LOS ANGELES COUNTY
EMERGENCY MEDICAL SERVICES COMMISSION

Los Angeles County's 9-1-1 Dispatch and Field Response to Mental Health and Substance Abuse Emergencies Survey

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Approved EMS Commission 1/16/19

BACKGROUND

The Emergency Medical Services Commission (EMSC) is an advisory body to the Board of Supervisors and the Director of Health Services regarding County policies, programs and standards for emergency medical care services throughout the County. In September 2015, the EMSC established an Ad Hoc Committee to address the significant issues identified by representatives of Fire Departments, EMS, and Law Enforcement personnel in the prehospital care of behavioral emergencies. Key members of the committee included representatives from the Los Angeles County Police Chief's Association (LACPCA).

The committee's final report, titled "*The Ad Hoc Committee on Prehospital Care of Mental Health and Substance Abuse Emergencies Final Report"* highlighted nine recommendations for change to the mental health / substance abuse field response, processes of care, and disposition by emergency medical services (EMS) and law enforcement. The report can be found at: *http://file.lacounty.gov/SDSInter/dhs/1006550_EMSCAdHocCommitteeReportNovember2016.pdf*

An important area of focus relates to 9-1-1 dispatch and triage of mental health and substance abuse (MH/SA) calls. The EMSC in coordination with the LACPCA, conducted a survey in early 2018 to develop a more thorough understanding of the challenges that LA County's law enforcement agencies encounter in

1) Dispatching 9-1-1 mental health calls, and
2) Responding to mental health emergencies.

Additionally, the Commission sought input on potential future solutions that could improve the care of such individuals in crisis.

This document summarizes the findings of the survey conducted by the EMS commission on the Los Angeles County 9-1-1 Dispatch and Field Response to Mental Health and Substance Abuse Emergencies.

SUMMARY OF FINDINGS

Details of the survey results are described in this report. 66% (28 of 42) of dispatch agencies and 61% (28 of 46) of law enforcement (LE) agencies responded to questions regarding mental health 9-1-1 calls that they received in 2017.

The overall key findings are as follows:

- 8% of 9-1-1 calls were coded as MH/SA emergencies by dispatchers.
- Only 1 in 5 agencies (18%) report having a standardized dispatch protocol for MH/SA emergencies. Many agencies agreed that a standardized dispatch protocol to determine whether the call is related to mental health related would be beneficial.
- Over 90% of the emergency MH/SA calls are initially dispatched to LE. Approximately 27% of calls will result in an EMS co-dispatch. It is extremely rare for EMS to be dispatched without LE to MH/SA calls (4%).
- 76% of law enforcement agencies have at least some embedded mental health clinicians, but their availability varies widely and is overall quite limited (often not 24 hours or 7 days a week).
- MH/SA training has increased significantly for LE officers. The current data suggests that MH/SA trained officers are able to respond to MH/SA emergencies 58% of the time.
- 96% of LE agencies agree that individuals who are experiencing a MH/SA emergency would benefit from continued and increased training of officers in managing such situations.
- 54% of MH/SA field encounters resulted in the placement of an involuntary psychiatric hold (range 2% to 99% depending on the LE agency)
- Main challenges in responding to MH emergencies included lack of resources (including for people who need services but do not meet hold criteria), time spent transporting/waiting in hospitals, stigma/lack of MH education, and lack of access to specialized mental health teams.
- 54% of LE provider respondents felt that the patient would benefit from EMS response
- LE agencies believe the response system could be improved by including more specialized MH/SA teams available 24/7, improved training for dispatchers to screen MH/SA calls, increasing training for LE responders.
- 28% of MH 9-1-1 calls were related to suicidal ideation without an attempt.
- Limitations: Data were obtained by survey only (no independent verification of data response), and results were not weighted resulting in average estimates. There may be substantial variation between agencies, based on size of department, volume of calls or encounters, geographic location, and proximity to nearby resources (such as psychiatric emergency department or mental health urgent care).

RECOMMENDATIONS

1. Consider a pilot project to evaluate whether diversion or co-triage of calls related to suicidal ideation without attempt to the Suicide Prevention Lifeline is feasible, and whether it would reduce field responses, mental health holds, and emergency department utilization, while increasing referral to appropriate mental health resources.
2. Recommend identification of the appropriate agencies to develop follow-up referrals or instructions for individuals who are not transported (left at scene).
3. Explore the feasibility / utility of developing standardized dispatch protocols that aid in identifying when 9-1-1 calls are MH/SA related.
4. Explore protocols for dispatching EMS along with, or after, LE response.
5. Explore avenues of funding for increased number and availability of 24/7 emergency mental health response teams, as well as resources for LE officers' MH/SA training.
6. Investigate the large variance in law enforcement agency's rate of utilization of 5150 psychiatric holds for 9-1-1 mental health emergencies (which was reported as between 2 and 99%).

