/chats/text, etc.). Upon completion of the training, the volunteers participate in an apprenticeship for three (3) months, within which he or she is monitored and supported by the shift supervisor. Many of DH's volunteers have their own "lived experience" or have a passion about mental health/suicide due to having experience with family members or loved ones.

The LAC 911 call center network includes seventy-eight (78) Public Safety Answering Points (PSAPs), which are currently led by law enforcement personnel who manage crisis calls. However, there are variations in screening, triage, handoffs, and dispatch processes among the PSAPs, as well as transfers to BH-related crisis contact centers. DH has call transfer protocols with all PSAPs within LAC and the region. And while the co-location of 988/911 resources has been an attractive and progressive development around the country to facilitate collaborative working relationships between crisis contact centers and 988, it is questionable given more recent COVID-related developments, whether physical crisis contact centers will continue to operate out of a call center location. Many crisis contact centers across the nation, including those affiliated with NSPL, were forced to operate remotely during COVID and they are each questioning whether or not to maintain a virtual operation or some type of hybrid, subsequent to COVID.

Since 2019, mobile users in LAC have had the ability to send text messages to 911, giving hearing and speech impaired residents, or those in situations where it is too dangerous to dial 911, and making noise could put their life in jeopardy, a potentially lifesaving option. It is anticipated that this capability will enable 988 and 911 to exchange text generated crisis communications.

In addition 911 is undergoing its own metamorphosis as depicted in the graphic below from Next Generation 911:



Next Generation 911 (NG911) refers to an initiative aimed at updating the 911 service infrastructure in the U.S. and Canada to improve public emergency communications services in a wireless mobile society. NG911 is a nationwide, standards-based, and secure emergency communications infrastructure. Current 911 systems were originally built using analog technology and focused on static land-line locations. NG911 is facilitating digital technologies and societal changes, by enabling mobile phone locations, capabilities of text and other multimedia communications between a 911 caller and a 911 center, and on to responders in the field.

Next Generation 911 fully embraces Geographic Information System (GIS), which is a computer system that analyzes and displays geographically referenced information, and it is being integrated into the center of the 911 system. In any 911 call, there are two GIS-based core services at play: the emergency call routing function, which dictates where to send the call for service, and the location validation function, which determines whether an address is valid for routing and dispatch.

The California 911 Emergency Communications Branch first published the California NG911 Roadmap in 2010, and since then significant progress has been made. The CA 911 Branch has successfully implemented several NG911 pilot projects; one of the most significant of these is the Pasadena RING project in LAC with eight (8) PSAPs. Since this Plan is under constant refinement, refer to the interactive dashboards for tracking GIS data upload progress by county, and also individual PSAP's transition progress to NG 9-1-1 which are available at: https://cams-lacounty.hub.arcgis.com/pages/ng9-1-1.

The success and reliability of 911 is being greatly improved with the implementation of NG911, as it will enhance emergency number services to create a faster, more resilient system that allows voice, photos, videos and text messages to flow seamlessly from the public to the 911 network. NG911 provides California with the technological infrastructure to effectively link 911 PSAPs with the LAC's 988 technology enabled crisis call center hub.

Another project that will facilitate collaboration between 911 and 988 within LAC is a City of Los Angeles pilot project entitled, Call Response to Ensure Suicide Safety (CRESS). The overarching goal of this pilot has been to redefine community safety by ensuring LA residents, in a BH crisis, that he or she will receive appropriate and timely support. LAPD and DH have worked together over the past four years to design this pilot to divert 911 calls so those in emotional distress can receive appropriate assistance. This program has been shown to lessen the burden on police patrol resources, decrease violent, traumatic encounters between police and people suffering from DH crises, and save the local police department millions annually, with savings to healthcare and other systems being even larger.

The DMH's Help Line operates 24 hours/day, 7 days/week as the entry point for mental health services in LAC. It takes crisis calls for the deployment of PMRTs. It also serves as an information and referrals resource, while tending to the gatekeeping of acute inpatient psychiatric beds, interpreter services and client transport. DMH has established a direct line for law enforcement agencies to step-down crisis calls/cases to the DMH Help Line for the triage to PMRTs. The Helpline is experienced in the dispatching of PMRTs to meet individuals who are in crisis in the community; however, it is rare that individuals receive a timely response, given the level of demand, the shortage of PMRTs, and other external barriers. The Helpline will continue to dispatch PMRT services upon request from 988 and 988 will have to rely on 911 for the dispatch of co-responder mobile crisis teams that operate throughout the County. It is critical, since the 988 call center will not be dispatching PMRT's directly, that the Helpline appropriately and immediately deploy PMRTs, at 988's request, without any additional screening, assessment, or utilization review. An optimized crisis response system is one that facilitates accessibility, while minimizing any barriers to care. For LAC to have an optimized 988 crisis call center hub, it is essential that it implement best practice technological enhancements. The Scope of Work (SOW) for LAC's recent procurement for a 988 call center provider was structured to meet this expectation.

DMH has made significant progress in the adoption of technology in alignment with the *National Guidelines*:

- The DMH Help Line upgrade and its 988 crisis call center procurement include clear expectations for modernizing the technology used by the respective call centers. These projects will help lay a foundation for improved service and the coordination of crisis calls, texts, and chats;
- The Mental Health Resource Locator and Navigator (MHRLN) is now operational. It is an application for tracking DMH bed availability, including crisis beds, across the County in real time. This capability meets recommendation #40 of the ATI Work Group to establish, expand, enhance, and coordinate the database and tools available for real time bed availability for all justice and health system partners;

- The InterQual utilization management system is likewise operational to assist with Level of Care (LOC) determinations for the DMH treatment bed network, including crisis beds;
- For individuals experiencing a BH crisis, the ability to exchange key information between crisis care providers about those individuals can be lifesaving. LAC currently exchanges some of this information in The Los Angeles Network for Enhanced Services (LANES), but many providers of crisis care are not yet connected to LANES. Furthermore, there are other existing exchange solutions that could complement LANES. DMH is examining potential technologies that would better support crisis information exchange and it is also exploring possible funding sources. The onboarding of providers onto these solutions is crucial to ensure that they are able to not only share and view vital crisis-relevant information, but more importantly actively engage in meaningful care coordination.

With the national implementation of 988 on July 16, 2022, it is anticipated that the contact volume of calls, texts, and chats and the variety of contacts for LAC's 988 crisis call center will increase by two to threefold. This anticipated increase in volume will necessitate the need for an increase in capacity and specific training to increase staff competency related to mental health, SUD, and Intellectual and Developmental Disabilities (IDD), and other disabilities for individuals across the lifespan.

When a person contacts the crisis contact center, he or she has metaphorically put a hand out and the crisis contact center team has taken it. The answering clinician will continue "holding the caller's hand" until there is confirmation that someone else has successfully taken hold. A warm hand-off is not deemed successful until there is verification that the caller successfully engaged with another entity that has accepted the clinical responsibility for the caller's care and support. This verification process is applicable to referrals to MCTs, law enforcement, or an ED. These approaches also apply for those with routine needs, who turn out not to be in crisis, but have been engaged by a MCT or the crisis contact center. The staff are expected to follow-up with everyone, 100% of the time. As a result, despite increasing numbers of referrals flowing through the system, individuals are being accepted into care faster and more effectively.

In addition to traditional crisis call centers, crisis response systems need to develop new tools to reach youth and young adults. One of these is operating crisis text lines, which are recommended as part of SAMHSA's *National Guidelines* to effectively "engage entire communities into care".

> In Colorado, when someone engages with its text line, they will receive a response from a live person. Between July 2019 and June 2020, Colorado Crisis Services received 16,460 texts into its crisis text line. Of these, 29.4% were from adolescents between the ages of 13 and 17, 26% from adults age 18 to 25, 27.7% from adults between the ages of 26 and 39, and 12.8% from adults ages 40 to 59. Fewer texts were received from youth under age 12 (2.6%), likely due to a lack of access to cell phones, and only 1.6% of texts were from adults ages 60 and over. Text messages primarily originated from the state's more urban counties. While crisis text lines are effective at engaging youth and young adults, reports indicate that it can cost three times as much to

operate a crisis text line when compared to the cost for a voice only crisis hotline, due to the additional personnel required to respond to the texts. Warm hand-offs also become more technologically challenging due to incompatibility between texting platforms.

LAC released a procurement solicitation on March 31st of this year for the 988 crisis call center and a contract is expected to be executed in time for July 16, 2022 launch of 988. The initial SOW for the 988 crisis contact center solicitation was developed by RI, and was reviewed and revised by DMH staff. The purpose of this procurement is to assure that LAC will have a robust 988 crisis contact center provider that cannot only meet the projected increase in utilization of the crisis call center, but also that it will employ a qualified workforce that can manage crisis contacts that are not limited to suicidal crisis and will have the technological capabilities to dispatch mobile crisis services and to coordinate follow-up services. It is anticipated that this service will divert BH crisis contacts from 911 PSAPs county-wide.

There are a number of more specialized Helplines/Hotlines operating within LAC. It is recommended that LAC use the advent of 988 as an opportunity to explore potentially consolidating the various countywide Helplines/Hotlines/Crisis Lines, so that residents, to the maximum extent possible, have only one simple three (3) digit number to remember to call when needing BH-related assistance, stabilization, and support. It is understood that there will continue to be Nurse Lines operated by commercial payers operating within LAC. In addition, employers will continue to offer Employee Assistance Program (EAP) numbers, and information and referral services, such as 211, will continue to operate. There are strong rationales for maintaining specialty crisis call/text/chat lines for domestic violence, rape crisis, child and elder abuse, and other needs; so it is important that DMH strike the right balance between the needs for 988 socialization and standardization and the customization needs associated with specialty populations.

A technology application that could be considered for adoption by the 988 crisis contact center is to either offer automated choices by specialty area, on initial contact, that connects the consumer with the relevant specialist within the 988 call center; or that routes the contact directly to another existing specialty call/text/chat resource. NSPL, for example, has had a contract with the Department of Veterans Affairs to provide crisis contact center services nationally. To accommodate the specific crisis needs of veterans, all veteran contacts are prompted to press #1 to access specialty veteran expertise.

As 988 matures, DMH should consider conducting a cost benefit analysis associated with the operations of potentially duplicative BH crisis contact center services within LAC. Once the results of such an analysis is completed and shared with relevant stakeholders, discussions can ensue regarding the potential economies of scale that can accrue by integrating other call center functions into 988 and/or how 988 and the various specialty call centers can work more collaboratively and apply technological tools in the interests of meaningful care coordination .

It is anticipated that the various specialty call centers will continue to operate after 988 goes live in July

2022. The advocates associated with these respective resources would understandably espouse the view that specialty crisis staff is more sensitive, knowledgeable and competent than those associated with a more generic service, such as 988. This position could be construed as a reason to divert local residents from utilizing 988. The RI consultant team believes that over time, specialty crisis contact volume will incrementally transition to 988, as 988 becomes socialized within LAC and across the country; and contend that avoiding market confusion with a plethora of crisis contact centers, maximizing the flow of crisis call traffic to 988, and reinvesting these existing specialty-based crisis contact center resources, especially staff, to assist with the workforce shortage, are all potentially positive developments for ACR.

988 Crisis Contact Center Recommendations: *Where LA County needs to go with crisis call center services over the next 3-5 years.*

A. Continue expansion, monitor demand and service quality, establish long-term funding.
   1. Fund a single point of access for crisis calls through the procurement process that is intended to meet the anticipated increase in crisis call, text, and chat volume due to 988 implementation beginning on July 16, 2022. It is anticipated with 988 implementation that the contact volume will increase to 307,379 crisis contacts during the first year, which is approximately three times the current crisis contact volume.
   2. Utilize the Erlang C Calculator capacity modeling that has been completed for the next 5 years to plan for the number and configuration of staff that the 988 crisis call center hub will need to manage the contact volume associated with the implementation of 988; an anticipated 221% increase in calls over five (5) years. Preliminary Erlang staffing calculations based on current projected call volume from 2023 - 2027 and cross referenced to actual call volume statistics for the Georgia Crisis and Access Line are included in Appendix D. These numbers should be recalculated at least every 6 months using ongoing actual LA County data to adjust as necessary to LA County conditions.
   3. The SOW within the Request for Proposals (RFP) for the 988 crisis call center includes new staffing requirements, training standards, and key performance indicators, therefore closely monitor performance metrics to assure contract compliance and consistent service effectiveness and efficiency.
   4. Work with CalAIM on a plan to fund 988 on an ongoing basis, including the leveraging of Medi-Cal funds (not currently utilized).
   5. Require additional accreditation, such as The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Utilization and Review Accreditation Commission (URAC), etc., for the 988 crisis call center. These accrediting bodies have a broader set of credentialing standards beyond those of the National Suicide Prevention Lifeline (NSPL).
   6. Collaborate with the seventy-eight (78) 911 PSAPs within LAC for the creation and implementation of a collaborative triage process.
   7. Implement protocols to divert 911 calls from the PSAPs to the 988 crisis call center. An

incremental, staged approach should be considered, starting with the virtual co-location of BH crisis consultants at LAC's PSAPs in partnership with California Office of Emergency Services (CalOES).

B. Build out the technological capabilities (in addition to dispatching) to make LA County 988, a true "crisis contact center hub"
   1. Collaborate with CalOES to ensure that 911/988 inter-connectivity works as intended.
   2. Add functionality to the crisis response system's technology to include scheduling DMH outpatient appointments, making direct referrals to available crisis beds, and dispatching MCTs. This latter function will have to be in collaboration with 911, which dispatches the co-responder mobile crisis teams, and with the DMH Help Line, which has had primary responsibility for deploying PMRT.
   3. Require that psychiatric inpatient facilities, facility-based crisis services, and crisis residential treatment providers participate in daily bed census updating.
   4. Fully implement a HIE and onboard BH providers and facilities, and other appropriate community resources, to ensure that they are able to not only share and view vital crisis-relevant information, but more importantly actively engage in meaningful care coordination.
   5. Evaluate in collaboration with the new 988 call center vendor, whether or not, Vibrant's Unified Technology Platform should be adopted in late 2022 versus maintaining the vendor's current technology platform or whether upgrading various components will yield a higher net benefit.
   6. Pursue the application of Crisis Care Mobile Unit (CCMU) program funding for technology/ training for dispatch support.
   7. Evaluate compatibility of all technology with Next Generation 911 (NG911).

C. Monitor system outcomes and be ready to make adjustments
   1. Work with the selected 988 provider to steadily onboard 911 PSAPs.
   2. Ensure the system is meeting equity metrics for access to 988 services; tailor marketing efforts accordingly.
   3. Implement new BH staff training standards, to enable the staff to increase their respective crisis intervention competencies.

D. Conduct a cost benefit analysis of the multiple other LAC crisis helplines that are currently operating such as rape crisis and domestic violence, and determine the degree to which these resources should be consolidated with the 988 crisis contact center versus remain a customized resource.

III. Someone to Respond: Mobile Crisis Teams in LA County



Mobile crisis services are intended to operate on a 24/7/365 basis and are typically comprised of a two-person (licensed clinician and peer support partnerships are common) mobile crisis team (MCT) that offers assessment, outreach, and support where people in crisis are, either in the person's home or a location in the community (not a healthcare facility). The two person model is intended to assure greater safety for the teams in their work in the community, to ensure that those served have the best opportunity for engagement, and to allow for the transportation of those served when warranted, eliminating the need for overuse of the police and ambulances for transportation. Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis contact center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup. The MCT provides a timely face-to-face response and requires the capacity to intervene quickly, day or night, wherever the crisis occurs. In cases where the person in crisis cannot be stabilized, the MCT assists in transferring this person to a higher-level of care and will provide transportation for those that are voluntary when it is safe to do so.

The CA FY2022-2023 budget proposal builds on existing Medi-Cal expansions and includes $108 million in total funds ($16 million in General Funds) to add community-based mobile crisis intervention services as a new Medi-Cal benefit. The American Rescue Plan Act of 2021 (ARPA), one of the federal COVID relief packages enacted by Congress, authorizes 85% federal matching funds for twelve (12) quarters during a five-year period for states to implement a "qualifying community-based mobile crisis intervention services" option in their Medicaid programs starting April 1, 2022.

Community-based mobile crisis intervention services are crisis intervention services provided to individuals experiencing a BH crisis whenever and wherever the service is needed. According to "Cal. Code Regs. Tit. 9, § 1810.209" Cal. "Crisis Intervention" is defined as "a service, lasting less than 24 hours, to or on behalf of a beneficiary, for a condition that requires more timely response than a regularly scheduled visit."

To meet the "qualifying" requirement, community-based mobile crisis intervention services must be:

- Provided to a Medicaid beneficiary who is experiencing a BH disorder crisis;
- Provided outside of a hospital or other facility setting;
- Furnished by a multi-disciplinary mobile crisis team that consists of at least one BH care professional capable of conducting an assessment of the individual and other professionals or paraprofessionals with appropriate expertise in BH crisis response (e.g. nurses, social workers, peer support specialists, etc.); *and*
- Available 24 hours per day, every day of the year.

Additionally, the mobile crisis team members must:

- Be trained in trauma-informed care, de-escalation strategies, and harm reduction;
- Be capable of responding in-person to the crisis in a timely manner;

- Be able to provide services, such as screening and assessment, stabilization and de-escalation, as well as follow-up care coordination, referrals, and transportation assistance as needed; and
- Maintain the privacy and confidentiality of patient information and relationships with relevant community partners.

Starting as soon as January 1, 2023, California will consider the option, in its Medicaid state plan, to provide mobile crisis intervention service for beneficiaries with BH conditions as a mandatory Medi-Cal benefit. DHCS plans to implement this benefit through county BH delivery systems by community-based multidisciplinary mobile crisis teams. In 2022, the state will also develop a plan to support connections between the various prevention and intervention systems, including hotlines, 988 crisis contact centers, peer support services, and mobile crisis service response.

In 2021, DHCS launched the Behavioral Health Continuum Infrastructure Program (BHCIP) and announced that it would release funding through six grant rounds targeting gaps that have been identified in the state's BH facility infrastructure. BHCIP released two rounds in 2021 including:

- Round 1: Mobile Crisis Team (MCT) Services for a total of $205 million in one-time funding. Of this amount, LAC received $51.8 million with approximately 75% of these funds being directed toward MCT infrastructure and equipment needs, and the balance towards MCT service delivery to those ineligible for Medi-Cal.
- Round 2: County and Tribal Planning Grants for a total of $16 million to expand the entire continuum of care for people with BH conditions. LAC received $300K under this round with 50% going to DMH and the other 50% to DPH.

ACR has affirmed that the majority of additional capacity needed for Mobile Crisis Team (MCT) response ought to focus on inter-disciplinary, non-law enforcement crisis response services utilizing shared response protocols; and that additional capacity is needed across the entire County. This consensus further holds that these teams need to be better coordinated, more easily dispatched, equipped to manage transportation of clients, and staffed with peers.

There are three main kinds of mobile crisis response programs in LAC:

1. Non-law enforcement behavioral health-specialized mobile crisis response;
2. Non-law enforcement emergency medical services; and
3. Law enforcement-based co-response or co-dispatch programs.

There are over one-hundred and thirty (130) different mobile crisis teams (MCT) actively operating within LAC and they are structured as follows:

Mental Evaluation Teams (MET)

METs are co-responder teams staffed by a Sherriff's Deputy and a DMH clinician that work together to assist well-trained patrol deputies, in plain clothes, responding to situations involving persons with mental health conditions. METs use an unmarked patient-centric design emergency vehicle capable of responding to high-risk crises reported countywide. MET specializes in de-escalation of crises, mental health evaluations for potential "involuntary holds" when necessary, and diversion of mentally ill patients away from the criminal justice system. MET endeavors to transport patients to mental health care facilities instead of jails whenever possible, resulting in 98% of MET cases being diverted in 2020. By the end that year, thirty-three (33) METs operated twenty (20) hours a day, seven (7) days a week from 6am to 2am. In 2020, MET conducted 7,246 interventions overall which represented about 69% of all reported crises. The average response time was eighteen (18) minutes. By the end of 2020, MET units were strategically responding to county-wide crises from fourteen (14) regional offices located in: South El Monte, Lancaster, Santa Clarita, Cerritos, Lennox, East Los Angeles, Lakewood, Carson, West Covina, Lost Hills, Norwalk, West Hollywood, Compton and La Crescenta. MET is credited with saving up to thirty-four (34) lives that year due to potential deadly force encounters, including fourteen (14) very high-risk incidents involving consumers attempting "suicide by cop." The next proposed MET program expansion would add twelve (12) teams for a total of forty-five (45) METs. This would allow for 24/7 mobile crisis response coverage and fill other critical service gaps. In addition, LASD and DMH are developing a co-response MET program specifically for veterans.

Law Enforcement Teams (LET)

LETs are partnerships between DMH and LAC, the City of Los Angeles, and other municipal law enforcement agencies to provide immediate field response to situations involving mentally ill, violent, or high-risk individuals. LET teams are composed of one licensed mental health clinician partnered with a law enforcement officer. Together, they respond to 911 calls or patrol car requests for assistance when persons suspected of having a mental condition are involved in an incident. The teams provide crisis intervention including assessment for WIC 5150, de-escalate potentially violent interactions between consumers, family members and police, make appropriate referrals to community agencies, and facilitate hospitalization. The teams decrease the need for inpatient psychiatric hospitalization by providing immediate field-based services. For a DCFS minor, LETs contact DCFS and initiate a joint DCFS-DMH assessment and necessary follow-up to address mental health needs of the child. During FY 2019-20, LETs responded to 14,472 calls, of which 31% involved homeless individuals; 3% resulted in arrests; and 61% required hospitalizations. There are thirty-four (34) LETs in operation:

- Long Beach LET is operational eighteen (18) hours a day, 7 days a week;
- Pomona and Pasadena are operating ten (10) hours a day, 6 days a week; and
- Pasadena 6 days a week 10 hours a day; and
- All other municipalities with LET operate ten (10) hours per day, Monday through Friday

Los Angeles County Metropolitan Transit Authority Crisis Response Unit (MTA-CRU)

MTA-CRU combines a Sheriff Deputy with a mental health clinician that respond to calls for service involving anyone experiencing a psychiatric crisis on bus, rail, or any other MTA property. The teams also provide homeless outreach services and crisis response to traumatic incidents on bus or rail lines throughout LA County. To expand on this service, DMH and MTA announced on May 26, 2022, that they have entered into an agreement to pilot utilizing PMRTs to assist individuals experiencing mental health crises while onboard Metro vehicles or at Metro stations. Once assigned, DMH and MTA will work together to deploy these teams where needed within distinct areas of the Metro system to de-escalate crises, provide linkage to appropriate mental health services, and educate the community. DMH will also provide mental health training to MTA staff county-wide and will commission a study to assess and help guide the program as it is implemented. "Hotspots" with high need for crisis response will be identified for the deployment of PMRTs. Under the signed agreement, this partnership between DMH and MTA will be ongoing for three years with the option to renew on an annual basis.

Psychiatric Emergency Teams (PET)

PETs are mobile response teams based in and operated by psychiatric hospitals approved by DMH to provide 5150 and 5585 evaluations. Team members are licensed mental health clinicians. PET operates similar to PMRT and provides additional resources in specific geographical regions. RI was unable to gain more specific information regarding this mobile crisis service.

School Threat Assessment Response Team (START)

START provides training, early screening and identification, assessment, intervention, case management and monitoring services in collaboration with school districts, colleges, universities and technical schools, and in partnership with local and federal law enforcement agencies. DMH staff, in collaboration with schools and law enforcement partners, respond to critical incidents and service requests from schools. The focus of the program is on persons with moderate to high threat levels, either on or off school campuses, and persons exhibiting a pattern of maladaptive behaviors that may be conducive to acts of violence. To ensure timely response, all incoming referrals are centralized and tracked by DMH prior to forwarding to the respective supervisors for case assignment. In FY 2019-20, START provided 5,102 services to 809 individuals at either suicidal or homicidal risk, and provided sixty-four (68) trainings to 3,823 attendees. The training topics include bullying, de-escalation of violent behaviors, targeted school violence, orientation to START services, suicide prevention, mental health awareness, and outreach. After years of services delivered in LAC, START has become one of the major violence crisis management resources. START is funded by the Mental Health Services Act (MHSA) and reports that 80% of calls received are requests for administrative services and trainings, not for crisis response. Through its partnership with the LADSD and the LACCD, START has established protocols for managing threats in educational settings. START services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. An evaluation of START by

the University of Chicago and UCLA in 2021 has demonstrated that nearly nine out of every ten participants, with moderate or high risk for violence, experienced decreased violence risk. Similar findings were also demonstrated for those with moderate to high suicidal risk.

System-wide Mental Assessment Response Teams (SMART)

SMARTs are operated by LAPD and provide crisis intervention, mental health services, psychological testing, and targeted case management services. SMART is designed to provide a cooperative, compassionate mental health/law enforcement response to assist affected citizens in accessing available mental health services. There are forty (40) SMARTs that operate twenty (20) hours per day, seven (7) days per week from 6am to 2pm. In 2020, SMART conducted a total of 5,174 interventions and has been adapted from a secondary responder to a co-responder model.

Homeless Outreach Mobile Engagement (HOME)

HOME is a service provided by DMH that is designed to assist people experiencing homelessness in LAC with outreach services. Calling 211 or filling out an outreach request at www.la-hop.org will dispatch a homeless services outreach team. Homeless individuals or others may call the line when seeking help for themselves or others. The 211 is available 24/7, with trained Community Resource Advisors. The outreach teams are comprised of DMH staff dedicated to immediate field response involving mentally ill homeless persons at risk for incarceration or involuntary hospitalization. In FY2018-19, HOME was expanded to include 161 staff to serve the homeless who have severe and persistent mental illness are the most vulnerable and difficult to engage individuals in need of intensive outreach, engagement and treatment.

Therapeutic Transport Teams (TT)

TTs were launched in 2019 and this service offers a supportive and expedited alternative to meet the transportation needs of acutely mentally ill clients requiring involuntary holds. It deploys the crisis response teams from City Fire stations via their Tiered Dispatch system and they are operated by PMRT. Utilizing specially-designed vans, each TT is staffed with an expert team from DMH that is comprised of a clinical driver, psychiatric technician, and a peer support specialist. Currently, there are eighteen (18) teams and each TT is dispatched on average three (3) times per day. This pilot increases LAC's civilian mobile crisis response resources by increasing transportation capacity for individuals in crisis. This is a critical need as wait times for ambulance transport can increase service times in the Psychiatric Mobile Response Teams (PMRT) program significantly and contribute to long wait times for response. This pilot also creates a truly 24/7 civilian mobile crisis response program for the first time in LAC as PMRT does not currently operate 24/7.

Emergency Response Teams (ERT)

ERTs are comprised of DMH staff specialized in providing field response to critical incidents such as school violence, earthquakes, or acts of terror. ERT provides on-scene consultation and crisis intervention services to survivors and their families, victims, first responders, and the community at large. In a major event, ERT collaborates with the Los Angeles County and City Offices of Emergency Management.

Psychiatric Mobile Response Teams (PMRT)

PMRTs are comprised of DMH clinical staff with authority per Welfare and Institutions Code (WIC) 5150 and 5585 to perform evaluations for involuntary detention of mental disordered adults and children respectively. PMRT is expected to respond to requests for mobile psychiatric services, county-wide in all eight (8) service planning areas and in all five (5) supervisorial districts within sixty minutes of the initial referral. For a Department of Children and Family Services (DCFS) minor, PMRT Staff will contact DCFS and initiate a joint DCFS-DMH assessment and necessary follow-up to address mental health needs of the child. There are no other non-law enforcement programs specializing in BH mobile crisis response that are operating at this scale and/or that have a similar capacity to serve as an alternative to law enforcement response for individuals in crisis. However, as of September 2020, PMRT only provides services on weekdays from 8 am to 5 pm. In addition, on weekdays from 5pm to 2am, and on weekends from 8am to 2am, the PMRT program relies on voluntary overtime staffing to provide services during those hours. There are typically no PMRT services available from 2 am to 8 am daily, although PMRT management remains on-call during those hours. Currently, there are thirty (30) PMRTs with a total of 21,118 interventions over the last year.

In addition to the mobile crisis response programs delineated above, there are emergency medical services (EMS) programs that are operated by LAC and municipal fire departments throughout LAC. They are not specialized providers of BH crisis response, but in cases where law enforcement is not required and PMRT is not readily available, EMS is preferable to a law enforcement response.

Some crisis calls require a law enforcement response, typically due to the presence of a serious and imminent threat to public safety. In these scenarios, co-response with BH crisis professionals and law enforcement ensures the individual in crisis is getting the crisis response that is appropriate. LAC's co-response programs are a key methodology to ensure that individuals in crisis get the right care even when law enforcement must also be present. There are some jurisdictions in LAC that regularly use a co-dispatch model, often co-dispatching law enforcement with EMS personnel, and sometimes co-dispatching law enforcement with PMRT. More commonly, co-response programs, where law enforcement officers are paired directly with BH professionals on the same team, are utilized for this purpose. DMH has partnerships with forty (40) law enforcement agencies to provide BH professional staff for various co-response programs. There is a need for more capacity in these co-response teams to ensure that all crisis calls needing a law enforcement response are also served by a BH co-response.

As indicated earlier, DMH has historically operated PMRTs directly, and unfortunately this mobile crisis service has had long crisis response challenges of over five (5) hours on average; and it is only intervening in the community on the average of two (2) times per shift with those in crisis. In order to improve on this performance, RI has developed a new SOW that was reviewed and revised by DMH and it has been incorporated into a new solicitation for this service to include a clinician and a peer support specialist. This procurement was released on March 31, 2022. In addition to this procurement, DMH is adding 16 peer support specialists to its existing, directly-operated PMRT program. To assure that PMRT is a consistently

responsive service for those in crisis, RI worked with DMH to establish PMRT key performance indicators (KPI) and twenty-five (25) draft policies and procedures that would be used to revise current policies and procedures to meet best practice guidelines. These best practices will support the onboarding and training of new PMRTs beginning this summer. Additional procurements will be necessary to eventually add eighty-three (83) PMRTs for a total of one-hundred and eighteen (118).

LAC's ATI Work Group, in its report, *Care First, Jails Last*, recommended that the number of DMH Psychiatric Mobile Response Teams (PMRTs) be significantly increased to reduce service wait times. The Work Group concluded that, "there are insufficient teams to meet the need for the number of calls received and wait times can be substantial." RI concurs that PMRTs be increased in numbers to provide greater county-wide accessibility, and that in order to improve PMRT response times that PMRT performance be managed to the newly developed KPIs. DMH has also been working to amelioriate the contextual barriers that have impacted PMRT response times, such as extended wait times for ambulance services.

To assist ACR with PMRT policy formulation, RI enlisted Behavior Health Link (BHL) and La Frontera EMPACT (EMPACT). Since 2006, BHL has been the operator of the Georgia Crisis & Access Line (GCAL) and in that role provides mobile crisis team (MCT) services statewide. EMPACT is a major MCT service provider in Maricopa County, Arizona. Both BHL and EMPACT are recognized nationally as *Crisis Now* exemplars in the provision of MCT services. BHL shared its MCT policies with ACR leadership and EMPACT provided policy suggestions to ACR through participation in dialogue sessions and through written guidance in response to questions raised during the process. Subsequently, RI participated in multiple meetings with ACR leadership utilizing the information gathered, to develop policies and procedures (P&P) for the efficient and effective operation of PMRTs in alignment with *Crisis Now* and *SAMHSA's National Guidelines for Behavioral Health Crisis Care*.

In order to further assist with determining the adequacy of these mobile crisis services relative to the *National Guidelines*, interviews were conducted with Miriam Brown, DMH Deputy Director of Emergency Outreach and Triage Division, on April 15, 2022, Capt. John Gannon, LA County Sheriff's Department on April 24, 2022, Capt. Brian Bixler, Commanding Officer of the LAPD Metropolitan Division and Lt. Ruthann Chavez of the LAPD OIC Crisis Response Section on April 25, 2022. The results of these interviews are presented in the following table:

Mobile Crisis Services								
	DMH PMRT	MET	SMART	Theraputic Transport Team	Comments	LASD MET	Comments	SMART
Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;	Yes	Yes	Yes	Yes		Yes		Yes

Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times	Yes	Yes	Yes	Yes	MET/SMART/ TTT do not respond to ERs	Yes	We stay basically within LAC with an emphasis on our jurisdiction, including all unincorporated +42 cities, but we can go into other areas (even LAPD areas) when requested, to provide mutual aid or when the area lacks resources	Yes
Connect individuals to facility-based care as needed through warm hands-offs and coordinating transportation when and only if situations warrant transition to other locations	Yes	Yes	Yes	Yes		Yes	MET units provide their own patient-centric transportation (specially designed SUVs)	Yes
Incorporate peers within the mobile crisis team;	No	No	No	Yes	DMH is in process of incorporating	Yes	For the VMET response we are partnered with DMH VPAN program (veteran peer access)	No
Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;	Yes	Partial	Partial	Yes	MET/SMART co-response officer and clinician	No	Level 4 Crises	No
Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; and	No	No	No	Yes	TTT dispatched through 911-Ipad has GPS location	Yes	MET units are GPS and GIS tracked in real time county-wide using CAD (all LE likely has), however these units are tracked by Triage Help Desk Dispatch not by DMH (although) DMH is co-located at Triage	No
Schedule outpatient follow-up appointment in a manner synonymous with a warm handoff in order to support connection to ongoing care	Partial	Partial	Partial	Partial	Outreach triage team or children outreach teams to ensure follow up services	Yes	The DMH clinician and/ or RAMP handle this. Also arrange care for follow up if client does not meet criteria for hold	Yes

It is fairly evident after a review of the information within this table, that the major deficiency in all of the various mobile crisis service types that operate within LAC is that peer support specialists have not been integrated into the provision of this service. As previously indicated in this Report, recent CA Legislation has finally paved the way for those with "lived experience" to be employed across the BH continuum of care, to include crisis care. This development will not only improve the quality of care, but it will also positively

contribute to addressing the BH workforce shortages. The other major deficiency associated with this service is the application of technology to improve crisis service responses by employing GPS technology for managing the deployment of mobile crisis teams. This shortcoming is currently being addressed, along with other technological limitations that exist within the crisis response system.

To assess the alignment of LAC's PMRT to best practices, the *Crisis Now* Scoring Tool for Mobile Crisis Service was applied. Again, PMRT provides a non-law enforcement-based mobile crisis response for those experiencing a BH emergency in the community. PMRT consists of LAC DMH clinicians designated to perform evaluations for involuntary detention of individuals determined to be at risk of self-harm or a danger to others, or who are unable to provide food, clothing, or shelter for themselves. PMRT enables successful triage of each situation involving mentally ill, violent or high-risk individuals. PMRT provides caring, deescalating and less traumatizing approaches to crisis intervention, and whenever possible avoids outcomes that involve hospitalization, incarceration, or additional injury. In the crisis response services inventory that RI completed, all of the various types of LAC mobile crisis response services were outlined and other than PMRT, most of them are co-responder models that typically involve law enforcement. Both the *Crisis Now* model and the *National Guidelines* are associated with practices that divert from law enforcement involvement with a BH crisis and thereby these co-responder teams fall outside what has become considered to be best practice. This is not to say that co-responder mobile crisis teams have no role to play when responding to a crisis. They can be particularly beneficial when intervening with a crisis episode that poses a risk to public safety. However, other than such an instance, co-responder teams have demonstrated over time to be significantly more costly, while not as effective, as civilian teams that are comprised of a BH clinician and a peer support specialist.

Crisis Now Scoring Tool (Mobile Crisis Service) PMRT					
Mobile Outreach	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
	☑ Mobile Teams are in Place for Part of the Region	☐ Meets Level 1 Criteria	☐ Meets Level 2 Criteria	☐ Meets Level 3 Criteria	☐ Meets Level 4 Criteria
	☑ Mobile Teams are Operating at Least 8 hours Per Day in at least part of	☑ Mobile Teams are Available Throughout the Region at Least 8 hours Per Day	☑ Mobile Teams are Available Throughout the Region at Least 16 hours Per Day	☐ Formal Data Sharing in Placing Between Mobile Teams and All Crisis Providers	☐ Real-Team Performance Outcomes Dashboards Throughout Crisis System
	☐ Mobile Teams Respond to Calls Within 2 Hours Where in Operation	☐ Mobile Teams Respond to Calls Within 2 Hours Throughout the Region	☐ Mobile Teams Respond to Calls Within 1.5 Hours Throughout the Region	☐ Mobile Teams Respond to Calls Within 1 Hour Throughout the Region	☐ GPS-Enabled Mobile Team Dispatch by Crisis Line
	☑ Mobile Teams Complete Community-Based Assessments	☑ Mobile Team Assessments include All Essential *Crisis Now* Defined Elements	☑ Directly Connect to Facility-Based Crisis Providers as Needed	☑ Support Diversion Through Services to Resolve Crisis with Rate Over 60%	☐ Support Diversion Through Services to Resolve Crisis with Rate Over 75%
	☑ Mobile Teams Connect to Additional Crisis Services as Needed	☑ Staff Trained in Zero Suicide/Suicide Safer Care and BH Services	☑ Some Mobile Team Access to Person Specific Health Data	☑ Mobile Teams Receive Electronic Access to Some Health Information	☐ All Mobile Teams Include Peers
		☑ Shared MOUs/ Protocols with Call Center Hub	☑ Shared MOUs/ Protocols with Call Center and Crisis Facility-Based Providers	☑ Shares Documentation of Crisis with Providers	☑ Shared Status Disposition of Intensive Referrals
		☑ Priority Focus on Safety/Security	☐ Trauma-Informed Recovery Model Applied	☐ Some Peer Staffing within Mobile Teams	☑ Meets Person Wherever They Are - Home/Park/Street/ Shelter etc.
				☑ Systemic Suicide Screening and Safety Planning	☑ Real-Time Access to Electronic Health Records
					☑ Suicide Care Best Practices That Include Follow-up Support
					☐ Full Implementation of all 4 *Crisis Now* Modern Principles (Required)
	Assessed Level = 3 Progressing	**Justification of Rating:** There is no a single Level where all of the criteria are met however PMRT will be "close" to being in alignment with the addition of peers to the PMRT workforce, the application of new technology, and the delivery of response times that meet standards.			

