Technical Assistance for City of San Antonio First Response System

DATA ANALYSIS, REVIEW, AND PROGRAM RECOMMENDATIONS

August 2021

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Contents

Executive Summary

The Meadows Mental Health Policy Institute (Institute) submits this analysis of San Antonio Police Department (SAPD) response to mental health emergencies to city of San Antonio (COSA) leadership, in fulfillment of our agreement with the city. This report includes findings and recommendations for expansion of policing and community approaches to mental health emergency response. Additionally, it describes findings from discussions with multiple key stakeholders in the COSA community as well as quantitative data analyses on the prevalence, intensity, and type of mental health emergency calls and high-volume response areas.

The Institute was engaged effective March 17, 2021, to provide technical assistance to COSA in improving the first response system. COSA's goal is to ensure that, in an incident involving an individual experiencing a mental health emergency, first responders facilitate access to clinical care as quickly as possible. The Institute was asked to identify potential programmatic and system transformation opportunities informed by existing data on integrated response best practices in the first response system to meet the goal of rapid access to appropriate clinical care.

We wish to acknowledge our project partners, including COSA, SAPD, and Southwest Texas Crisis Collaborative (STCC), a division of Southwest Texas Regional Advisory Council (STRAC). Each has provided significant and ongoing support throughout the data collection and analysis phases.

Our analysis of available data and current policies and protocols are detailed in this report. We found significant strengths and opportunities within COSA specifically and the broader San Antonio community for transforming first response options for people in behavioral health crises. The Institute's recommendations were developed based on our analysis of available data, program reports and protocols, and interviews with key informants and stakeholders. The recommendations provide a roadmap for COSA to follow that will transform the first response to people experiencing a mental health emergency, ensuring individuals receive appropriate clinical care as quickly as possible while also protecting public safety.

Key findings include:

- There is a strong foundation of effective, cross-system collaboration among first responder agencies, local leadership, community providers, and health systems.
- COSA and its key partners, including and most specifically the Center for Health Care Services (the Bexar County local mental health authority [LMHA]), have in the past partnered to create a team approach to integrated intervention. These past experiences will be useful in informing the process of broader system transformation.
- As in most communities in Texas, the current crisis care continuum in COSA considers transport to an emergency department for evaluation as the primary/initial response to people in experiencing a mental health emergency.
- Data sharing to support service decisions is an important component of a comprehensive crisis continuum of care. The Signify Community data-sharing platform

managed by STRAC is an important community resource in data sharing that can support implementation of our recommendations for system transformation.

Key recommendations are:

- Follow a data-driven public safety model as system transformation is developed and implemented.
- Refine the current data-entry processes of police within the COSA data system to further identify gaps in information, namely by requiring entry of disposition or outcome codes, and develop process and reporting protocols to collect and disperse identified information to proper leadership for program development and response refinement purposes.
- Integrate licensed clinicians into the 911 Call Center to support identification, alternative response decision making, and consultation for public safety response to behavioral health emergency calls.
- COSA and its public safety partners should adopt the Multi-Disciplinary Response Team (MDRT) model. Existing collaborations and services can be leveraged so that the MDRT model is implemented based upon identified needs and service utilization patterns; this information as well as our call for service data analysis can inform the locations and time coverage for initial MDRT deployment.
- Align and enhance all six essential conditions of MDRT success with the program roll out in San Antonio. To date, the Meadows Institute has identified six essential conditions for MDRT success, one of which is adding a clinician to the 911 call center. The other five are noted in the report. While each is present in San Antonio currently or could be added, but they will need to be augmented and aligned with MDRT implementation, if that implementation is to be successful
- Assess the optimal roles of peers and licensed clinicians over time. The key is both efficiency and optimal credibility within the system in general, and with the law enforcement agency in particular, regarding diagnosis and judgment as to whether the individual can remain safely in the community or requires a more structured setting.

The recommendations included in this report are grounded in the principle that response to mental health emergency should be medically facing and mental health care is best delivered as part of all other health care. These recommendations provide COSA with an opportunity to achieve its goal of facilitating access to clinical intervention as quickly as possible when a person with behavioral health needs comes in contact with the first response system in this community.

Introduction

COSA engaged the Institute to support its goal of improving the first response system so that first responders can facilitate rapid access to appropriate clinical care for people in crisis who also have mental health treatment needs. We were asked specifically to assess the current state of law enforcement response to mental health related calls in COSA's first response system, provide best-practice recommendations, and develop a workplan to support the city in implementation efforts. Our engagement included a data-driven analysis, stakeholder interviews, community program review, and a review of best practices to support recommendations for policy and program developments. COSA also requested a narrative report and final presentation by the Institute to stakeholders with findings and recommendations.