DETAILED SURVEY RESULTS

GENERAL NOTES

- Two simultaneous surveys were conducted for Law Enforcement Dispatch and Field Response.
- Law Enforcement Dispatch Survey Response Rate: 28 of 42 (66%) LA County Law Enforcement Dispatch agencies responded to the dispatch survey. The majority of police departments and the Sheriff do their own dispatch and only dispatch for their department. There is one regional law enforcement dispatch center that dispatches for six (6) police departments.
- Law Enforcement (LE) Field Response Survey Response Rate: 28 of 46 (61%) Law Enforcement Agencies completed the survey with reliable data (31 total responded, 3 were either duplicate or unusable data).
- All data reported are for calendar year 2017.

DISPATCH AGENCIES SURVEY RESULTS

1. ***How often do dispatch agencies receive MH/SA emergency calls?***
   - On average, 8% of 9-1-1 calls received by dispatch agencies were coded as MH/SA emergencies by dispatch. Note: many agencies report the unreliability of their estimates, given no standard classification system, and reliance on public reported incidents.
   - Dispatch providers estimated the proportion of mental health calls in the following categories:

Suicidal Thoughts (no attempt)	28%
Suicide Attempt	13%
Homicidal thoughts, behaviors; agitation; erratic or dangerous behaviors	30%
Other non-suicidal, non-homicidal, non-dangerous mental health issues	29%

   - The estimated number of total 9-1-1 calls received by survey respondents was 5,881,851 for calendar year 2017.

2. ***How often are the calls dispatched to law enforcement (LE), EMS, or both?***
   - While >90% of the emergency calls are initially dispatched to LE, in a little more than 1/4 of the cases (27%) EMS will also be co-dispatched. 4% of the time EMS is dispatched independently.
   - Triggers to dispatch EMS include: known injury or medical issue (such as accidental overdose of prescription medication, panic attack, unconscious subjects, self harm requiring medical attention), if the situation was clearly recognized as non-dangerous / non-violent, expectations that the patient will require an ambulance transport, drug/alcohol use, delirium tremens or excited delirium.
   - It appears that the identification of “mental illness” is sufficiently risky or variable in terms of dangerousness that LE are typically dispatched.

3. ***Do dispatchers have triage protocols, or standardized lines of determining if a call is mental health related?***
   - A large majority, 82% (23 of 28) of dispatch agencies do not have a procedure that includes defined questions to determine if this call is related to a MH/SA emergency.
   - Roughly 1 in 5 agencies (18%) report having a standardized dispatch protocol. Many agencies commented that a standardized dispatch protocol that aids in determining whether the call is mental health related would be beneficial.

4. ***Do dispatchers have a protocol to determine if/when mental health trained personnel should respond? (MET/SMART, mental health trained officers, or mental health clinicians)***
    - Roughly half of the dispatch agencies have a protocol that determines when to deploy the specialized response (57% with protocol, 43% without)
    - Often, the responding police unit determines whether a special mental health teamresponse is needed (e.g. SMART, MET) response.
    - Due to limited availability, the MH/SA clinician is often not the first responder.

5. ***Open Response: How would you improve the dispatch protocols for 9-1-1 mental health emergencies?***
    - Increased training for dispatchers on specific mental illnesses, verbal queues, and trigger words
    - Standardized protocol/defined questions and training for dispatch to triage MH/SA conditions
    - Requesting to have a full time clinician with an officer instead of just have one periodically
    - If “drop off” procedure could be streamlined that so that LE wouldn’t have to wait in EDs for hours while person is being evaluated
    - Having the officer who handled a call which turns out to be mental health related (though not originally recognized as such) advise the dispatchers that it was a MH/SA emergency, in order to improve data accuracy
    - “Have mental health experts attend more patrol line training to touch base with officers and dispatchers and advise them of available resources to use as referrals.”