The assessment level for PMRT has been evaluated at the Progressing Level 3. With DMH's plans to increase the number of PMRTs, this enhancement will contribute to improving PMRTs alignment with best practices.

As CA and LAC are building a peer support specialist workforce, this will also add momentum to the quest for better alignment with best practices, since these peers will comprise roughly 50% of the PMRT staffing, which DMH is in the process of achieving. PMRTs will need to have shared protocols with the 988 crisis call center since this service is deployed by the DMH Helpline, where protocols are in place.

To be consistent with the *National Guidelines*, mobile crisis response teams should be better coordinated, more easily dispatched, equipped to manage the transport of clients on voluntary status, staffed with clinicians and peers. A major shortcoming of mobile crisis services currently offered within LAC is the lack of standardization throughout the County. For example, there does not appear to be a common set of access standards for this service, many of the current response teams do not operate 24/7/365, and response times are too often protracted, sometimes taking days. With the expectation that 988 implementation is going to significantly increase crisis service volume, challenges associated with responsiveness can only be expected to be exacerbated and mobile crisis services efficiencies will become increasingly critical.

Mobile Response and Stabilization Services (MRSS)

While LAC has MCTs operating at some level throughout the County and has policies related to how these services can best meet the needs of youth, there has been no specialty MCT services tailored to the needs of children, youth, and families. In reality, MCTs have been basically an adult intervention and neither the *Crisis Now* model nor the *National Guidelines* address the unique needs of young people and their families relative to experiencing a crisis. With the intent of addressing this service gap, it is recommended that DMH convene a workgroup and examine ways in which this need could best be met. Mobile Response and Stabilization Service (MRSS) is a rapid response and integrated service based on the needs of the youth, young adult and/or their family/caregiver. It is a continuum of stabilization and support services that include an initial MCT intervention, but extend beyond that intervention to strengthen the resiliency of children, youth, and families/caregivers.

MRSS is intended to assist youth, young adults, parents and/or caregivers that is initiated through the 988 centralized referral system. MRSS will link youth, young adults and their families/caregivers to local services, supports and resources appropriate to the concerns identified during the mobile crisis response intervention. MRSS supports young people and their families and/or caregivers in stabilizing a crisis and averting unnecessary ED visits, out-of-home placements, placement disruptions, homelessness, arrests/ incarceration or other adverse outcomes. Youth is defined as a young person ages, infant to 17, regardless of their developmental progression; and Young Adult means a young person ages 18-21.

MRSS is available face-to-face 24/7/365 and provides onsite interventions in the home or any setting where the crisis may be occurring. MRSS provides coordination of services to also address the needs of youth with co-occurring IDD and SUD. Services are trauma informed and culturally, linguistically, and developmentally appropriate.

MRSS may be provided up to eight (8) weeks, or as long as necessary to provide the youth and their family with sufficient stabilization and connections with community-based resources. The eight weeks of

engagement, links youth, young adults and their parents/ caregivers to necessary supports and services within their community. After the initial presenting problems are addressed, staff facilitate the youth and parent and/or caregiver's transition to accessing identified supports, resources and services consistent with the mutually developed and agreed to ongoing service and support plan.

MRSS facilitation of involuntary psychiatric admission at a hospital or non-hospital facility, may be provided, but only when alternative resources have been demonstrated to be ineffective and/or when a young adult's (ages 18-21) safety and stability is at-risk. Young adults discharged from psychiatric inpatient (IP) care may receive follow-up care through MRSS or through the adult crisis system based on the recommendations from the MRSS team.

Transportation Services

RI also appraised the Department of health Services, Emergency Medical Services' (DHS-EMS) seven contracts for ambulance services against available performance reports for this service. These contracts are intended to provide Patient/Client Transportation Services (PCTS) for emergency and non-emergency transportation services for severely and persistently mentally ill adults and seriously emotionally disturbed (SED) children and adolescents throughout LAC. The DMH Access Center (AC) operates 24/7 as the entry point for mental health services in LAC. Services include deployment of Psychiatric Mobile Response Teams (PMRT), information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services, and patient/client transport.

The ambulance vendors are each expected, under contract, to provide transportation for DMH patients/ clients only upon AC request by telephone and to accept 80% of these requests for transport. Unfortunately in a review of PCTS performance reports for FY 2021-22, none of the contracted ambulance services met this expectation. Only two (2) of the seven (7) contracted ambulance services came close to this expectation, with a combined average response rate of 67%. Of the remaining five (5), their response rates were all 50% or less, with a low of 17%.

Given these performance levels, RI has recommended that DMH issue a Contractor Discrepancy Report (Exhibit B-1 of the contract) to each PCTS vendor and have each of them contacted by AC to develop a corrective action plan to address this non-compliance with contractual performance requirements. It is also recommended that DMH conduct a trend analysis pre and post COVID to determine how much of this unacceptably low performance is attributable to COVID. As an alternative to PCTS, DMH is encouraged to purchase designated county vans for PMRTs to transport those on voluntary status to UCCs. Involuntary transports should continue to be a function of PCTS, but higher payment rates are probably needed to also enhance performance levels. Another alternative that was recommended for DMH, was to be added to the existing LAC Department of Health Services, Emergency Medical Services (DHS-EMS) Agency ambulance contracts and adopt DPH's rate structure. This recommendation was accepted and enacted on October 24, 2021.

Mobile Crisis Team Recommendations: ***Where LA County needs to go with mobile crisis services over the next 3-5 years.***

A. Continue the expansion of civilian MCTs, monitor service demand and quality, and establish long-term funding.

The projections of the need for mobile crisis service is just over 71,701 episodes annually, which could be addressed 24/7/365 by one-hundred and thirty-eight (138) PMRTs, comprised of a BH clinician and a peer support specialist. There are currently over ninety (90) law enforcement co-responder mobile crisis teams in operation across the county, which RI believes is sufficient, compared to only thirty-five (35) civilian PMRTs.

B. Continue with phased expansion, monitoring demand, utilization, and performance metrics, while establishing sustainable funding.

1. Plan for the phased expansion of PMRT to 120 teams, the capacity projected utilizing the Crisis Now Capacity Calculator, from the current thirty-five (35) and adjust these capacity projections overtime as circumstances warrant.
2. Monitor and manage average response times, with the goal of reaching a less than one (1) hour average response time countywide.
3. Ameliorate PMRT workforce shortages by continuing to integrate the use of para-professionals and peers into each PMRT.
4. Advocate with CalAIM to include as many crisis-related situations as possible as a billable Medi-Cal service (e.g. welfare checks, conflict resolution, and other non-violent crisis calls in addition to traditional BH crises).
5. Adopt and implement the use of a set of common KPIs for this service.
6. Create a common scope of practice for mobile crisis services and monitor and manage the degree to which PMRTs operate within that scope.
7. Conduct PMRT competency training across the lifespan and evaluate child/adolescent specific mobile crisis service in areas where there is sufficient population density to support doing so.

C. Continue to improve PMRT operations and efficiency.

1. Improve operational flow through training, standardized protocols, and systems of accountability to reduce average time on scene from five (5) to four (4) hours and thereby, increase from two (2) to three (3), the average number crisis intervention episodes per shift.
2. Initiate a performance improvement project (PIP) to improve PMRT inefficiencies.
3. Adjust team schedules to better match service demand patterns.
4. Expand PMRT service hours to 24/7 county-wide.
5. As new PMRTs are implemented, firmly establish the one hour average crisis response time as the performance standard and expectation.
6. Make the necessary technological enhancements to facilitate concurrent service documentation by PMRTs during service delivery.

7. Review and conduct a performance improvement project on PMRT's application of 5150 involuntary hold practices, as the usage of such practices appears to be abnormally high.
8. Establish and fund standardized scopes of practice and training for peer support specialists as they are further integrated into PMRT.

D. Convene a MRSS workgroup and examine the utility of this model to meet the mobile crisis response need of children, youth, and families.

E. Offer incorporated cities a leadership role in mobile crisis response, just as they have in police and fire/EMS services.
   1. Incentivize the development and implementation of city-specific mobile crisis teams by leveraging Medi-Cal.
   2. Offer cities the option of taking over the mobile crisis response service entirely within city limits, subject to LAC's oversight.
   3. ACR will reduce cities' needs to expand police/fire, and the associated system savings should be reinvested in further optimizing the crisis response system.
   4. Negotiate agreements with Law Enforcement Teams to drop-off those in crisis to crisis receiving centers as opposed to EDs and county detention.

F. Resolve client transport barriers.
   1. To enhance transportation, equip MCTs with vans as the standard vehicle utilized and permit MCTs to transport those in crisis who are on a voluntary status.
   2. Utilize CCMU funding to purchase vans.
   3. Transition from the use of BLS vehicles for the transport of those in crisis, since the current response times range from two (2) to eight (8) hours.
   4. Evaluate alternative 5150 assessment and transport options per regulations and assess the potential of MET to be used regarding 5150 associated procedures.
   5. Assure that ambulance vendors are in compliance with their contractual obligations regarding response times.
   6. Issue a Contractor Discrepancy Report (Exhibit B-1 of the contract) to each PCTS vendor and have each of them contacted by AC to develop a corrective action plan to address the non-compliance with contractual performance requirements; and conduct a trend analysis pre and post COVID to determine how much of this unacceptably low performance is attributable to COVID.
   7. Involuntary transports should continue to be a function of PCTS, but negotiate higher payment rates to incentivize improved performance.

IV. Somewhere Safe to Go: Crisis Care Facilities in LA County



Facility-based crisis services begin by offering short-term BH crisis care for individuals who need support and observation. Design of these facility-based crisis services may vary, but ideally they include a medically staffed flexible observation and stabilization area with recliners, instead of beds, (usually limited to less than 24 hours of care); and operate under a "no wrong door" approach. Under this approach, walk-ins, law enforcement, and other first responder referrals, are immediately accepted without requiring any form of medical clearance prior to admission. This approach also includes accepting voluntary and involuntary admissions. Therefore, it is imperative that the facility is staffed and equipped to assure the health and safety of everyone within the facility. These centers are typically a high-speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge planning and community coordination of services.

These introductory crisis observation stabilization programs are typically paired with a subacute short-term (2-5 day) facility-based crisis program to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs. This facility needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of those admitted to the 23-hour center with recliners, who were not sufficiently stabilized during the 23-hour observation stay, and who may receive crisis stabilization services for up to fourteen (14) days. Using DMH licensure types as a reference, the first of these core crisis facilities, that operate for up to twenty-four (24) hours using recliners, most closely align with DMH's psychiatric Urgent Care Centers (UCC). However, the second type of crisis facility that utilizes beds will be referred to as Short-Term Acute Crisis Centers (STAAC), and these appear to align most closely with three different facility licensure types that can be used in CA for the provision of acute psychiatric care: an Acute Psychiatric Hospital (APH), a General Acute Care Hospital (GACH), or a Psychiatric Health Facility (PHF).

Both settings should be designed as inviting non-institutional environments that are enhanced by natural light, and hopeful and inspiring aesthetic features. Safety and security are built into the staffing model and physical plant, yet still offer a "living room" feel. Program interventions are delivered by both professional (MD, PNP, RN, Clinician) and para-professional (certified peer support specialists) staffs designed to support ongoing recovery, and to engage in comprehensive discharge planning and community coordination of care. Equally important is that this interdisciplinary team creates and sustains an environmental milieu where all "guests" are treated with dignity and respect, are authentically and meaningfully engaged, and when dysregulated, they are allowed the space, time, and support necessary to de-escalate. As a result, these stabilization settings, when appropriately staffed, are able to assure greater safety than normally expected in crisis settings. Seclusion and restraints are available, but rarely applied.

Alternative Crisis Services (ACS) provide a comprehensive range of services and supports for mentally

ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care; reduce homelessness; and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs, e.g., FSP and Assertive Community Treatment programs, housing alternatives, and treatment for co-occurring substance abuse. ACS serves individuals 18 years of age and older of all genders, race/ethnicities, and languages spoken.

In 2019, Countywide Resource Management integrated with the Managed Care Division and changed its name to the Intensive Care Division. It remains responsible for overall administrative, clinical, integrative, and fiscal aspects of programs that serve the most severely ill individuals with mental illness. This includes planning, developing, and implementing urgent care centers and enriched residential programs for these specialized populations. Also, it coordinates functions to maximize the flow of clients between various levels of care and community-based mental health services and supports. The ACS intended outcomes are to reduce the utilization of psychiatric emergency rooms and inpatient acute psychiatry and to reduce the incarceration of persons with severe and persistent mental illness.

DMH MHSA ACS programs:

- Provided to a Medicaid beneficiary who is experiencing a BH disorder crisis;
- Residential and Bridging Care (RBC) Program;
- Psychiatric Urgent Care Centers (UCC);
- Enriched Residential Services (ERS);
- Crisis Residential Treatment Programs (CRTP); and
- Law Enforcement Teams (LET).

LETs have already been included in the previous section on mobile crisis services. UCCs and CRTPs will be covered in this section on facility-based crisis services. While RBC and ERS are not crisis services, they can be of benefit to those that have been in crisis. These programs are not considered to be core crisis response services under the *National Guidelines*.

Behavioral Health Urgent Care Centers (UCC)

While LAC has BH 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 (SUD). These facilities are critical to stabilizing individuals in a BH 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 facility-based crisis resources that would support a reimagined ACR system.

There is a strong ACR consensus that many more of these facilities are needed and should be geographically and equitably distributed throughout LAC, especially in the more rural areas of the County. Locating these facilities on hospital campuses (key components of LAC's "Restorative Care Village" model) is also important

to address siting challenges and proximity to public transportation. Additionally, the improved ACR system requires better utilization of extant community and non-governmental mental health bed capacity.

In terms of facility-based crisis services within LAC, there are ten (10) UCCs currently operating with up to one-hundred and thirty-four (134) chairs or recliners, and not beds. One-hundred and thirty-four of these chairs are designated for adults and thirty-eight (38) for youth. These UCCs are all Medi-Cal certified and County Lanterman-Petris-Short (LPS) designated facilities that can operate as secure environments, accept involuntary admissions, and provide intensive crisis stabilization services and supports to individuals who otherwise would be brought to an emergency room or end up in County detention. These facilities have stays of up to twenty-three (23) hours and fifty-nine minutes and are licensed by the California DHCS. UCCs are intended to offer immediate care and linkage to community-based resources. In addition to MH crisis stabilization services, these facilities deliver integrated services for those with co-occurring SUD.

These facilities most closely resemble the crisis receiving centers or entry level of crisis care that are featured in the *National Guidelines*. However, because of LAC's bifurcated system between MH and SUD services, these UCCs are unable to provide withdrawal management, medication-assisted treatment, and harm reduction for those with SUD. In addition, the RI consultant team found no evidence to indicate that these facilities are prepared to admit those with Intellectual and Developmental Disabilities. Another barrier is that one of these facilities only offers limited hours of operation. In addition, not all of these programs are providing a "no-wrong-door" service and some of them are generally under-utilized.

So that the UCCs can operate more as crisis receiving centers and in alignment with the *National Guidelines*, RI has proposed a revised SOW for these facilities and the new solicitation for UCCs has been amended to include this revised SOW. In addition, DMH has sent a letter to all law enforcement partners with a request to transport to crisis receiving facilities first, instead of emergency rooms. It is expected that the UCCs be able to accept every referral from law enforcement and to do so in under three (3) to five (5) minutes, so that law enforcement can expeditiously return to its public safety mission.

Urgent Care Center (UCC)	Location	Service Area	Hours	Recliners (Ages 18+)	Recliners (Ages 17 & Under)
Providence Little Company of Mary Urgent Care Center	San Pedro	SA 8	24/7	20	0
Exodus Recovery Urgent Care Center at Harbor	Torrance	SA 8	24/7	14	4
Star View Behavioral Health Urgent Care Center	Long Beach	SA 8	24/7	12	6
Star View Behavioral Health Urgent Care Center	Lancaster	SA 1	24/7	12	6
Star View Behavioral Health Urgent Care Center	Industry	SA 3	24/7	12	6

Exodus Recovery Eastside Urgent Care Center	Los Angeles	SA 4	24/7	16	0
Exodus Recovery Westside Urgent Care Center	Culver City	SA 5	24/7	16	8
Exodus Mental Health Urgent Care at MLK	Los Angeles	SA 6	24/7	16	8
Olive View Community Mental Health Urgent Care Center	Sylmar	SA 2	24/7	8	0
Telecare Mental Health Urgent Care Center	Long Beach	SA 8	M-F, 8am-7pm	6-8	
Totals				132-134	38

There are several new UCC or crisis receiving facilities in the pipeline, including:

- Two (2) UCCs for children (ages 5 to 12 years), no target date for opening established;
- One (1) UCC on the LAC+USC Medical Center Campus, no target date for opening established;
- One (1) UCC on the Rancho Los Amigos medical campus, no target date for opening established;
- The Sobering center located at the Behavioral Health Center (BHC) on the Martin Luther King, Jr. (MLK) Medical Campus is expected to begin delivering services by mid-2022 (15 beds).

With the current level of chairs/recliners at one-hundred and seventy-two (172) and with an additional seventy-nine (79) in the pipeline, LAC needs to stand-up additional UCCs with a total chair capacity of one-hundred and forty-three (143) chairs to meet the projected demand for this resource at three-hundred and ninety-four (394) chairs or recliners.

LAC Psychiatric Emergency Departments:

In addition to UCCs, LAC also has three (3) psychiatric emergency services (PES) with fifty-two (52) beds for adults and seven (7) beds for adolescents, for a total of fifty-nine (59) beds.

1. Harbor - UCLA Medical Center Psychiatric Emergency Service (SA 8)
2. Olive View-UCLA Medical Center Psychiatric Emergency Service (SA 2)
3. LAC USC Psychiatric Emergency Service (SA 4)

Most commonly, a Psychiatric Emergency Service (PES) is a distinct hospital operation dedicated to managing and treating psychiatric emergencies. Most can accept patients around the clock, either directly from the field via police or ambulance or at other times, individuals will self-present. These programs are often affiliated with major academic hospitals, as is the case in LAC, and they typically work closely with

a nearby medical emergency department. It is not unusual for psychiatry residents to provide much of the direct care under the supervision of attending psychiatrists. While numerous variations exist, many programs have individual rooms for patients, similar to an inpatient psychiatric ward, but will attempt to limit stays to less than 24 or 48 hours. They are staffed by psychiatric physicians, advanced providers, nurses, and therapists. Use of physical restraints and injected medication can occur, but they typically occur at lower rates than a medical ED.

LAC Sobering Centers

A sobering center is a short-term care facility designed to allow an individual who is intoxicated and nonviolent to safely ameliorate the debilitating effects of alcohol and drugs. The centers typically operate 24/7, and have lengths of stay ranging from four to just under 24 hours. They are also known as stabilization programs, diversion centers, and sobering stations. Sobering centers are separate and distinct from two other kinds of alcohol-related care facilities: detoxification centers, which support individuals in the gradual and complete cessation of alcohol and/or drug consumption over a period of days, and sober living houses, which provide a group residential setting for those in recovery and abstinent from drugs and alcohol. Though sobering centers may support an individual's desire to be abstinent and pursue recovery, the primary focus is on reducing harm.

New interest in this old approach has been triggered by California Advancing and Innovating Medi-Cal (CalAIM), which is a multi-year process led by the California Department of Health Care Services to improve the health outcomes and quality of life experienced by Medi-Cal recipients. CalAIM has designated sobering centers as one of fourteen (14) reimbursable, non-traditional services available to augment or supplant medical care. The reforms are designed to foster greater integration between physical health, mental health, and social services for all Medi-Cal enrollees. There are two Sobering Centers currently operating within LAC with support from DMH:

- David L. Murphy Sobering Center is operated by Exodus Recovery, Inc. which is located in Downtown LA. It is intended to reduce incarcerations, minimize hospitalizations and assist active, chronic and serial inebriates living on and around Skid Row by providing a path to recovery in a safe and a welcoming environment. The Center is open 24/7, but it does not accept walk-ins. Referrals must come from law enforcement, some emergency personnel, and designated outreach teams working within the Skid Row area. It has a fifty (50) bed capacity providing respite, showers, hydration, light snacks, and some medical monitoring, if necessary. The length of stay is typically from 6-12 hours. (SA 4)
- Mark Ridley Thomas (MRT) Behavioral Health Center was slated to open in 2021 as an innovative facility which houses more than a half dozen County departments and partners, including clinical and BH staff from DMH, Public Health, Public Works, and Health Services. The Departments of Probation and Workforce Development, Aging and Community Services, along with the Office of Diversion and Reentry, provide the rehabilitative, vocational, and training opportunities to give people the skills they need to reintegrate into the community. Included in its many offerings, is a fifteen (15) bed Sobering Center. (SA 6)

Psychiatric Health Facilities (PHF)

PHFs are licensed by the State Department of Health Care Services (DHCS) and they can provide 24-hour acute crisis stabilization care for those admitted to UCCs that cannot be stabilized in under twenty-four (24) hours. Care includes, but is not limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services. However, LAC currently has four PHFs that are not providing crisis care, but serve instead as longer term BH care facilities. Three (3) of these are for adults with a total of fifty-two (52) beds and the forth is for adolescents with sixteen (16) beds:

• Exodus Recovery Psychiatric Health Facility	Culver City, CA	16 beds
• La Casa Psychiatric Health Facility	Long Beach, CA	16 beds
• Ocean View Psychiatric Health Facility	Long Beach, CA	20 beds
• Star View Adolescent Center Psychiatric Health Facility	Torrance, CA	16 beds

PHFs can be established to closely resemble the short-term crisis beds centers with beds that are featured in the *National Guidelines*. However, because of LAC's bifurcated system between MH and SUD services, these PHFs are also unable to provide withdrawal management, medication-assisted treatment, and harm reduction for those with SUD. In addition, the RI consultant team found no evidence to indicate that these facilities are prepared to admit those with Intellectual and Developmental Disabilities.

In addition, these PHFs do not currently act in a manner consistent with the *National Guidelines*. They have higher exclusionary criteria and much longer lengths of stays, that average from weeks to months, instead of days. As a result, after much discussion with DMH and the Office of the CEO, it was decided that while the PHFs could function in the role of a crisis stabilization center with beds, to convert the current beds to align closely to the *National Guidelines* was unrealistic. As a result, the decision was made to not count these beds in the overall capacity modeling.

Currently, LAC does not have sufficient crisis stabilization bed capacity to reliably divert from jails, emergency rooms, and hospitals. RI estimates that every year, approximately 36,184 persons in crisis end up in a traditional psychiatric inpatient hospital beds when a crisis stabilization chair or a short-term crisis bed would have been a more appropriate level of care. Currently, LAC is in need of four-hundred and eighty-nine (489) Short-Term Acute Crisis Center (STAAC) beds. The good news is that once these additional STAACs are fully operational, the County and those in crisis will become less dependent on traditional psychiatric inpatient admissions. RI estimates that once the crisis system has adequate capacity and efficiencies, it could reduce the need for psychiatric inpatients beds by approximately 1,430 beds from its current licensed capacity.

Crisis Residential Treatment Programs (CRTP)

Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and

therapeutic, home-like setting. CRTPs provide services 24/7/365. CRTPs have a maximum bed capacity of sixteen (16) individuals per site. While the average length of stay in CRTPs is ten to fourteen (10-14) days, an individual's maximum stay should not exceed thirty (30) days. CRTPs serve as an alternative to hospitalization, reduce the psychiatric inpatient days of individuals, and may serve as a resource for individuals who might otherwise be incarcerated without appropriate community services. CRTPs are licensed by the California Department of Social Services (CDSS) as Social Rehabilitation Programs, with the mental health program component is certified by the California Department of Health Care Services (DHCS), and are all Medi-Cal certified. CRTPs are centrally accessed through DMH's Intensive Care Division (ICD). County Hospital Psychiatric Emergency Services (PES) and inpatient treatment staff work collaboratively with DMH ICD liaisons to identify potential referrals to CRTPs. Urgent Care Centers (UCCs) refer individuals directly to DMH's ICD for authorization.

On December 17, 2020, LAC issued a Request for Proposals (RFP) to solicit proposals from qualified organizations interested and capable of providing CRTP services at four hospital campus sites: The four hospital campus sites are fully owned by LAC and are separately leased to the CRTPs. The lease agreement term runs concurrent with the CRTP services contract and is administered by the LAC Chief Executive Office (CEO), Real Estate Division (RED).

Crisis Residential Treatment Programs (CRTP)	Location	Service Area	Hours	Beds (Ages 18+)	Accepts DMH Admits
Didi Hirsch Mental Health Services, Inc. – Excelsior House	Inglewood	SA 8	24/7	12	Yes
Didi Hirsch Mental Health Services, Inc. – Jump Street	Los Angeles	SA 5	24/7	10	Yes
Exodus Recovery, Inc.	Los Angeles	SA 5	24/7	12	Yes
Gateway Hospital Social Rehabilitation Program	Los Angeles	SA 4	24/7	16	Yes
Hillview Mental Health Crisis, Inc.	Pacoima	SA 2	24/7	15	Yes
MLK Behavioral Health Center – Restorative Care Village	Los Angeles	SA 6	Not Open**	16	Yes
Olive View Medical Center – Restorative Care Village (5)	Sylmar	SA 2	Not Open**	80	Yes
LAC+USC Medical Center – Restorative Care Village (4)	Sylmar	SA 4	Not Open*	64	Yes
Rancho Los Amigos National Rehabilitation Center - Restorative Care Village	Downey	SA 7	Not Open**	80	Yes

LA Centers for Alcohol & Drug Abuse (LACADA) – Allen House	Santa Fe Springs	SA	Not Open**	16	Yes
Special Service for Groups, Inc. (SSG) - Florence House	Los Angeles	SA 4	Not Open**	16	Yes
The Teen Project - Freehab	Sun Valley	SA 2	24/7	16	Yes
Total	13			353	

*Building not ready for occupancy.

**Providers are in process of contracting with DMH. Remaining implementation steps include licensing, Medi-Cal certification, etc. After that, the move-in process, start-up, and on-boarding can begin. Estimated 8-12 weeks until open.

For FY 2019-20, there were a total of 1,392 CRTP referrals, with 601 admissions and 579 discharges. Of the 790 clients not admitted, they were designated as 'no longer referred'. Clients received this designation for a variety of reasons, including having been discharged from the hospital prior to admission.

When existing CRTP beds are combined with the anticipated CRTP beds that are currently in the pipeline, LAC will have a total of 353 beds. This number is just fifteen (15) beds shy of the 378 projected bed capacity as presented in the following table, assuming the ALOS is limited to fourteen (14) days. If the ALOS is closer to twenty-eight (28) days, then an additional 658 beds would be required; and if the ALOS is even greater, more beds would be required and could be accommodated by also increasing the number of peer respites.

Crisis Residential Bed Needs		
Referral Volume	ALOS (Days)	Beds Needed
9,867	14	378

Restorative Care Village

In 2017, the Board of Supervisors voted unanimously to move forward with Restorative Care Villages to help address the needs of some of the County's most vulnerable populations providing wrap-around care for homeless patients after they are discharged from County hospitals,. And presumably from facility-based crisis services. In 2022, four Restorative Care Villages are set to open on four of LA County's medical campuses. The sites featuring Restorative Village Programs, are:

1. MLK Behavioral Health Center, with sixteen (16) residential treatment beds, along with a variety of residential and outpatient treatment programs for mental health and substance use disorders;

2. Rancho Los Amigos National Rehabilitation Center, with eighty (80) residential treatment beds and fifty (50) recuperative care beds;
3. Olive View-UCLA Medical Center will hold eighty (80) residential treatment beds and forty-eight (48) recuperative care beds alongside mental health outpatient and urgent care centers; and
4. Los Angeles County + University of Southern California (LAC+USC) Restorative Care Village (RCV) Project, which consists of a Recuperative Care Center with ninety-six (96) beds and a Residential Treatment Program (RTP) consisting of four buildings that provide a short-term alternative to hospitalization. There will be sixteen (16) beds in each of the four buildings (64 beds total).

Together, these facilities, along with others planned throughout the County, are essential components of a broader strategy to help vulnerable residents fully recover. They offer a safe, clean, sober and nurturing environment, while permanent housing solutions are sought. The RCV is the first phase of a larger resource array of facilities and services that will not only divert individuals with complex healthcare needs from city streets, arrest and detention, ED's and hospitalization, but also support successful re-integration into the community.



(Courtesy CannonDesign)

In December 2021, the LAC Board of Supervisors decided to provide additional support to RCVs with trained and responsible crisis intervention teams to quickly de-escalate and intervene to prevent violence, suicides or mental health crises from occurring or escalating at restorative care village campuses.

To better assess whether or not these existing UCCs meet some of the basic features of crisis receiving centers as presented in the *National Guidelines*, interviews were conducted with A. Yvonne Lozano, M.S., LMFT, Administrator and Steve Albrecht, MSED, MBA, Regional Administrator, Star View Behavioral Health on April 12, 2022; Luana Murphy, MBA, President/CEO and Kathy Shoemaker, RN, COO of Exodus Recovery, Inc. April 13, 2022; Stephanie Nolan, DNP, RN, CPAN, NEA-BC, Executive Director Acute Care Nursing at Providence Little Company of Mary San Pedro on April 21, 2022; and Katherine Lee, Ph.D., LCSW, Regional Director of Operations, LAC and Kern County Telecare. Their collective inputs are included in the following table:

Mental Health Urgent Care Centers								
	Star View Includes 3 campuses: Long Beach, Lancaster, and the City of Industry	Comments	Exodus Includes 4 campuses: Harbor, Eastside, Westside, and MLK	Comments	Providence includes 1 campus San Pedro	Comments	Telecare La Casa MHUCC	Comments
Accept all referrals	No	Admit Criteria	Yes	Unless it is clearly a physical concern	Partial	No adolescents/ pediatrics	Yes	
Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program	No	No medically complex	Yes	No medical clearance required	No		Yes	
Design their services to address mental health and substance use crisis issues	No	No SUD Services	Yes		Yes		Yes	
Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed serviced if needed	No	LVN Screening; only treat routine medical	Yes		Yes		No	
Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including: a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used) b. Nurses c. Licensed and/or credentialed clinicians capable of completing the assessment in the region; and d. Peers with	Partial	Prescriber - yes Nursing - yes; LVN and clinician interchangeable and not always present. Do not heavily use	Partial	Prescriber - yes Nursing - yes clinicians 7AM to 7PM peer incorporated into work	Yes		No	Open from 8AM to 7PM Monday-Friday
Offer walk-in and first responder drop-off options	Yes	"Front door" is open 8AM to 8PM walk-ins and drop offs 24/7 in the back	Yes		Yes		No	No drop off
Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with no rejection policy for first responders	Partial	First responders are aware of criteria	Yes		Partial	ED is considered front door wherein all BH patients are accepted however not all go to OBHC	Yes	

Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated	Yes	Based on assessment acuity, observation, and history	Yes		Yes		Yes	
Screen for violence risk and complete comprehensive violence risk assessment and planning when clinically indicated	Partial	No combative people	Yes		Yes		Yes	
Function as a 24 hour or less crisis receiving and stabilization facility	Yes		Yes		Yes		Yes	
Offer a dedicated first responder drop-off area	Yes	First responders use back door	Yes		Partial	ED is front door	No	
Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support	Partial	Established community relationships used PRN	Yes		Yes		No	
Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources;	No	Does that exist?	No	If it existed we would participate	No		No	
Coordinate connection to ongoing care	Yes	Strive for warm hands offs`	Yes		Yes		Yes	

From the interviews conducted with present-day UCC leadership, it is apparent that there is considerable variability between the UCCs in meeting the basic expectations of crisis receiving centers as presented in the *National Guidelines*. For example, one of the UCCs is ninety-three percent (93%) in alignment with best practices, while another operates at fifty-seven percent (57%). These results suggest either that the standards that the UCC are expected to contractually meet may be out of alignment with national best practice or that some UCCs are partially out of compliance with DMH contractual obligations.

The third score sheet of the *Crisis Now* Scoring Tool, assesses the best practice alignment of Crisis Receiving Centers or in the case of LAC, Mental Health Urgent Care Centers (UCC). These UCCs are all Medi-Cal certified and County Lanterman-Petris-Short (LPS) designated facilities that can operate as secure environments and accept involuntary admissions. These facilities provide intensive crisis services to individuals who otherwise would be brought to emergency rooms, including those on 5150 involuntary holds. They provide up to 23 hours of immediate care, crisis intervention services, including integrated services for co-occurring SUD. They each focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment or arrest and detention. The UCCs are geographically disbursed throughout the County.

Crisis Now Scoring Tool (Crisis Receiving Center) MHUCC					
Crisis Receiving Center	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
	☑ Sub-Acute Stabilization is in Place for Part of the Region	☑ Meets Level 1 Criteria	☑ Meets Level 2 Criteria	☐ Meets Level 3 Criteria	☐ Meets Level 4 Criteria
	☑ Have 24/7 Access to Psychiatrists or Master's Level Clinicians	☑ Some From of Facility-Based Crisis is Available Throughout the Region	☐ Crisis Beds/Chairs Available at a Ratio of at Least 3 per 10,000 Census	☐ Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	☐ Real-Time Performance Outcomes Dashboard Throughout Crisis Systems
	☑ In Countries with Sub-Acute Stabilization, at Least 1 Bed/Chair per 100,000 Census	☑ Crisis Beds/Chairs Available at a Ratio of at Least 2 per 100,000 Census	☑ Offers Crisis Stabilization/ Observation Chairs as well as Sub-Acute/Residential	☐ Crisis Beds/Chairs Available at a Ratio of at Least 4 per 1000,000 Census	☐ Crisis Beds/Chairs Available at a Ratio of at Least 5 per 100,000 Census
		☑ Shared MOUs/ Protocols with Other Crisis Providers	☑ Multiple Providers Offering Facility-Based Crisis Services	☐ Support Diversion From Acute Inpatient at Rate Over 60%	☐ Support Diversion From Acute Inpatient at Rate Over 70%
		☑ Staff Trained in Zero Suicide/Suicide Safer Care and BH Services	☐ Some Crisis Facility Access to Person Specific Health Data	☐ Incorporates Crisis Respite Services into the Facility-Based Crisis Continuum	☐ No Refusal to First Responder Drop offs as Primary Service Location
		☑ Priority Focus on Safety/Security	☑ Trauma-Informed Recovery Model Applied	☐ Operates in a Home-Like Environment	☐ Bed Inventory and Referral Centralized Through Crisis Line
			☑ Direct Law Enforcement Drop-Offs Accepted	☐ Systematic Suicide Screening and Safety Planning	☐ Suicide Care Best Practices That Include Follow-up Support
			☑ Least Restrictive Intervention and No Force First Model	☐ Some Peer Staffing within the Crisis Facility	☐ Utilize Peers as Integral Staff Members
				☐ Sub-Acute Stabilization Receive Electronic Access to Some Health Information	☐ Shared Status Disposition of Intensive Referrals
				☐ Shares Documentation of Crisis with Providers	☐ Law Enforcement Drop-Off Time Less Than 10 Minutes
					☐ Full Implementation of all 4 *Crisis Now* Modern Principles (Required)
	Assessed Level = 3 Progressing	**Justification of Rating:** Multiple MHUCC provider agencies are operating crisis receiving chairs across LA County with some level of congruency to the *Crisis Now* model.			

UCCs, as they are currently operating, come the closest to being aligned with national best practices and are assessed at Level 3: Progressing. However, the UCCs tend to utilize exclusionary admission criteria and are not adequately staffed, trained, or have facilities that are necessarily designed to operate under a "no wrong door" approach for those experiencing an acute crisis. The Local Emergency Medical Services Authority (LEMSA) created a medical screening tool for use by UCCs that are Alternative Destination Sites to screen potential admissions. Operating under "no wrong door," UCCs would be better positioned to say, "Yes" one-hundred percent (100%) of the time to those presenting for admission and the medical screening tool requires modification for this to possible.