Specifically, COSA engaged the Institute to complete the work detailed below. Following the process outlined below, we gathered quantitative and qualitative data, which led to key findings, including potential programmatic needs and service system responses and gaps:

- Analyze data focused on outcomes of calls determined to be mental health related. To quantify frequency and develop potential recommendations for alternative response, we examined these factors: all levels of response to resistance, number of arrests of people reported as having mental health issues, and calls categorized as mental health specific received by 911 and others.
- Analyze 911 calls and dispatch data to identify potential opportunities within the 911 Call Center's processes for triage and dispatch changes regarding mental health calls.
- Inventory local programs to identify opportunities to expand upon, coordinate with, and leverage San Antonio's existing strong foundation of community mental health and crisis response programming (Mobile Integrated Healthcare [MIH], Specialized Multidisciplinary Alternative Response Team [SMART], Chronic Crisis Stabilization Initiative [CCSI], Program for Intensive Care Coordination [PICC], Mobile Crisis Outreach Team [MCOT], and possibly others).
- Review data and information collected in existing reports related to emerging best practices in response to mental health calls from other communities and identify strategies that align with COSA's system framework.
- Identify emerging best practices found in existing assessments/reports completed by the Institute and in other communities, including Austin, Houston, and Dallas, regarding response to individuals experiencing mental health emergencies in community first response systems. Utilize these as potential models to be integrated into COSA agencies, such as San Antonio Police Department and San Antonio Fire Department.
- Identify enhancements/changes to existing programs and trainings and/or develop additional interventions with key stakeholders that address the identified goal of improving the first response to mental health emergencies.
- Identify any policy or procedure changes across systems that would be necessary or desirable to support the goals identified above.

- Identify strategies to bring together stakeholders, including community-based organizations, to ensure the new first response strategies developed fulfill the stated purpose and goal of the planning process.

Stakeholder Involvement and Planning

To evaluate the current state of cross-system coordination, SAPD partner relations, and first response gaps and strengths, the Institute requested stakeholder feedback with leadership from SAPD, the Bexar County Sherriff's Office (BCSO), the Center for Health Care Services (CHCS), and other key stakeholders representing San Antonio's crisis response and behavioral health programming resources.

While preparing the report, the Institute met with SAPD leadership on an ongoing basis to understand the background of the data, confirm our interpretation of the data, and gather input on data findings and possible recommendations. Leadership of the city manager's office also reviewed findings and recommendations throughout the report writing process to gain awareness and provide feedback.

At the request of the assistant city manager, the Institute provided an interim presentation to the Community Health and Equity Committee. The Institute gave a final presentation to the Public Safety Committee to provide an in-depth understanding of report content and allow key COSA stakeholders to confirm our information prior to finalizing and sharing the report.

A complete list of stakeholders can be found in Appendix A.

Data Sources and Analysis

The most reliable data source for call type identification is an officer disposition or outcome code.[1] However, SAPD does not have a system in place to allow, or mandate, an officer to add a dispositional or outcome code to identify when an emergency call required mental health intervention or resources. Therefore, we are only able to provide analysis for the calls identified as primarily mental health related in dispatch. Although this may underrepresent the true volume of mental health emergency calls, we targeted our data on the three primary codes used by SAPD to indicate a mental health issue. Those three Mental Health Call Codes (MH Call Codes), from lower to higher priority and level of response, are included in Table 1 below.

[1] Neusteter, S. R., Mapolski, M., Khogali, M., & O'Toole, M. (2019). *The 911 call processing system: A review of the literature as it relates to policing*. The Vera Institute of Justice. https://www.vera.org/downloads/publications/911-call-processing-system-review-of-policing-literature.pdf

Table 1: Mental Health Call Codes[2]

Mental Health Call Codes	
Call Code	**Description**
Mental Health Routine (MH Routine)	Used when a subject is reported to be mentally or emotionally unstable and/or has a history of mental or emotional disorder. Police assistance is requested to prevent a disturbance from occurring. Used when a call does not fall under a higher priority such as Mental Health in Progress or Mental Health Disturbance.
Mental Health Disturbance (MH Disturbance)	Used when subject is reported to be mentally or emotionally unstable and/or has a history of mental or emotional disturbance. Subject is loud, argumentative, unruly, disturbing the peace, or any other occurrence that the reporting person feels requires police attention. Subject and/or public may require medical attention.
Mental Health in Progress (MH in Progress)	Used when a subject is reported to be mentally or emotionally unstable and/or has a history of a mental or emotional disorder. Subject poses an imminent threat to self and/or other with or without a weapon.

Frequency Data Analysis

Table 2 indicates the volume of MH Call Codes by year. There are two mental health call types which make up the greatest number of SAPD mental health emergency calls: MH Disturbance and MH Routine.

Table 2: Mental Health Calls by Type (January 2019–April 2021)

Mental Health Calls by Type (January 2019–April 2021)				
Call Type	**2019**	**2020**	**January–April 2021**	**Grand Total**
Mental Health Routine	8,869	9,648	3,444	21,961
Mental Health Disturbance	8,732	10,300	4,185	23,217
Mental Health in Progress	3,897	4,226	1,631	9,754
Total	21,498	24,174	9,260	54,932

This data, which are calls received in SAPD dispatch, are visualized below using heat maps, or two-way displays of data matrices where data values are transformed to color scale. The color

[2] San Antonio Police Department (personal communication, 2021).

of each cell is proportional to its position along a color gradient. The gradient used for this analysis ranges from dark green to dark red, with dark green representing lower call volume and dark red representing higher call volume.

Map 1 displays emergency calls identified as a mental health emergency by SAPD call takers in 911 dispatch from January 2019–April 2021. As can be seen below, the highest rates of mental health calls occur between 10:00 AM and 7:00 PM Monday through Friday, with the greatest frequency taking place between Tuesday and Thursday.