LAW ENFORCEMENT FIELD RESPONSE SURVEY RESULTS

1. ***What types of MH/SA emergencies do LE encounter?***
   - LE providers estimated the proportion of mental health calls in the following categories:

Suicidal Thoughts (no attempt)	36%
Suicide Attempt	11%
Homicidal thoughts or behaviors; agitation; erratic or dangerous behaviors	27%
Other non-suicidal, non-homicidal, non-dangerous mental health issues	26%

2. ***What is the availability of embedded mental health clinicians?***
   - 76% of departments (n=22) have embedded mental health clinicians (social workers, psychologists, or physicians) responding to mental health emergencies.
   - 14% (n=4) do not have embedded mental health clinicians.
   - The real-time availability of mental health clinicians is varied:
     7 days / week (5 departments)
     3-6 days / week (Mon-Thu) (10 departments)
     0.5-2 days / week (7 departments).
     (Vast majority 8-10hrs/day, 4 agencies have 20-24hr/day coverage)

3. ***How often do mental health trained personnel respond to MH/SA emergencies?***
   - 58% of the time a mental health trained officer, clinician and/or a "special response" team (including MET, SMART) is able to respond to 9-1-1 mental health emergencies. Eight (8) agencies reported a MH/SA trained response in 90-100% of cases.

4. ***What kind of training do sworn officers receive?***
   - Sources of mental health training for sworn officers in the past 5 years included the following:

Mental Health Awareness: Crisis Intervention for Law Enforcement	50%
Mental Health Intervention Training	29%
Crisis Intervention Training (CIT)	16%
Mental Health First Aid	24%

   (Total percentages >100% due to training in more than one course)

   Other courses that officers attended: Mental Health Decision Making, L.A.P.D/SMART Team training, Policing the Mentally Ill, Mental Health Domestic Violence, Interacting with the Mentally Ill, Investigations within Mental Health, Field Encounters with the Mentally Ill, Emergency Personnel Response to Individuals with Mental Illness.

5. ***How adequate is the training for LE?***
   - 96% of respondents agree or strongly agree that individuals who are experiencing a mental health emergency would benefit from increased training of officers in managing such situations

6. ***Who is the most appropriate first responder?***
   - 54% agree or strongly agree that individuals who are experiencing a 9-1-1 mental health emergency would benefit from a response by EMS personnel as opposed to law enforcement if there is no acute violence or safety issues.
   - 32% disagree or strongly disagree (9 departments), 14% undecided (4 departments)

7. ***What are the barriers to increased mental health training?***
   - The barriers to increased mental health training for officers were reported as follows:

Barrier	Agree or strongly agree
Lack of funding	75%
Lack of time	75%
Individual officers' resistance	29%

8. ***Where do Law Enforcement transport patients to for mental health emergencies?***
   - Average of law enforcement agency responses (not weighted for actual # of encounters)

Destination	Percentage
Psychiatric Urgent Care Centers (such as Exodus, Olive View UCC)	26%
Free standing Psychiatric Hospital	14%
Psychiatric Emergency Service (Harbor-UCLA, LAC+USC or Olive View)	21%
LPS designated hospital emergency department	18%
Non-LPS designated hospital emergency department	5%
Jail	3%
Sobering Center	2%
Leave at Scene	12%
Other (describe)	1%

9. ***What is the frequency of involuntary detainment in the field?***
   - 54% of mental health field encounters result in the placement of a 5150 involuntary psychiatric hold (range 2% to 99%)

10. ***Open ended question: What are the most significant challenges for your agency/department in responding to mental health emergencies?***
    - More mental health cases than resources available
    - Challenge to locate available beds at facilities other than LAC+USC in order to not overutilize their hospital
    - Not enough LPS hospital beds and placement options
    - Time spent transporting/waiting in hospitals
    - Not enough resources to deal with juveniles
    - Lack of resources for people who need MH services but do not meet LPS hold criteria
    - Repeated calls regarding pts after just being treated
    - Responding to mental health calls takes an extended amount of time
    - Stigma, cultural barriers/lack of education
    - No access to SMART/MET team, not enough staffing, time

11. ***Open ended question: Describe ways that you believe that the 9-1-1 mental health emergency response system could be improved***
    - More MET staff/teams available 24/7 to respond to calls
    - More hospital beds and placement options
    - More housing facilities
    - Dispatchers better trained to screen mental health related calls for service
    - Increased training for both dispatches and first responders
    - Continued efforts for multi-agency and multi-disciplinary training and education
    - Diverting more calls away from police response to medical, mental health, or crisis line
    - More psychiatric urgent care facilities, long term placements and housing

- Access to MH services for those who do not meet 5150 criteria
- Allow paramedics to transport to LPS facilities outside their area
- Better solutions to drug abuse