In RI's experience, this open access facilitates law enforcement drop-offs because of the UCC's consistent reliability. RI not only assures law enforcement of this reliability regarding admissions, but also that law enforcement officers will be back on the street in under three (3) to five (5) minutes following a drop-off. The UCCs operated by Exodus Recovery, Inc. appear to come the closest to practicing in alignment with best practices. RI has finalized recommendations on capacity and geographic coverage needs that will inform site selection and capital development planning for new crisis receiving facilities. RI anticipates that LAC needs a total of approximately four-hundred and fifty (450) BH urgent care UCC "chairs/recliners."

Crisis Residential Treatment Programs (CRTP) were not included in this assessment of alignment with BH crisis care best practices, because a residential LOC is not viewed to be a core crisis service within the *Crisis Now* model nor within the *National Guidelines*. Typically, residential treatment is considered to be an intermediate LOC and is not associated with or appropriate for the acuity level of care that crisis services demand. Nor does this LOC have the level of payment required to support acute crisis care.

It should be pointed out that crisis care is not treatment. It is not about diagnostics and the development and execution of a treatment plan. It is instead about intervening with someone in crisis by de-escalating any extreme behaviors and subsequently helping to determine one's baseline functioning and identifying the precipitating event or events that moved this person beyond baseline. Once this is accomplished, subsequent interventions revolve around determining how to mitigate such events in the future and provide the necessary treatment and supports in the community to sustain baseline functioning, to prevent a recurrence, and reinforce recovery.

RI projects that LAC needs approximately four-hundred and eighty-nine (489) STAAC beds, which will provide crisis stabilization stays for up to fourteen (14) days, for the roughly thirty percent (30%) of those admitted to a UCC who cannot be sufficiently stabilized in under twenty-four (24) hours. Similar to the UCCs in LAC, these STACCs will need to be Medi-Cal certified and County LPS-designated facilities that can operate as secure environments and accept involuntary admissions. These STACCs need to be distinguished from CRTPs which LAC has increasingly invested resources to expand throughout the County. Before committing to the further expansion of CRTPs beyond what is currently in the pipeline, it is recommended that LAC plan instead on standing-up the necessary STACCs to overcome the most major gap in LAC's crisis response system.

Without this type of facility-based crisis service, it is anticipated that client flow within the crisis response system will reach a choke point. This is anticipated to occur when an individual is not sufficiently stabilized upon discharge from a UCC and remains too acutely unstable to meet the admission criteria of the CRTP. The only option at that point will be a psychiatric inpatient stay for this individual, which the UCC was seeking to avoid in the first place. Should a psychiatric IP bed not be available to this individual, he or she will remain within the UCC beyond twenty-four (24) hours. Should this occur too often, the facility will be forced to go on a diversionary status. In order to keep the UCC "front door" open, it requires that "the back door" remain open as well. In this way, the crisis response system is able to remain responsive and maintain client flow, thereby contributing positively to the efficiency of the crisis response system.

With the State's plan to obtain an IMD Waiver, LAC would be free to construct facilities based on needed capacity rather than being limited to sixteen (16) beds. In time, as the LAC crisis response system matures, LAC should evaluate whether or not some of CRTPs should be converted to STACCs, that also provide SUD withdrawal management and medication assisted treatment, along with harm reduction. In addition, these facilities need to be prepared to serve adolescents and those with IDD and other disabling conditions. Likewise, as the crisis response system becomes increasingly optimized and diverts crisis care from ED's and hospitals, it will be worth considering the conversion of acute hospital-based psychiatric inpatient units, to STACCs as an alternative to new construction.

Without financial support for construction, equipment, and start-up costs associated with the establishment of facility-based crisis services, it is very challenging for providers to standup these facilities. Most providers do not have the assets necessary to assume these costs and therefore, without capital and initial financial operating assistance, these facilities will not be established. Therefore, LAC, private foundations, and local health systems should collaborate and explore all available financing options to support the capital and initial operating costs to standup facility-based crisis services.

Fortunately in 2021, DHCS launched the Behavioral Health Continuum Infrastructure Program (BHCIP) and announced that it would release funding through six grant rounds targeting gaps that have been identified in the state's BH facility infrastructure. Remaining BHCIP rounds to be released in 2022 include funding for MHUCC projects. Round 3 was for "Launch Ready Projects" for a total of $518.5 million. These grants provide funding for launch-ready projects to construct, acquire, and rehabilitate real estate assets to expand the BH continuum of treatment and service resources in settings serving Medicaid beneficiaries.

For distribution purposes under this round of funding, it is anticipated that an additional $120 million will be available under Round 3 that will be competitively bid and will allow applicants who require more time to develop their application. Additional rounds will include:

- Round 4: Children and Youth for a total of $480.5 million which has not been released.
- Round 5: Crisis and Behavioral Health Continuum is anticipated to be released in November of 2022 for a total of $480 million.
- Round 6: BH Needs Assessment Phase Two for a total of $480 million which has not been released.

Facility-based Crisis Services Recommendations: *Where LA County needs to go with facility-based crisis services over the next 3-5 years.*

A. Expand the capacity of psychiatric Urgent Care Centers (UCC) with recliners and establish Short-Term Acute Crisis Centers (STACC) with beds.
   1. Develop STAAC bed capacity to 489, by establishing 256 new STAAC beds and converting 233 currently operating psychiatric inpatient beds.
   2. Collaborate with hospitals to convert psychiatric inpatient units, comprised of 233 beds, to STAACs.
   3. Utilize geo-mapping to facilitate siting additional UCCs to ensure that 98% or more of LA County's residents are within 25 minutes of a UCC.
   4. Construct STAACs with a bed capacity beyond sixteen (16) beds, as appropriate, for improved economies of scale (an option to be available with the upcoming Medicaid IMD waiver).
   5. Co-locate STAACs on the same site as UCCs whenever possible to facilitate the LOC transitions.
   6. Implement a formal agreement between the UCCs, as the crisis facility gatekeeper and the STAACs, to provide those requiring transfer from the UCC with extended stabilization services when warranted.
   7. Develop and implement a plan for expanding facility-based crisis services to meet the needs of children, youth, and families

B. Implement the proposed financing strategy for facility-based crisis services.
   1. Refer to pages 63-68 of this Report for the financial planning and execution necessary to achieve and sustain these facility benchmarks over the course of the next 3-5 years.
   2. Develop and execute a strategic plan for the utilization of financial resources generated by the anticipated ROI (e.g. from reduced ED/hospital and criminal justice expenses) in addition to available funds.
   3. Evaluate the square footage requirements for each new UCC and STAAC, based on the chairs/beds needed for a given service area, utilizing the *Crisis Now* Capacity Calculator.
   4. Use the proposed staged growth plan for the establishment of additional UCCs and STAACs that is presented on pages 63-68 of this Report.
   5. Enlist LAC's private foundations, and health systems to explore all innovative financing options to support the capital and initial operating costs to standup facility-based crisis services.

C. Manage alignment of facility-based crisis services to national best practices.
   1. Implement a "no-wrong-door" 100% admission acceptance model at all DMH funded LPS designated UCCs and STAACs, to include admission of those with SUD, co-occurring disorders, IDD, and other disabling conditions.
   2. Integrate the mental health crisis stabilization services of these facilities with withdrawal management services, medication-assisted treatment, and harm reduction services for those with SUD and with co-occurring disorders, in partnership with DPH-SAPC.

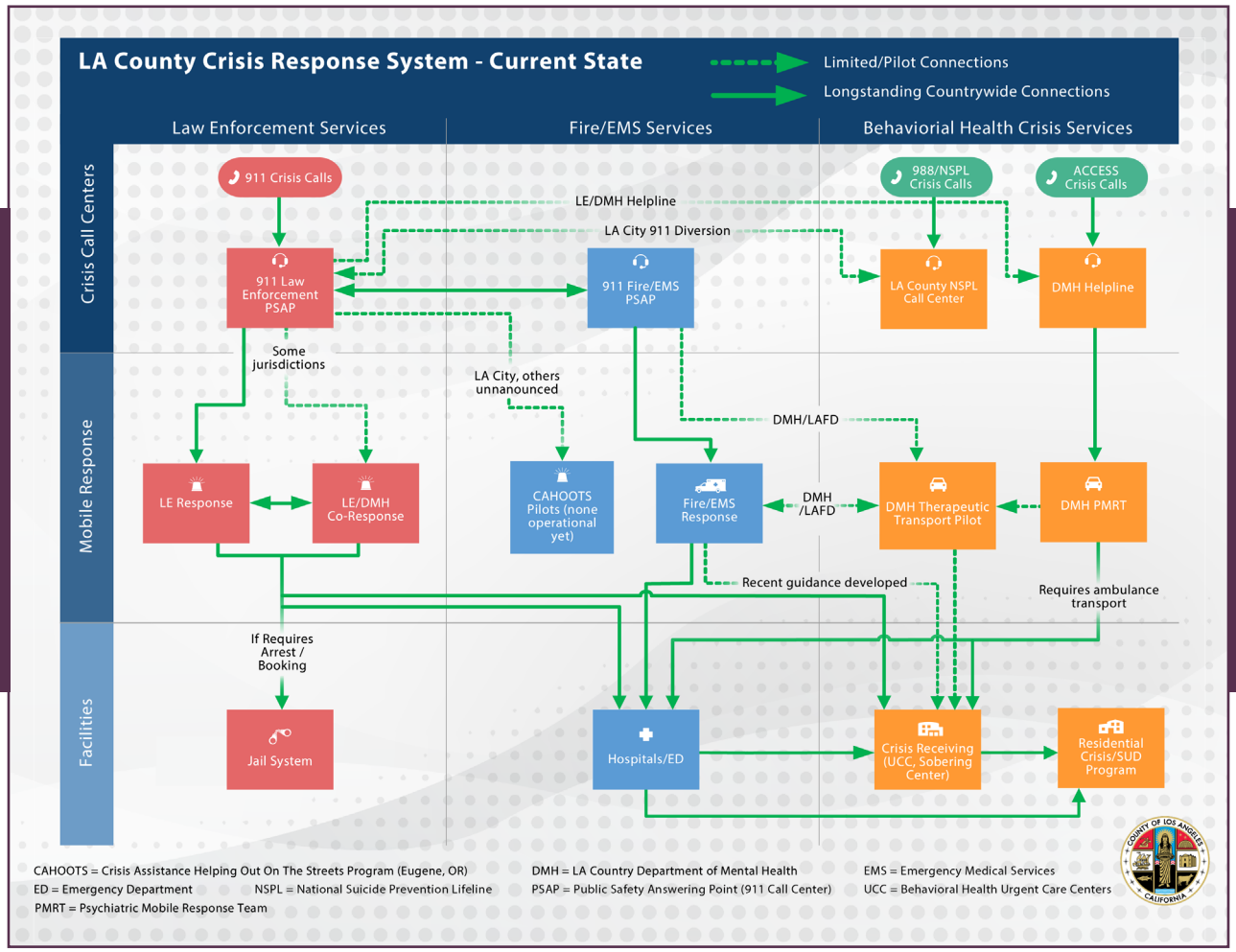
3. Remove any advance medical clearance requirements for UCC admissions.
4. Establish a performance requirement that UCC's manage the escalation of care to Emergency Departments when medically warranted and monitor these dispositions for a potential transition back to the UCC.
5. Implement a "no force first" policy at each UCC and STAAC, and reinforce it with the de-escalation training necessary to minimize the use of seclusion and restraint and thereby create a safer environment for those who are in care and for facility personnel.
6. Require national accreditation of facility-based crisis services improve their outcomes and the quality of care by improving their structure and organization.
7. Modify the UCC and STAAC multi-disciplinary staffing models to include peer support specialists, who can make-up as much as 50% of the staffing and thereby better mitigate workforce shortages and significantly enhance the meaningful engagement with those in care.

V. Cross-Cutting Concerns: Robust Infrastructure and Capacity to Support the Crisis System in LA County



Understanding what the future crisis system will look like and the general impact that it will have

All of the crisis care components associated with having someone to call, someone to come, and somewhere safe to go, when taken together, become LAC's BH crisis response system. In order to provide all of LAC's stakeholders with a quick reference to better understand this system in its current state and be able to contrast it against what it will look like when it is fully optimized, RI worked with DMH to create process flow maps; the first illustrates LAC's current crisis response system:



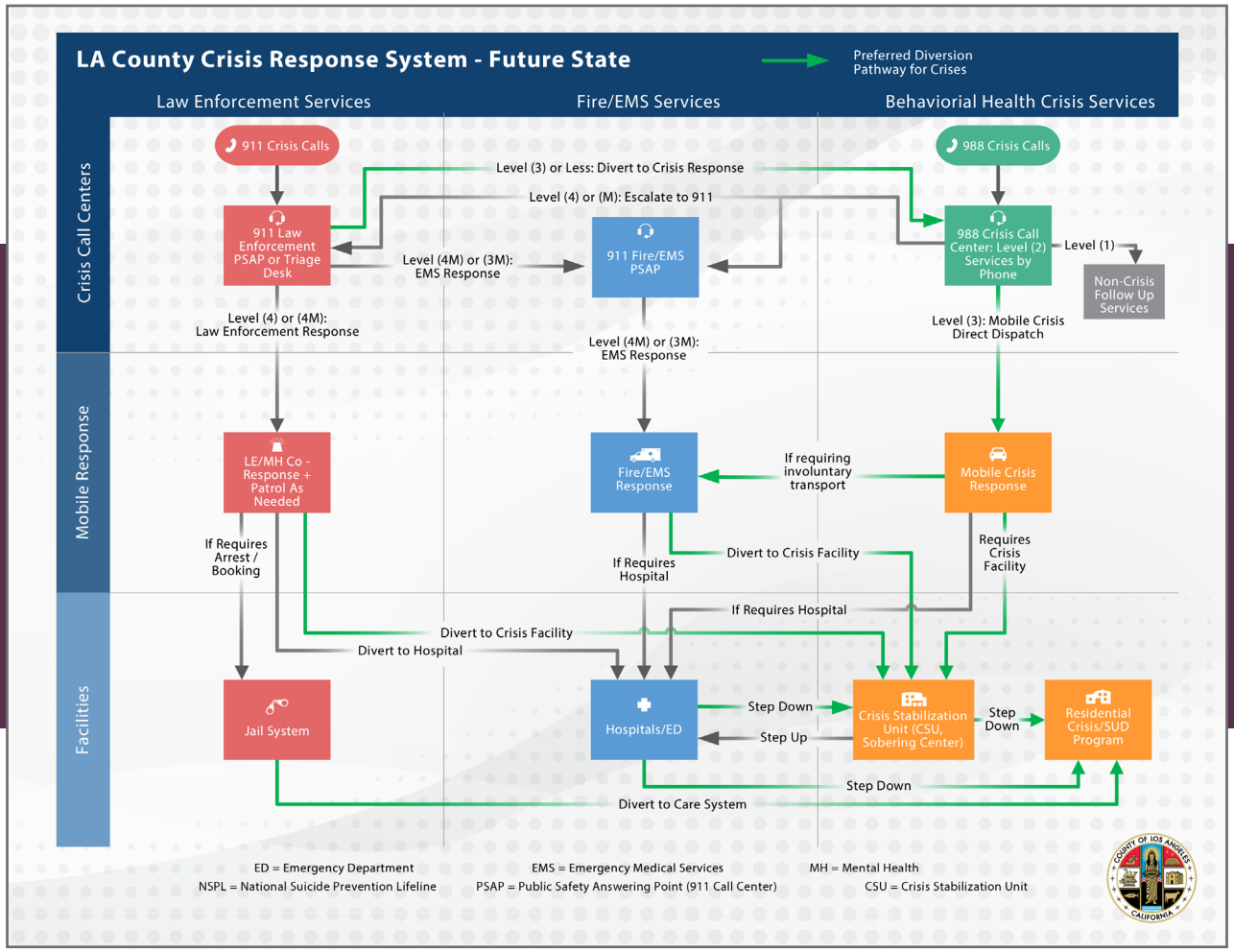
To assess LAC's current crisis response system against best practice, RI utilized the results of each of the previously scored *Crisis Now* Scoring sheets for each of LAC's core crisis service components. These results were fed into a composite crisis response system scoring sheet which appears below:

Crisis Now Scoring Tool (*Crisis Now* System)									
Crisis Now	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progress-ing)		Level 4 (Close)		Level 5 (Full)	
	☑ System Includes at Least Level 1 Implementation in All Areas of *Crisis Now*		☑ System Includes at Least Level 2 Implementation in All Areas of *Crisis Now*		☐ Meets Level 2 Criteria		☐ System Includes at Least Level 3 Implementation in All Areas of *Crisis Now*		☐ System Includes at Least Level 3 Implementation in All Areas of *Crisis Now*	
	☑ Some Implementation of at Least 2 *Crisis Now* Modern Principles		☑ Some Implementation of at Least 3 *Crisis Now* Modern Principles		☐ Some Implementation of All 4 *Crisis Now* Modern Principles		☐ Substantial Implementation of all 4 *Crisis Now* Modern Principles		☐ Full Implementation of all 4 *Crisis Now* Modern Principles	
	The 4 *Crisis Now* Modern Principles Are:	1	Priority Focus on Safety/Security	2	Suicide Care Best Practices (Systematic Screening, Safety Planning and Following)	3	Trauma-Informed Recovery Model	4	Significant Role of Peers	
	Assessed Level = 2 Basic	Justification of Rating: All 3 elements of the *Crisis Now* model are represented and functioning within LA County: call center hub, mobile crisis services, and MHUCCS with some degree of congruency to the *Crisis Now* model.								

Crisis Now Scoring Tool (Summary)	
Overall Crisis Now Score - 2	**Summary Notes:** LAC's crisis response system alignment with national best practice remains at the Basic Level. With the priorities associated with CalAIM, ATI and ACR, LAC's crisis response system is rapidly progressing. A major drawback to keep from being rated at the Progressing Level is the absence of the peer support specialty within the crisis response system. Given recent legislation, this will soon be changing. A much larger hurdle to overcome is the establishment of crisis facilities with beds that are LPS designated with stays of under 14 days. RI is providing LAC with an implementation plan to address this missing core component. While PMRT as a service is growing, it continues to provide unacceptably low crisis response times. To overcome this, LAC has a substantive growth plan for this service. Lastly, the application of technology to crisis care has been lacking. However, this deficit too is rapidly being addressed. When combined, these initiatives will substantially move LAC to Level 5 which would be Full Alignment.

The overall assessment of LAC's crisis response system against national best practice, speaks for itself. While a rating of "Basic" may, on-face-value, be disappointing, the LAC community at large should be proud of how the crisis response system is progressing and how rapidly that progress is occurring. When this system is fully optimized, it will indeed be a model for the rest of the country. While there are localities that have become national exemplars in one or more components of the crisis response system as envisioned by the *National Guidelines*, no state or county as of yet, has made it a reality. LAC is well on its way to being the first to do so.

The process flow map below is intended to illustrate the future state of LA County's Crisis Response System will function:



It should be readily, apparent when comparing these two diagrams and tables, that as LAC implements 988 and optimizes the crisis response system, that it will become increasing simplified, while at the same time, more responsive and efficient. Equally important is that the crisis response system will also progressively expand its capacity and thereby it's potential to serve as a diversion from law enforcement involvement, including arrest, booking, and detention; and from emergency department utilization and hospitalization.

While the preceding visualizations provide a useful way of "seeing" the contrast between the current crisis system as it is, versus what it will become, neither of them capture the impact that these changes will make in terms of those being served and the associated costs of crisis system optimization. To convey this impact, the next table depicts the individuals served with associated DMH costs claimed by the various service components within the existing crisis response system:

LA COUNTY HISTORIC CRISIS SERVICES TABLE

CRISIS SERVICE	INDIVIDUALS SERVED AND CONTRACT AMOUNT		
	FY 18-19	FY 19-20	FY 20-21
LAC NSPL Call Center	130,154 calls, texts, & chats	133,837 calls, texts, & chats	129,328 calls, texts, & chats Contract: $5,747,974
DMH Helpline	Total Call Volume: 129,361	Total Call Volume: 147,188	Total Call Volume: 147,919
DMH PMRT	Individuals Served: 15,008 Claimed Amount: $26,017,797	Individuals Served: 14,515 Claimed Amount: $34,260,056	Individuals Served: 12,687 Claimed Amount: $40,927,896
Psychiatric Urgent Care Center	Individuals Served: 54,760 Claimed Amount: $43,015,027	Individuals Served: 56,768 Claimed Amount: $37,889,775	Individuals Served: 49,910 Claimed Amount: $30,658,679

The table below indicates the projected number of individuals served with associated projected DMH costs claimed by the various service components within the "future state" of the crisis response system:

LA COUNTY PROJECTED CRISIS SERVICES TABLE

CRISIS SERVICE	INDIVIDUALS SERVED AND ASSOCIATED CLAIMS COST		
	Anticipated Use FY 2023	Anticipated Use FY 2024	Anticipated Use FY 2-25
Combined LAC 988/DMH Helpline Combined	Total Contact Volume: 297,100 988 Crisis Call Center Contract: $5,300,000	Total Contact Volume: 323,100	Total Contact Volume: 444,756
Mobile Crisis Teams	Annual Capacity: 20,594 Operating Cost: $25,461,750	Annual Capacity: 47,503 Operating Cost: $32,481,000	Annual Capacity: 61,360 Operating Cost: $37,584,000
Psychiatric UCC (Chairs)	Annual Capacity: 20,594 Operating Cost: $25,461,750	Annual Capacity: 56,591 Operating Cost: $55,461,750	Annual Capacity: 69,863 Operating Cost: $78,016,195
Short-Term Acute Crisis Center (Beds)	Annual Capacity: 4,464 Operating Cost: $17,747,760	Annual Capacity: 4,464 Operating Cost: $17,747,760	Annual Capacity: 9,538 Operating Cost: $43,167,729

The most impressive takeaway from these tables is that the mobile crisis service costs are reduced by approximately $2.4 million, from FY21 to FY 25, while the numbers of those in crisis who receive this service, will increase almost five-fold. This result will be mainly attributable to the reduced costs associated with using peer support specialists to comprise approximately fifty-percent (50%) of the MCT workforce; and to each MCT operating under the newly established MCT performance standards. Also notable, is that facility-based crisis services will be able to serve 29,491 more individuals in FY25 than it had in FY21.

System Oversight

RI recommends that a dedicated organizational entity within LAC be responsible and accountable for the oversight, resourcing, and administration of the behavioral health (BH) crisis response system. RI has shared information with DMH regarding potential organizational structures for such a function. As it currently stands, DMH has an Emergency Outreach and Triage Division that would understandably assume this role. The RI Consultant team believes that the Division is in need of additional capacity beginning with a Crisis Response Systems Administrator who would oversee a team that would be responsible for crisis system management, contract compliance, data collection, continuous quality improvement, care coordination, and reporting.

Financial Plan

RI worked with ACR leadership to develop a sustainable five year ACR financial plan and enlisted the support of Tom Betlach, a Partner with Speire Healthcare Strategies, who advises government and private sector clients on complex health policy and strategic initiatives. He is a nationally-recognized thought leader on Medicaid and health care policy, known for his expertise in serving complex populations, delivery system transformation, value-based purchasing, managed care, and cost containment. Prior to joining Speire, he spent twenty-seven (27) years serving in a variety of leadership roles for the state of Arizona. He served five governors in three different cabinet positions. Most recently, Tom served as director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's state Medicaid agency. AHCCCS provided health care coverage to 1.9 million Arizonans at an annual cost of $13 billion.

The Financial Plan covers a five (5)-year period beginning with Fiscal Year 2023 through Fiscal Year 2027. The model delineates costs associated with the Mobile Crisis Teams (MCT), Crisis Receiving Centers (CRC) and Psychiatric Health Facilities (PHF) as those are phased in during that time period. The model also breaks out new costs from the costs of maintaining existing capacity. New costs are further detailed between one-time capital costs, all of which occur in the first three years of the plan, and ongoing operational costs, which occur over five years, increasing as capacity is built and implemented. The Financial Plan provides both a comprehensive annual summary and more detailed monthly operating estimates.

Overall, as detailed in Table A below, the 5-Year Financial Plan is estimated to cost $1.6 Billion from FY23 to FY27. Existing costs account for $334 million over that same time. New capital costs are estimated at $619.3 million and new operating costs are $647.1 million. By FY 2027, the fully operational crisis response system is estimated to cost $364 million in annual operating expenses. Of this amount $66.8 million is to support existing capacity and $297.3 million is associated with expansion.

TABLE A: 5 YEAR COST OPERATING AND CAPITAL ESTIMATE

	2023	2024	2025	2026	2027	All Years
Maintain Existing						
Operating	66,801,750	66,801,750	66,801,750	66,801,750	66,801,750	334,008,750
New Operating	8,748,000	21,141,000	79,641,340	240,280,137	297,267,085	647,077,562
New Capital	147,183,852	307,003,704	165,151,852			619,339,407
Total	**222,733,602**	**394,946,454**	**311,594,942**	**307,081,887**	**364,068,835**	**1,600,425,720**

Table B details the annual operating costs for each of the three core components of the crisis response system. The 5-year costs associated with MCT are expected to be $165 million. Over the same period CRCs are projected to have a cumulative cost of $457.7 million and PHFs will cost $358 million. As detailed above, of the $981 million in operating costs from FY 2023 to FY 2027, the overall projected operating cost for increased capacity is $647 million.

TABLE B: 5 YEAR PROJECTED OPERATING COSTS

	2023	2024	2025	2026	2027	All Years
MCT	20,088,000	32,481,000	37,584,000	37,584,000	37,584,000	165,321,000
UCC	55,461,750	55,461,750	78,016,195	123,125,085	145,679,530	457,744,310
STACC			30,842,895	146,372,802	180,805,305	358,021,002
Total	75,549,750	87,942,750	146,443,090	307,081,887	364,068,835	981,086,312

Table C delineates the projected increase in capacity associated with this overall Financial Plan. Over the 5-year period, MCT will grow from 20,594 to a projected increase of 61,360 individuals served. UCCs will experience a significant increase in capacity growing from serving 56,591 to 152,854. Finally, STACCs will increase in capacity from 4,464 to 53,499 served.

TABLE C: ANNUAL ESTIMATED MEMBERS SERVED

	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
MCT	20,594	47,503	61,360	61,360	61,360
UCC	56,591	56,591	69,863	119,232	152,854
STACC	4,464	4,464	9,538	44,842	53,499

The expansion of capacity and the costs associated with that expansion are predicated on a number of different assumptions. The accuracy of this modeling is highly dependent on the accuracy of the assumptions, so understanding the model inputs is critical to evaluation of the model's results. Table D below highlights the timing and costs associated with several of the assumptions used to calculate the overall Financial Plan.

TABLE D: KEY ASSUMPTIONS

	Capacity/# of Units	Timeline	Key Cost Details
MCT			
Capital	62 vans	Purchased 7/22, Delivered 7/23	Per van cost: $86,000
Operating	Total Target Teams: 118		Monthly operating cost per team: $27,000
	Existing Teams: 35		
	Phase 1 New Teams: 27	Phase 1 Go Live: 7/1/22	
	Phase 2 New Teams: 27	Phase 2 Go Live: 7/1/23	
	Phase 3 New Teams: 29	Phase 3 Go Live: 2/1/24	
UCC			
Capital	Build 244 new chairs	Phase 1 Build: 7/1/22-1/1/25	Capital cost per new chair: $1.1 million
		Phase 2 Build: 7/1/23-1/1/26	
Operating	Total Target Chairs: 394		Operating cost per chair: $30,812 per month/$1,013 per day
	Existing Chairs: 150		
	Phase 1 New Chairs: 122	Phase 1 Go Live: 1/1/25	
	Phase 2 New Chairs: 122	Phase 2 Go Live: 1/1/26	
STACC			
Capital	Build 256 new beds	Phase 1 New Beds: 128	Capital cost per new bed: $1.15 million
	Convert 233 existing IP beds	Bed Conversion: 249	Capital cost per bed converted: $200,000
		Phase 2 New Beds: 128	
Operating	Total Target Beds: 489		Operating cost per bed: $30,812 per month/$1,013 per day
	Existing Beds: 0		
	Phase 1 New Beds: 128	Phase 1 Go Live: 1/1/25	
	Bed Conversion: 233	Conversions Go Live: 3/1/25-12/1/25	
	Phase 2 New Beds: 128	Phase 2 Go Live: 1/1/26	

The second component of the Financial Plan model is the development of funding source estimates. As part of this analysis, the model looked at allocating crisis costs based on projected payer contributions. The funding source estimates are based on data provided by LAC as well as information derived from experience in Arizona. Like the funding assumptions, the accuracy of the model depends upon the information provided regarding funding distribution by payer in LAC.

Annual projected crisis care operating expenditures by funding source are included in Table E that follows. Table F then offers some insight into how the ratio of these funding contributions varies by service type based on the data available at the time of this report. Funding sources have been bucketed into Medi-Cal

federal, state and local county match contributions, Commercial, Medicare and uninsured/underinsured with an understanding that the actual sources of this funding will include SAMHSA Mental Health Block Grant, SAMHSA Substance Use Block Grant, other grant funds, American Rescue Plan Act (ARPA) funding and multiple state appropriations available to advance crisis care in Los Angeles County. Table E (below) provides a high-level summary of the estimated funding sources needed for operating costs based on the proposed implementation plan in this report. As detailed in the table, by year five (5) it is projected that the total Medi-Cal funding needed will be $228.8 million or 62.8% of the total $364.1 million in annual projected crisis care costs. Federal funding contributions to Medi-Cal would account for approximately 68% ($155.4 million) of that total Medi-Cal spend.

TABLE E: FUNDING SOURCES

	2023	2024	2025	2026	2027	Totals
Medi-Cal State Match	6,168,697	8,203,601	14,879,300	25,553,356	29,543,635	84,348,589
Medi-Cal Local Match	8,482,015	9,786,440	16,862,501	36,835,129	43,833,723	115,799,808
Medi-Cal Total State Match	14,650,712	17,990,041	31,741,801	62,388,485	73,377,358	200,148,396
Medi-Cal Federal	31,768,145	37,124,985	60,146,612	130,883,829	155,420,813	415,344,385
Total Medi-Cal	46,418,858	55,115,026	91,888,413	193,272,314	228,798,171	615,492,781
Commercial	1,524,679	2,465,308	4,394,770	10,171,266	11,892,891	30,448,914
Medicare	150,660	243,608	3,366,170	14,919,160	18,362,411	37,042,008
Other/ Uninsured	27,455,553	30,118,809	46,793,737	88,719,147	105,015,363	298,102,609
Annual Total All Funds	75,549,750	87,942,750	146,443,090	307,081,887	364,068,835	981,086,312

The Financing model also estimates that, by year five (5), approximately $105 million will be needed to cover uninsured and underinsured individuals. This level of funding is required due to anticipation that Medicare and Commercial coverage will continue to be very limited in reimbursement for crisis services; representing an underinsured expense to the state or county. Please note that despite Medicare and Commercial Insurance having their own rows in Table E (above), the consultant team believes many more individuals with these payer sources in place are likely accessing services and landing in the other/uninsured category as a result of a known lack of reimbursement for crisis care from these insurers; leading to a failure by the provider to capture this insurance information in the reported data. Any policy changes made to increase expectations for Medicare and Commercial to cover crisis services would result in a significant reduction in local cost that directly correlates to payment received by these payer sources in the uninsured and underinsured category (analysis to follow).

Table F below details the assumptions used to calculate the funding sources estimated for mobile crisis teams (MCT), psychiatric Urgent care Centers (UCC) and Short-Term Acute Crisis Centers (STACC). For MCT and UCC, the payer allocations (Medi-Cal, Medicare, Commercial, Uninsured, , and Underinsured) are based on data provided by LAC. For STACCs, the payer allocations are based on the UCC data from LAC.

TABLE F: FUNDING SOURCE ASSUMPTIONS

	MCT	UCC	STACC
% of Medi-Cal			
EPSDT and MCHIP	41%	7.14%	7.14%
"Regular" Adult Medi-Cal	30%	39.40%	39.40%
Expansion Medi-Cal	29%	53.10%	53.10%
% of Total			
Total Medi-Cal	70.17%	58.28%	58.28%
Commercial	7.59%	0.00%	0.00%
Medicare	0.75%	0.00%	0.00%
Other/Uninsured	21.49%	41.72%	41.72%
	100.00%	100.00%	100.00%

According to the United States Census Bureau, 10.2% of Los Angeles County residents under the age of 65 are uninsured yet 42% of crisis facility utilizers are reported to fall into the other/uninsured category. Those same reports suggest that none of the crisis facility utilizers have commercial or Medicare coverage. The table that follows offers a model of more likely insurance coverage by utilizer for crisis facility services by modeling out a division of the other/uninsured bucket so actual uninsured utilization aligns with the utilization of the Medicaid population. The remainder of that "other/uninsured" bucket (which includes underinsured) has been proportionately distributed between Medicare and commercial buckets based on national coverage ratios since LA County-specific enrollment of these plans was not readily available.

TABLE G

Los Angeles County Crisis Facility Utilization Modeling				
	Medicaid	Commercial	Medicare	Other/ Uninsured
Reported	58.28%	0.00%	0.00%	41.72%
County Population	37.13%	*66.5%	*18.4%	10.20%
Modeled Group	58.28%	20.14%	5.57%	16.01%

** Commercial insurance & Medicare "County pop" data are national rates applied for ratio analysis only*

This model suggests that 20.14% out of the 41.72% of individuals receiving facility-based crisis care may be covered by a commercial insurance. Parity payment for these services would then reduce the county expenditure for other/uninsured by 48%. California's recent legislation around parity represents an opportunity to dramatically reduce the cost of crisis care funded by Los Angeles County so focused effort around accurately collecting payer information, submitting claims for these services and addressing any short-falls in payment is highly recommended.

Capital Investment

The Financial Plan includes $619.3 million in capital investments. As detailed in Table H below, the vast majority of the capital investments are associated with building out of UCCs and STACCs. While these capital investments are not specifically fund sourced, the County has indicated that there are several different programs that may be leveraged for MCT, UCC and STACC infrastructure. This includes one-time sources such as American Rescue Plan Act (ARPA) and Department of Healthcare Services (DHCS) grants. DHCS has $2.2 billion that has been provided by the legislature to expand community-based behavioral healthcare options through the Behavioral Health Continuum Infrastructure Program.

TABLE H: CAPITAL INVESTMENTS

	2023	2024	2025	All Years
Vans for MCT	5,332,000			5,332,000
UCC Phase 1	67,777,778	67,777,778		135,555,556
UCC Phase 2		67,777,778	67,777,778	135,555,556
STACC Phase 1	74,074,074	74,074,074		148,148,148
STACC Phase 2		74,074,074	74,074,074	148,148,148
STACC Bed Conversion		23,300,000	23,300,000	46,600,000
Total Capital Costs	147,183,852	307,003,704	165,151,852	619,339,407

Crisis Response System Bill Coding

<u>24/7 Crisis Care Traffic Control Center Hub</u>

LAC's crisis contact center, operated by Didi Hirsch Mental Health Services (DH), extends to the entire County in a manner similar to 911. Although there is some ability to verify certain eligibility information regarding a crisis caller by phone, many callers prefer to remain anonymous and/or are unable to provide any health plan enrollment information at the time of the call. Therefore, reimbursement from health insurers cannot financially sustain a crisis contact center. However, Arizona has chosen to allow Medicaid billing for eligible enrollees who access this service through the use of HCPCS code H0030 - Behavioral Health Hotline Service. Currently the DH crisis contact center is supported mostly by county and private funds. Data elements such as member phone numbers of Medicaid enrolled or privately insured individuals can be combined with caller ID technology to support fee-for-service billing efforts.

An alternative funding mechanism to advance 988 crisis call center implementation is to utilize a Medicaid Administrative Match of 50% for these services. For example, New Mexico offsets about 25% of the cost of its statewide crisis contact center in this way. There may be limitations with regards to administrative claiming given the current Medi-Cal funding structure for LAC. The ability to leverage this approach would be dependent on having sufficient administrative capacity in the current cost-based payment approach utilized by DMH for LAC. As the state transitions to a service-based payments, there should be an opportunity to revisit this issue with an anticipated impact between 20 and 40 percent (%) of the total crisis call center spend covered through federal Medicaid match revenue. LAC could utilize a population-based funding stream to support a service that originates from an assessment on phone usage. This is a funding option authorized by the National Suicide Hotline Designation Act of 2020; encouraging states to levy fees for local 988-related services on wireless/IP carrier bills. This option is dependent on the California Legislature enacting this phone surcharge, which the telecommunications industry has generally opposed. As this report is being finalized, it appears likely California will have some telecommunications fee structure in place that will cover some of these costs. If the telecommunications fees start at $0.08 per line as projected, this will likely not cover the full cost of crisis line (988) operations but could combine with financial contributions from Medicaid described above to minimize any demand on Los Angeles County for the service.