Map 1: All Mental Health Calls (January 2019–April 2021)

	Day of Week						
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	213	193	226	220	262	235	258
1.00	193	188	197	197	223	200	222
2.00	194	142	166	164	179	181	178
3.00	172	150	140	136	144	155	172
4.00	126	137	123	138	128	152	163
5.00	119	120	118	140	111	124	137
6.00	102	151	150	136	138	132	117
7.00	163	203	246	204	236	204	138
8.00	164	282	314	342	316	282	270
9.00	237	345	490	413	410	396	348
10.00	283	442	513	501	494	428	430
11.00	301	501	511	489	509	482	440
12.00	358	450	587	583	522	484	418
13.00	336	498	560	577	520	473	430
14.00	352	511	549	586	535	459	375
15.00	337	420	440	439	483	413	346
16.00	343	429	479	449	421	483	394
17.00	341	472	458	504	427	410	343
18.00	377	448	424	527	443	379	388
19.00	356	453	444	524	445	393	354
20.00	402	434	397	464	382	410	363
21.00	336	390	365	431	411	334	330
22.00	299	322	332	342	333	294	312
23.00	244	285	285	238	291	270	298

In Map 2, mental health calls are differentiated by type. MH Routine calls show significant saturation beginning at 9:00 AM but begin to slow in frequency at 2:00 PM, whereas disturbance calls are less saturated but begin at a similar time and continue through 9:00 PM. This is important to note when considering services that might be required within specific types of response. MH Routine calls, as an example, might require the officer or team dispatched to facilitate a connection to community-based services or to complete an emergency detention for a patient at a local emergency department. However, MH Disturbance calls frequently occurred in areas with high overlap of other public safety calls, such as disturbance, family violence, and calls for service with weapons present.[3] A response to these calls might result in a more intense formal disposition, such as a potential arrest or an emergency detention initiated on the call scene. It was important to consider these details as we developed recommendations and interventions, as discussed later. MH Disturbance calls occur most frequently from 12:00 PM –

[3] For more, see Table 6.

9:00 PM Monday through Friday. MH Routine calls occur frequently from 9:00 AM – 12:00 PM Monday through Saturday but are most concentrated during that same time on Tuesdays and Wednesdays.

Map 2: All Mental Health Calls by Type (January 2019–April 2021)

	Problem / Day of Week																							
	Mental Health Disturbance							Mental Health In Progress ^							Mental Health Routine									
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat			
0.00	96	89	108	92	120	104	126	34	30	38	39	36	38	33	83	74	80	89	106	93	99			
1.00	68	81	97	89	111	101	118	29	37	35	23	42	30	37	96	70	65	85	70	69	67			
2.00	91	63	87	76	72	79	84	29	29	22	32	34	29	23	74	50	57	56	73	73	71			
3.00	81	66	58	46	67	80	88	18	26	19	31	19	21	22	73	58	63	59	58	54	62			
4.00	47	66	52	61	69	76	82	23	16	17	20	20	21	25	56	55	54	57	39	55	56			
5.00	46	43	51	57	47	64	62	26	29	18	24	20	19	18	47	48	49	59	44	41	57			
6.00	43	72	71	55	66	61	51	19	27	27	23	23	25	20	40	52	52	58	49	46	46			
7.00	67	89	118	93	106	81	56	33	30	42	30	34	33	20	63	84	86	81	96	90	62			
8.00	73	112	129	143	138	104	97	33	51	55	59	48	39	47	58	119	130	140	130	139	126			
9.00	119	120	188	134	166	133	97	52	52	59	56	48	59	47	66	173	243	223	196	204	204			
10.00	139	168	198	179	186	158	127	57	74	56	62	61	55	47	87	200	259	260	247	215	256			
11.00	129	201	182	187	172	154	136	75	78	75	70	86	94	74	97	222	254	232	251	234	230			
12.00	165	179	202	211	207	204	132	83	75	78	88	76	70	77	110	196	307	284	239	210	209			
13.00	156	195	194	218	190	177	154	78	81	83	107	99	81	92	102	222	283	252	231	215	184			
14.00	162	216	242	211	221	189	134	71	86	74	95	91	89	84	119	209	233	280	223	181	157			
15.00	151	198	201	164	187	174	140	64	72	67	84	83	81	69	122	150	172	191	213	158	137			
16.00	137	221	212	208	173	197	173	83	69	102	71	93	112	73	123	139	165	170	155	174	148			
17.00	158	231	223	207	176	182	138	60	97	94	102	96	92	82	123	144	141	195	155	136	123			
18.00	170	222	217	203	188	176	184	83	72	79	111	96	71	75	124	154	128	213	159	132	129			
19.00	156	224	220	233	203	171	141	84	94	92	101	88	81	72	116	135	132	190	154	141	141			
20.00	180	211	184	213	171	186	167	85	82	79	97	68	84	70	137	141	134	154	143	140	126			
21.00	138	195	187	221	180	133	141	84	78	58	74	79	74	63	114	117	120	136	152	127	126			
22.00	126	146	131	154	156	132	141	64	59	79	67	75	63	64	109	117	122	121	102	99	107			
23.00	93	136	115	107	139	129	128	49	45	53	31	47	40	54	102	104	117	100	105	101	116			

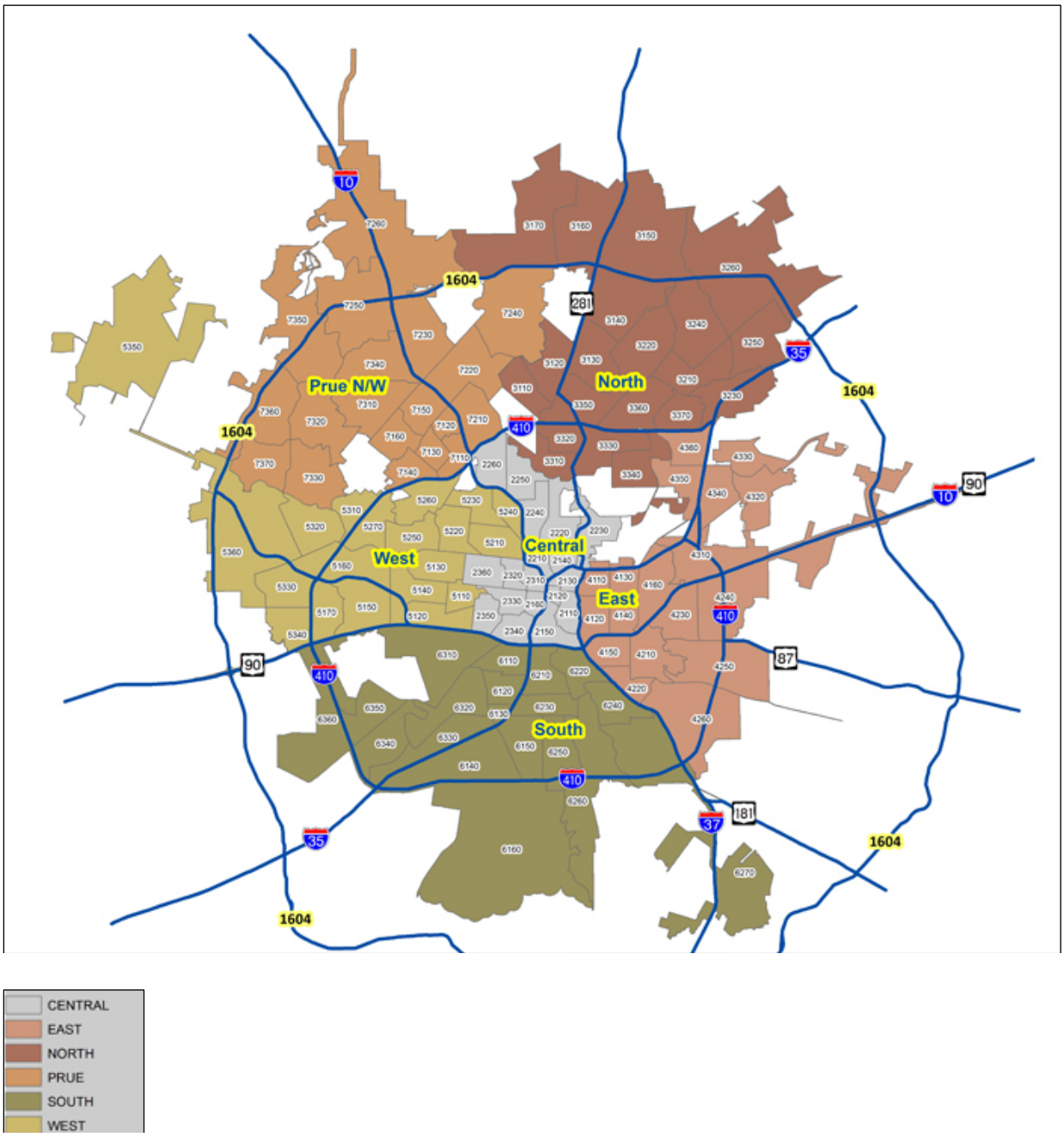
We also examined mental health calls by districts to determine the areas of most need. Map 3 shows SAPD's six service districts: Central, East, North, Prue, South, and West. Together, these districts cover a 500 square mile service area; Table 3 shows the square mileage of each district, organized by size.

Table 3: San Antonio Police Department Service Areas[4]

San Antonio Police Department Service Areas	
Service Area	**Service Area Square Miles**
Central	26 sq. miles
East	69 sq. miles
West	79 sq. miles
Prue	94 sq. miles
North	101 sq. miles
South	132 sq. miles

[4] San Antonio Police Department (2020). Internal Affairs Annual Report. https://www.sanantonio.gov/Portals/0/Files/SAPD/IAReport_2020.pdf

Map 3: San Antonio Police Department Substation and District Maps[5]



Maps 4 and 5 show that two districts account for the greatest number of mental health emergency calls: Central and PRUE. Central is SAPD's smallest service area, covering 29 sq. miles in the downtown area.

[5] SAPD Strategic Intelligence & Analytics (2014). San Antonio Police Department Substation and District Maps. https://www.sanantonio.gov/SAPD/Substations-Map

Map 4: Mental Health Calls by Day of Week, Hour, and Battalion (Central, East, North) (January 2019–April 2021)