Mobile Crisis Teams (MCT)

Crisis mobile response services are analogous to fire and ambulance responses for Medi-Cal emergencies. As such, funding should align with the cost of the service so that adequate capacity can be in place to serve the entire County on a 24/7 basis. Los Angeles County's ability to secure Medicaid's enhanced 85% FMAP for mobile crisis services does require 24/7 access to the service. Given that service demand is not completely predictable, each MCT will experience periods of low utilization. Hence, reimbursement rates must be set at a level to maintain the service, while the payer can still realize value, which will largely accrue from the ensuing reductions in ambulance, ED, inpatient, and detention expenses. If commercial health insurance and Medi-Cal ever reimburse for this service at a reasonable rate, funding required by the County would be significantly reduced.

MCT services, when provided by BH staff, should be billed using the nationally recognized HCPCS code of H2011: Crisis Intervention Service per 15 Minutes. By limiting the use of this code to MCTs, funders will be better positioned to set a reimbursement rate that represents the actual cost of delivering this safety net service. When applicable, MCT transportation services, for voluntary transports, should be billed separately from crisis intervention services. In some states, this is allowable with the Medicaid program and should be viable as a Medi-Cal non-emergent transportation service. If crisis intervention services continue during the transport, then this time can become billable and serve to defray transportation expenses should they be determined not billable through Medi-Cal.

Another payment option to consider is an episodic rate with reimbursement that is sufficient to cover the total costs associated with delivering this service. Doing so significantly reduces the administrative burden associated with 15-minute intervals of billing under fee-for-service (FFS) and also incentivizes efficient provider practices when tied to value-based arrangements for specific outcomes such as rate of community stabilization.

Up to this point in time, LAC has been assuming the BH capacity costs of PMRTs, while DMH capacity costs associated with law enforcement co-responder teams is significantly less, but this may not be the case for much longer. California recently was one of twenty (20) states that were awarded a CMS grant for the purpose of developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. If California's plans are successful, it will qualify for Medi-Cal matching funds of 85% to support MCT services, thereby taking much of the burden for financing these services from the County. Given the state's recent $1.43 billion allocation of funding for reimbursement of mobile response for Medicaid members, the County will be well positioned to shift existing mobile crisis service expenditures to care for non-Medi-Cal enrolled residents.

Another approach to consider is to separate claiming for the assessment part of the mobile crisis team intervention from the Crisis Intervention Service (H2011). The reason for considering the additional provider burden of separating these two services in a claiming system is because all payers, including Medicare and commercial insurers, will reimburse for professional assessment services. This would lead to all payers reimbursing for this piece of the mobile crisis response service while the County uses their funding to cover the gap for underinsured and uninsured residents of LA County. Coding for that professional assessment service must be based on the credentials of the clinician delivering the service.

Facility-Based Crisis Services

Facility-based crisis services are analogous to the acuity found in a hospital emergency department (ED) designed to address physical health distress for anyone arriving with a reported need. Nevertheless, when it comes to reimbursement rates, they typically fall under a crisis intervention claims coding system within Medi-Cal that offers payment via hourly or daily intervals and/or per diem reimbursement that is not adequate to compensate for this high acuity level of care (and corresponding staffing). Most states struggle with how to best categorize these facilities within existing Medi-Cal facility and provider type structures.

UCC services should be billed using the HCPCS Code of S9484: Crisis Intervention Mental Health Services per Hour. Code modifiers can be used to distinguish between the provider types (professional disciplines) delivering the service. In a review of the rates associated with reimbursing for professional services in a UCC, the rates are generally adequate. However, neither nursing staff nor care managers are recognized under Medi-Cal's emergency mental health provisions as being eligible for reimbursement. As a result, if Medi-Cal reimbursement of UCC services were possible, its regulations do not conform to National Guidelines and would not support these additional professionals necessary to operate under "no wrong door."

HCPCS Code S9485: Crisis Stabilization Mental Health Services per diem, can be used to reimburse for services delivered by a STACC or a UCC. Medications, radiology, laboratory, and professional evaluation and treatment services should be billed separately or may be bundled into the per diem rate. The STACC will not be conducting radiology or laboratory services. Professional fees are usually billed in addition to a per diem but could be billed as a bundled service if this option were made available. The benefit of separate billing for professional services is that most third-party payers currently reimburse for professional services, while few outside of Medicaid recognize crisis facility reimbursement. Getting some of the expense covered by these payers is better than none.

Given the limitations of the current payment system for crisis care, it is hoped that CalAIM will remedy this situation with new policies, regulations, and financing to support county crisis response systems throughout the State under 988 implementation, which occurred on July 16, 2022.

Finance Action Plan / Recommendations

Based on the financial needs associated with implementing the Five (5) Year plan described above, the following steps are recommended:

Capital Costs

1) Allocate $5.3 million in funding that has already been awarded for MCT one-time costs to cover the capital resources associated with purchasing 62 new vans and execute the purchase of these vehicles.
2) Support the DMH application to DHCS for BH CIP – Continuation Grant for Facilities - $3 Billion – CCMU. These funds should be used for the $614 million in capital costs associated with 244 new UCC chairs, 256 new STACC beds and the conversion of 233 existing inpatient psychiatric beds that are phased in over three years.
3) Pursue other capital funds that may be used if the DHCS grants are insufficient. These options may include additional ARPA funds or Prevention and Early Intervention one-time carry forward funds.
4) Support DMH in the procurement of the new facilities that are established as part of the 5-year plan.
5) Support DMH in completing any necessary grant reporting that may be required from DHCS.

Operating Plan

1) Over the course of the 5-year funding plan, operational costs will grow approximately $300 million. Medi-Cal total funding accounts for about $190 million of the increase. Uninsured/Underinsured represents $80 million. Medicare and Commercial are $29 million of the increase but may be even higher as noted in the modeling that suggests these two "underinsured" groups are represent nearly half of the other/uninsured bucket of individuals receiving crisis care.
2) Over the next 5 years, the finance team will need to budget the projected Medi-Cal increases in local county match funds that are necessary to support the annual incremental growth associated with the operating plan. The net annual increases are delineated in the table I1 (below). Annual increases over the FY 23 baseline are detailed in table I2 (below bottom).
3) The finance team will need to develop budget estimates that identifies and secures funding to cover the anticipated growth in resources needed to cover the uninsured and underinsured populations. These amounts are delineated in the tables below.
4) On an annual basis, the finance team should evaluate some of the potential savings options described above to determine what resources may be available to offset the new local costs for crisis care. Realized offsets may include decrease in hospital ED utilization, lower inpatient psychiatric care utilization and reduction in ambulance transport for individuals in mental health and/or substance use distress. Additional opportunities are identified above including Medi-Cal claiming for call center services.

TABLE I1: NET ANNUAL INCREASES

	FY 2024	FY 2025	FY 2026	FY 2027
Medi-Cal Local County Match	1,304,400	7,076,100	19,972,600	6,998,600
Other/Uninsured	2,663,300	16,674,900	41,925,400	16,296,200
Total	3,967,700	23,751,000	61,898,000	23,294,800

TABLE I2: TOTAL ANNUAL INCREASES OVER FY 2023 BASELINE

	FY 2024	FY 2025	FY 2026	FY 2027
Medi-Cal Local County Match	1,304,400	8,380,500	28,353,100	35,351,700
Other/Uninsured	2,663,300	19,338,200	61,263,600	77,559,800
Total	3,967,700	27,718,700	89,616,700	112,911,500

It is critical that DMH focus on operational efficiencies. For example, decreasing the ALOS by 3.3% (6 hours) in psychiatric inpatient units decreases the need for 37 inpatient beds, saving $12,421,899 annually; and decreasing the time on-scene for PMRTs by 20% (one hour) decreases the need for 29.58 PMRTs, saving $9,613,500. The following table demonstrates the effect that crisis response efficiencies can have:

SENSITIVITY ANALYSIS					
Integrated Data Points	Data	Data Change	Capacity Impact	County Financial Cost/ Savings after FMAP - FFS	Full Impact
Population Census	10,114,009	100,000	2,400 Crisis Events	$2,906,465	Total Costs = $7,149,722
ALOS of Acute Inpatient	7.50	6 hours	37 Beds	$3,161,373	Total Costs = $12,421,899
Acute Bed Occupancy Rate	90%	1.00%	8 Beds	$0	Cost Based = $2,685,816
Escalation Rate of Crisis Facility (to inpatient)	25%	1.00%	12 Beds	$1,863,762	Total Costs = $3,035,340
ALOS of STACC Bed	3.0	2.4 hours	16 Beds	$827,363	Total Costs = $4,047,120
STACC Occupancy Rate	90%	1.00%	6 Beds	$0	Cost Based = $1,517,670
Rate of Escalation to a STACC Bed	35%	1.00%	14 Beds	$2,053,332	Total Costs = $6,459,985
ALOS of UCC Chairs	0.8	1 hour	21 Chairs	$0	Cost Based = $6,599,948
UCC Occupancy Rate	85%	1.00%	4 Chairs	$0	Cost Based = $1,256,513
Escalation Rate of Mobile (from Crisis Fac.)	30%	1.00%	2 Chairs	$789,060	Total Costs = $2,062,901
Mobile Team Time of Scene (hours)	5.00	1 hour	29.58 Teams	$0	Cost Based = $9,613,500

Close and Fully Integrated Crisis Services Collaboration

In 2010, the Milbank Memorial Fund published the landmark "Evolving Models of Behavioral Health Integration in Primary Care," which included a continuum from "minimal" to "close to fully integrated."This established the gold standard for effective planned care models and changed the views of what is acceptable community partnership and collaboration. Prior to this, coordination among BH and primary care providers had frequently been minimal or non-existent and it would have been easy to accept any improvement as praiseworthy.

In fact, the Milbank report portrayed close provider-to-provider collaboration (evidenced by personal relationships of leaders, MOUs, shared protocols, etc.) at the lowest levels of the continuum and deemed them insufficient. They described these community partnerships and their coordination as minimal or basic, citing only sporadic or periodic communication and inconsistent strategies for care management and coordination. They called for frame-breaking change to the existing systems of care, and their report continues to reverberate throughout the implementation of integrated care.

For a crisis response system to provide "Close and Fully Integrated" care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7:

- Status Disposition for Intensive Referrals
- 24/7 Outpatient Scheduling
- Shared Bed Inventory Tracking
- High-tech, GPS-enabled Mobile Crisis Dispatch
- Real-time Performance Outcomes Dashboards

The DMH Mental Health Resource Locator and Navigator is available at: https://dmh.lacounty.gov/pd/. It has an application for tracking DMH bed availability, including crisis beds, across the County in real time. This capability meets recommendation #40 of the ATI Work Group to establish, expand, enhance, and coordinate the database and tools available for real time bed availability for all justice and health system partners. It should be noted that compliance with keeping the bed registry up-to-date by provider organizations tends to erode over time. To assure the ongoing reliability of the bed registry, states have made daily reporting of bed availability a mandatory requirement for provider organizations receiving public funds.

In addition, the crisis response system should provide electronic inter-connectedness, in the form of secure HIPAA-compliant, and easy-to-navigate web-based interfaces and community partner portals, such as a Health Information Exchange (HIE). This functionality supports communication between service and support organizations (including emergency departments, social service agencies, and community mental health providers) with intensive service providers (such as acute care psychiatric inpatient, community-based crisis stabilization, inpatient detoxification, and mobile crisis response services).

One of the advantages that LAC has in this regard is the implementation of LANES. The Los Angeles Network for Enhanced Services (LANES) accelerates population health management in LAC to ensure better healthcare outcomes. Quality healthcare depends on the completeness and clinical enrichment of a patient's record at the point of care and across the population. LANES connects providers to instant 360° view of the patient — longitudinal information generated at the point of care.

For individuals experiencing a BH crisis, the ability to exchange key information between crisis care providers about those individuals can be lifesaving. Valuable information could include a current crisis care plan, contact information for primary BH providers (such as a Full Service Partnership program), and any psychiatric advance directives (PAD) the individual has authorized. All of this information can be vital to ensure that when an individual experiences a crisis, any care provider who encounters that individual has the key information that would assist them in providing better care and ensuring the most appropriate follow-up services.

LAC currently exchanges some of this information in LANES, but many providers of crisis care are not yet connected to LANES. Furthermore, there are other existing exchange solutions that could complement LANES. DMH is examining potential technologies that would better support crisis information exchange and it is also exploring possible funding sources. The onboarding of providers onto a care coordination solution

is crucial to ensure that they are able to not only share and view vital crisis-relevant information, but more importantly actively engage in meaningful care coordination and collaboration.

Staff Training

RI developed the foundational structure of a role specific, evidence-based Crisis Training Academy to be conducted on behalf of DMH for all staff employed within the LAC crisis response system (call centers/ mobile teams/facility-based crisis services). RI also shared with ACR leadership the Academy syllabus and the standards necessary to develop a crisis certification credential for those working in the crisis response system. All staff employed within LAC's crisis response system should be required to obtain such certification to assure a minimum set of performance standards are being met system-wide. Such a credential, along with continuing education requirements, would also allow staff to become more marketable by continuing crisis specific education and improving one's competency in the process. RI also advocates that ACR sustain strong partnerships with law enforcement, EMS, and PSAPs to maintain the current momentum in optimizing LAC's crisis response system.

The Crisis Training Academy was modeled in part by RI's experience in developing and managing the *Crisis Now* Academy. https://crisisnowacademy.com/. Sponsored by the CA Mental Health Services Oversight and Accountability Commission (MHSOAC), RI has managed The *Crisis Now* Academy, which is a ten (10) month learning community designed to support California counties in optimizing their BH crisis response system. Based on this foundational experience, RI has worked with DMH on a three-week (3) syllabus for the proposed LAC Crisis Academy, which appears under Appendix I of this Report.

Workforce Challenges and Solutions

According to the California Office of Statewide Health Planning and Development (OSHPD) in the 2020-2025 Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan, issued in February of 2019,

> *"California's public mental health system (PMHS) has serious workforce shortages and mal-distribution in nearly all professions. There is a recognized lack of workforce diversity, underrepresentation of professionals with consumer and family member experience, and of racial, ethnic, and cultural communities providing services and support. These shortages are particularly severe for public mental health practitioners with adequate competencies to work effectively with individuals with serious mental illness (SMI) or serious emotional disturbance (SED) across the lifespan of age groups, as well as diverse racial, ethnic, and cultural populations."*

The purpose of the five-year WET Plan is to guide efforts to improve and expand the PMHS workforce throughout California. The WET Plan includes the vision, values, mission, measurable goals, objectives, funding principles, performance indicators, a statewide needs assessment, and career pathway recommendations. It provides a framework for strategies that the State and local government, community partners, education and training institutions, and other stakeholders can enact. This statewide WET

Plan acknowledges that in addition to an overall shortage, there is a PMHS workforce mal-distribution throughout the state, with a shortage of providers who reflect the state's cultural and linguistic diversity. This includes individuals with lived experience to provide consumer- and family-driven services that promote wellness, recovery, and resilience. This statewide 5-year BH workforce plan is available at the following link: https://hcai.ca.gov/wp-content/uploads/2020/10/WETFive-YearPlan.pdf.

LAC has its own MHSA - Workforce Education and Training (WET) Plan which also seeks to address the fundamental concepts of creating and supporting an ample workforce (both present and future) that is culturally competent, consumer/family driven, and promotes the transformation of mental health services to a strength-based approach that is inclusive of recovery, resiliency, and wellness. In terms of the workforce development required for LAC's crisis response system, the following table portrays a calculation of the current capacity of the crisis response system versus its future need, and the actual delta for each clinical discipline:

Clinical Discipline	Calculated Current Capacity	Estimated Future Capacity	
Behavioral Health Prescribers	35*	118	101
Registered Nurses	81	266	185
Licensed Vocational Nurses	26	123	97
Licensed Clinicians	212	622	410
Certified Peer Support Specialists	511	1213	702

The LCA Plan follows the framework provided by the statewide OSHPD WET Plan and it provides opportunities to recruit, train and re-train public mental health staff to meet those mandates. In FY 2021-22, DMH planned on spending $19.0 million on WET initiatives. Over the course of LAC's three-year Plan, that amount is expected to total $57.1 million to provide training and technical assistance, navigator skill development, a learning management system, and pipeline and financial incentive programs. Given that up to 1,495 additional BH personnel will be needed over the course of the next three (3) to five (5) years for the crisis response system, additional financial resources will be needed to support this expanded capacity.

Planning, to address the gap in current and future workforce capacity needs for the crisis response system, has included ensuring the financing necessary to adequately compensate BH practitioners, developing the peer support specialist workforce through peer employment training opportunities, and improving professional and para-professional training through a LAC Crisis Academy. It is anticipated that as LAC's crisis response system becomes increasingly optimized and as peer support specialists become more prevalent, that there will be BH workforce shifts that will mitigate some of the BH workforce shortages. There will be some other shifts as psychiatric inpatient programs experience decreased utilization.

In an effort to assist with the hiring challenges that many 988 crisis centers are facing, SAMHSA has developed a web portal that links prospective applicants to crisis center hiring or volunteer pages. SAMHSA

is promoting this resource nationally through the use of social media, sharing in listservs, and in any appropriate events. This resource is available at: https://www.samhsa.gov/find-help/988/jobs.

ACR should focus on attracting and supporting those from Black, Indigenous, and People of Color (BIPOC), queer and trans-sexual BIPOC (QTBIPOC) populations, to careers within BH. Given this needed focus, in the first quarter of calendar year 2022, DMH began participating in a multi-county learning collaborative. This initiative was informed by the work of Solano County and was comprised of training from the University of California, Davis (UC Davis) Center for Reducing Disparities. The intent is to apply the Culturally and Linguistically Appropriate Standards (CLAS) to populations that DMH specifies, and to utilize quality improvement approaches to reduce disparities. DMH views this opportunity as a vehicle for disparity reduction efforts and as a way to strengthen community voice.

The Cultural Competency Unit (CCU) within DMH allows for cultural competence to be integrated into DMH's quality management program. Within this structure, the Cultural Competency Committee (CCC) is invested in making the Cultural Competence Plan Requirements (CCPR), the CLAS standards, and California Reducing Disparities Report (CRDP) recommendations active components in DMH's framework to integrate cultural competency in service planning, delivery and evaluation.

DMH offers a considerable number of cultural competence trainings designed to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge and cross-cultural skills, all of which are essential to effectively serve culturally and linguistically diverse communities. The trainings offered by the OAO-Workforce Education and Training (WET) Division incorporate a multiplicity of cultural competency elements.

DMH has also established a policy framework that is based on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) and the State's Cultural Competence Plan Requirements (CCPR). This policy establishes guidelines for participation, implementation, and compliance with Federal and State regulations regarding cultural and linguistic competence. This policy, which was effective in September of 2019, informs the system of care that culturally and linguistically appropriate, effective, and equitable services are provided at all levels of service delivery. Further, it fosters a collective sense of shared responsibility for the implementation of culturally and linguistically responsive interventions that address health inequities among the staff from directly operated, contracted, and administrative programs.

Over the past several years, BH providers and education systems are recognizing the value of the National CLAS Standards in advancing BH equity. To advance this effort, SAMHSA collaborated with OMH to develop the Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (Behavioral Health Guide). This Behavioral Health Guide underscores the ways in which the National CLAS Standards can improve access to BH care, promote quality BH programs and practice, and ultimately reduce persistent disparities in BH treatment for underserved minority communities and should be considered for adoption by DMH.

- Behavioral Health Implementation Guide: https://www.minorityhealth.hhs.gov/Assets/PDF/clas%20standards%20doc_v06.28.21.pdf
- Development of a Long-Term Evaluation Framework for the National CLAS Standards: https://www.minorityhealth.hhs.gov/assets/PDF/Natn_CLAS_Standards_Evaluation_Framework_Report_PR-3598_final_508_Compliant.pdf
- Evaluation of the National CLAS Standards: Tips and Resources: https://www.minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_Toolkit_PR3599_final.508Compliant.pdf

RI has strongly encouraged ACR leadership to further advance the development of Peer Support as not only a way to improve crisis care and to foster recovery, but also as a means to most expediently expand the capacity of the BH crisis care workforce. Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with BH conditions. This mutuality between a peer support specialist and person experiencing a crisis promotes connection and inspires hope. By sharing their own lived experience and practical guidance, peer support specialists help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-¬determined lives for themselves. They provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery journey (Davidson, et al., 1999).

Up until the passage of SB 803 Peer Support Specialist Certification Act of 2020, California had no uniform education and training standard for BH peer support services and no peer services-specific Medi-Cal billing codes or rates. Fortunately, DMH did not sit by idly, waiting for the State of California to create the regulatory and financing structures to sustain peer support services; and instead has implemented the following peer support initiatives in advance of SB 803:

- Intensive Mental Health Recovery Specialist Training Program
- Parent Partners Training Program
- Parent Partner Training Symposium
- Community Inclusion and Peer Support Program

SB 803 establishes statewide training standards for peer support specialists and requires the DHCS to activate a billing code for peer services in Medi-Cal, enabling participating counties to receive matching federal funds. Counties can opt-in to the program to provide certified peer support specialist services within the county. Under this legislation, a participating county is responsible for training and certifying a peer, and providing program oversight. It also defines the range of responsibilities and practice guidelines for peer support specialists, specifies required training and continuing education requirements, determines clinical supervision requirements, and establishes a code of ethics and processes for revocation of certification. This legislation permits peers certified in one county to practice in counties that opt-in to the program.

On December 20, 2021, per the state's request, the Peer Support Services portion of State Plan Amendment (SPA) 20-0006-A was approved by CMS to have an effective date of July 1, 2022 to coincide with the

establishment of the state's peer specialist certification program. Given this development, LAC has the authority and the Medi-Cal financing to immediately implement the development of a peer support specialist workforce to not only add capacity to the workforce available to the crisis response system, but the entire BH continuum of care. Given all of peer support specialty initiatives within the County's MHSA - Workforce Education and Training (WET) program and the passage of SB 803 Peer Support Specialist Certification Act of 2020, LAC will be well-positioned to integrate those with "lived experience" throughout the crisis service continuum and beyond.

Outcome and Quality Measurements

The Kennedy Forum, in its Issue Brief titled, *Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services*, presented the following key policy recommendation:

> *"All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected."*

The reality is that for many systems of care, the usual practice does not include the regular use of validated and quantifiable symptom rating scales in the manner described in this Issue Brief. This point is equally valid when it comes to the delivery of crisis care, which presents its own unique challenges when attempting to engage in meaningful outcome measurement. Stakeholders who participated in Kennedy Forum focus groups identified that a key barrier in implementing measurement-based care was the lack of knowledge about existing validated symptom rating scales that could be suitable for widespread adoption. To address this barrier, The Kennedy Forum issued a Supplement to its original Issue Brief entitled, *A Core Set of Outcome Measures for Behavioral Health across Service Settings* (https://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf), to provide clinicians, payers and quality improvement entities with a list of commonly used and validated symptom rating scales. Particularly relevant for measuring outcomes associated with the delivery of crisis care, is that the experts, associated with the development of this Supplemental Brief, were sensitive to workflow integration issues. As a result, the Supplement is focused on validated instruments that can be administered in a brief amount of time. It is recommended that DMH utilize these Kennedy Forum outcome measurement resources as major references when developing an outcome measurement system for its crisis response system.

In addition to outcomes measurement, it is equally critical that DMH is able to evaluate how the crisis response system is actually preforming. Toward that aim, a listing of KPIs have been developed and it is available in Appendix H along with KPI dashboards for the crisis response system and for each of the core crisis service components. The KPIs have been incorporated into a set of dashboard designs based on national guidelines and the input of key community stakeholders. Dashboards are only tools to visualize

performance data. Their effectiveness depends on how organizations use them to enhance internal performance and external accountability and transparency. DMH should be cognizant of both the strengths and weaknesses of dashboards. Dashboards need to be useful to support DMH's decision-making processes and to support external accountability. In this context, both the dashboard performance measures and the underlying data need to be publicly accessible for credible organizational accountability.

Addressing the Crisis Needs of Children, Youth, and Families

The Roadmap to the Ideal Crisis System (2021), advocates that all programs in the crisis care continuum, that may be serving populations that include children, youth and/or older adults, should have clinical practice guidelines and competencies for all staff. Staff should be expected to understand and respond to the unique needs for the children and older adults they will be serving. The ideal crisis system must be able to respond to individuals of all ages in crisis, their families and caregivers. In some settings, there may be the capacity to develop and implement a specialized crisis service for children and adolescents, but in most systems, this population will be served to some extent by generic crisis response staff. In either case, all the crisis practice guidelines described in Appendix K should be adapted for the specific needs of youth.

Addressing the Crisis Needs of Persons with Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities (PWIDD) are at high risk for co-occurring mental health conditions, with the incidence of psychiatric disorder estimated to be more than three times higher in the IDD population compared to the general population. One of the challenges in providing mental health services for these individuals in all age groups is in addressing their broader spectrum of unique needs. The vulnerabilities faced by these individuals are pronounced and can lead to catastrophic consequences, including, pronounced rates of victimization, lack of access to appropriate treatment with multiple transitions in care that can create regression, the potential for criminalization of behavior as an unfortunate result of miscommunication, and other challenges. Therefore, the facility staff and all those that are part of the crisis response system must develop the requisite competence to serve PWIDD. The National Association of State Mental Health Program Directors' (NASMHPD) Technical Assistance Coalition White Paper Assessment #7 from August 2017, entitled, The *Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System*, makes a number of recommendations that would be beneficial for DMH to consider and they appear in Appendix L of this Report.

Assessing Community Impact and Health Inequities

<u>Introduction</u>

In recent years there has been a concerted push to transform the crisis care system in America. Many states and local communities have been exploring and implementing crisis management and diversion alternatives as research has shown that relying on tools of arrest, prosecution, and incarceration has not been effective in helping people become stable, productive members of society or creating safer communities.

BH crises have been fragmented with a default reliance on law enforcement, hospitals, and jails. A look at national data trends highlights the over-representation of people with BH conditions in the criminal justice system. Previously incarcerated individuals have been shown to be ten times more likely to be homeless; homelessness has been linked to poor mental health outcomes and people experiencing homelessness are more likely to interact with the criminal justice system. Nationally, the number of people over utilizing emergency medical systems has swelled by thirty (30) percent, from 96 million visits in 1995 to 115 million in 2005, and public resources have tightened, further emphasizing the need for innovative solutions since this data has not made significant improvements to date.

States and local communities are eagerly assessing their crisis response systems in attempts to move from siloed and insufficient crisis services to a comprehensive, coordinated system, informed by community crisis data, and led by a diverse group of community stakeholders. As LAC assesses its communities' needs and further implements interventions to address existing crisis system gaps, measuring the impact of interventions will be crucial for understanding how crisis response system improvements are affecting residents of LAC and whether these interventions are sufficiently addressing the unique needs of LAC's diverse demographic groups.

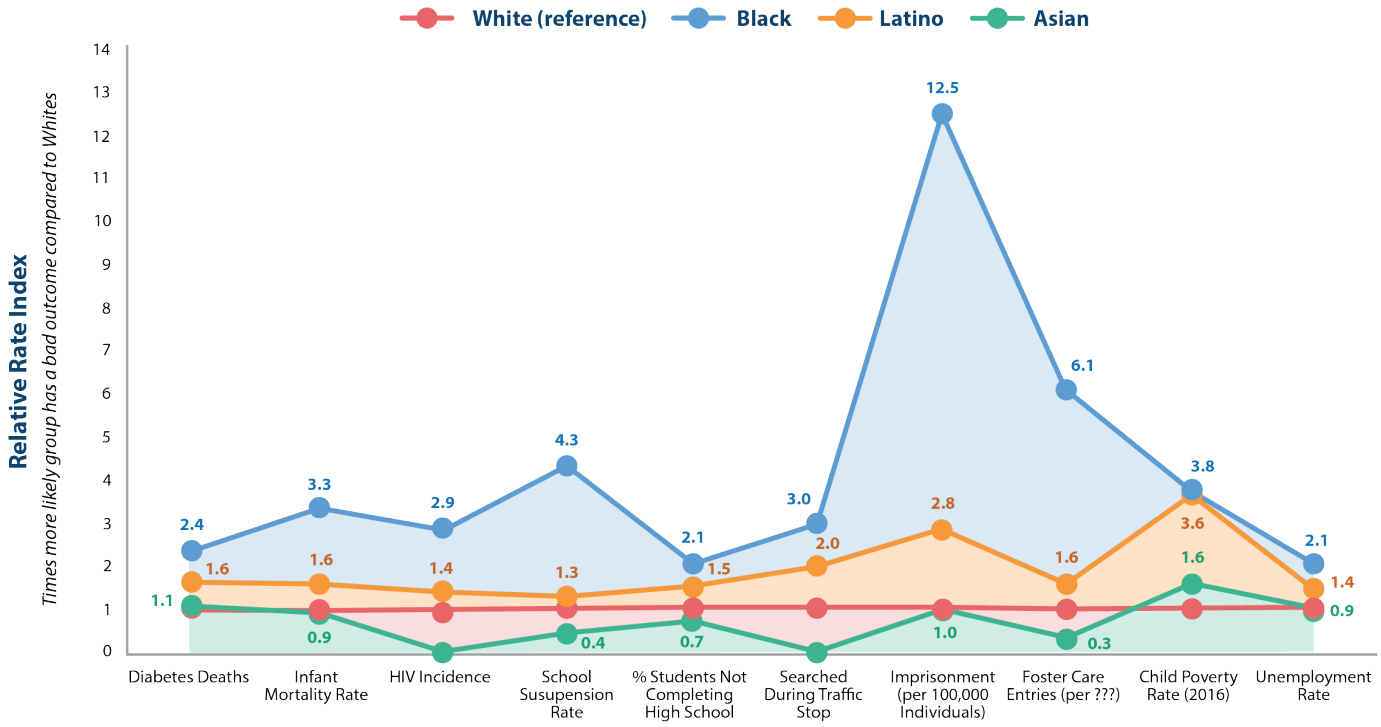
Current State of Inequities in LAC
Incarceration Rates and Racial Inequities

The Los Angeles County Sheriff's Department (LASD) reports that the number of people in the LAC jail system with mental health conditions increased 119% from 2010 through 2020. With few other options, a growing number of people with mental health conditions in LAC end up incarcerated in jail. In 2020, the average number of people with mental health conditions accounted for 38% of the jail population (up from 35% in 2019).

Incarceration in LAC is also a story of racial inequality. The county's justice system consistently and disproportionally impacts people of color. The racial demographic for LAC's jail population in 2020 was 54% Hispanic, 30% Black, and 13% White. Blacks made up a disproportionate share of the jail population, as compared to the overall county population (about 9%). Black and Latinx people's over-representation in the county jail system stands in stark contrast to the under-representation of white people in the LAC jail system. Within LAC, Black residents are 12.5 times more likely to be incarcerated; 4.3 times more likely to be homeless; 2.3 times more likely to die by overdose; 3.8 times more likely to experience child poverty; and 2.1 times more likely to be unemployed than white residents of the county (see graphic below).

Blacks represent 9% of LAC's population but 20.1% of those utilizing crisis services. Black residents are 223% more likely to receive crisis care than the general population according to existing LAC crisis service utilization data. Increases in availability of crisis services, within targeted areas of LAC, and enhanced ongoing care to underserved communities offers the potential for dramatic increases in pre-booking jail diversion opportunities for Black residents; connecting those individuals to care instead of incarceration.

Relative Rate Index for Equity Measure Across Health, Education, Criminal Justice, Child Welfare and Economic Well-being in LA County



LAC residents booked into jail come predominantly from five zip codes within South Central, Compton, Long Beach, and the Antelope Valley communities. As the County's Portrait of LA Report puts it, these zip codes are "struggling" and "precarious." Validation of this disparity is evident when those booked into LAC's jails most-frequently report their employment status as "unemployed." As we have seen in the overall jail data, a large number of these individuals are struggling with BH challenges.

Homelessness

Homelessness – also known as a state of being unhoused or unsheltered and it– has been at a crisis level in LAC for decades. According to the Los Angeles Homeless Services Authority (LAHSA), the lead agency in the Los Angeles Continuum of Care that coordinates housing and services for homeless families and individuals in LAC, the number of unhoused individuals in LAC increased from 2015 to 2020 and more than 66,400 people were experiencing homelessness in LAC at the start of 2020, a 13% increase from the year prior.

The rise in homelessness in LAC is a result of stagnant income, rising housing prices, lack of investment in BH services, lack of tenant protections, and discriminatory land use. Another major factor is mass incarceration. LAHSA found that 60% of L.A.'s homeless population has cycled through the criminal justice system.

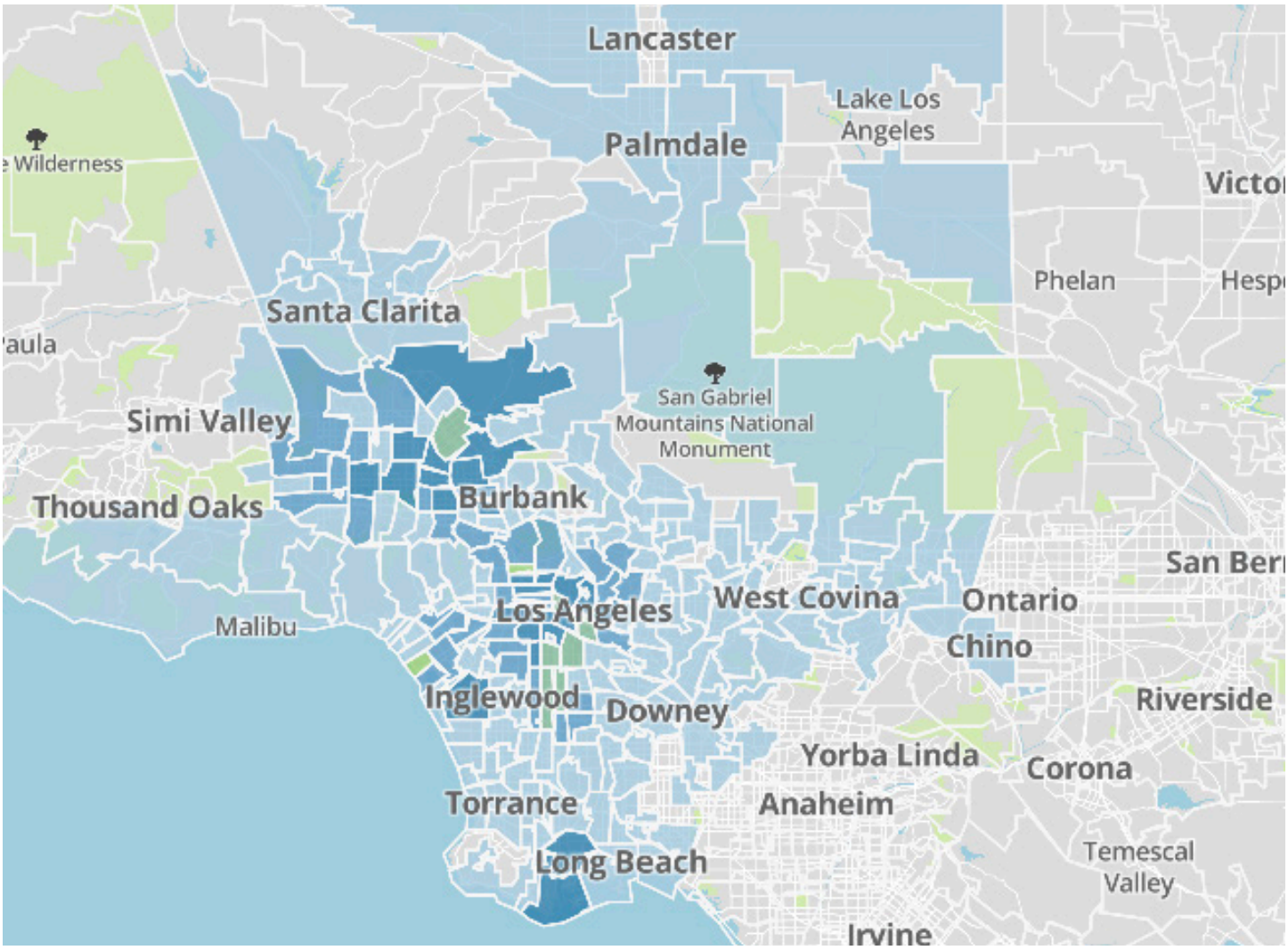


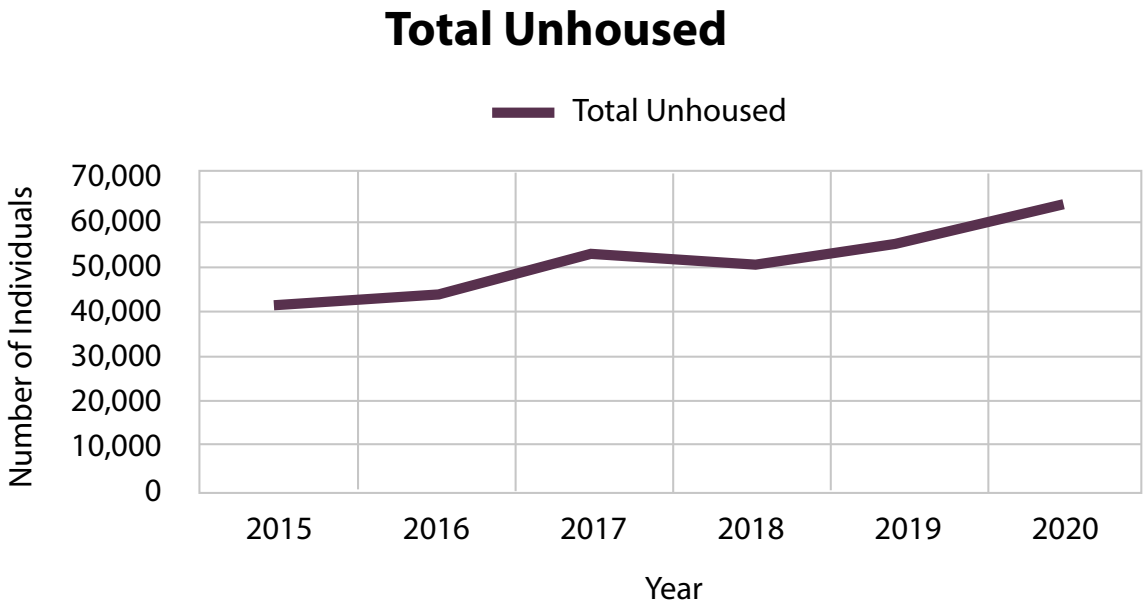
Figure: Arrest data from 2016-Present obtained from LAC Open Data.