	CENTRAL							EAST							NORTH						
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	37	36	47	39	47	48	55	21	24	36	32	35	29	20	39	29	33	25	52	41	50
1.00	34	37	42	37	41	43	40	22	31	30	21	28	24	34	23	20	32	38	33	36	46
2.00	35	33	32	34	37	43	43	19	20	23	20	20	17	24	40	19	25	25	29	24	28
3.00	35	47	34	28	33	24	32	20	16	13	15	11	20	27	27	13	22	26	19	34	24
4.00	34	32	31	22	19	30	33	12	13	18	21	20	23	21	16	21	18	29	24	22	21
5.00	34	30	24	37	25	25	28	15	14	15	22	14	17	13	12	20	19	23	14	17	22
6.00	24	16	31	18	29	28	23	19	15	20	16	12	14	17	10	21	14	18	26	16	9
7.00	28	46	47	43	48	35	28	21	29	24	42	41	29	16	29	31	44	28	34	35	28
8.00	31	69	72	89	75	69	67	28	38	44	40	47	27	30	25	33	47	57	54	45	42
9.00	46	61	89	88	91	70	80	35	50	62	50	58	50	55	38	60	86	63	61	65	47
10.00	57	83	100	86	120	84	58	27	63	65	77	72	62	58	41	61	93	67	70	70	62
11.00	64	107	106	101	108	110	56	43	73	60	60	70	69	58	33	69	84	66	74	77	77
12.00	60	80	114	117	97	89	69	52	76	89	74	77	63	66	71	76	91	85	72	83	66
13.00	70	74	99	85	82	98	70	45	63	75	76	66	54	65	58	95	82	94	91	59	63
14.00	58	78	105	98	111	93	73	50	65	72	73	71	54	50	65	83	86	92	70	78	71
15.00	54	67	81	84	87	90	82	28	53	48	58	69	54	48	72	70	78	66	87	64	59
16.00	56	64	77	84	85	86	72	35	66	74	57	57	71	47	69	74	91	74	61	87	71
17.00	61	83	81	85	66	62	57	50	60	59	66	47	58	40	50	72	76	80	75	70	67
18.00	66	72	67	85	77	70	73	47	54	60	64	57	48	43	59	80	73	73	74	61	76
19.00	51	74	76	83	78	81	84	44	51	58	51	57	52	48	70	86	79	90	73	75	62
20.00	75	76	67	88	64	81	70	49	69	54	54	48	55	40	60	72	72	87	71	71	60
21.00	64	73	71	72	67	56	67	50	52	40	58	62	47	40	58	63	75	61	68	50	62
22.00	49	70	51	54	56	53	58	36	35	36	45	49	42	45	52	55	54	68	49	41	44
23.00	51	57	61	43	57	54	57	38	32	30	36	25	33	38	34	61	41	39	47	36	46

Map 5: Mental Health Calls by Day of Week, Hour, and Battalion (Prue, South, West) (January 2019–April 2021)

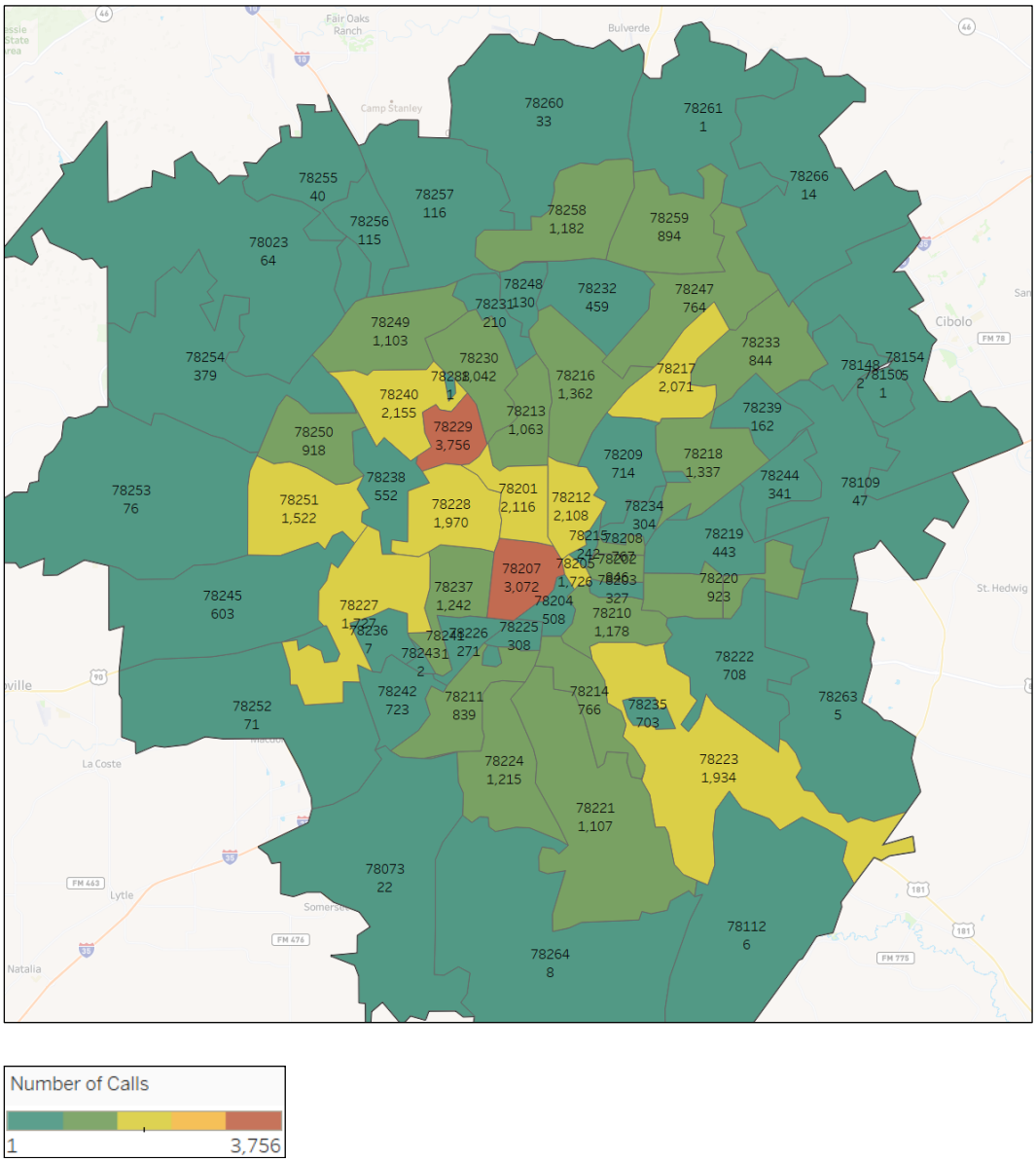
	PRUE							SOUTH							WEST						
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	45	27	38	47	51	31	47	35	38	48	31	50	41	42	35	38	24	43	22	42	42
1.00	43	40	35	42	37	37	28	36	33	26	33	43	33	37	34	24	27	25	37	25	34
2.00	39	30	30	25	35	29	25	34	27	29	32	31	39	27	26	13	25	27	25	28	30
3.00	31	32	33	21	30	24	27	29	19	22	19	21	25	30	26	20	13	27	29	22	29
4.00	24	33	20	31	19	28	37	19	18	17	18	24	29	25	20	19	17	17	20	17	22
5.00	21	21	29	24	24	28	31	24	18	15	18	17	24	24	13	15	14	15	15	12	19
6.00	16	30	39	32	24	22	28	19	38	26	23	27	26	23	13	29	20	26	16	24	16
7.00	35	35	42	36	31	33	27	26	33	40	34	43	31	19	24	25	43	21	35	38	20
8.00	34	44	44	51	49	51	47	26	50	51	54	38	40	39	18	44	46	40	37	32	29
9.00	41	49	88	72	61	54	44	42	42	60	53	61	62	39	33	61	66	43	51	60	43
10.00	60	75	76	77	76	76	68	44	70	71	65	67	56	53	51	72	77	72	60	42	52
11.00	54	77	80	91	104	77	81	46	68	70	73	69	60	65	59	78	83	79	60	55	67
12.00	64	75	119	109	92	103	70	57	62	64	86	61	55	50	51	58	73	70	86	67	65
13.00	60	99	99	107	92	101	81	62	75	75	65	71	67	58	40	67	82	110	77	69	59
14.00	55	106	89	108	105	101	67	50	82	77	84	61	58	48	71	63	75	88	85	64	40
15.00	80	92	79	98	87	82	67	56	68	78	60	72	56	36	42	61	59	49	61	55	40
16.00	71	94	87	92	88	86	75	56	66	68	64	63	85	72	48	64	75	64	55	59	47
17.00	76	107	104	99	91	103	70	57	79	58	80	71	62	61	47	68	74	70	63	48	47
18.00	78	96	80	92	93	84	73	59	69	68	73	69	59	54	67	73	74	76	67	54	65
19.00	63	105	85	100	80	76	69	64	59	80	87	78	45	50	61	74	63	64	68	60	37
20.00	87	72	75	78	75	84	72	68	62	67	87	62	57	52	57	75	58	66	58	59	64
21.00	63	81	71	89	87	72	59	44	53	49	71	63	54	63	52	65	53	74	60	48	34
22.00	48	59	81	62	61	58	65	54	53	58	59	55	42	54	58	48	46	51	56	55	40
23.00	42	50	56	45	59	54	62	40	39	45	37	57	60	47	37	43	50	36	46	31	45

Geographic Information System Analysis

We also used geographic information system analysis to take a closer look at call locations and narrow the call frequency to specific ZIP codes. The following maps show mental health calls by ZIP code, including a breakdown of the three types.

On Map 6, two ZIP codes emerge as the most frequent locations for all mental health calls: 78207 and 78229. Maps 7 and 8 help to explain what drives these frequencies: MH Routine calls in 78229 and MH Disturbance in calls 78207.

Map 6: SAPD Mental Health Calls (January 2019–April 2021)