Despite the programs, funding, and attention that LAC places on the homelessness crisis, the population facing homelessness continues to rise. The chart above shows trends of total unhoused individuals in LAC from 2015 to 2020.

Moving Toward an Ideal Future State of Crisis Services in LAC

LAC's existing crisis data emphasizes the need for bolstering LAC's comprehensive crisis response system and using data to continually assess and improve outcomes. To improve outcomes for people in need of a BH crisis response, and identify opportunities for improvement, LAC must collect data that is consistent

and accurate to understand the extent and distribution of behavioral health crisis response inequities in LAC communities and measure the impact of the crisis response system in these communities. The data must be used to continuously monitor, assess, and re-calibrate what is needed to drive impactful changes in outcomes. Using data and findings from crisis care can be especially valuable in communities with higher



rates of historic disenfranchisement, trauma, and that are more socioeconomically vulnerable and where stressors are more extreme. When broadly available, information gathered during crisis service delivery can be a powerful tool for measuring baselines and advancing progress in tackling health inequity and community impact.

LAC has already begun to transform its crisis response system by developing the Los Angeles County Alternative Crisis Response (LAC ACR) System of Care, which is designed to create low-barrier access to care and divert community members away from justice involvement and avoidable emergency medical use while also effectively managing, reducing, and even preventing crises. Measuring and responding to indicators of community stability overtime will demonstrate the efficacy of ACR performance. This approach includes using an evidence-based framework that bolsters health equity using diversity, equity, and inclusion (DEI) principles and practices applicable to the people served. In addition, this approach includes key partners and measures outside of BH and healthcare, and includes other indicators of community stability, like missed days of school and truancy among youth, rates of criminal justice involvement, housing stability and longevity, and sustained employment – all common-sense indicators of a stable community with households that are at reduced risk for needing crisis care.

Proposed Approach to Performing Community Impact Assessment

Bolstering the crisis response system in LAC can enhance the achievements of more macro-level goals like health equity and community improvement, but it requires a comprehensive plan using incremental

actions that foster service excellence, alignment, and partnerships at the County and neighborhood levels. To sustain the effectiveness and improve the efficacy of the ACR as a mitigator of BH inequities requires assessing the social and community impacts of the program via a rapid cycle feedback process.

Impact assessments must be data-driven and attuned to demonstrating not only what segments of the ecosystem are impacted, but also what factors underlie their impact to allow innovation for more appropriate care and better outcomes for all residents of LAC regardless of race, gender, and sexual orientation among others.

Data can play a transformative role in setting, refining, and evaluating collective impact strategies and programs. Shared measurement—grounded in a culture of learning and focused on equitable processes and outcomes— offers pathways to shared understanding of the societal challenges communities face. LAC should align data collection and use, with the stakeholder's and consumer's priorities and values, and to make sure that ACR decision-support includes accessing has the knowledge and resources necessary to use data to measure success and impact. LAC can then use the analysis to continually modify strategies that meet the needs and improve stability of the individuals and communities served or at risk for needing services. Data is essential as a tool for continuous quality improvement and realignment.

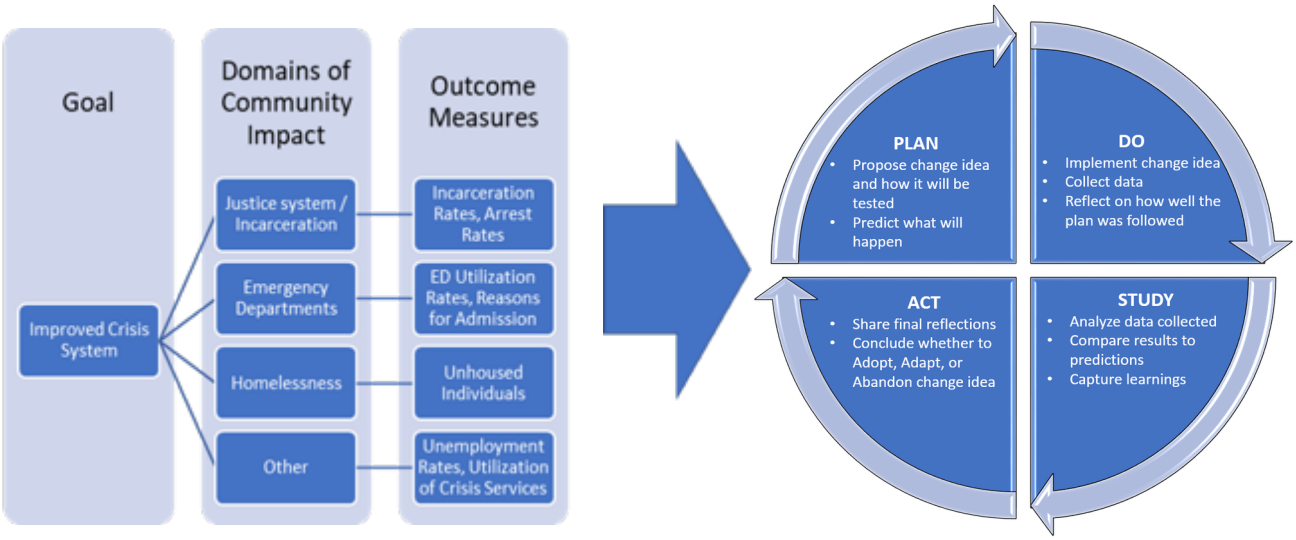
LAC should adopt the Plan-Do-Study-Act model, coupled with applying a standardized health equity framework to measuring community impact, and utilizing data and partnerships to guide LAC through properly, efficiently, and strategically measuring the impact of the ACR System of Care. The Plan-Do-Study-Act (PDSA) model (graphic below) is a time-tested and adaptable methodology for implementing and measuring the impact of these initiatives on individuals needing support. This will allow LAC to identify existing challenges, implement proposed solutions, continuously monitor, and re-calibrate to align existing programs to shifting population needs and community challenges. The PDSA model's iterative rapid cycle problem-solving technique will equip LAC to carry-out demonstrated change and continuously evaluate the outcomes of changes made to assure they drive desired outcomes, especially in relation to law enforcement, justice system, and homelessness in LAC.

As illustrated in the graphic below and described in the following sections, LAC's implementation of PDSA for measuring community impact would include several iterative action steps.

Plan

For real change to permeate throughout LAC and serve as a national exemplar, it is essential for LAC to build a strong foundation that forms the basis for how the crisis response system will ultimately function. As part of the "Plan" phase of this methodology, LAC will need to proactively select and report on a set of outcome measures as illustrated in the table below:

An impact assessment must be tied to the overarching goals – to reduce the number of crises and the over-reliance on the criminal justice system and emergency medical response and EDs, and to do so in a manner that promotes diversity, equity, and inclusion. The figure below demonstrates the interaction between the overarching goal, impacts on the various community domains, and how those impacts can be measured.



Identify Additional Data to Collect

In addition to the measures above, LAC will need to collect socio-demographic data to assess and measure the crisis response system's baseline and impact by race, ethnicity, sexual orientation, education level,



- Identify outcome measures
- Identify additional data to collect
- Determine data sources

- Execute plan
- Incorporate lessons learned from other markets
- Applying a standardized health equity framework to community impact measurement
- Establish and strengthen community partnerships and stakeholder engagement efforts

- Analyze data trends and impact
- Monitor data and outcome measures
- Analyze successful crisis support interventions from other markets

- Update approach as needed
- Improve post-intervention oversight and monitoring

housing status, and other social determinants of health (SDOH). An adequate understanding of these factors requires a detailed and sustained evaluation of data that reflects the intervention goals. To determine arrest diversion rates, incarceration recidivism rates, access to health care, public safety, emergency department utilization, as well as others will be essential for the impact analysis. Collecting other types of data that demonstrates the impact of LAC's facility-based crisis services will be critical in determining how these centers contribute to a solid crisis service continuum for residents who would otherwise be incarcerated if they encountered law enforcement.

Measure	Potential Data Points	How Will This Measurement Demonstrate Impact?
Rates of Criminal Justice Involvement	By race, age, gender, zip code, etc.: 1. Number of arrests; 2. Reason for arrests; 3. Number of people incarcerated and; 4. Number of people who are justice involved with behavioral health conditions.	Reviewing these data points and trends will show if LAC is successful in: 1. Diverting people away from the criminal justice system; 2. Implementing law enforcement training programs; 3. Addressing the disparate impact of the criminal justice system.
Emergency Department (ED) Utilization Rates	By race, age, gender, zip code, etc.: 1. Utilization rates of EDs; 2. Reasons for admission; 3. Length of stay.	Reviewing these data points and trends will show if LAC is successful in: 1. Diverting people away from inappropriate use of the ED; 2. Implementing the law enforcement training programs. 3. Addressing the immediate BH crisis need(s) of individuals, providing stabilization, and linking individuals with on-going services and supports.
Unhoused Individuals	By race, age, gender, zip code, etc.: 1. Number of unhoused individuals; 2. Number of unhoused individuals who are accessing health and BH services; 3. Number of unhoused individuals who establish permanently housed; 4. Number of unhoused individuals who are utilizing EDs; 5. Number of unhoused individuals who are justice involved.	Reviewing these data points and trends will show if LAC is successful in: 1. Diverting people away from the criminal justice system; 2. Implementing law enforcement training programs; 3. Addressing the immediate need of individuals, providing stabilization, and linking individuals with on-going services and supports.

Measure	Potential Data Points	How Will This Measurement Demonstrate Impact?
Indicators of post-crisis stabilization	By race, age, gender, zip code, etc.: 1. Education rates; 2. Housing stability; 3. Unemployment; 4. Food insecurity; 5. Access to health care; 6. Student absenteeism rate; 7. Utilization of preventative care; 8. Self-perceived health status; 9. Rates of poverty; 10. Rates of substance abuse.	Reviewing these data points and trends will: 1. Illuminate the level of stability that the LAC residents are facing; 2. Display topics and locations of highest need; 3. Display topics and locations of success to replicate.
Utilization of the crisis response system	By race, age, gender, zip code: 1. Utilization rate of all crisis programs in LAC, 911 and 988 utilization rates, etc.	Reviewing these data points and trends will show if the crisis response services in LAC are: 1. Equitably being accessed; 2. Addressing the immediate BH crisis need(s) of individuals referred, providing stabilization, and linking individuals with on-going services and supports.

Determine Data Sources

The availability of complete and timely data is needed to illuminate communities in need of the ACR, to address BH crisis response system inequities in LAC, and track progress. In 2015, the LAC Board of Supervisors authorized the implementation of the LA County Open Data Portal, which is a public website that houses vast amounts of publicly available county data in an accessible, user-friendly format designed to increase transparency and spur innovation. In addition, the State of California has an Open Data Portal that houses data by county that LAC should utilize for the data analysis to measure community impact. Specifically, LAC should be analyzing the following data sets from the California Department of Public Health: Suicide, Deaths per 100,000 population, Adult Depression, vaccination rates, percentage of household overcrowding, educational attainment, among others. Additionally, the California Department Health Care Services has 143 data sets and the California Department of Social Services has 14 data sets that will illuminate individual and community impact. Using the LA County Open Data Portal and the California Open Data Portal will allow for on-demand, accurate, and complete data to analyze and interpret to show trends and impact.

LAC should also utilize and build upon the Los Angeles County Health Survey, the population-based telephone survey that provides information concerning the health of LAC residents. This self-reported data

set can be used in the LAC crisis response system implementation to assess the health-related needs of the population, for program planning and policy development, and for program evaluation. Many, if not all the data points collected, tie into the overall health of LAC residents which can inform LAC on where to provide more resources. The data collected should include self-perceived health status, households with a family emergency plan, housing quality, percentage of people who have tried to access care over a 12-month period, among others. The data is organized by age, race/ethnicity, service planning area, and health district. The 2022-23 survey is currently underway which will provide LAC with a baseline of rich datapoints to measure and track community impact and health equity of the LAC ACR from the perception of the LAC residents.

Establish Community Partnerships and Stakeholder Engagement Efforts

LAC should continue to develop partnerships with similar programs and partner agencies to collectively improve data collection, data analysis, and determine how data can be a tool for continuous quality improvement. Collaborations can be developed to work toward seamless integration by establishing formal partnerships, developing Memorandums of Understanding (MOUs), shared protocols, and data-sharing agreements. Because BH crises services are dynamic and usually temporary, individuals will often be referred to other services within the crisis continuum of care or other healthcare or social services. The data-sharing agreements, in particular, will be critical for serving a dynamic array of individuals as they flow through the BH system. Robust data-sharing will help LAC work toward a closed-loop referral system in which LAC is able to see past a transactional referral to follow-up care and measuring individuals' outcomes. In addition to collaboration with other organizations, the work that needs to be done to eliminate health inequities must include a fundamental shift in how LAC structures authority, decision-making and community engagement. Therefore, in addition to utilizing existing data and partnering with other agencies, actively engaging in meaningful care coordination LAC should develop a Quality Metric Workgroup that meets with community stakeholders and with utilizers of the crisis response system to evaluate the systems and make recommendations about which data points to collect and which metrics to include for monitoring and accountability. LAC should also use the existing components to receive and utilize data from the community to determine impact on the community.

Potential Community Partners



Do

After LAC has developed a plan to implement mechanisms to measure the community impact of its optimized crisis response system, the Plan must be executed. Upon Plan implementation, LAC should continuously evaluate its status and observe the impact on the community. To do so, LAC should identify several critical factors, including who is responsible for the phased approach to establishing facility-based crisis services, where these facilities are targeted, and the time period to be measured.

A critical component of the "Do" phase of this approach will be to analyze data associated with the approach in real time to observe the impact for each deployed intervention. This will require data gathering, analyses, and establishing data sharing agreements to gain access to the information needed for real time analyses and building upon the relationships and measures identified in the planning phase.

As outlined in the "Plan" phase above, LAC should work closely with a variety of stakeholders to evaluate implementation in real time. As these interventions will be the responsibility of several stakeholder groups, LAC should establish regular touchpoints with first responders, healthcare facilities, state and county BH and health services agencies, and crisis care, and advocates to promote consistent communication and identify channels to efficiently address challenges as they arise. These regular touchpoints will allow LAC to receive a "boots on the ground" updates from stakeholders interacting with the crisis support system on a day-to-day basis.

Additionally, LAC should identify a standardized time period to evaluate quantitative data through the channels defined in the "Plan" phase. Whether LAC elects to evaluate data on a monthly, quarterly, or semi-annual basis, LAC should establish a regular cadence to review the data across each of the outcome measures defined above to assess community impact (i.e., rates of justice involvement, emergency department utilization rates, indicators of post-crisis stabilization, utilization of the crisis response system homelessness).

This combination of regular qualitative and quantitative data analyses to review the optimization of the crisis response systems will allow LAC to maintain a real-time perspective on the successes or failures in target communities. This process will further inform the subsequent phases of the PDSA model, where LAC can further study and trend outcome measure data and act upon results to continuously strengthen the system

Successful Crisis Support Interventions from Other Markets

Although LAC is a unique market given its size and its ability to invest in a robust crisis response system, there are lessons that LAC can learn by exploring interventions from other communities. Although no one system works everywhere, these examples indicate that communities are making tremendous strides in improving crises care. Learning from other programs will help LAC avoid potential pitfalls and learn from opportunities and successes. There are several communities across the nation that have implemented crisis supports that LAC can consider when evaluating the potential impact of successful crisis support deployment, as outlined in the table below.

Successful Crisis Response Examples from Other Communities

Intervention	Community and Program Description	Potential Impact in LAC
Enhanced Jail Diversion	In Miami-Dade County, ninety-seven (97) people spent 39,000 days in either jail, emergency rooms, state hospitals, or psychiatric facilities over a five-year period, costing taxpayers $13.7 million. As a result, police shifted their approach to prioritize diversion. From 2010 to 2014, Miami police safely stabilized the majority of crises or provided diversion by linking people to community-based crisis care, for more than 10,000 people. **Due mainly to these efforts, the local jail population fell from more than 7,000 in 2008 to just over 4,700 in 2014, and the County was able to close a jail facility, saving nearly $12 million per year.** Over the course of these six (6) years, Miami-Dade County experienced a 33% reduction in its jail population by offering jail diversion with crisis care.	If we applied that same 33% reduction to LAC for 2020, **LAC's jail admissions would have been reduced by 18,698, from 56,661 to 37,963.** Had this occurred, this would have resulted in 10,097 fewer Hispanics, 5,609 fewer African-Americans, and 2,431 fewer Whites incarcerated. LAC has already experienced significant jail diversion by virtue of the comprehensive package of ATI and ACR initiatives and it will experience even greater gains with the pending crisis service enhancements that are in the pipeline. With the implementation of the recommendations contained within the Report, by FY 26-27, RI International is confident that LAC will exceed the gains made by Miami-Dade County.
Mobile Crisis Teams and Crisis Triage Supports	In Bexar County, Texas, the co-responder mobile crisis teams have access to a 24-hour Crisis Care Center which treats individuals within an hour of arrival, **saving $2.4 million in jail costs tied to public intoxication, $1.5 million in mental health services, and $1 million in emergency room costs.** A similar program in Minneapolis saved **$2.16 for every dollar spent on its crisis triage center**, and one in Salt Lake City led to a ninety-percent (90%) decrease in ER visits by patients with psychiatric conditions.	LAC, with a fully optimized crisis response system (FY 26-27), will be intervening with approximately 962,463 crisis episodes annually. Due to LAC's size and available budget for investment, we can expect that LAC will benefit from a significantly greater return on investment (ROI) over the next few years just on detention savings alone. This does not include the additional savings that accrues from the diversion from law enforcement and the court system. **If we extrapolate from the experience of Minneapolis, where $2.16 was saved for every dollar invested in its crisis triage center, it would be expected that in FY 25, with expenditures of $43,167,729 in crisis stabilization centers with beds, that LAC could experience an estimated ROI of $93,242,295.**

In addition to the anticipated savings to the criminal justice system, LAC is expected to see an additional forty-four percent (44%) reduction in annual healthcare spending when the crisis response system is fully optimized. This savings is expected to exceed over $507 million annually. The projected impact to Black residents, is that 80,000 additional individuals are anticipated to be connected to crisis care annually in the evolving system. Many of these individuals will be diversions from the criminal justice system. The graphic below outlines the anticipated increase in the utilization of crisis care between FY20/21 and FY26/27 by service type (e.g., mobile crisis teams, crisis stabilization units, call centers) and by race with the optimization of the crisis response system.

Service	Total Service (FY 20/21)	Anticipated Usage FY 26/27	Increased Utilization
Mobile Crisis Teams	12,687	61,360	48,673
Crisis Stabilization Units (Chairs)	49,910	152,854	102,944
Short-Terms Beds	1,126	53,499	52,373
Psychiatric Emergency Rooms	6,681	6,681	0
Call Centers Combined	213,794	688,069	474,274
Totals	284,198	962,463	678,265

Race	Total Service (FY 20/21)	Anticipated Usage FY 26/27	Increased Utilization
American Indian or Alaska Native	2,083	6,978	4,894
Asian	16,878	56,535	39,657
Black or African American	57,878	194,023	136,145
Native Hawaiian or Other Pacific Islander	1,819	6,383	4,564
White	86,657	291,009	204,352
Hispanic/Latino (Not Otherwise Specified)	114,371	387,560	273,189
Multi (multiple Selections)	4,591	16,135	11,544
Totals	284,198	962,463	678,265

Study / Act

A fully successful implementation will require LAC to "Study" and "Act" on the results of programmatic changes to assess impact and to identify potential opportunities to modify policies and procedures to align with shifting population needs or emerging challenges. To accomplish this task, LAC should consider how to collect and use actionable data to improve the crisis response system. A key component to accomplishing this is to also focus on population sub-sets to determine key differences or areas of opportunity, intervention strategies, education, or marketing campaigns that could be successful in further supporting successful crisis response system optimization.

LAC should consider incorporating a rapid cycle feedback process that allows the evaluation of data on a more frequent, near-real-time basis to act and adjust approaches that may not be trending in the right direction. For example, a September 2021 brief by the NASMHPD highlights a case study from Georgia's State Mental Health Agency (SMHA) and their approach to measuring the impact of the statewide crisis call center. The SMHA receives daily reports of call volume and weekly reports of call abandonment rates, average speed to answer, and other factors. Monthly, the SMHA receives a report on average speed to answer a call, abandonment rate, and the hold time. The SMHA then uses this information to most effectively

manage call center operations and improve the caller experience. For example, to address hold times on calls, they changed the way that call center staff handed calls off to clinicians, so the staff would remain with the caller as they are waiting to hand them off to the clinician.

As we describe in the "Plan" and "Do" phases above, LAC should develop a data aggregation approach that allows for rapid analysis of these key metrics and other relevant data sources. LAC can then study this data and take clear actions to deploy people, training programs, or other supports to improve existing programs and align more closely with the needs of the LAC population.

It is imperative that the data collected is focused and based on previous similar projects to be sure that any conclusions support appropriate action items. Recurring collaboration with appropriate stakeholders to determine the efficacy of data collection will help to ensure that data not relevant to the system are not collected while those that are highly applicable are collected with accuracy. Subject matter experts should be consulted to determine what factors are important for the outcome or outcomes of interest. This may include sociologists, criminologists, healthcare providers, and public health practitioners. This data must be collected on multiple levels as the interventions must also exist on multiple levels.

At the individual level, surveys of sentiments and effects of these programs should be collected. At the community level, data should be collected regarding socio-economic indicators, ED admissions, homelessness, and use of BH services. Data should be collected regarding policy changes and shifts in many of these indicators to determine what data can be associated with the crisis response system and what is attributable to shifts on broader scale. Data at each of these levels can then be layered with existing qualitative and quantitative datasets to develop data analyses, risk-assessment tools, and interactive evaluation tools. Dynamic dashboards can be created to present this data to relevant groups. This can include reports for individuals who are carrying out intervention programs, those adjusting these programs, and those who have contributed financially to these programs to show the impacts of contributions.

Rigorous data collection, analysis, and visualization can then be used to add to existing literature regarding evaluation. These datasets and tools can also be used to create generalizable recommendations and tools that can be used in other cities. At the core of developing these tools is recognizing and defining the specific goals of these crisis response programs.

A critical component of the Plan, Do, Study, Act framework involves continuous evaluation and assessment of implemented interventions and supports. For LAC to develop and maintain a truly innovative and effective crisis support system, they must also implement a robust data collection and analysis methodology, leveraging partnerships and data sharing agreements with a variety of stakeholders across the community (e.g., law enforcement, non-profit organizations, local agencies). Consistently reviewing the data will allow LAC to evaluate the success of implemented solutions and make necessary modifications to drive the changes they desire. As LAC develops a robust data analysis methodology and review cadence, they should also consider how their framework will advance health equity and regularly measure for progress in this space.

Applying a Standardized Health Equity Framework to Community Impact Measurement

In many communities, the barriers that community members encounter when attempting to access BH services are largely attributable to stigma. Sub-populations have distinct, root causes that are influenced by cultural, environmental, and educational impacts. Stigma related to being in crisis and needing crisis support coupled with systemic bias toward a range of minority populations can be co-contributors that increase poor BH outcomes and impede proper and timely care and treatment.

Applying an equity lens to the optimization of the crisis diversion system will help determine what high-impact changes are needed to ensure that all residents, no matter race, age, socioeconomic status, disability status or immigration status, have access to crisis care. Applying a proven health equity framework to guide efforts will also enable LAC to identify systemic bias and communal stigma on seeking crisis care. LAC should identify the various modes of access to care (e.g., crisis call center, mobile crisis services, and facility-based crisis services) for those most impacted. Communities in LAC can vary widely by environmental and socioeconomic status factors, and the mode of access in one community may not be appropriate, or effective, for another.

LAC has a long-standing history of applying a health equity lens to County related interventions, for example, the Community Health Equity Project (CMHEP) seeks to address and reduce health disparities among California's most vulnerable populations through a cutting-edge collaborative effort between the California Department of Public Health (CDPH) Office of Health Equity (OHE) and the Department of Health Care Services (DHCS) Medi-Cal Behavioral Health Division (MCBHD). CMHEP utilizes an equity lens to achieve cultural inclusion, promote tailored mental health service delivery and create intersectional partnerships.

By seeking a culturally inclusive BH system, CMHEP's goal is to address BH disparities through a holistic method. This includes addressing inequality from multiple levels, refining health education efforts, improving workforce development support, increasing BH service access, and supporting technological advances. LAC also introduced a $187.7 million "Care First Community Investment" spending plan that invests in equity and communities. By utilizing an equity lens, the county is seeking to "transform Los Angeles County with innovative programs that serve our chronically under-resourced communities to address negative outcomes caused by racially driven criminal justice inequities and long-term community economic disinvestment."

By ensuring equity is a core priority in all considerations, LAC should be well-positioned to ensure the most vulnerable populations have access to crisis care.

Equitable access to crisis diversion systems requires a tailored approach that is multidirectional, multifaceted, and multisectoral. A theoretical framework to guide this process is the Socio-Ecological Model – a Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) backed public health and health promotion standard that illustrates the dynamic multidirectional interplay of factors operating within and across respective levels from macro (policy) through micro (individual). LAC can utilize this model to develop a deeper understanding of the dynamic effects of personal and environmental factors

and how they relate to and affect BH. According to the CDC, to ensure access to crisis diversion systems are equitable, strategies must target multiple levels of the model, and be consistent, coherent, and concurrent.

The World Health Organization (WHO) added this piece from a global campaign addressing violence prevention and the Social Ecological Model:

> *The ecological framework treats the interaction between factors at different levels with equal importance to the influence of factors within a single level. For example, longitudinal studies suggest that complications associated with pregnancy and delivery, perhaps because they lead to neurological damage and psychological or personality disorder, seem to predict violence in youth and young adulthood mainly when they occur in combination with other problems within the family, such as poor parenting practices. The ecological framework helps explain the result—violence later in life—as the interaction of an individual risk factor, the consequences of complications during birth, and a related risk factor, the experience of poor parenting.*

Below are examples of what interventions at each level of the model could look like in LAC:

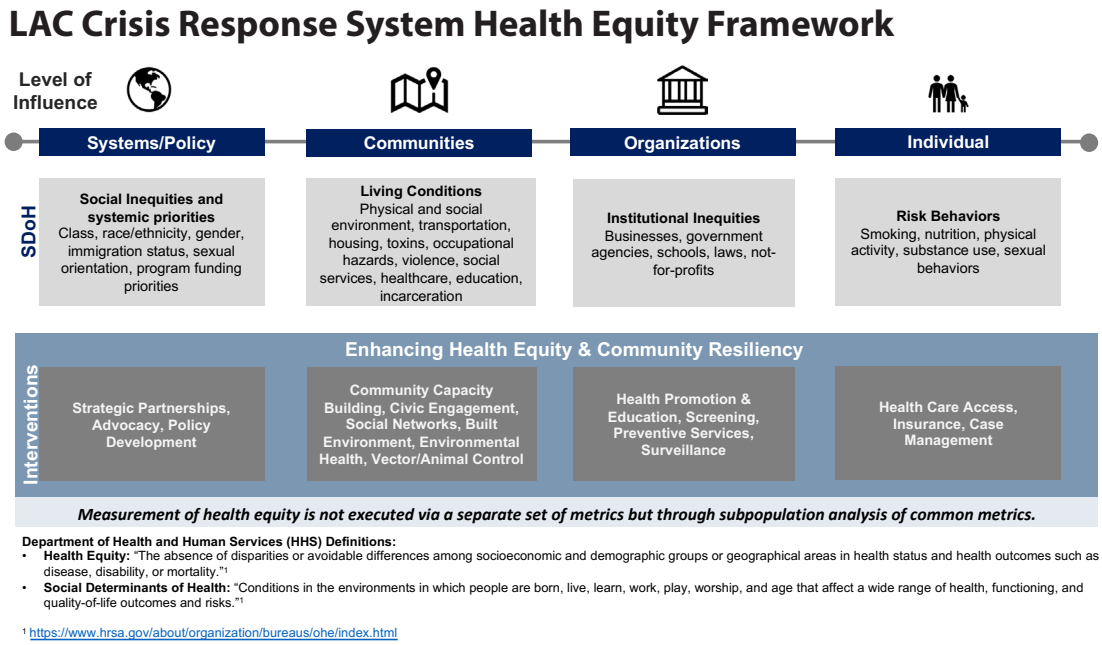
(1) Intervention at the Policy Level will allow LAC to target larger macro-level factors and policies that are antiquated or influence BH disparities, directly or indirectly. Interventions at this level should seek to create and promote norms, policies, and laws that support increased access to BH services, the reallocation of funding to support these services, and ensure that an equity lens is applied to all policy decisions.

(2) Intervention at the Community Level will allow LAC to address factors that lead to increased risks and disparities based on catchment area, community environments, and social influences. Proximity and access to community resources and supports and meaningful engagement with schools, workplaces, and house and nutrition assistance should be a priority for LAC at this level.

(3) Intervention at the Organizational Level should start with the collection of data on existing healthcare and BH organizations to gauge access and utilization based on the catchment area, and a great tool to use for on-demand data is the LA County Open Data Portal. Interventions at this level should be designed to promote the use of health services, advance the full continuum of health in LAC, and facilitate individual behavior changes by influencing organizational systems and policies. Example priorities at this level may include but are not limited to, education opportunities, cross-sector organizational collaboration, increased community connections to services offered, and local partnerships. While LAC has developed and implemented programs addressing crisis and diversion alternatives, there appears to be considerable fragmentation, duplication, and inefficiency that impact the effectiveness of the crisis response system across LAC. The innovative and ambitious ACR initiative requires LAC to evaluate successful crisis intervention and diversion alternative strategies and programs to build and maintain a robust, effective crisis system of care. Learning from and with other programs and progressive thought leaders will help LAC avoid potential pitfalls and learn from opportunities and successes.

(4) At the Interpersonal Level, the relationships LAC residents have built with peers, partners, and family members can influence the need for and stigma toward crisis diversion services. On the other hand,

inadequate positive social interactions can lead to social isolation, and according to The American Journal of Lifestyle Medicine, healthy social connections are crucial to mental health. Interventions at this level may include behavior change communication that works through interpersonal communication streams such



as social media platforms. Behavior change communication is an effective intervention because it helps to reduce stigma, promotes attitude and behavior changes, and raises awareness about a particular health problem at a large scale. Other interventions at this level can include social mobilization led by community leaders, and advocacy.

(5) At the Individual Level of the Socio-Ecological Model, LAC will have the opportunity to address biological, personal history, and attitudes/beliefs that increase adverse health effects among individuals. Strategies at this level will include the promotion of health-seeking behavior, reduction of mental health stigma, and the utilization of behavior change communication. LAC should tie in existing health and BH education programs that are currently offered by DMH to create a robust well-rounded behavior, change program. Data shows that prisons and jails incarcerate a disproportionate amount of people who have a current or past mental health problem, with a large portion of these individuals being of color. At the Individual Level, RI International recognizes that Crisis Receiving Centers will play a central role in mitigating the avoidable number of individuals being incarcerated for non-violent mental health crises. By individualizing and applying an equity lens responding to people in crisis, LAC will be positioned to upend an antiquated response system and create one that is culturally, racially, and equity informed.

Overwhelmingly, LAC residents experiencing criminal justice involvement come predominantly from five zip codes within South Central, Compton, Long Beach, and the Antelope Valley communities. According to UMMA Clinic health data and Measure of America the social and environmental barriers to health in

these areas lead to a lower-than-average life expectancy, and an increase in justice involvement. The SDOH issues faced range from local food deserts in which access to local markets and fresh food is non-existent in some areas, to there being only one full-scale ER/trauma center to serve over one million residents. As a result of only one full-scale ER/trauma center being available, 45% of adults and 18% of children in South Central have difficulty accessing medical care. These areas also have a lack of inviting green space, some of the highest rates of homelessness and displacement in the county, lower than average median personal earnings, and a higher than the national average rate of youth who are not in school or working.

According to the CDC, the disproportionate rate of incarceration experienced in minority communities is the result of a myriad of risk factors influenced by race, socioeconomic status, gender, and where people live. Due to the SDOH factors listed above, residents of the five zip codes within South Central, Compton, Long Beach, and the Antelope Valley communities can be more vulnerable to violent crimes and their repercussions, including higher incarceration rates, than other communities. Notably within LAC according to the Migration Policy Institute's (MPI) analysis of U.S. Census Bureau data, in 2019 there were roughly 951,000 individuals with an unsatisfactory immigration status (UIS) residing in LAC. Among the 951,000 individuals, 40% are at or above 200% of the poverty level, and 52% of people do not have English as their first language. Studies featured by the American Psychological Association found that individuals with a UIS face disproportionate rates of mental health issues such as anxiety and depression compared to the general population in the United States. To that end, a key focus in addressing equitable access to the crisis response system should be LAC's response to the undocumented population receiving equitable care.

Applying the Social Ecological Model to understand and resolve barriers to access for those who fear use of government-provided services, may be the key to reaching a dense population of individuals and households known to restrict access to services due to fear of law enforcement, immigration officials, and the overall use of public resources. This is also an applicable strategy for the broader population of Hispanic citizens residing in the county who may be conscious of potentially exposing household members or informal supports to immigration officials.

Although these communities have areas that are predominantly Hispanic, they each have substantial populations of Black residents as well. This is worth noting because of the BH stigma in the community, particularly among Black men. According to NCHS Data Brief, 26.4% of Black and Hispanic men ages 18 to 44 who experienced daily feelings of anxiety or depression were less likely to have used mental health services, compared with 45.4% of non-Hispanic White men. Like other communities of color, the Black community is more likely to experience health disparities that affect their access to care, health education, and social and economic resources – all of which may contribute to negative BH outcomes, per NAMI California. According to the NAACP Adult Black men face disproportionate rates of justice involvement coupled with a lack of access to care and pressing mental health stigma, intervention in this community is urgently needed.

988 Marketing and Communication Planning

While 988 messaging to the public may not begin until after July 2022, LAC can begin planning immediately on how to engage stakeholders to ensure that an overall 988 communications strategy is in place that

addresses messaging and defines the audiences who will receive the messages. According to the *988 Convening Playbook for States, Tribes, and Territories* [2022], by the National Association of State Mental Health Program Directors (NASMHPD), messaging should be focused on two audiences, with disparate needs for communication vehicles, specific messages, and timing:

- Partners (e.g., state agencies, crisis services organizations, nonprofits); and
- Public (e.g., individuals in crisis / recovery, family and allies, specific populations, general population, media).

Prior to the July 2022 transition to 988, communication is best centered on basic information about 988 and engaging with partners who play a role in BH crisis care delivery. Specific topics to consider when communicating with partners may include:

- What 988 is, how it works, and how it fits within the broader crisis service ecosystem:
  - 988 is the new dialing code that provides direct, life-saving services to people experiencing BH crises—or family members and advocates of those in need—through the existing NSPL. When people call, text, or chat 988, they will be connected to trained counselors that are part of the existing NSPL network. These trained counselors will listen, understand how their problems are affecting them, provide support, and connect them to resources if necessary."
  - Additional resources for basic information on 988:
    - SAMHSA FAQ: https://www.samhsa.gov/find-help/988
    - Vibrant FAQ: https://www.vibrant.org/988/
    - Suicide Prevention Lifeline and 988: https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/
    - Suicide Prevention Lifeline How 988 Calls are Routed: https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-toBasics.png
    - CEO Huddle 988 Toolkit: https://www.thekennedyforum.org/988toolkit/
- Relationship between 988 and 911:
  - 988 and 911 are designed to be complementary. 911 is currently used for all emergencies, including BH emergencies. However, 911 dispatchers may not be trained on how to handle these types of calls. On the other hand, 988 is a BH crisis number and 988 counselors are trained to assist people in emotional distress, suicidal crisis, or struggles with substance use. In many cases, 988 counselors can de-escalate a crisis over the phone and connect callers with community resources for ongoing support. Ongoing collaboration between 988 and 911 will help individuals in crisis get the appropriate support, potentially providing options like MCTs in place of police or emergency medical services (EMS) responders when needed and where available."
  - LAC can utilize its own reference on the relationship between 988 and 911: http://file.lacounty.gov/SDSInter/bos/supdocs/149282.pdf

Communication after the transition to 988 can expand to the public once CA's readiness to support 988 is complete. As the infrastructure to support 988 and crisis care is built, LAC will need to determine when to expand messaging to the public. Timing considerations for messaging may include: 1) Messaging materials have been updated from the suicide hotline number (1-800-273- TALK) to 988; 2) There is sufficient 988 crisis call center capacity to meet the anticipated demand; Connections and linkages have been established between 988 and MCTs or other rescue units to escalate care as needed; and 3) There is sufficient BH provider and service to respond to crisis episodes that escalate beyond contact centers and mobile response.