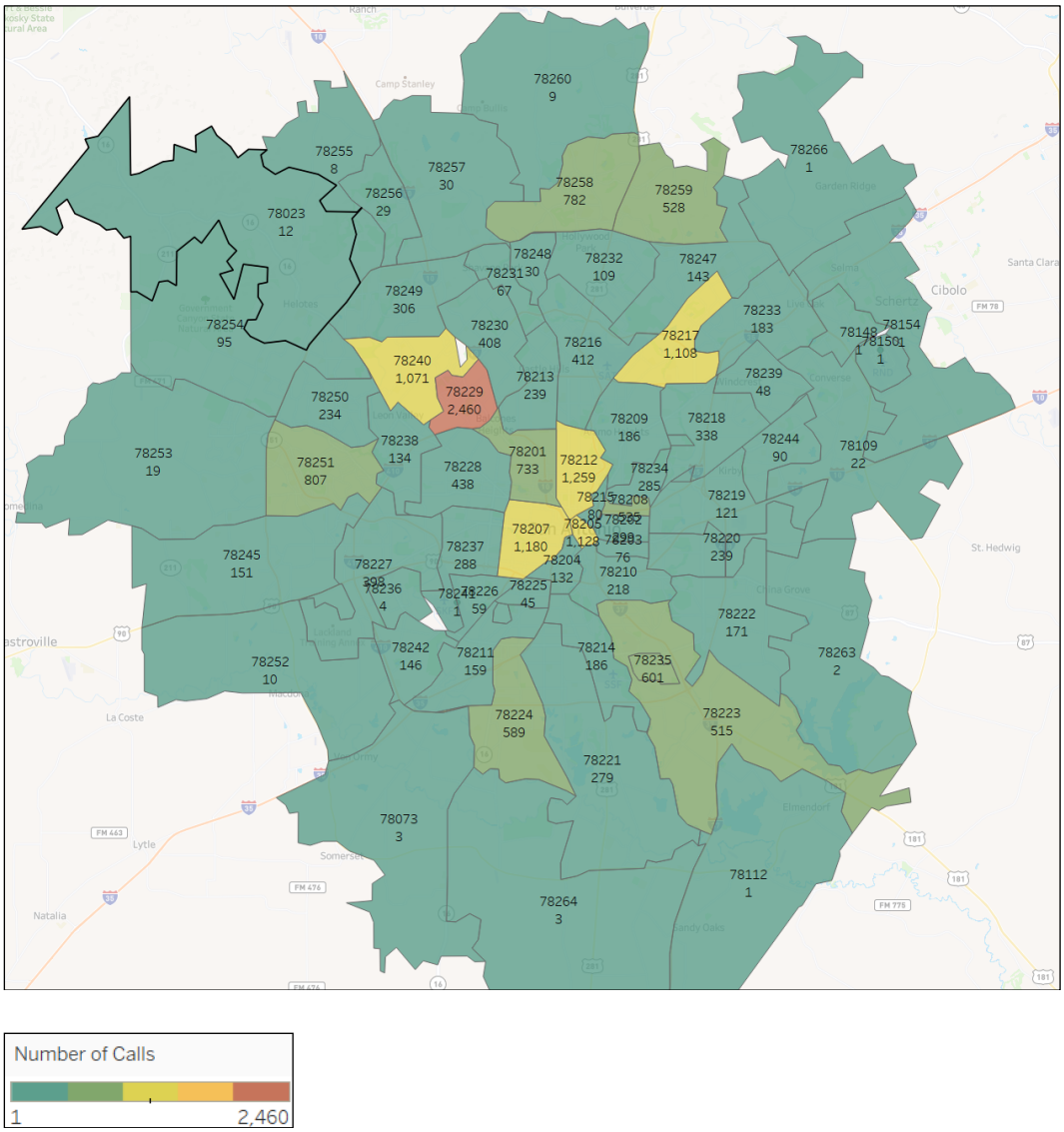


Number of Calls

1 3,756

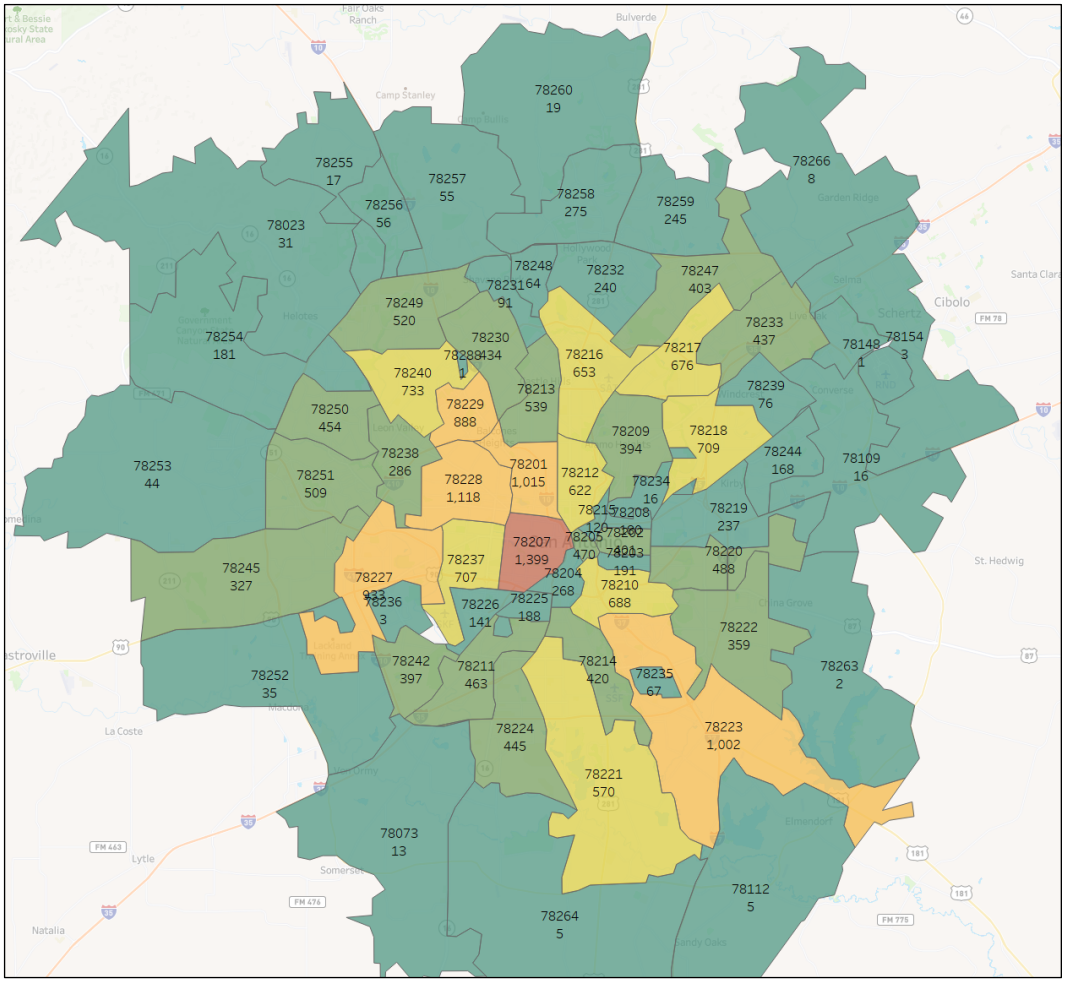
Map 7 shows that MH Routine calls occur with greatest frequency in 78229. There were 2,460 MH Routine calls for service in this ZIP code. During the same data analysis period, the area with the second highest frequency reported had 1,259 routine calls. The large number of hospitals with emergency departments requesting emergency detention services from SAPD may account for this localized saturation. Considering a partnership for emergency detention processing may be beneficial in this area.