SAMHSA recognizes the need for governments, states, counties, tribes, crisis centers, and partners to speak with one voice to ensure there is a clear understanding about what 988 is and how it will work. It encourages the use of its 988 Partner Toolkit, which is available at: https://www.samhsa.gov/find-help/988/partner-toolkit. At this web portal, the communication outreach materials are intended to assist community coalitions in meeting the needs of specific audiences. In addition to key messages, this Toolkit offers FAQs, Fact Sheets, 988 Logo and Branding, an E-Newsletter Template, Radio PSA Scripts, Presentation Deck, and Future Toolkit Materials Timeline.

Building on these national messaging resources, RI engaged both DMH and Yett Marketing to produce an introductory one minute 988 animated video and resources for the social media toolkit. These resources are available at: https://thesocialpresskit.com/countyofla and a sample from the toolkit appears below:

Cross-Cutting Recommendations: ***Where LA County needs to go with cross-cutting issues involving crisis care over the next 3-5 years.***

A. Follow the proposed financial plan on pages 65-70 of this Report to finance the staged development of each core service component over the course of the next 3-5 years.

B. Implement a DMH organizational entity with the authority, responsibility, and accountability for the crisis response system.

C. Develop the crisis response provider workforce.
   1. Establish streamlined and value-based contracts to reduce administrative burdens.
   2. Conduct monthly collaborative meetings with cohorts of crisis response providers, focusing on data analysis and performance improvement.
   3. Establish a Technical Assistance Center for crisis response providers that supports providers in improving quality and efficiency.
   4. Operationalize a Crisis Training Academy with a standardized crisis certification training.
   5. Implement the clinical practice guidelines and competencies for serving children, youth, and families described in Appendix J for all crisis response staff.
   6. Adopt the provisions of the *Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (Behavioral Health Guide)*. This Behavioral Health Guide underscores the ways in which the National

CLAS Standards, already adopted by LAC, can specifically improve access to BH care, promote quality BH programs and practice, and ultimately reduce persistent disparities in BH interventions for underserved minority communities.

7. Adopt the provisions the crisis response system must develop the requisite competence to serve PWIDD. The National Association of State Mental Health Program Directors' (NASMHPD) Technical Assistance Coalition White Paper Assessment #7 from August 2017, entitled, *The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System*, makes a number of recommendations that would be beneficial for DHS to consider and they appear in Appendix L of this Report.
8. Establish a crisis intervention training program for peer support specialists.

D. Advocate for legislative and regulatory change to support an optimized crisis response system.
   1. Leverage the anticipated MediCal IMD waiver for mental health and substance use disorders so that LAC is no longer limited to sixteen (16) beds when planning for and constructing PHFs.
   2. Collaborate with the California Insurance Commissioner to enforce the mental health parity law to require commercial health insurance to reimburse for crisis response services.

E. Establish a process and outcome measurement system for the core service components of the crisis response system and provide transparent reporting of the performance and outcome achievements over time.
   1. Stand up public-facing dashboards that highlight the 988 crisis response system key performance indicators (KPI) in real-time.
   2. Disaggregate utilization and outcome data in order to analyze the equity of crisis response services.
   3. Utilize an oversight body to monitor these outcomes and guarantee equitable access and outcomes.
   4. Utilize the Kennedy Forum's *A Core Set of Outcome Measures for Behavioral Health across Service Settings* as the major source document when developing an outcome measurements for the crisis response system.

F. Create and monitor utilization benchmarks to support an increase in capacity, if existing crisis services are failing to meet anticipated growth projections (phased growth).

G. Adopt the use of a HIE as a standard of practice to assure crisis care follow-up and care coordination.

H. Focus on the efficient operation of all core service components in the crisis response system, which will yield significant cost savings and contribute to ongoing sustainability.

I. Continue to buildout LACs BH care continuum and the services that address the social determinants of health to both prevent BH-related crises and to provide community-based services and supports for those recently stabilized from a crisis episode.

J. Use existing data to illuminate historical inequities, learn from partnerships and their data and methodologies of analyzing and implementing changes based on the data, receiving data directly from LAC residents, stakeholders, and consumers, and establishing new data points to collect and measure with the community.

K. Adopt the Plan-Do-Study-Act model, coupled with applying a standardized health equity framework, to measure community impact.

L. Align data collection with the stakeholder's and consumer's priorities and values, and to make sure that ACR has the knowledge and resources necessary to use data to measure success and impact.

M. Develop community partnerships to collectively improve data collection and data analysis.

N. Develop a Quality Metric Workgroup that meets with stakeholders in the community and utilizers of the programs to evaluate the LAC crisis response system and determine which data points to collect and which metrics to include for monitoring and accountability.

O. Use existing programs to receive and utilize data from the community to identify program impact.

P. Establish regular touchpoints with first responders, healthcare facilities, state and county BH-related agencies, and crisis services groups and advocates to promote consistent communication and identify channels to efficiently address emerging challenges.

Q. Gauge the target population's initial knowledge, biases, and beliefs to effectively intervene.

R. Utilize the Socio-Ecological model and The Equity Lens framework to identify BH inequities and disparities, identify social determinants of health, create a community engagement plan, and establish multidisciplinary teams and partnerships to advance health equity.

S. Develop a Quality Metric Workgroup that meets with stakeholders in the community and utilizers of the programs to evaluate the LAC crisis response system and determine which data points to collect and which metrics to include for monitoring and accountability.

T. Utilize SAMHSA's 988 Partner Toolkit which is referenced in this Report to develop and implement an ongoing 988 marketing plan.

VI. Key Takeaways



LAC's crisis response system's alignment with national best practices remains at a basic level. Given the national priorities associated with 988 implementation, the California and LAC priorities in support of 988 implementation, and innovations associated with CalAIM, ATI, and ACR, LAC's crisis response system is progressing at a rapid pace. A major shortcoming has been the absence of the peer support specialty integrated within the crisis response system, but given recent legislation LAC will soon be the beneficiary of the many gifts that those with "lived experience" will bring to bear. A much larger hurdle to overcome is the establishment of LPS-designated STACCs with beds that offer stays of up to 14 days. Within the Financial Plan of this Report, LAC now has a roadmap over the next 3-5 years for addressing this missing core crisis service component while also optimizing the entire crisis response system. PMRT has been expanding mobile crisis service, but unfortunately it continues to provide unacceptably low crisis response times. To overcome this, PMRT needs a system of accountability to assure that it meets the KPIs that have been developed as part of this project. Lastly, the application of technology to crisis care has been lacking. However, this deficit too is promptly being addressed. When combined, these initiatives build on LACs innovations of the past and substantially move LAC toward full alignment with national best practices.

The LAC community at large should be proud of how the crisis response system is progressing and how rapidly that progress is occurring. When this system is fully optimized, it will indeed be a model for the rest of the country. While there are localities that have become national exemplars in one or more core components of a crisis response system as envisioned by the National Guidelines, no state or county as of yet, has made it a reality. LAC is well on its way to being the first to do so.

VII. Appendix



APPENDIX A: ACRONYMS

ACCESS	Department of Mental Health Helpline
ACO	Accountable Care Organization
ACPF	Acute Care Psychiatric Facility
ACR	Alternative Crisis Response
ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADP	Alternate Destination Program
AHCCCS	Arizona Healthcare Cost Containment System
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
ARPA	American Rescue Plan Act
APM	Association of Project Management
ASL	American Sign Language
ASO	Administrative Services Organization
ATI	Alternatives to Incarceration
BH	Behavioral Health
BHL	Behavioral Health Link
BHWDP	Behavioral Health Workforce Development Project
BIPOC	Black, Indigenous, (and) People of Color
BOS	Board of Supervisors
CAHOOTS	Crisis Assistance Helping Out On The Streets
CalAIM	California Advancing and Innovating Medi-Cal
CalOES	California Office of Emergency Services
CAMH	CMS Alliance to Modernize Healthcare
CANS	Children and Adolescent Needs and Strengths instrument
CAQH	Council for Affordable Quality Healthcare
CARF	Commission on the Accreditation of Rehabilitation Facilities
CARS	Center for Applied Research Solutions
CAT	Crisis Assessment Tool
CCC	Cultural Competency Committee
CCO	Coordinated Care Organization
CCPR	Cultural Competency Plan Requirements
CCSS	Comprehensive Community Support Service
CDSS	California Department of Social Services
CEO	Chief Executive's Office
CFR	Code of Federal Regulations
CIP	Crisis Intervention Program
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services

CLWA	Clinical Institute on Withdrawal Assessment
CCBHC	Certified Community Behavioral Health Clinic
CMCS	Center for Medicaid and CHIP Services
CMHC	Community Mental Health Center
CMHP	Community Mental Health Program
CMS	Centers for Medicare and Medicaid
CPI	Crisis Prevention Institute
CQI	Continuous Quality Improvement
CRC	Crisis Receiving Center
CRDP	California Reducing Disparities Report
CRISES	Crisis Reliability Indicators Supporting Emergency Services
CRTP	Crisis Residential Treatment Programs
CSECY	Commercial Sexually Exploited Children and Youth
CSG	Council of State Governments
CSU	Crisis Stabilization Unit
DCFS	Department of Child and Family Services
DH	Didi Hirsch Mental Health Services
DHCS	Department of Health Care Services
DHS	Department of Health Services
DHHS	U.S Department of Health and Human Services
DMH	Department of Mental Health
DPH	Department of Public Health
ED	Emergency Department
EHR	Electronic Health Record
ELM	Empaneled Life Management
EMPRN	Emergency Practice Research Network
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ERS	Enriched Residential Service
ERT	Emergency Response Team
ESN	Emergency Service Number
FAQ	Frequently Asked Questions
FCC	Federal Communications Commission
FFRDC	Federally Funded Research and Development Center
FFS	Fee-for-Service
FGI	Facility Guidelines Institute
FMAP	Federal Medical Assistance Percentages
FOCUS-PDCA	Find, Organize, Clarify, Understand, Select - Plan, Do, Check, and Act
FSP	Full Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
GPS	Global Positioning System

HIPAA	Health Information Portability and Accountability Act
HOME	Homeless Outreach Mobile Engagement
ICP	Initiative for Community Psychiatry
IDD	Intellectual and Developmental Disability
IP	Inpatient
IPA	Independent Practice Association
IPS	Individual Placement and Supports
IOP	Intensive Outpatient Program
IMD	Institution of Mental Disease
ITP	Interpreter Training Program
KPI	Key Performance Indicator
LA-HOP	Los Angeles Homeless Portal
LAN	Health Care Payment Learning & Action Network
LANES	Los Angeles Network for Enhanced Services
LAPD	Los Angeles Police Department
LASD	Los Angeles Sheriff's Department
LASHA	Los Angeles Homeless Services Authority
LET	Law Enforcement Team
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer
LOCUS	Level of Care Utilization System
LPS	Lanternman-Petris-Short
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MET	Mental Evaluation Team
MH	Mental Health
MHBG	Mental Health Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MHUCC	Mental Health Urgent Care Center
MHRLN	Mental Health Resource Locator and Navigator
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
WLMRSS	Mobile Response and Stabilization Service
MSAG	Master Street Address Guide
NASMHPD	National Association of State Mental Health Program Directors
NG911	Next Generation 911
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPO	Non-Profit Organization
NSPL	National Suicide Prevention Lifeline
OEI	Office of Equity and Inclusion
OP	Outpatient

OUD	Opioid Use Disorder
OVP	Public Health Office of Violence Prevention
PAD	Psychiatric Advance Directive
PAD	Paramedic Alternative Destination Program
PCTS	Patient/Client Transition Service
PDS	Peer Delivered Services
PET	Psychiatric Emergency Team
PHF	Psychiatric Health Facility
PHP	Partial Hospitalization Program
PHS	Permanent Supportive Housing
PMCH	Police-Mental Health Collaboration
PMHP	Public Mental Health Partnership
PMHS	Public Mental Health System
PMRT	Psychiatric Mobile Response Team
PNP	Psychiatric Nurse Practitioner
PPfW	Public Partnership for Wellbeing
PRN	Pro Re Nata (as needed)
PSAP	Public Safety Answering Points
PSH	Permanent Supportive Housing
PTSD	Post-Traumatic Stress Disorder
PUCC	Psychiatric Urgent Care Center
PWIDD	Person With an Intellectual and Developmental Disorder
QMP	Quality Management Plan
QMHA	Quality Mental Health
Associate QMHP	Quality Mental Health Professional
RBC	Residential and Bridging Care
RCV	Restorative Care Village
RHBA	Regional Behavioral Health Authority
RED	Real Estate Division
RI	RI International
ROI	Return on Investment
RSA	Recovery Services Administrator
RTF	Residential Treatment Facility
RFP	Request for Proposals
RTT	Ready to Transition
SALT	Service Area Leadership Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SASH	Substance Abuse Service Hotline
SC	Sobering Center
SDoH	Social Determinants of Health
SE	Supported Education
SFTP	Secure File Transfer Protocol

SMART	System-wide Mental Assessment Response
Team SME	Subject Matter Expert
SPA	State Plan Amendment
SPC	Didi Hirsch Suicide Prevention Center
START	Substance Treatment and Reentry Transition Program
STRF	Secure Residential Treatment Facility
SMI	Severe Mental Illness
SOW	Scope of Work
SPA	Service Planning Area
SPMI	Serious and Persistent Mental Illness
SPRC	Suicide Prevention Resource Center
SRAS	Suicide Risk Assessment Standards
SUD	Substance Use Disorders
TAC	Technology Assisted Care
TAC	Technical Assistance Collaborative
TAY	Transitional Age Youth
TTP	Therapeutic Transport Program
TIP	Treatment Improvement Protocol
UM	Utilization Management
UPS	Universal Power Supply
URAC	Utilization Review Accreditation Commission
UsCC	Underserved Cultural Committee
WET	Workforce Education and Training

Appendix B: References

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Appendix C: The National and California Context for 988 Implementation

National Context

In response to the emerging consensus that the U.S. has been increasingly in need of a behavioral health (BH) crisis response system to be on par with the 911 emergency medical response system, the following national policy developments were initiated:

- August 2018: The National Suicide Hotline Improvement Act (H.R.2345) became law. This initial legislation called on the Federal Communications Commission (FCC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to report on the feasibility of designating a three-digit dialing code for the National Suicide Prevention Lifeline ("Lifeline," 1-800-273-8255).
- August 2019: The Federal Communication Commission (FCC), in conjunction with SAMHSA, indicated that the 988 dialing code would be the optimal three-digit number for the Lifeline and that additional resource would be necessary to support crisis contact centers responding to 988 callers.
- October 2019: The National Suicide Hotline Designation Act (S.2661) was introduced to support the designation and implementation of the 988 dialing code and strengthen local crisis response capacity to meet 988-service demand. Local crisis contact centers have been chronically underfunded and under-resourced; many localities are not equipped to respond to current crisis call volume, much less, any projected increases once 988 becomes widely available.
- July 2020: The FCC officially designated 988 as the three-digit dialing code for the Lifeline — to be nationally available by July 2022.
- September-October 2020: During September Suicide Prevention Month, the National Suicide Hotline Designation Act passed through Congress unanimously. The President signed it into law in October 2020, calling on legislation to be enacted in all fifty states and D.C. to support 988 implementation and establish a sustainable funding mechanism for the 988-crisis response system as allowed for in federal law.
    - The (federal) National Suicide Hotline Designation Act included language allowing each state to pass their own legislation funding 988 the same way as 911, through state-managed monthly customer service fees.
    - The federal law allows for the revenue generated by these fees to go toward funding local crisis centers and supporting the development and implementation of wraparound crisis care services. Current 911 fees vary by state, between $.25 and $5.00; some state fees are charged on a percentage basis.
    - Ideally, fees will be collected across all wireless and wireline providers in each state.
- January 2021: States received 988 Implementation Planning Grants from Vibrant Emotional Health (Vibrant), administrators of the National Suicide Prevention Lifeline (Lifeline). Through this grant opportunity U.S. states, territories, and Lifeline centers received grant awards and were expected to:

- Develop clear roadmaps for how they will address key coordination, capacity, funding and communication strategies that are foundational to the launching of 988, which will occur on or before July 16, 2022.
- Plan for the long-term improvement of in-state answer rates for 988 calls.
- The 988-crisis response system is expected to consist of:
  - Well-resourced crisis contact centers that are able to answer callers quickly and effectively in-state 24/7/365 and follow up as needed.
  - Mobile crisis outreach teams and crisis stabilization centers that work together with crisis contact centers to provide the full continuum of crisis care.
  - Flexible and sustainable funding options — including federal appropriations, state appropriations, grants, and service fees that ensure standard quality and delivery of services across the country.
  - Public education and awareness campaigns that promote the new 988 number and the availability of crisis services; and that encourage and normalize seeking help for mental health and suicide crises.
  - Robust administration and reporting of 988 services. Oversight of services provided and populations served will facilitate greater understanding of the 988 crisis care continuum and support a quality, standardized service for callers in need.
- April 2022: States received SAMHSA's FY 2022 Cooperative Agreements for States and Territories to Build Local 988 Capacity, and California was awarded $14,488,135.

California Context

Didi Hirsch Mental Health Services was the recipient of California's 988 Implementation Planning Grant, in the amount of $335,000, with the intent that it would participate in the development of strategic plans for California in preparation for the projected infrastructure needs, volume growth, and access to the Lifeline's new 988 number. Under this grant, Didi Hirsch was expected to work alongside twelve (12) other Lifeline Crisis Centers in California to develop clear roadmaps to address coordination, capacity, funding, and communications surrounding the launch of 988, in collaboration with state leadership, suicide prevention experts, people with lived experience, and others to create a California 988 implementation plan and support Lifeline's operational, clinical, and performance standards that allow access to care. To ensure that the implementation plan will allow California to be ready for the nationwide July 16, 2022 launch, the grant required Didi Hirsch to:

- Start planning for the 988 line on February 1, 2021, and end in September 1, 2021; and
- By Dec. 30, 2021, submit a final plan to both Vibrant and the Substance Abuse and Mental Health Services Administration (SAMHSA), the branch of the U.S. Department of Health and Human Services that oversees and funds for the National Suicide Hotline.

These timelines were later modified by Vibrant, and as a result, Didi Hirsch submitted its Interim 988 Implementation Plan prior to September 30, 2021 and the final report prior to January 21, 2022.

The California Legislature attempted in 2021 to respond to the needs associated with 988 implementation, with the introduction of AB 988 which would have assessed a phone surcharge to fund 988 implementation to include the crisis response services necessary to respond to 988 calls, texts, and chats. However, this measure failed to pass in 2021. In lieu of this development, on September 4, 2021 the Department of Health Care Services (DHCS) announced that it would invest $20 million in California's network of emergency call centers to support the launch of 988. On March 7, 2022, this allocation was made from the SAMHSA Mental Health Services Block Grant. This allocation was the basis for the signing of a contract between DHCS and Didi Hirsch to support California's network of thirteen (13) local and regional crisis contact centers, to expand their respective capacity for the launch of 988. With this funding, additional infrastructure will be developed and deployed at these 988 crisis centers to meet the significant increased demand. Aligned with the realities of disproportionate need, a special focus in the use of this funding will be on serving several populations: the young; Black, Indigenous, and people of color (BIPOC); and LGBTQ+ identifying individuals.

California's Department of Health Care Services (DHCS) received a SAMHSA FY 2022 Cooperative Agreement for States and Territories to Build Local 988 Capacity, in the amount of $14,488,135. CA has committed to partner with Didi Hirsch Mental Health Services to oversee workforce expansion, training, data collection and analysis, and collaboration among California's thirteen (13) Lifeline Crisis Centers in preparation for the launch of 988. DHCS will work with Didi Hirsch to develop plans that ensure all Lifeline Crisis Centers throughout the state have the appropriate workforce, technology, and other capacity needs to meet the anticipated increase in call, chat, and text volume.

As the nation's most populous state, California experiences the largest amount of calls to the National Suicide Prevention Lifeline (NSPL). In 2020, about one (1) out of eight (8) calls to the Lifeline originated in CA. Of 304,222 calls, twenty percent (20%) were transferred to the Veteran's Crisis Line and 8,810 were handled through the Spanish Language Line. Between 2016 and 2020, CA Lifeline volume increased 67%. The anticipated demand for calls, chats, and texts from CA for the first year of 988 implementation is 899,100. This represents nearly a three-hundred percent (300%) increase from the 312,261 calls, chats, and texts originating throughout the State during 2021.

To handle the 1.5 million expected call, chat, and text volume throughout the two-year project period, DHCS is distributing funds to each crisis contact center and coordinating statewide planning to ensure the adoption of consistent policies and procedures that maximize the effectiveness of behavioral health (BH) crisis services throughout CA, including the ability of all thirteen (13) call centers to link 988 callers with 911 and relevant local BH services. By the end of the grant period, DHCS intends to meet the following goals and objectives with the support of Didi Hirsch Mental Health Services as its lead partner:

- Goal 1: Recruit, hire, and train the BH workforce to staff CA's Lifeline crisis centers to respond, intervene, and provide follow-up to individuals experiencing a BH crisis.
  - Objective 1.1: DHCS will directly support the workforce of state selected Lifeline crisis centers via subcontracts to ensure 100% state or territory coverage of calls and greater than 90% answer rate by end of grant.

  - Objective 1.2: By June 2023, staff and volunteers at each 988 crisis call center will have access to a statewide directory of BH resources (e.g. BH Access Lines, crisis lines, warm lines, behavioral health crisis triage services, peer warm lines, and health plans) for information, linkage, and referrals when appropriate.
- Goal 2: Engage Lifeline crisis centers to unify 988 response across CA.
  - Objective 2.1 By April 2022, DHCS will develop and disseminate a standard data collection and analysis protocol among the 988 call centers.
- Goal 3: Expand CA's crisis call center staffing and response structure needed for the successful implementation of 988.
  - Objective 3.1 By July 2022, all 988 crisis call centers will answer at least 90% of in state calls.
  - Objective 3.2 By July 2023, all 988 crisis call centers will provide at least 8 hours of chat/text services.

The CA FY2022-2023 budget proposal builds on existing Medi-Cal expansions and includes $108 million in total funds ($16 million in General Funds) to add community-based mobile crisis intervention services as a new Medi-Cal benefit. The American Rescue Plan Act of 2021 (ARPA), one of the federal COVID relief packages enacted by Congress, authorizes 85% federal matching funds for twelve (12) quarters during a five-year period for states to implement a "qualifying community-based mobile crisis intervention services" option in their Medicaid programs starting April 1, 2022.

Community-based mobile crisis intervention services are crisis intervention services provided to individuals experiencing a BH crisis whenever and wherever the service is needed. In California, "Crisis Intervention" is defined as "a service, lasting less than 24 hours, to or on behalf of a beneficiary, for a condition that requires more timely response than a regularly scheduled visit."

To meet the "qualifying" requirement, community-based mobile crisis intervention services must be:

- Provided to a Medicaid beneficiary who is experiencing a BH disorder crisis;
- Provided outside of a hospital or other facility setting;
- Furnished by a multi-disciplinary mobile crisis team that consists of at least one BH care professional capable of conducting an assessment of the individual and other professionals or paraprofessionals with appropriate expertise in BH crisis response (e.g. nurses, social workers, peer support specialists, etc.); and
- Available 24 hours per day, every day of the year.

Additionally, the mobile crisis team members must:

- Be trained in trauma-informed care, de-escalation strategies, and harm reduction;
- Be capable of responding in-person to the crisis in a timely manner;
- Be able to provide services, such as screening and assessment, stabilization and de-escalation, as well as follow-up care coordination, referrals, and transportation assistance as needed; and

- Maintain the privacy and confidentiality of patient information and relationships with relevant community partners.

Starting as soon as January 1, 2023, California will consider the option, in its Medicaid state plan, to provide mobile crisis intervention service for beneficiaries with BH conditions as a mandatory Medi-Cal benefit. DHCS plans to implement this benefit through county BH delivery systems by community-based multidisciplinary mobile crisis teams. In 2022, the state will also develop a plan to support connections between the various prevention and intervention systems, including hotlines, 988 crisis contact centers, peer support services, and mobile crisis service response.

In 2021, DHCS launched the Behavioral Health Continuum Infrastructure Program (BHCIP) and announced that it would release funding through six grant rounds targeting gaps that have been identified in the state's BH facility infrastructure. BHCIP released two rounds in 2021 including:

- Round 1: Mobile Crisis Team (MCT) Services for a total of $205 million in one-time funding. Of this amount, LAC received $51.8 million with approximately 75% of these funds being directed toward MCT infrastructure and equipment needs, and the balance towards MCT service delivery to those ineligible for Medi-Cal.
- Round 2: County and Tribal Planning Grants for a total of $16 million to expand the entire continuum of care for people with BH conditions. LAC received $300K under this round with 50% going to DMH and the other 50% to DPH.

The remaining BHCIP rounds to be released in 2022 include:

- Round 3: Launch Ready Projects for a total of $518.5 million. These grants provide funding for launch-ready projects to construct, acquire, and rehabilitate real estate assets to expand the BH continuum of treatment and service resources in settings serving Medicaid beneficiaries. For distribution purposes under this round of funding, LAC is considered to be a region and qualified for a $130 million award for launch-ready capital projects that will be used for facility-based crisis services. It is anticipated that an additional $120 million will be available under Round 3 that will be competitively bid and will allow applicants who require more time to develop their application.
- Round 4: Children and Youth for a total of $480.5 million which has not been released.
- Round 5: BH Needs Assessment Phase One for a total of $480 million which has not been released.
- Round 6: BH Needs Assessment Phase Two for a total of $480 million which has not been released.

In essence, the confluence of national and state crisis care policy developments, with the Los Angeles County's ATI and ACR policy initiatives, have created the "perfect storm." A significantly enriched environment has been created within which LAC's crisis response system can be better aligned with the National Guidelines to appropriately serve anyone, anytime and anywhere, who is experiencing a BH crisis.

Appendix D: Erlang C Projections

2023							
Full Time Staff Required	Erlang C FTE Call Agents Only	Supervisor	Manager	Trainer	HR Gen	IT Support	Total FTE Erlang C Model
for 95% Service Level	88.03	11.00	2.20	2.93	2.08	4.25	110.50
For 100% Service Level	113.05	14.13	2.83	3.77	2.68	5.46	141.91

2024							
Full Time Staff Required	Erlang C FTE Call Agents Only	Supervisor	Manager	Trainer	HR Gen	IT Support	Total FTE Erlang C Model
for 95% Service Level	94.68	11.83	2.37	3.16	2.24	4.57	118.84
For 100% Service Level	122.15	15.27	3.05	4.07	2.89	5.90	153.33

2025							
Full Time Staff Required	Erlang C FTE Call Agents Only	Supervisor	Manager	Trainer	HR Gen	IT Support	Total FTE Erlang C Model
for 95% Service Level	124.08	15.51	3.10	4.14	2.94	5.99	155.75
For 100% Service Level	156.80	19.60	3.92	5.23	3.71	7.57	196.83

2026							
Full Time Staff Required	Erlang C FTE Call Agents Only	Supervisor	Manager	Trainer	HR Gen	IT Support	Total FTE Erlang C Model
for 95% Service Level	151.90	18.99	3.80	5.06	3.59	7.33	190.68
For 100% Service Level	193.55	24.19	4.84	6.45	4.58	9.34	242.96

2027							
Full Time Staff Required	Erlang C FTE Call Agents Only	Supervisor	Manager	Trainer	HR Gen	IT Support	Total FTE Erlang C Model
For 95% Service Level	179.81	22.48	4.50	5.99	4.26	8.68	225.72
For 100% Service Level	215.25	26.91	5.38	7.18	5.09	10.39	270.20

2023 - Data Elements	
Total Contacts per Year	297,100
Average Handling Time	25 Minutes
Target Answering Time	20 Seconds
Shrinkage	16%
Max Occupancy	85%

"Time slot beginning (enter start time in top cell)"	Incoming calls	Agents Required for 95% Service Level	Agents Required for 100% Service Level
8:00	29.8	19	25
9:00	40.6	25	31
10:00	48.0	28	36
11:00	52.3	30	39
12:00	53.3	31	39
13:00	54.4	31	40
14:00	54.1	31	40
15:00	54.1	31	40
16:00	52.2	30	39
17:00	46.3	27	35
18:00	42.0	25	33
19:00	38.5	23	30
20:00	35.4	22	28
21:00	33.0	21	26
22:00	29.7	19	25
23:00	25.4	17	21
0:00	21.8	15	20
1:00	19.9	14	18
2:00	16.9	13	16
3:00	13.3	10	14
4:00	11.5	9	11
5:00	11.3	9	11
6:00	12.3	10	13
7:00	17.6	13	18

2024 - Data Elements	
Total Contacts per Year	323,100
Average Handling Time	25 Minutes
Target Answering Time	20 Seconds
Shrinkage	16%
Max Occupancy	85%

"Time slot beginning (enter start time in top cell)"	Incoming calls	Agents Required for 95% Service Level	Agents Required for 100% Service Level
8:00	32.4	20	26
9:00	44.2	26	34
10:00	52.3	30	39
11:00	56.8	33	41
12:00	58.0	33	43
13:00	59.2	34	43
14:00	58.8	34	43
15:00	58.8	34	43
16:00	56.8	33	41
17:00	50.4	29	38
18:00	45.7	27	35
19:00	41.8	25	33
20:00	38.5	24	30
21:00	35.9	22	29
22:00	32.4	20	26
23:00	27.6	18	24
0:00	23.7	16	21
1:00	21.7	15	20
2:00	18.4	13	16
3:00	14.5	11	15
4:00	12.5	10	13
5:00	12.3	10	13
6:00	13.4	10	14
7:00	19.1	14	18

2025 - Data Elements	
Total Contacts per Year	444,756
Average Handling Time	25 Minutes
Target Answering Time	20 Seconds
Shrinkage	16%
Max Occupancy	85%

"Time slot beginning (enter start time in top cell)"	Incoming calls	Agents Required for 95% Service Level	Agents Required for 100% Service Level
8:00	44.6	27	34
9:00	60.8	35	44
10:00	71.9	40	50
11:00	78.3	43	54
12:00	79.8	44	55
13:00	81.5	44	56
14:00	81.0	44	56
15:00	81.0	44	56
16:00	78.2	43	54
17:00	69.3	39	49
18:00	62.9	36	45
19:00	57.6	33	43
20:00	53.0	31	39
21:00	49.4	29	36
22:00	44.5	27	34
23:00	38.0	23	30
0:00	32.7	21	26
1:00	29.8	19	25
2:00	25.3	17	21
3:00	20.0	14	18
4:00	17.2	13	16
5:00	16.9	13	16
6:00	18.5	13	16
7:00	26.3	17	23

2026 - Data Elements	
Total Contacts per Year	566,413
Average Handling Time	25 Minutes
Target Answering Time	20 Seconds
Shrinkage	16%
Max Occupancy	85%

"Time slot beginning (enter start time in top cell)"	Incoming calls	Agents Required for 95% Service Level	Agents Required for 100% Service Level
8:00	41.6	25	43
9:00	38.0	23	40
10:00	32.3	20	35
11:00	25.4	17	28
12:00	21.9	15	25
13:00	21.5	15	25
14:00	23.5	16	28
15:00	33.5	21	37
16:00	56.8	33	55
17:00	77.5	42	72
18:00	91.6	49	83
19:00	99.7	53	88
20:00	101.6	54	90
21:00	103.8	55	92
22:00	103.2	55	92
23:00	103.1	54	92
0:00	99.5	53	88
1:00	88.3	47	80
2:00	80.1	44	73
3:00	73.3	40	68
4:00	67.5	38	63
5:00	62.9	35	60
6:00	56.7	33	55
7:00	48.4	28	48

2027 - Data Elements	
Total Contacts per Year	688,068
Average Handling Time	25 Minutes
Target Answering Time	20 Seconds
Shrinkage	16%
Max Occupancy	85%

"Time slot beginning (enter start time in top cell)"	Incoming calls	Agents Required for 95% Service Level	Agents Required for 100% Service Level
8:00	69.1	39	46
9:00	94.1	50	61
10:00	111.3	58	70
11:00	121.1	63	75
12:00	123.4	64	76
13:00	126.1	65	79
14:00	125.3	65	77
15:00	125.3	65	77
16:00	120.9	63	75
17:00	107.3	57	68
18:00	97.4	52	62
19:00	89.1	48	57
20:00	82.0	44	54
21:00	76.4	42	50
22:00	68.9	39	46
23:00	58.8	34	40
0:00	50.6	30	36
1:00	46.2	27	33
2:00	39.2	24	29
3:00	30.9	20	24
4:00	26.6	18	21
5:00	26.1	17	21
6:00	28.6	19	23
7:00	40.7	25	30

Appendix E: Los Angeles County Crisis Capacity Modeling

LA County *Crisis Now* Crisis System Calculator		
	Child/Adolescent	Adult
# of Crisis Episodes Annually (200/100,00 Monthly)	51,432	188,904
# Initially Served by Acute Inpatient	7,200	26,447
# Referred to Acute Inpatient From Crisis Facility	2,899	10,476
Total # of Episodes in Acute Inpatients	10,099	36,923
# of Acute Inpatient Beds Needed	**231**	**843**
Total Cost of Acute Inpatient Beds	**$77,409,453.18**	**$283,012,495.58**
# Referred to Crisis Bed From Stabilization Chair	11,594	41,904
# of Short-Term Beds Needed	**106**	**383**
Total Cost of Short-Term Beds	**$26,783,134**	**$96,799,190**
# Initially Served by Crisis Stabilization Facility	27,773	102,008
# Referred to Crisis Facility by Mobile Team	5,354	17,719
Total # of Episodes in Crisis Facility	33,127	119,727
# of Crisis Receiving Chairs Needed	**85**	**309**
Total Cost of Crisis Receiving Chairs	**$33,541,031**	**$121,223,475**
# Served Per Mobile Team Daily (10 hour shift)	2.5	2.5
# of Mobile Teams Needed	**27.45**	**90.86**
Total # of Episodes with Mobile Team	17,846	59,062
Total Cost of Mobile Teams	**$8,922,818**	**$29,530,976**
$ of Unique Individuals Served	**51,432**	**188,904**
TOTAL Inpatient and Crisis Cost	**$146,656,437**	**$530,566,137**

Appendix F: Stakeholder Participation and Inputs

Under this project, RI was tasked with completing an inventory of existing crisis system resources to include stakeholder perceptions of community need and the identification of opportunities to best meet the need. Toward meeting this expectation, RI engaged in one-hundred and fifteen (115) key stakeholder meetings that were centered on BH crisis care, with community members from both the public and private sectors from across LAC. These stakeholder groups included: community members, peer service organizations, crisis contact centers, mobile response agencies, crisis receiving centers, crisis residential providers, county departments, infrastructure representatives, outpatient programs, hospitals/EDs, local jurisdictions, school systems, Fire/EMS, and law enforcement.

In each of these meetings, there was a brief presentation on the work of RI, the National Guidelines, and the purpose of this consultancy. What resulted was typically a spirited discussion around the application of the National Guidelines, community expectations, an expression of opinions regarding the existing crisis service components, and beliefs about the quality of crisis care. These meetings also provided an opportunity for participants to ask questions, share perspectives, and express any frustrations regarding the current crisis response system and the proposed ACR. These initial meetings served to rally support for ACR system optimization through the lens of the National Guidelines.

The stakeholder engagements that were convened were accomplished in consultation with and facilitated by DMH and included representatives from the following organizations:

- ACR Budget & Finance Committee
- ACR Cultural Competence Committee
- Alternative Crisis Response Marketing Committee
- Alternatives to Incarceration Board of Supervisor Deputies
- Alternative to Incarceration Community Cabinet
- Ballmer Group
- California Advancing and Innovating Medi-Cal
- California Governor's Office of Emergency Services
- Chief Executive Office-Alternatives to Incarceration
- Community Based Organizations-Behavior Health
- County Behavioral Health Directors Association of California
- Department of Health Services (Hospitals & EDs)
- Department of Mental Health
- Department of Mental Health Access Helpline
- Department of Mental Health County Finance
- Department of Mental Health Information Technology
- Department of Mental Health Psychiatric Mobile Response Teams
- Department of Mental Health Service Area Leadership Teams
- Department of Public Health-Substance Abuse Prevention and Control
- Didi Hirsch Mental Health Services

- Emergency Medical Services Agency
- Exodus Recovery
- Glendale Police Department
- Kennedy Forum
- Los Angeles County Fire Department
- Los Angeles County School System
- Los Angeles Fire Department
- Los Angeles Police Department
- Los Angeles Sheriff's Department
- San Gabriel Valley Council of Governments
- Self-Help And Recovery Exchange
- Stars
- Star View
- Steinburg Institute
- Youth Justice Reimagined

Within these various group engagements were representatives from the following organizations:

- Underserved Cultural Communities (UsCC)
- American Indian/Alaska Native (UsCC)
- Asian Pacific Islander (UsCC)
- Black and African Heritage (UsCC)
- Eastern European/Middle Eastern (UsCC)
- Latino (UsCC)
- LGBTQIA-S (UsCC)
- CIELO (Comunidades Indigenas en Liderazgo)
- Sycamores-a better life
- Huma House
- Modality Org, Inc.
- Twin Town Treatment Centers
- Mind Body and Spirit Counseling Services
- NAMI
- Integrated Recovery Network
- UCLA Mednet
- 1st Home For You
- UNITE-LA
- Community Build
- The Bail Project
- ACLU of Southern California
- LA County Public Defender
- Project Caring

- Probation Los Angeles County
- Heritage Group Homes
- Vera
- Homeboy Industries
- Reclaim Possibility LLC
- LISC-LA (Local Initiatives Support Corporation)
- Youth Advocate Programs Inc.
- Community Reflections Inc.
- Human Development an d Community Services
- Love Home Inc.
- Center for Living and Learning
- Youth Justice Coalition

Individual meetings were also convened with:

- Fesia Davenport, CEO, of Los Angeles County
- Judge Songhai Armstead, Executive Director of the Alternative to Incarceration Initiative
- Captain John Gannon, LA County Sheriff's Department
- Captain Brian S. Bixler, Commanding Officer, Detective Support and Vice Division
- Dr. Clayton Kazan, Medical Director, LA County Fire Department
- Dr. Saman Kashani, Assistant Medical Director, LA County Fire Department

The following individuals were convened as a group:

- Chad Druten, President, LA County Ambulance Association
- Eric Garcia, Fire Chief, Burbank Fire Department
- Richard Tadeo, Assistant Director, LA County EMS Agency
- Dr. Stephen Sanko, Acting Medical Director, EMS Bureau, LAC Fire Department
- Captain Aaron Guggenheim, Los Angeles City Fire Department
- Chief W. Paul LeBaron, City of Hermosa Beach Police Department
- Lt. Landon Phillips, Hermosa Beach Police Department
- Chief Kelly Gordon, Monterey Park Police Department
- Chief Shelly Vanderveen, Claremont Police Department

It was evident, within each meeting and across meetings, that there exists an overwhelming sense of community pride in LAC that is accompanied by a strong commitment to significantly improving the response to those in crisis. LAC currently possesses some of the foundational components of a crisis response system, as outlined in the National Guidelines; however, there appears to be considerable fragmentation, duplication, and inefficiency that impact the effectiveness of the crisis response system across LAC. Therefore, the crisis response system needs to be re-engineered in order to achieve the benefits that can accrue from a fully optimized ACR system.

The specific stakeholder inputs from these engagements are delineated below:

- Deaf and hard of hearing people in LAC get arrested & shot when we call DMH PRMT or 911 and yet for this meeting we don't have CART or ASL for DMH consumers and community. We don't even have DMH services for our deaf and hard of hearing folks. And when we request ADA disability accommodations for this meeting we are left out? Some of our deaf and hard of hearing have reported not having ASL services to access DMH emergency services for at least seven months.
- Why RI? There are other peer/disability organizations that have been/are doing this work? How can this group understand the diverse communities of LA County? They are not even part of the peer community in LA or CA? This may hurt us more.
- Latino/Hispanic folks make up the largest ethnic community in LA County and are the largest number of residents. Yet we are not represented at all in this group or by DMH. That is not equity at all when our community is not here.
- Latino/Hispanic people are more likely to get shot and killed by law enforcement in LA County because of lack of DMH services and the lack of representation in this group can only exacerbate that disparity.
- LAC has the largest number of Native American/Alaska Native people in the country. How has this group addressed the special needs of our communities? Has there been consultation with the local tribal nations in LA County?
- The *Crisis Now* difference path is not new or innovative. We know that it fails BIPOC people the most, and it also hurt our LGBTQIA2S+ communities in places like Arizona and other parts.
- In Arizona our immigrant and undocumented American communities fear using this service because of the direct fear of being handed or reported to immigration.
- In Riverside and San Diego, has RI consulted with the Native American tribes in those locations to develop these services? What other disability organizations have it engaged in those areas? How has this group worked to ensure participation and focus of NA/AN, Hispanic, LGBTQIA2s+, and other disability communities?
- How much is this group getting paid for this work? What is the oversight and accountability elements that LA County stakeholders have over this work?
- I am a DMH consumer and they have never reached out to folks like me
- Law enforcement will always escalate the situation. We need a law enforcement free model- that is innovative and what communities want.
- I helped w/ the national bill of the Suicide Lifeline LACDMH consumers representing
- In central CA, a woman called 911 on a Latino man she described as dangerous and unstable. He was shot and killed by law enforcement. The man was not in crisis, he was just a person of color and the woman was afraid of him.
- Is there CART and or captions for this meeting?
- Where are folks w/ lived experience (LACDMH consumers)?

- Deaf and hard of hearing people in LA County get arrested & shot when we call LACDMH PRMT or 911 and yet for this meeting we don't have CART or ASL for our LACMDH consumers and community, We don't even have LACDMH services for our deaf and hard of hearing folks. And yet when we request ADA disability accommodations for this meeting we are left out?
- Some of our deaf and hard of hearing have reported not having ASL services to access LACDMH emergency services for at least 7 months. And yet this meeting leaves us out w/ no accommodations.
- There are more than 2 million people w/ disabilities in LA County. We have one of the largest deaf and hard of hearing populations in the county yet this community stakeholder group is leaving us out.
- Why RI? There are other peer/disability organizations that have been/are doing this work?
- This is not a very diverse team. How can this group understand the diverse communities of LA County? They are not even part of the peer community in LA or CA? This may hurt us more.
- Latino/Hispanic folks make up the largest ethnic community in LA County and are the largest # of residents. Yet we are not represented at all in this group or by this agency. That is not equity at all when our community is not here.
- Latino/Hispanic people are more likely to get shot and killed by law enforcement in LA County because of lack of LACDMH services and the lack of representation in this group can only exacerbate that disparity.
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- I am looking forward to continuing the conversation on inclusion for under-served cultural communities in the crisis conversation.
- Want the crisis system to be data-driven and centered in building trust, peer support network with quality culturally appropriate services.
- Do this crisis analysis for Latino/Latina population and include a percentage graph of African Americans served.
- Is RI contracted to do this work in connection with ATI?
- Is this Crisis team already operating in Los Angeles, or is this team operating in the Carolinas?
- We encourage RI to speak with consumers and peer support specialists here in LA County
- Are there formerly incarcerated people on your team that will be consulting here in LA?
- Steve Balmer is funding this, that's concerning!
- How will the police be held accountable to not simply arrest a person if 911 is called?
- Is there any plan to understand the background that has brought a person to crisis? For example, in LA there are companies that don't pay like the law requires. If you are young and don't know what to expect from an employer, you can get caught in a low-income situation that you may never get out of. This does happen in Los Angeles.
- LA is a big community and they don't all communicate and/or have the same lifestyle. Because of that they need different types of help. What do you do to determine what that of help is right for a specific person?
- What is being done to review and/or change laws about how people with mental health issues that are problematic and are just not working well?
- With social media some people, like cancel culture activists, think they can treat their neighbors and associates. This problem worsens mental health in the community, right? Family and neighbors influence each other's and others mental health. Is there a public education program planned to be included in the Los Angeles RI service?
- There are so many levels of mental health problems. How have you identified them and how do you address them in your RI program. Does a person get transferred from a 988 call to a mental health hotline if they seem not so "crisis" like?
- Is there already a 988 number established here in Los Angeles? Who, specifically, does it respond to, a mom with a crying baby? What happens on the 988 side of the call? I think to comment on how this is developed, we, as "consultants" need to know what the protocols at 988 are.
- How does RI plan to respond to people who call because they are concerned about someone else?
- Before this was implemented in Arizona and the point of this response, what is the effective rate and difference that has been made since being in Arizona?
- What is being done to address the system of care issue? Part of the problem is that there is a gap in services for people with severe mental health issues. The current options are hospitalization and residential treatment for SUD. There is no in-between. We need residential treatment facilities for people with severe mental illnesses without exclusionary criteria. These are the people that are ending up homeless and in jail because there is no system of care for them.

- As outreach and engagement is expanded, treatment options/availability must be expanded. This is inclusive of outpatient and inpatient treatment.
- Are community mental health nonprofits who do community crisis work also being considered stakeholders?
- It's important that it's not only licensed providers whose function is to involuntarily hospitalize people - there need to be paid community members who are doing de-escalation work that is completely voluntary/consent-based as well.
- Please include the LAC Development Authority (Housing Authority) in providing responses to your six questions based on our experiences across the County at sixty-eight housing sites.
- Where does AZ get the $110 million for the Phoenix effort? Can we get at least a basic breakdown of how that budget is spent?
- Are those general funds without any Medicaid reimbursements counted?
- Family members are often the ones who make the initial call for crisis care. Just as the involvement of peers in development of ACR is essential, so is the involvement of their families.
- Plan to fully equip law enforcement dispatch stations in contract cities and cities with their own PD to be fully versed on 988 capacity and are equipped (on the back-end tech) to transfer mental health crisis calls to 988, out of 911.
- Strong relationships need to be established between 988 (Didi Hirsch) and the relevant local mental health service provider based on where caller is located (DMH directly operated, DMH funded agencies, phone-based counseling) to help people access community-based services that have slots available (don't want to refer people to community agencies that have no open slots available).
- Also, ensure that older adult serving community-based agencies are engaged as stakeholders in development and implementation of this crisis model.
- After the program is implemented, does the role of LAC jail system as the largest mental health provider in the county, get smaller? Like, could it be the #2 provider of mental health services? (Happy to be corrected if they are not #1 right now).
- Can you explain the possible funding streams (e.g. the IMD exclusion, the 85/15 split) and possible timelines? And what we can do more immediately.
- I think it's important to challenge ourselves to go beyond interpretation support, and actually recruit diverse community members to field 988 calls. Without their direct involvement, some of the cultural context may be lost in translation, and we may end up perpetuating many of the inequalities that we are seeking to avoid, especially when determining how to refer callers/code responses.
- Inclusion of peers with lived experiences and elements of antiracism training for people that are to be employed for this work also take a look at alternatives to conservatorship for people of color.
- Is there a way to get some of this up and running sooner like a receiving center some possible workarounds and testing this out in the mean-time consider customization of services for West Hollywood.

- Contingency plans as we evolve into the desired system.
- Funding sources for developing ACR, are there sustainable sources being considered for long term growth?
- The tension of tracking decrease in 911 and increase in 988 how to track and funding shifts.
- Law enforcement offers really good pay, so are we thinking of a way to enhance benefits for those in 988 to be comparable
- What is the criteria for peer work force and what type of clinician are you seeking?
- There are no national standards currently in place. There is a need for oversight and guardrails the main priority is to insure people do not get hurt.
- How do we make sure protections of civil rights for people of color? Sometimes people call 911 for racist reasons, which leads to traumatizing contact with law enforcement.
- Families call teams in desperation - it is not up to the mobile team to hospitalize or conserve. I had to conserve my son as he was DTO/DTS.
- We have the staff now that can do this, but we don't have the place to put people some people require an assessment of the people's condition.
- Housing is a greatest issue that we need to figure out money for.
- See that board and care facility funds were received in the process.
- We have not given up hope of a pilot to divert calls to Didi Hirsh seeking a funding source.
- There is an existing work force of existing community-based organizations staffed with credible messengers.
- Clinicians can assist in the training of members of the community
- I want to echo the need for community-based services and housing options and that in board and care settings are not often best and community based options.
- Recruiting people of color those, with experiences of racial trauma and linguistic competency, should be prioritized and living wage payments.

Appendix G: Outcome and Quality Measurements

The Kennedy Forum, in its Issue Brief titled, Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services, presented the following key policy recommendation:

> "All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected."

The reality is that for many systems of care, the usual practice does not include the regular use of validated and quantifiable symptom rating scales in the manner described in the Issue Brief. This point is equally valid when it comes to the delivery of crisis care, which presents its own unique challenges when attempting to engage in meaningful outcome measurement. Stakeholders who participated in Kennedy Forum focus groups identified that a key barrier in implementing measurement-based care, was the lack of knowledge about existing validated symptom rating scales that could be suitable for widespread adoption. To address this barrier, The Kennedy Forum issued a Supplement to its original Issue Brief entitled, *A Core Set of Outcome Measures for Behavioral Health across Service Settings,* to provide clinicians, payers and quality improvement entities with a list of commonly used and validated symptom rating scales. Particularly relevant for measuring outcomes associated with the delivery of crisis care, is that the experts, associated with the development of this Supplemental Brief, were sensitive to workflow integration issues. As a result, the Supplement is focused on validated instruments that can be administered in a brief amount of time. It is recommended that DMH utilize these Kennedy Forum outcome measurement resources as major references when developing an outcome measurement system for its crisis response system.

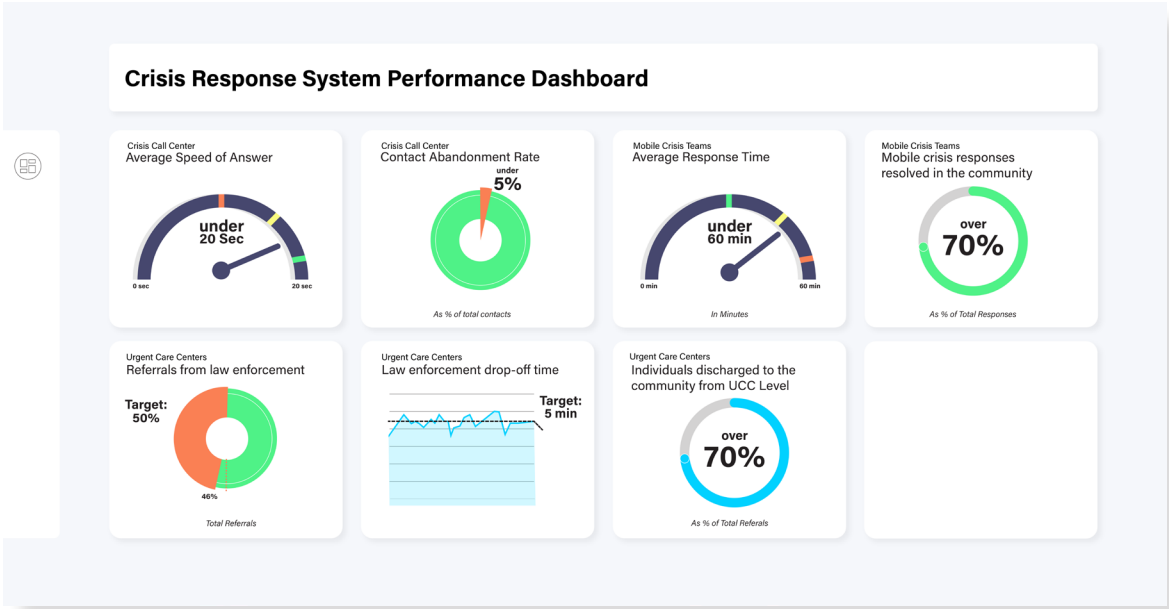
In addition to outcomes measurement, it is equally critical that DMH is able to evaluate how the crisis response system is actually preforming. Toward that aim a listing of KPIs have been developed which appear in the three tables below:

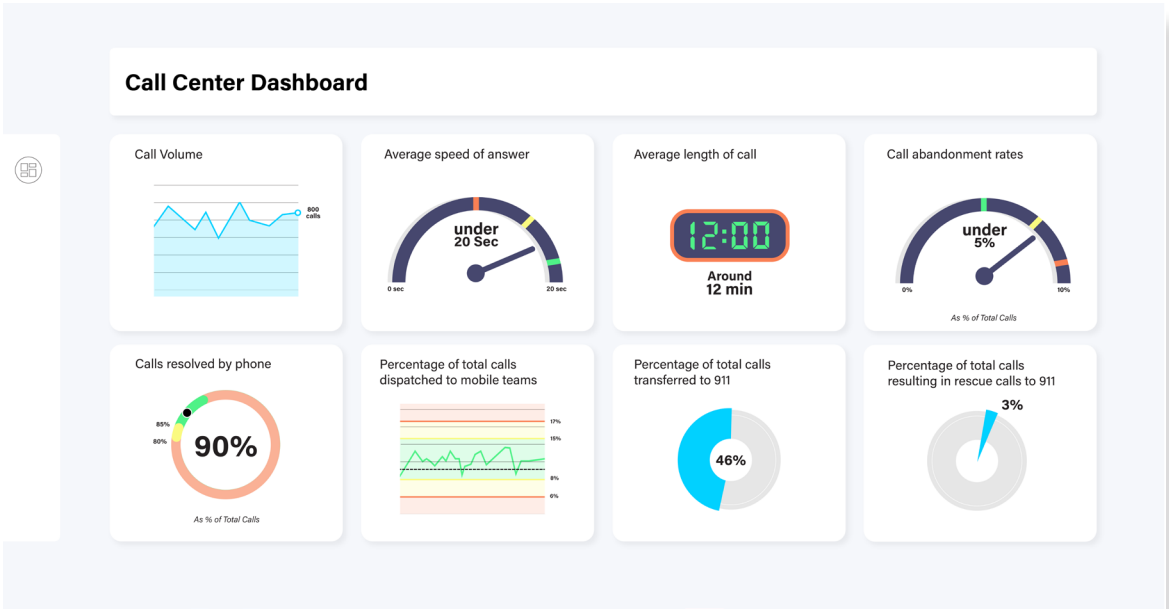
988 Crisis Call Center							
KPI	Unit	Initial Target	Outcome	Disagreg-gated	Accountable Entry	Type of Analysis	Notes
Call volume	Total Number of Calls	Based on Latest		ALL	Multiple	Track	Can predict our own or use Vibrants
Average speed of answer	Under 20 Seconds	Under current		N/A	Provider	Actionable	NSPL - Does not Have Standard - BHL Contract under 30 seconds. Oklahoma Under 20 sec in RFP. Solari 7.73 NSPL 95% under 20 seconds
Average length of call	In Minutes	17 minutes		ALL	Provider	Track	Track for Efficency / NSPL 55% of centers average 11 minutes. Mean is 10.77 Median is 10
Call abandonment rate	As Percentage of Total Calls	Under 5%		N/A	Provider	Actionable	
Perentage of calls resolved by phone	As Percentage of Total Calls Answered	Over 87%		ALL	Provider	Track/Trend then Actionable	Solari / BHL Bath
Mobile Teams Dispatched	As Percentage of Total Call Answered	Under 10%		ALL	Multiple	Track	
911 Transfer Calls	As Percentage of Total Calls Answered	Above 1.5%		ALL	Multiple	Track/Trend then Actionable	Looking at AZ and GA. This should be even lower
Number of Rescue Calls (calls to 911)	As Percentage of Total Calls Answered	Under 3%		ALL	Multiple	Track/Trend then Actionable	
Caller Satisfaction Survey	% favorable	Above 93%		ALL	Provider	Actionable	NSPL Standards for Back-Up - None.

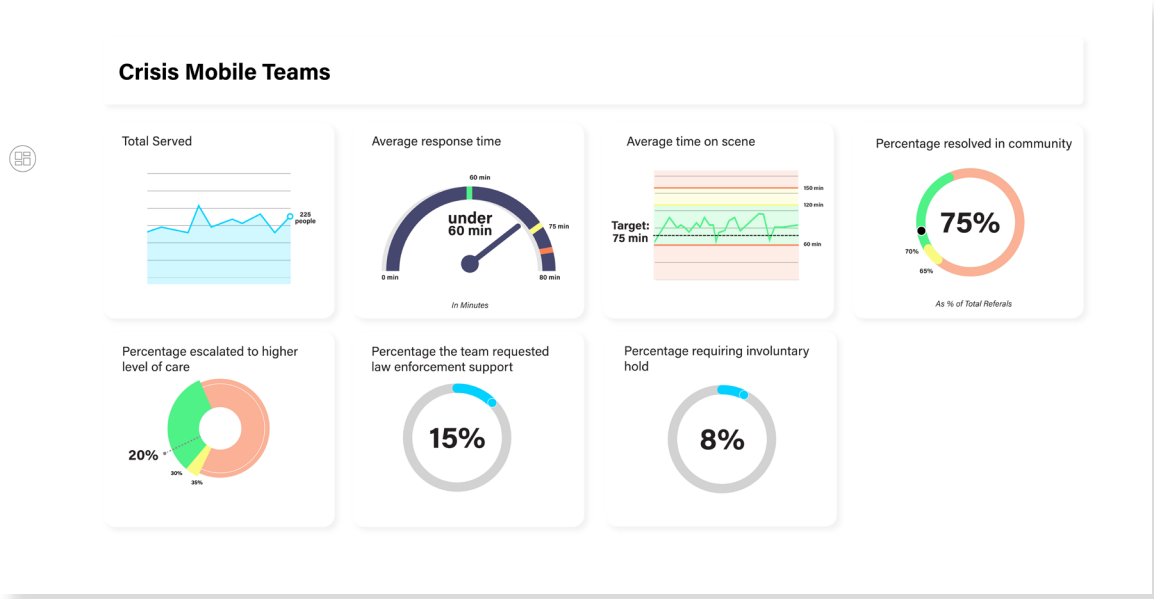
Mobile Crisis Service							
KPI	Unit	Initial Target	Outcome	Disagreg-gated	Accountable Entry	Type of Analysis	Notes
Total Number Served	Total	Based on Latest		All	Call Center / Provider	Track	
Average Time on Scene	In Minutes	Under 480		All	Provider	Track/ Trend Then Actionable	
Average Response Time	In Minutes	Under 60		All	Provider	Actionable	National Guidelines
Calls responded to within 60 minutes	As Percentage of Total Responses	Over 85%		All	Provider	Actionable	Understand Rural
Calls responded to within 120 minutes	As Percentage of Total Responses	Equal to 100%		All	Provider	Actionable	Understand Rural
Longest response time	In Minutes	Under 120		All	Provider	Actionable	
Mobile crisis responses resolved in the community	As Percentage of Total Responses	Over 70%		All	Provider	Track/ Trend Then Actionable	Multiple Exemplars, Need to really think about Stretch
Mobile crisis responses requiring higher level of care	As Percentage of Total Responses	Under 30%		All		Track/ Trend Then Actionable	Should be inverse of metric above
Responses Requiring Involuntary Hold	As Percentage of Total Responses	Under 10%		All	Multiple initially	Track/ Trend Then Actionable	For Civilian - Will need to discuss MET
Total Number of Transports for HLOC	As Percentage of Total HLOC Outcomes	90% of total transport		All	Multiple initially	Track/ Trend Then Actionable	MULTI-MODAL
Total Number of Transports	As Total	TBD		All	Multiple initially	Track	MULTI-MODAL
Total Number of Request for LEO involvement	As Percentage of Total Responses	Under 3% Total Interventions		All	Multiple	Track	MULTI-MODAL

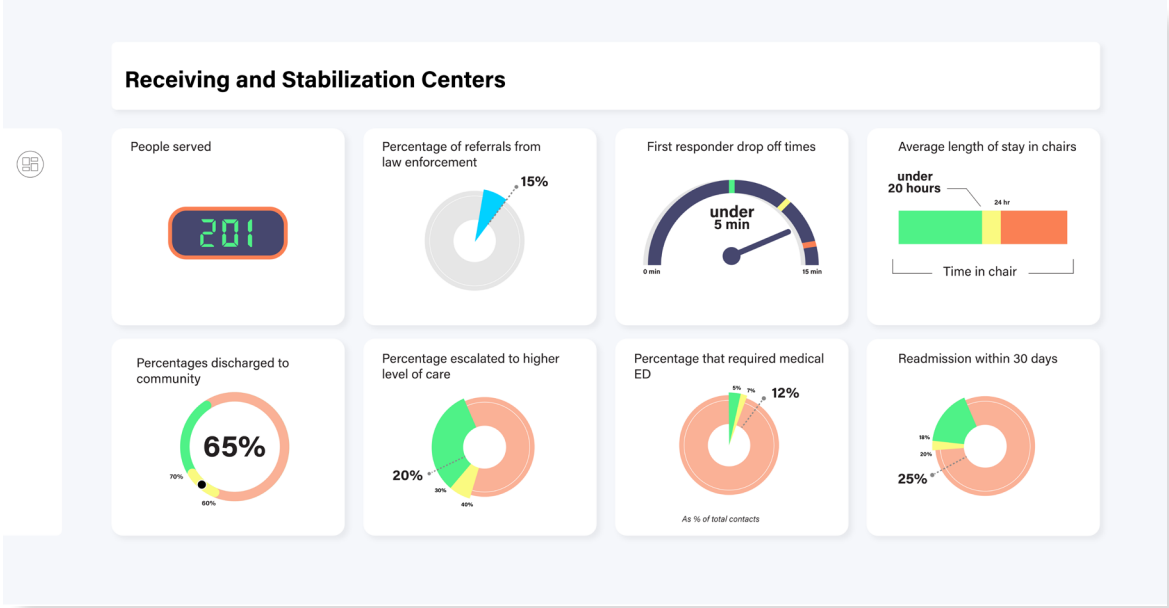
Facility-based Crisis Services							
KPI	Unit	Initial Target	Outcome	Disagreg-gated	Accountable Entry	Type of Analysis	Notes
Individuals served (per chair per 30 day)	Total	Based on Latest		All	Call Center/ MCOT/ Provider	Track	
% of referrals accepted	Percentage of Total Referals	100%		All	Provider	Actionable	SAMSHA, CRISIS NOW
Referrals from law enforcement	Percentage of Total Referrals	No Target		All	Multiple	Track	
Law enforcement drop-off time	Minutes	Under 5		All	Provider	Actionable	SAMSHA, CRISIS NOW
Referrals from EMS	Percentage of Total	TBD		All	Multiple	Track	
EMS drop-off time	Minutes	Under 5		All	Provider	Acitonable	
Average length of stay in Chairs	Hours	Under 20		All	Multiple Initially	Track/Trend Then Action-able	
Individuals discharged to the community from UCC Level	Percentage of Total Referrals	Over 70%		All	Multiple Initially	Track/Trend Then Action-able	
5150/5585 referrals converted to voluntary	Percentage of Total Involuntary Admits	Over 65%		All	Provider	Actionable	AZ Numbers
Referred to ED for medical care	Percentage of Total Admits	Under 4%		All	Multiple Initially	Track	Needs Supporting Actions
Medi-Cal Readmission Rate - Under 3 days	Percentage of people discharged and readmitted within 3 days to a HLOC rolling averages as percentage of total Admits	Under 5%		All	Provider	Actionable	

Medi-Cal Readmission Rate - 4 -20 days	Percentage of people discharged and readmitted within 4 -20days to a HLOC rolling averages as percentage of total Admits	Under 5%		All	Provider/ Community Agencies	Track	
Medi-Cal Readmission Rate - Over 20 days days	Percentage of people discharged and readmitted in over 20 days to a HLOC rolling averages as percentage of total Admits	Under 5%		All	Community Agencies	Track	
% completing an outpatient follow-up visit post discharge	Percentage of discharges seen by a professional within 7 days of D/C	Over 85%		All	Multiple	Track	NEDIS
Total cost of care for crisis episode	Total cost of Facility / number of discharges	TBD		N/A	Provider	Internal	
Guest service satisfaction	Percent of Guests/ Patients that are satisfied or extremely satsified with care	Over 85%		All	Provider	Actionable	
% of individuals reporting improvement in ability to manage future crisis	TBD						
% of completed satisfaction survey	TBD						


Crisis Response System Performance Dashboard
Crisis Call Center
Average Speed of Answer
under 20 Sec
0 sec
20 sec
Crisis Call Center
Contact Abandonment Rate
under 5%
As % of total contacts
Mobile Crisis Teams
Average Response Time
under 60 min
0 min
60 min
In Minutes
Mobile Crisis Teams
Mobile crisis responses resolved in the community
over 70%
As % of Total Responses
Urgent Care Centers
Referrals from law enforcement
Target: 50%
46%
Total Referrals
Urgent Care Centers
Law enforcement drop-off time
Target: 5 min
Urgent Care Centers
Individuals discharged to the community from UCC Level
over 70%
As % of Total Referals


Call Center Dashboard
Call Volume
800 calls
Average speed of answer
under 20 Sec
0 sec
20 sec
Average length of call
12:00
Around 12 min
Call abandonment rates
under 5%
0%
10%
As % of Total Calls
Calls resolved by phone
85%
80%
90%
As % of Total Calls
Percentage of total calls dispatched to mobile teams
17%
15%
8%
6%
Percentage of total calls transferred to 911
46%
Percentage of total calls resulting in rescue calls to 911
3%


Crisis Mobile Teams
Total Served
225 people
Average response time
60 min
under 60 min
75 min
0 min
80 min
In Minutes
Average time on scene
Target: 75 min
150 min
120 min
60 min
Percentage resolved in community
75%
70%
65%
As % of Total Referals
Percentage escalated to higher level of care
20%
30%
35%
Percentage the team requested law enforcement support
15%
Percentage requiring involuntary hold
8%


Receiving and Stabilization Centers
People served
201
Percentage of referrals from law enforcement
15%
First responder drop off times
under 5 min
0 min
15 min
Average length of stay in chairs
under 20 hours
24 hr
Time in chair
Percentages discharged to community
65%
70%
60%
Percentage escalated to higher level of care
20%
30%
40%
Percentage that required medical ED
5%
7%
12%
As % of total contacts
Readmission within 30 days
18%
20%
25%

The KPIs have been incorporated into a set of dashboard designs based on national guidelines and the input of key community stakeholders. Dashboards are only tools to visualize performance data. Their effectiveness depends on how organizations use them to enhance internal performance and external accountability and transparency. DMH should be cognizant of both the strengths and weaknesses of dashboards. Dashboards need to be useful to the DMH's purposes. In internal organizational management, this implies that dashboards are used in the decision-making process. At the external accountability level, use of dashboards means that DMH will be exposing its performance metrics to public scrutiny. In this context, both the dashboard performance measures and the underlying data need to be publicly accessible for credible organizational accountability.
Typically, dashboards display data that is integrated from multiple sources and exhibited in an easy-to-comprehend, informative graphic representation with explanatory text. This allows a reader to understand complex information in less time than it would take to read a full report. At the same time, dashboards are a self-contained explanation.

The dashboards displayed below are simply mock-ups of a crisis response dashboard array that DMH might choose to adopt that are based on the proposed set of best practice KPI's for each core crisis response service. Currently, DMH does not operate on a single comprehensive management platform from which data can be generated to populate performance dashboards for the crisis response system. Therefore, DMH should consider an incremental approach that involves integrating disparate data sources into static monthly reports from which dashboards can be constructed, while more robust reporting platforms are being developed and implemented and can eventually feed dashboards utilizing data in real time.

Appendix H: Crisis Academy Syllabus

LA County Crisis Academy 3-Week Class Syllabus Week One				
	Topic	Hours	Assignment / Reading	Notes
Day 1	**Orientation**	0.5	To be developed by provider	In-Class Activity
	Client/Family Centered Crisis Response Network	3		
	An overview of core training of the crisis system of care in LA County, foundational learning to handle crises, and how to implement into care.			
	Recovery Model	4.5		
	Introduction to recovery model of care and the importance of lived experience; EQ.			
Day 2	**Overview of System of Care** Teaching about how mobile teams, call centers, and facilities all work in one system of care. Provide case examples of crisis care. Overview of interworking of system and how to provide warm hand-offs of care.	8	To be developed by provider	In-Class Activity
Day 3	**Wellness**	8	To be developed by provider	In-Class Activity
	Building resiliency as a crisis services provider, building stress reduction models and tools, and knowledge of resources in community.			
Day 4	**Community Relations** ***Ethics*** Summarize ethical standards and expectations of profession Understanding the brain and human behavior Risk factors for unethical behavior Recognizing and reporting unethical behavior	8	To be developed by provider	In-Class Activity
Day 5	**Community Relations**		To be developed by provider	In-Class Activity
	Diversity & Cultural Competency	8		
	Improving cultural awareness and reducing biases			
	CLAS Standards			

Week Two				
	Topic	Hours	Assignment / Reading	Notes
Day 1	**Community Relations**		To be developed by provider	In-Class Activity
	Customer Service, Workplace Communication,	4		
	Recognize impact of professionalism			
	Recognize interpersonal conflict and apply adaptive approaches toward resolutions.			
	Enhance problem solving skills			
	Client Rights/Grievances/Appeals	4		
	Handling client rights with care, timely processing of grievances, etc.			
	Identify need for confidentiality and implications when used improperly			
Day 2	**Resource Utilization & Aftercare Planning**	3	To be developed by provider	In-Class Activity
	Enhance ability to identify and utilize resources available to community			
	Collaboration with LEO			
	How to manage individualized needs of clients, and connect to proper aftercare			
	Power of Support	2		
	How/When to involve support system; collaborating with support system when available			
	Documentation	3		
	How to document effectively, and recognize risk of ineffective and inaccurate documentation			
	Managing clients with difficulty navigating services outside of crisis system of care			
Day 3	**Behavioral Health**	8	To be developed by provider	In-Class Activity
	Recognize actions and behaviors that indicate a person may be experiencing a behavioral health crisis. Incorporate peers in this module.			
	De-escalation strategies to effectively work with an individual in crisis			
	How to identify individuals who use crisis services often and how to effectively engage them in furthering recovery			Practice Scenarios

Day 4	**Motivational Interviewing**	8	To be developed by provider	Annual refresh
	How to guide communication with person in distress in a way that is empowering and moves toward recovery			
Day 5	**Trauma-Informed Care**	8	To be developed by provider	Annual refresh
	How to serve persons in distress with awareness of potential trauma and triggers			

Week Three

	Topic	Hours	Assignment / Reading	Notes
Day 1	Call Center: Technology	8	To be developed by provider	In-Class Activity
	Mobile Teams: EHR and Documentation	8		
	Facilities: EHR and Documentation	8		
Day 2	Call Center: Call Handling	8	To be developed by provider	In-Class Activity
	Mobile Teams: Comprehensive Assessment & Case Planning	8		
	Facilities: Comprehensive Assessment & Case Planning	8		
Day 3	Call Center: Scenarios	8	To be developed by provider	Day 1 - Curriculum
	Mobile Teams: CPI, ASIST, (or similar) & Critical Incidents	8		Annual refresh
	Facilities: CPI, ASIST (or similar) & Critical Incidents	8		
Day 4	Call Center: Scenarios	8	To be developed by provider	Day 2 - Hands On
	Mobile Teams: CPI, ASIST, (or similar) & Critical Incidents	8		Annual refresh
	Facilities: CPI, ASIST (or similar) & Critical Incidents	8		
Day 5	Final and/or Presentations and/or Vignettes		To be developed by provider	Flesh out what the final competency assessment looks like and how to "pass" the academy.
	Graduation			

Additional Considerations

- Award Continuing Education Units (CEU) to signify successful completion as a non-credit course for professional development and for maintaining professional crisis certification status.
- A forty (40) hour version of this course could be adopted for attorneys, judges, and others working in the criminal justice system.
- Sixteen (16) hours of related coursework would be required every two (2) years to maintain crisis certification.

Appendix I: SAMHSA's National Guidelines for Behavioral Health Crisis Care

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines a BH crisis stabilization service, as:

> *"A direct service that assists with de-escalating the severity of a person's level of distress, and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery."*

Like a physical health crisis, a BH crisis can be devastating for individuals, families and communities. While a crisis cannot be planned, we can plan how services are structured and organize them to best meet the needs of those individuals who experience a BH crisis. Too often that experience is met with delay, detainment, aggression, and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as "no-wrong-door" services, it is important to distinguish what crisis services are and what they are not. Crisis services are for anyone, anywhere and anytime without undergoing a prescreening process or medical clearance in advance of accessing them. Examples of emergency medical response services seen in communities around the country include: (1) 911 accepting all calls and dispatching support based on the assessed need of the caller; (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community; and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources.

Similarly, BH crisis response should include (1) crisis lines accepting all calls and triaging the call based on the assessed need of the caller; (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments); and (3) facility-based crisis services that serve everyone that comes through their doors from all referral sources. A simple test regarding whether a service meets this standard definition of a crisis service is to inquire whether there is any screening of referrals by location, acuity, eligibility or other exclusionary criteria; or any limitation of the service based on availability during certain days of the week or hours of the day. If such screening exists, the service may still represent an important part of a community's system of care, but the service is not representative of the *SAMHSA's National Guidelines for Behavioral Health Crisis Care*.

There appears to be general agreement, in LAC and elsewhere, that far too many persons with BH issues are arriving in hospital emergency departments (EDs), or are being charged and transported by law enforcement to detention facilities; and they are not being well served in either setting. In fact, criminal justice settings have been increasingly referred to as, "the de facto BH system."

Long waits, often for hours or even days, in often-chaotic ED environments, may exacerbate symptoms and trigger trauma responses. In addition, "boarding' consumes hours of law enforcement officers' time, which they commonly refer to as, "wall time." To exacerbate this problem further, EDs typically do not have the appropriate BH personnel onboard to effectively engage and intervene when someone presents in a BH crisis. According to a 2015 Emergency Medicine Practice Research Network (EMPRN) poll, 70% of the emergency physicians surveyed reported psychiatry patients being boarded on their last shift. Over half reported average boarding times of up to two days and up to five patients at a time. The backup and boarding EDs of psychiatric patients waiting for an evaluation or inpatient bed is a troubling phenomenon on a national scale for EDs and mental health consumers alike.

Another unproductive dynamic involves BH crisis dispositions by EDs. These have become known as, "streeting." This occurs when those, with presenting BH conditions, are not appropriately screened and triaged and, as a result, have been discharged prematurely usually without appropriate treatment and/or supports. In either case, "boarding" or "streeting" is damaging to not only those in crises, but also frequently the significant others who must endure these dynamics as well. From a cost standpoint, ineffective interventions in EDs or jails are poor uses of resources and they exacerbate costs. They perpetuate the crisis response dynamic of the "revolving door" that saps the resources of health care, law enforcement, the judiciary, incarceration settings, and social services. The ED is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. Likewise, costs associated with 911 dispatch, law enforcement, EMS, and the criminal justice system for those in crisis, are costs that could be better spent and with better outcomes using an adequately resources BH crisis response system.

The underlying issues that impede the appropriate interventions for a person in a BH crisis are complex. For instance, many large service systems may be involved with someone who has complex needs. Each of these intervening service systems have their own respective missions, cultures, competencies, and entry points with rules for accessing services. The BH system has its own complexities and issues with having a dearth of intermediate and intensive community-based treatment options that serve people in their natural environments. Care for these individuals is left too often to EDs and hospitals at one end of the care continuum, and routine outpatient services on the other.

There are significant legal issues that serve as barriers to accessing BH crisis care, including professional scope of practice laws, facility and service licensing (including ambulance emergency destination restrictions), and protections for those in care, including medical clearance and "certifications for involuntary admissions." Financing of BH treatment services has its own set of challenges, since insurers (public and private) have their own systems, rules, and payment rates that only reimburse certain services operated by only certain facility and provider types. And let's not forget, there are still those who are uninsured and require safety net funding in order to access services.
According to the paper published by the National Association of State Mental Program Directors (NASMHPD) and co-authored by RI's CEO, David W. Covington, LPC, MBA, Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness, August 2018, individuals in crisis often interface with the justice system, first responders, hospital

emergency departments (EDs) and correctional facilities. These resources are essential to supporting a healthy community, but they are not designed to meet the unique needs of individuals experiencing a BH crisis.

Therefore, the key elements of a comprehensive BH crisis response system as delineated in the National Guidelines and as anticipated with 988 implementation are:

1. **Care Traffic Control Crisis Contact Center Hubs**
   The "front door" of a modern crisis system is a crisis contact center that meets National Suicide Prevention Line (NSPL) standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis contact centers as indispensable resources for suicide prevention. Nationally more than 180 call centers meet the standards of and participate in the NSPL. Such a crisis contact center is equipped to connect individuals in a BH crisis to needed care. These programs use GPS technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day. That real-time care coordination requires electronic linkage with every BH inpatient, and residential bed and with every outpatient treatment slot in the service area. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards. In order for Call Centers to be accessible to youth, it is critical that they include the technology and the staffing to support both texting and chat capabilities. The crisis call function can be further complemented by a Peer-to-Peer Warm Line, which is staffed by Certified Peer Support Specialists. This service can provide 24/7 readily accessible support, outreach, and post-vention which can prevent the emergence of future crises or re-stabilize an individual who is beginning to feel over-stressed, overcome with drug cravings, or feelings of loneliness, hopelessness, and burdensomeness.

   Vibrant Emotional Health (Vibrant), the administrator of the National Suicide Prevention Lifeline, has provided recommendations and defined the vision and mission of 988 as follows:
   - Vision: 988 serves as America's mental health safety net. It will reduce suicides and mental health crises and provide a pathway to well-being.
   - Mission: Everyone in the U.S. and its territories will have immediate access to effective suicide prevention, crisis services and behavioral healthcare through 988.

   The new Lifeline number, 988, holds the promise of an equitable healthcare response to a healthcare issue with better outcomes as people receive the services and supports they need to remain in their communities and thrive. This promise will only be fulfilled if adequate resources are available to accommodate increased call/chat/text volume, as well as the continuum of crisis care services that can respond as appropriate. Crisis care

services are more impactful when they include and are informed by individuals with diverse backgrounds, including lived experience, who are trained to respond in an empowering and culturally responsive manner. For example, 988 presents an opportunity to invest in mobile crisis teams that can be deployed to respond instead of police. People in crisis may need an appropriate place to go for assessment that is not jail or a hospital emergency department, which are often the only options for law enforcement to offer. 988 provides the opportunity to invest in resources, such as crisis stabilization centers, crisis beds, or peer respite centers, which allow for individuals in need to receive mental health evaluation and resources. The key features of 988 include:

d. Universal and Convenient Access, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication;
e. High Quality and Personalized Experience that is tailored to the unique needs of the individual while also in line with identified best practices;
f. Connection to Resources and Follow Up to ensure all persons contacting 988 receive additional local community resources as needed.

A BH crisis needs a BH response. Increased collaboration between 911 and 988 would provide more options for those in crisis, such as transferring BH crisis calls to 988 call centers, dispatching MCTs to individuals in BH or suicidal crises rather than police or EMS, and greater coordination around access to care options like crisis stabilization units. However, a robust BH response is only possible with appropriate funding for the network, individual crisis centers, and the crisis care continuum. In order to ensure a robust infrastructure, states should exercise their authority to implement a 988 fee, similar to the current 911 fee that would be restricted to crisis center and service provider expenses. In 2018, fees for 911 generated $2.6 billion to support that service; similar investment is needed for BH crisis response services. The fee revenue should supplement, not supplant, funding from diverse sources, including federal, state and local governments, Medicaid, and private insurance. States need to assess their current crisis response systems, identify gaps, and ensure adequate funding to overcome those gaps.

The 988 implementation should be designed to provide an empowering, personalized, high quality and culturally responsive experience for individuals in crisis. The system should be designed to optimize and support services that ensure access and inclusion within the 988 crisis response to meet the unique needs of at-risk groups, including youth, rural populations, BIPOC communities, and LGBTQ+ individuals. Multiple modalities such as text and chat should be available in addition to phone support. Crisis staff should reflect the communities served and engage people with lived experience at all levels of response. Individuals providing those services should be trained to be culturally responsive in order to ensure dignity for the person being served. Services should also be linguistically

appropriate for the communities served. Data driven metrics, including performance and user experience by race and ethnicity, are needed to ensure quality service and positive outcomes for all members of the community.

2. **Centrally Deployed Mobile Crisis Teams on a 24/7 Basis.** Mobile crisis services are typically comprised of a two-person (licensed clinician and peer partnerships are common) mobile crisis team (MCT) that offers assessment, outreach, and support where people in crisis are either in the person's home or a location in the community (not a healthcare facility). The two person model is intended to assure greater safety for the teams in their work in the community, to ensure that those served have the best opportunity for engagement, and to allow for the transportation of those served when warranted, eliminating the need for overuse of the police and ambulances for transportation. Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis contact center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup. The MCT provides a timely face-to-face response and requires the capacity to intervene quickly, day or night, wherever the crisis occurs. In cases where the person in crisis cannot be stabilized, the MCT assists in transferring this person to a higher-level program and will provide transportation for those that are voluntary when it is safe to do so.

3. **Crisis Observation and Stabilization Facilities.** These facility-based crisis services offer short-term BH crisis care for individuals who need support and observation. Design of these facility-based crisis services may vary, but ideally they will include a medically staffed flexible observation and stabilization area with recliners, instead of beds, (usually limited to less than 24 hours of care); and operate under a "no wrong door" approach. Under this approach walk-ins, law enforcement, and other first responder referrals, are immediately accepted without requiring any form of medical clearance prior to admission. This approach also includes accepting both voluntary and involuntary admissions. Therefore, it is imperative that the facility is staffed and equipped to assure the health and safety of everyone within the facility. These centers are typically a high-speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge planning and community coordination of services.

   These observation stabilization programs are typically paired with a subacute short-term (2-5 day) facility-based crisis program (either inpatient, respite or residential) to offer more

than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs. This facility needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of those admitted to the 23-hour center with recliners, who were not sufficiently stabilized during the 23-hour observation stay.

Both settings should be designed as inviting non-institutional environments that are enhanced by natural light, and hopeful and inspiring aesthetic features. Safety and security are built into the staffing model and physical plant, yet still offer a "living room" feel. Program interventions are delivered by both professional (MD, PNP, RN, Clinician) and para-professional (certified peer support specialists) staffs designed to support ongoing recovery, and to engage in comprehensive discharge planning and community coordination of care. Equally important is that this interdisciplinary team creates and sustains an environmental milieu where all "guests" are treated with dignity and respect, are authentically and meaningfully engaged, and when dysregulated, they are allowed the space, time, and support necessary to de-escalate. As a result, these stabilization settings, when appropriately staffed, are able to assure greater safety than normally expected in crisis settings. Seclusion and restraints are available, but rarely applied.

It should be noted that once these core crisis service components are in place and operating as intended, there are additional crisis response system service enhancements that can be made. These can include a Peer Navigator service that assists individuals who have accessed crisis services to subsequently navigate health and human services systems in order to access the benefits and services that potentially further stabilize and improve one's quality of life, such as permanent supportive housing, supported employment or education. Another option is a Peer Respite Center that is managed by and staffed with Peer Support Specialists. Crisis Respite is typically a short-term (two-week) residential environment that operates as a transition from crisis stabilization to the community, or as a step up from the community to prevent a potential crisis. Other alternative models are being developed as communities become freer to innovate in meeting identified needs and garner a broader base of practice-based evidence.

Communities that lack a crisis service continuum pay the price in terms of the cost of law enforcement engagement in addressing BH crises, the expense of incarceration, and the negative impact on the quality of life for individuals in the community, and ED and hospitalization costs. Those unable to access needed services in a timely manner endure the effects of psychiatric boarding (waiting in an ED for hours or days) and the exacerbation of symptoms and distress. For payers of healthcare, a lack of adequate crisis care translates into paying unnecessary ED bills that are estimated to cost between $1,200 and $2,260. In contrast, 96% of individuals directly referred to a crisis provider do not require an ED visit. Additionally, acute psychiatric inpatient care often comes with a higher per diem rate and a longer average length of stay than crisis facilities. The escalated expenses increase healthcare costs by an estimated 100% of the costs realized within a comprehensive crisis system.

The desired model is to connect individuals to a crisis provider as quickly as possible using a systemic method that is analogous to the healthcare delivery system's approach to medical emergencies. This prototype can also be used as a tool to help model reimbursement for these similar crisis services in a manner consistent with parity expectations. The chart below demonstrates the differences between our 911 medical emergency response systems in comparison to our traditional BH crisis response systems. The final column illustrates how an optimized crisis response system, can operate on par to our traditional medical emergency response system. In so doing, those with BH conditions in crisis can be subject to life-saving interventions, rather than routinely being endangered and traumatized, or even worse, exposed to deadly force. The table below highlights how the BH crisis response systems are intended to be comparable to emergency medical response systems:

Medical Emergency Response versus a BH Crisis Response			
	Medical System	Traditional BH Crisis System	National Guidelines
Call Center	911	Crisis Line or 911	Crisis Line – 988 in 2022
Community Service	Ambulance / Fire	Police	Mobile Crisis Team
Facility Option	Emergency Dept.	Emergency Dept. Arrest/detention	Acute Crisis Observation & Stabilization Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes
Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

The C*risis Now Transforming Crisis Services: Business Case* suggests that a comprehensive crisis system is affordable and within reach of most communities. The cost of crisis response services can be further supported by the reinvestment of savings from the decreased spend on hospital-based services and incarceration/detention. In Maricopa County, Arizona for example (which includes the greater Phoenix area), the associated savings of a crisis response system containing all three-core components have experienced the following system efficiencies in 2018:

- Thirty-seven (37) full-time equivalent (FTE) police officers' time was spent engaged in public safety, instead of being engaged with BH crises;
- Reduction in ED accumulated boarding time of forty-five (45) years annually; and
- Decrease in inpatient hospitalization spend by $260 million.

The escalating costs communities pay for not investing in a comprehensive crisis system are unsustainable; manifesting as demands on law enforcement, other first responders, criminal justice systems, emergency departments, service providers of all types, and public and private payers. These escalating demands in our communities are pushing the limits of what is affordable and sustainable,

while resulting in adverse outcomes for those in need of care and the communities within which they reside. The impact to vulnerable and marginalized members of our communities, and their families, is devastating. A comprehensive crisis response system that includes the three core components is essential to all communities. Zero unnecessary admits for BH conditions to emergency departments and jails (where only nuisance crimes have been committed) are attainable goals through the implementation of the *National Guidelines.*

Core Principles and Practices

There are several additional elements that must be systematically "baked into" excellent crisis response systems, in addition to the core structural elements, that are essential for modern crisis response systems. These essential principles and practices are:

- Embracing recovery;
- Significant role for peers;
- Trauma-informed care;
- Suicide safer care;
- Safety/security for staff and consumers; and
- Crisis response partnerships with law enforcement.

Embracing Recovery

Crisis providers must embrace the reality that individuals and families move beyond their BH challenges to lead happy, productive and connected lives, each day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) *Crisis Now* Summit, consumer Misha Kessler ended his description of his direct experiences with crisis services, "Mental illness is [just] one part of my tapestry." The fact that recovery is possible and that it means not just the absence of symptoms, but also the development of meaning and purpose in life, has begun to transform mental health care (Anthony, 1993). The President's New Freedom Commission on Mental Health (Hogan, 2003), recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is critical for those in crisis, and thus for crisis settings. In an outmoded, traditional model, crises typically reflect "something wrong" with the individual. Risk is often viewed as something to be contained, often by means of an involuntary commitment to an inpatient psychiatric unit. In worst-case scenarios, people end up restrained on emergency room gurneys or in jails. These actions in turn are traumatizing to those who are subjected to them, and often they further reinforce the likelihood that the person will soon again recycle through this same revolving door of inadequate crisis interventions.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are ameliorated in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery, and ability to respond effectively to future crises. The recovery-oriented approach to crisis care is integral to transforming a broken system.

Implementation Guidance

1. *Commit to a "no force first" approach regarding care that is characterized by engagement and collaboration;*
2. *Create engaging and supportive environments that are as free of barrier, as much as possible. This would include eliminating Plexiglas from crisis stabilization facilities and minimal barriers between team members and those being served, in order to support stronger connections;*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly and frequently to those in care regarding all intervention options, and offer materials regarding any processes in writing, in the individual's preferred language whenever possible;*
4. *Ask the individual served about their preferences and do what can be done to align any actions to those preferences; and*
5. *Work to convert those with an involuntary commitment to voluntary, as soon as practical, so they become more invested in their own well-being and recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to engage the experience, capabilities, and compassion of those who have experienced BH crises. Integrating those "with lived experience" within the components of crisis care has repeatedly demonstrated that they "take all of [their] experiences; regardless of the pain, and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007). This reality has been increasingly substantiated by studies investigating peer services and supports. This body of work has found support for a range of peer support benefits including strengthened hope, relationship, recovery, and self-advocacy skills, and improved community living skills (Landers & Zhou, 2011).

Utilizing peers, especially those who have experienced suicidality and suicide attempts, and learned from these experiences, can provide a safe, authentic, and respectful context within which the feelings of aloneness and burdensomeness, associated with suicidality, can be permeated. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11%-50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following an ED referral (Kessler et al., 2005). Peers support specialists can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement, while reducing distress.

The role of peers—specifically survivors of suicide attempts, as well as, survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.
Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible; including, but not limited to, gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age considerations;*
2. *Develop support and supervision that aligns with the needs of the program's peer staff; and*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program. This would include peers who:*
    a. *Are available for connection with crisis line operations;*
    b. *Serve as one of two mobile team members; and*
    c. *Are one of the first individuals to greet someone upon entrance to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served with BH services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance use disorders, and poor medical health (Finkelhor et al., 2005). Persons with a history of trauma or trauma exposure are more likely to engage in self-harm and suicide attempts; and their trauma experiences make them acutely sensitive to how care is provided to them. When crisis care involves a loss of freedom, noisy and crowded environments, and/or the use of force, there is an exacerbation of presenting symptoms. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened increased agitation or withdrawal, and often followed a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calming can facilitate stabilization and healing. Therefore, trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited five guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer Support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; and
6. Cultural, historical and gender issues.

These principles should inform treatment and recovery services. When these principles are applied to practice, they become self-evident to staff, clients, and their significant others. The program's culture becomes transformed. All clients are screened for trauma exposure and its impact on overall well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.
Developing and maintaining a healthy therapeutic and supportive environment also requires support for staff, who may have a trauma history or may experience post-secondary trauma because of working with other trauma victims. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): Trauma-Informed Care in Behavioral Health Services (TIP 57). Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis, especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed; and*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Crisis intervention programs have always focused on suicide prevention. This stands in contrast to other health care and BH services, where suicide prevention was not always positioned as a core responsibility. Every crisis provider in the nation must make two transformational commitments:

1. Adoption of suicide prevention as a core responsibility, and
2. Commitment to reductions in suicide among people under care. These changes were adopted and advanced in the revised National Strategy for Suicide Prevention (2012), "Promote suicide prevention as a core component of health care services."

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at the Education Development Center, Inc. (EDC). The following seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Develop a competent, confident, and caring work force;
3. Systematically identify and assess suicide risk among people receiving care;
4. Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means;

5. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Provide continuous contact and support, especially after acute care; and
7. Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL). NSPL has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, while promoting collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis response systems are the most urgently important clinical service for suicide prevention; and since most parts of the country do not have adequate crisis care, a national and state-level commitment to implementing comprehensive crisis services is foundational to suicide prevention. It is anticipated that health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare) will increasingly require this to an expectation that best practices in suicide care.

Implementation Guidance

1. Incorporate suicide risk screening, assessment and planning into the new employee orientation for all staff;
2. Assign the completion of Applied Suicide Intervention Services Training (ASIST) or similar training to all staff;
3. Incorporate suicide risk screening, assessment and planning into crisis care practices;
4. Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic health record (EHR); and
5. Commit to a goal of Zero Suicide as a crisis response system.

Safety and Security

Safety for both guests and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff is also a priority. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been dropped-off by law enforcement and may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. Nevertheless, much more than a philosophy is involved. Keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent or who may find the crisis environment over-stimulating;
- Established policies and procedures emphasizing "no force first" prior to any implementation of safe physical restraint or seclusion procedures; and
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for those served; and decreases the risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and guests in crisis care settings.

Ukeru® which is a newer safe, comforting and restraint-free crisis management technique developed by and for BH caregivers and educators, is gaining increasing traction across the country. Named for the Japanese word, "receive," this award-winning program helps people engage, sense, and feel, and then respond to what someone is trying to communicate through their actions. Ukeru has helped BH providers and schools reduce the use of restraint, seclusion, and injury, while lowering workers' compensation costs and employee turnover.

As a companion to Ukeru, SafeClinch Training System is also emerging as a promising physical intervention practice. SafeClinch is a group of restraint techniques that relies more on 2-3 people restraint holds, although it does teach individual/solo restraint techniques and personal safety as well. The SafeClinch Training System provides verbal de-escalation; restraint training; and proven instructional strategies. SafeClinch teaches standing and floor restraints. The program is customizable for a wide variety of organizations that deal with uncooperative behaviors and the person with special needs. Participants learn escort and escape techniques; group restraint techniques; use of mechanical restraints; passive restraint techniques; and most importantly verbal de-escalation. The consultants have found that the application of these techniques is consistent with a recommended policy of, "No Force First."

Adequate staffing for the number and clinical needs of guests under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support specialists) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006). This is particularly critical, since neither law enforcement nor security personnel are employed in these settings.

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both guests and staff; and may ultimately re-traumatize individuals who have experienced physical and/or emotional trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat of punishment, alternative to appropriate staffing of crisis programs, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment, while assessing risk for violence and collaboratively developing de-escalation and safety plans for individuals served. Debrief staff and individuals involved in those interventions after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability of the future use of such interventions.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the perception of safety is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies a psychological crisis.

Implementation Guidance

1. Commit to a "no force first" approach to care;
2. Monitor, report and review all incidents of seclusion and restraint with a goal to minimize the use of these interventions;
3. Barriers do not equal safety. The key to safety is engagement and the empowerment of the individual served while in crisis;
4. Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all;
5. Incorporate quiet spaces into the crisis facility for those who would benefit from time away from the milieu of the main stabilization area; and
6. Engage team members and those served in discussions regarding how to enhance safety within the crisis setting, make safety truly "Job One."

<u>Law Enforcement and Crisis Response—An Essential Partnership</u>

Law enforcement agencies have reported a significant increase in police contacts with people with BH conditions in recent years. Some involvement with BH crises is inevitable for police. As first responders, they are often the principal point of entry into emergency care for individuals experiencing a BH crisis. Police officers are critical to mobile crisis services as well; by either providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995); or by serving as a referral source delivering "warm hand-offs" to crisis mobile teams or facility-based crisis services. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of "repeat players"; and
- Often transport individuals to an emergency medical facility where they may wait for extended periods for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated BH crisis care has made local law enforcement the de facto BH mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement to address emergent public safety risk is essential and important. With good BH crisis care in place, MCTs can collaborate with law enforcement, which will improve both public safety and produce better outcomes for those in crisis. Unfortunately, well-intentioned law enforcement responders to a crisis call can often escalate the situation just based on their presence. Police vehicles and armed officers can generate anxiety or agitation for far too many individuals in a crisis.
We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between BH personnel and law enforcement, found the alliance between first responders and BH professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to BH crises included specialized police response, police-based specialized BH response, and BH-based specialized BH response. These forms of collaboration share the common goal of diverting people with BH crises from criminal justice settings into BH treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by BH professionals in order to provide crisis intervention and to act as liaisons to the BH crisis system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use disorders, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and BH programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006). Crisis care programs should engage in ongoing dialogue with local law enforcement agencies to support continuous quality improvement and collaborative problem solving. Optimized crisis response systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between BH crisis care systems and law enforcement are essential for public safety, suicide prevention, connection to care, justice system diversion, and the elimination of psychiatric boarding in emergency departments. The absence of a comprehensive crisis response system has

been the major "front line" cause of the criminalization of those with BH conditions, and a root cause of shootings and other incidents that have left too many people, including police officers, dead. Collaboration is the key to reversing these unacceptable trends.

Implementation Guidance

1. Have local crisis providers actively participate in CIT training sessions;
2. Incorporate regular meetings between law enforcement and crisis providers into the schedule so that these partners can work to continuously improve their practices;
3. Include BH crisis provider and law enforcement partnerships in the training for both partner groups; and
4. Share aggregate outcomes data, such as: numbers served, percentage stabilized and returned to the community, and connections to ongoing care.

The *Crisis Now* model and the *National Guidelines* became practice-based evidence on how to best serve adults in crisis at anytime, anywhere, or anyplace. As states and communities are planning for 988 implementation, it has become abundantly clear that these models require further refinements to address the unique crisis needs of children, youth, and families.

Appendix J: Crisis Care Guidelines for Serving Children, Youth, and Families

The Roadmap to the Ideal Crisis System offers the following set of crisis care guidelines for serving children, youth and families:

<u>Clinical competencies: knowledge and skills</u>

- Engagement of youth with the use of play as an engagement tool.
- Engagement of youth and families in a culturally sensitive manner without re-traumatizing or blaming youth and families for the crisis.
- Matching engagement and intervention to age and development of child/youth.
- Assessment, including psychiatric and medical diagnosis and attention to social issues with greatest impact for youth (e.g., child welfare and juvenile justice involvement).
- Developmental milestones, including language development.
- Distinguishing symptoms of mental illness from imaginary play.
- Collaboration with family and caregivers because crisis for the child is usually crisis for the family.
- Coordination with community resources, including, but not limited to:
  - Early intervention programs, schools, including pre-schools and colleges.
  - Teams, clubs and other peer groups or organizations.
  - Medical pediatric teams.
  - Protective services for children, juvenile justice services.

  - Age-specific non-pharmacologic interventions and age-specific medication sensitivities and dosing.
  - Balance of privacy and individual focus with need for family/community input.
- Age specific rights and limitations.

Resources:

All staff should have access to written resources (handy tools) to help with the unique needs of children. For example:

- Developmental milestones, language and cognitive development.
- Unique impact and related intervention for youth exposed to community and interpersonal violence/trauma.
- Protective service referral processes and criteria.
- Access to home-based crisis resources.
- Cultural variations in youth experience, including immigrant communities.

Consultation:

Pediatric specialists/child psychiatrists (or equivalents) should be available remotely and with near-time direct access for the following functions:

- Clinical functions: Complex diagnostic assessment and intervention.
- Complex multisystem involvement, involving resource coordination:
  - Use of "safe havens" and other domestic violence crisis services with a family focus.
  - Child protection services available for crisis diversion when the child is not safe at home.
  - Protocols for case consultation and alternative planning for individuals who have failed to link with community resources and repeat visits to the crisis center.
  - Protocols for using community crisis resources outside the behavioral health system, including protective services and more normative resources. Some communities have respite services for families with youth who are difficult to parent or hard to treat. These services are ideally used before the crisis point; however, they should be considered at the point of crisis if not already in use.
  - Protocols for coordination with juvenile justice.
  - Engagement and coordination with schools and special education services.

Continuous quality improvement:

Regular QI planning actively leads to improvement of quick disposition, caregiver satisfaction and adverse events, including episodes of challenging behaviors/violence.

Practice guidelines:

Clinical practice protocols specific to this population are incorporated into the policies and procedures of crisis providers and monitored both individually for both success and poor outcomes and in the aggregate for the purpose of quality improvement and performance incentives.

Appendix K: Serving Persons with Intellectual and Developmental Disabilities in the Mental Health System

The National Association of State Mental Health Program Directors' (NASMHPD) Technical Assistance Coalition White Paper Assessment #7 from August 2017, entitled, The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System, makes a number of recommendations that would be beneficial for DHS to consider::

- Policymakers should work to develop cross-agency guidelines for greater inter-system collaboration, recognizing that PWIDD will and do appear in the mental health service system. The development of these collaborative efforts should include input from a variety of stakeholders and examine collaboration across all ages, including persons served in the child/adolescent, adult, and older adult sectors. Perspectives of persons served, their families, and representative advocacy organizations will be critical in the development of guidelines. Examples of important areas for these guidelines to address include:
  - Development of shared data to understand total numbers of individuals served across systems and those denied services because of overlap issues, and the development of planning based on those data;
  - Development of approaches to handle requests for services for people that do not neatly fit into administrative lines for particular services and the development of approaches for reviewing individual cases where overlapping needs are present but are not being met;
- Foster leadership to develop methods through blended and braided funding streams for continuum of care services that address the dual need populations;
- Establish intersystem partnerships, such as with law enforcement and jail diversion programs, to include interventions for persons with both IDD and SMI;
- Establish mutual workforce development;
- Systemic data collection must be done to better identify population prevalence and needs across systems.
- Prioritize the ability to develop self-directed and person-centered care planning, focusing on the PWIDD's strengths, capabilities, and potential to contribute to their community.
- Partner with IDD agencies overseeing services for these persons, and together there should be interagency outreach and collaboration with law enforcement, courts, and corrections to provide skilled de-escalation, diversion approaches, cross-discipline education, and linkages to services and guidance in developing greater supports to

accommodate persons with disabilities in justice and forensic systems, as well as, build bridges to programs reflecting alternatives to incarceration. Partner in cross-agency activities and policy development to strengthen appropriate services for the IDD population within corrections and offer strategies to advance improved conditions of confinement targeting this sub-population's needs.

Recommendations for practitioners include the following:

- Co-occurring challenges such as psychiatric disorders, other neurodevelopmental disorders, hearing loss, and other sensory challenges, are important to take into account among the PWIDD population across the continuum of care and support services. There is much heterogeneity in the population, so generalizations and cookie-cutter approaches are risky.
- Rates of trauma and victimization are alarmingly high in PWIDD. Safeguards, self-scrutiny, and monitoring are of ongoing critical importance.
- All behavior reflects some type of communication. An individual's limited ability to verbally communicate anxiety, mood issues, or a psychotic disorder may manifest in aggression or externalizing behaviors, which can often result in missed diagnoses or opportunities for treatment. Always ask, "What is the communication or behavior trying to achieve?"
- Given the limited guidance on helpful medication strategies for PWIDD in the literature, the evidence for psychopharmacology should be case-specific, data- informed rather than anecdotal, coming from behavioral evidence and comprehensive contextual information (e.g., behavior tracking reports) for the specific individual.
- Gather information from all sources, especially direct service professionals, who can provide a wealth of information to inform program and planning. Peer partners, provider treatment networks, and an emphasis on environmental precipitants to behavioral challenges should be helpful.
- Secure access to current policy and regulatory guidance in your state governing the provision of services to persons with co-occurring IDD and MH conditions. The guidance would include coverage and reimbursement guidelines, as well as, criteria for case reconciliation carried out by interagency health and human services bodies designed to parse eligibility, and clinical and financial responsibility, for complex cases crossing multiple authorities.
- Current practitioners should update their skills in working with PWIDD through continuing education activities. Trainees must be instructed in best practices in the appropriate bio-psychosocial approach to psychiatric diagnosis and treatment of PWIDD.

This publication is available at https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-vital-role-specialized-approaches-persons. Another issue paper on this topic is, Findings of Joint NASMHPD/NADD/NASDDDS Roundtables on Supporting Individuals with Co-Occurring Mental Health

Support Needs and Intellectual/Developmental Disabilities which can be accessed at https://www.nasmhpd.org/content/findings-joint-nasmhpdnaddnasddds-roundtables-supporting-individuals-co-occurring-mental-0.

Appendix L: Crisis Adjacent Services

BH Crisis response systems, in order to be efficacious, are highly dependent on a complete BH continuum of care and on a complex array of services to address the SDoH. Particularly critical are community-based intensive levels of care, such as CRTP, peer run respite, and FSP.

Crisis Residential Treatment Services (CRTP)

At the time that the preliminary recommendations of this Report were made, the role of CRTPs in the crisis care continuum remained under analysis. It was planned at that time that RI would examine the "goodness of fit" of CRTPs with the overall crisis response system within the County. In addition, RI committed to create defined scope of practice for this LOC; an algorithm to determine optimal number of residential beds needed for voluntary clients discharging from UCCs and PHFs, but in need of residential treatment and support, and an algorithm to determine impact overall. These estimates are clarified further in this report.

CRTP refers to a short-term, community-based, homelike setting with multi-day lengths of stay, often serving as a step-down from, or alternative to, psychiatric hospitalization. CRTPs are designed to serve individuals who are experiencing an acute BH impairment and whose adaptive functioning is moderately impaired. CRTPs provide short term, intensive and supportive services in a home like environment through an active social rehabilitation program designed to improve the lives and adaptive functioning of those it serves.

The Crisis Residential Association (CRA) has developed CRTP standards with decades of collective experience working in and administrating CRTPs across the nation, as well as, previous research done on BH crisis programs. CRS asserts that CRTPs should adhere to the following standards:

Values:

- Integrity: We conduct ourselves professionally according to the highest ethical standards.
- Respect: We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- Accountability: We take responsibility for our choices and their outcomes.
- Collaboration: We work together toward common goals by partnering with the whole community, sharing knowledge, building strong consensus and sharing decision-making.
- Dedication: We are committed to improve the behavioral health of our clients and communities.

- Transparency: We openly convey our ideas, decisions and outcomes to ensure trust in our organization.
- Quality and Excellence: We identify the highest personal, organizational, professional and clinical standards and commit ourselves to achieving those standards by continually improving.

Treatment Goals:

- Develop and implement individualized stabilization plans
- Crisis resolution
- Emotional & behavioral stabilization
- Symptom reduction
- Life skills development
- Connect with community resources
- Re-establish a sense of functionality & independence
- Linkage to care coordination and mental health services

Services Offered:

- Self-help skills and peer support
- Individual and group interventions
- Social Skills
- Medication support
- Co-occurring disorder services
- Pre-vocational / educational support
- Discharge planning that starts within 12 hours of admission

Program Administration:

- Evaluate and track the following at a minimum:
  - Client Satisfaction
  - Client symptoms (pre and post)
  - Staff satisfaction
- Ability to admit individuals 24/7
- Response time to referrals under two hours
- Direct drop off and self-admission capabilities
- Home like environment and unlocked facility (though could be "secured" facility)

Peer Respite

Peer respites are peer-run, voluntary, short-term (typically up to two weeks), overnight programs that provide community-based, non-clinical support for those experiencing or at risk of an acute BH crisis.

Peer respite facilities operate 24/7 in a homelike environment and can provide a "step-down" from facility-based crisis services, where peer navigation services are provided to assist with transition back to the community. Peer respites also allow users to take a break from stressful life circumstances, while building a community of support with other peers.

Peer respites are designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a BH crisis. The premise behind peer respites is that psychiatric emergency services can be avoided, if less coercive or intrusive supports are available in the community. Peer respites engage guests in mutual, trusting relationships with peer staff. Peer support involves a process of mutual helping based on the principles of respect and shared responsibility. Peer support includes interactions in which individuals help themselves and others through fostering relationships and engaging in advocacy to empower people to participate in their communities.

All individuals in program management positions have "lived experience" associated with BH conditions and are engaged in active recovery. Often, they are certified peer support specialists. The peer respite center either is operated by a peer-run organization, or has an advisory group with 51% or more of its members having "lived experience."

This web portal, at the link below, was created by Live & Learn, Inc. to provide the public access to resources about peer respites in the United States. The resources available include the criteria and definition of a Peer Respite, the Peer Respite Directory (updated in 2018), and the Guidebook for Peer Support Program Self-Evaluation, and reports from the Peer Respite Essential Features Surveys, which document nationwide trends in organizational characteristics and policies. This resource now serves as an archive for work that was completed prior to 2019, and it hosts a repository of research on peer respite programs. https://www.peerrespite.com/.

Live & Learn counts thirty-three (33) peer respites today in the U.S., up from nineteen (19) six years ago. They now operate in at least fourteen (14) states. California has five, in the San Francisco Bay Area and Los Angeles County. Peer respites are free for guests, but they are rarely covered by insurance. States and counties typically pick up the tab. Located in Long Beach, Hacienda of Hope's $900,000 annual operating costs are covered by LCA through the MHSA funds.

Full Service Partnership

Adult Full Service Partnership (FSP) programs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness and who would benefit from an intensive service program. The foundation of Full Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness. Full Service Partnerships embrace client driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers. Adult FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have a co-occurring

mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community and other locations. Peer and caregiver support groups are available.

The Children's Full Service Partnership (FSP) program is a unique intensive in-home mental health service program for children ages 0 – 15 and their families. Child FSP providers are dedicated to working with children and their families to assist them plan and accomplish goals that are important to the health, well-being, safety and stability of the family. Services may include but are not limited to individual and family counseling, 24/7 assessment and crisis services, and substance abuse and domestic violence counseling and assistance. Services are provided in the language of the families' choice.

The DMH Full-Service Partnership Program (FSP) Redesign and Transformation initiative was launched in July 2021 and represents an innovative large-scale approach to align payments and accountability with meaningful life outcomes for clients. The amended three-year contracts, which require the deployment of dedicated service teams responsible for specific client populations, were developed over the past three years in partnership with Third Sector, whose work was funded by the Ballmer Group. The FSP transformation involves 196 contracted and in-house clinics serving more than 15,000 clients with serious mental illness and impacts $300 million in annual MHSA spending (more than half of the MHSA funding allocated to DMH). Under the new design, contractors can receive up to six percent (6%) in outcomes payments for achieving specific targets, including retaining the highest-acuity clients in the program voluntarily and helping clients obtain/maintain stable housing, avoid street/jail recidivism and reduce psychiatric hospitalizations.

The redesign incorporated feedback across stakeholder groups, including clients, on outcomes targets, incentives, data reporting and the service model. UCLA, through its Public Partnership for Wellbeing in collaboration with DMH (PPfW), supported the development of a unified evidence-based "whatever it takes" model, and is delivering ongoing provider capacity building and technical assistance. DMH has received initial data from providers, and is now focused gathering data on new outcomes and enrollment metrics and share new data-actionable reports to show progress. The PPfW has also launched a series of Learning Collaboratives to support continuous quality improvement. The first incentive payments were distributed in early 2022, based on progress in the first six months of the new contracts.

As another community-based intensive level of intervention, treatment, and support, FSP offers those with severe BH conditions to become stable in the community and to sustain such stability. It prevents the precipitation of crisis and helps to provide a "safe-landing" when crisis do occur.