Map 7: SAPD MH Routine Calls (January 2019–April 2021)



Map 8 examines MH Disturbance calls by ZIP code. These calls occur most frequently in 78207 and require the greatest level of intensity and public safety needs, signifying that a specialized hybrid public safety response may be effective in this area.

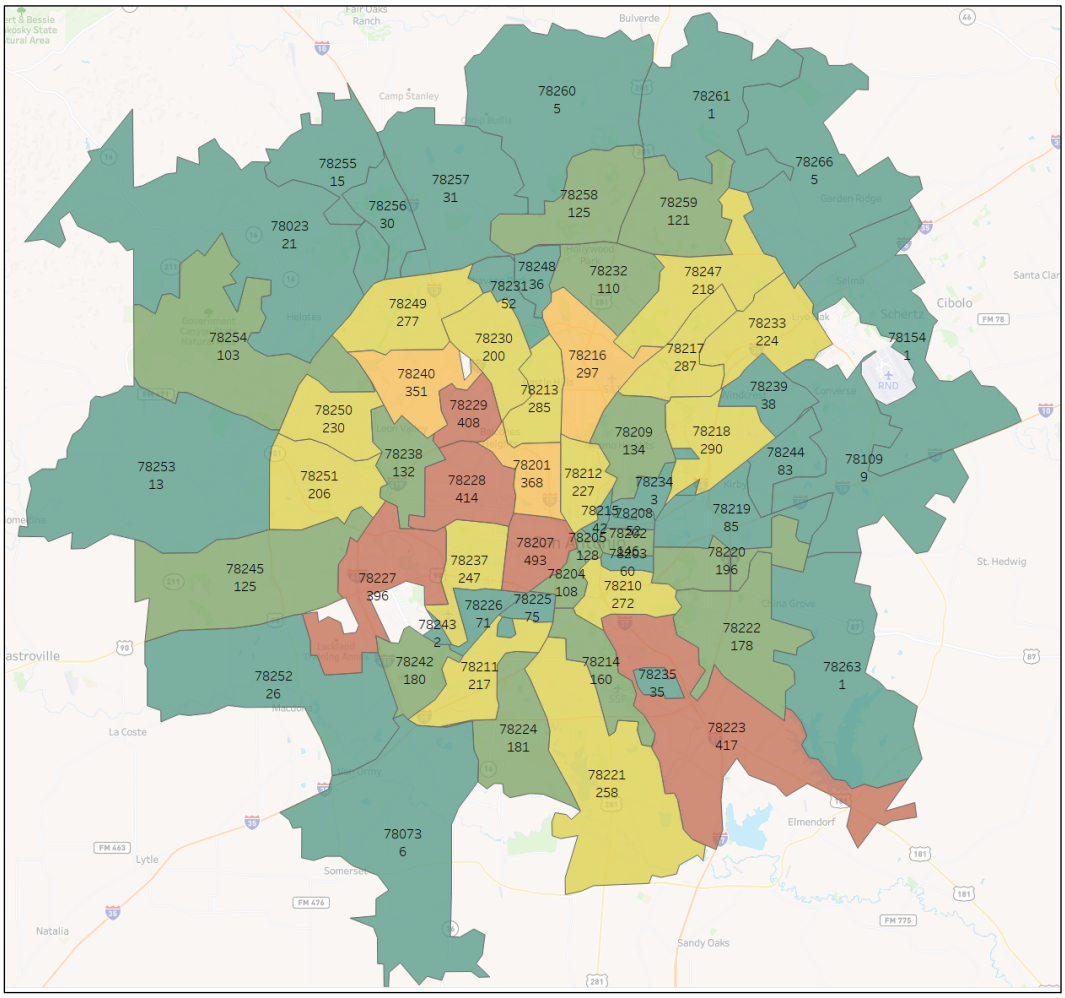
Map 8: SAPD MH Disturbance Calls (January 2019–April 2021)

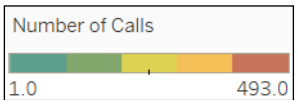


Number of Calls

1 — 1,399

Map 9: SAPD MH in Progress Calls (January 2019–April 2021)

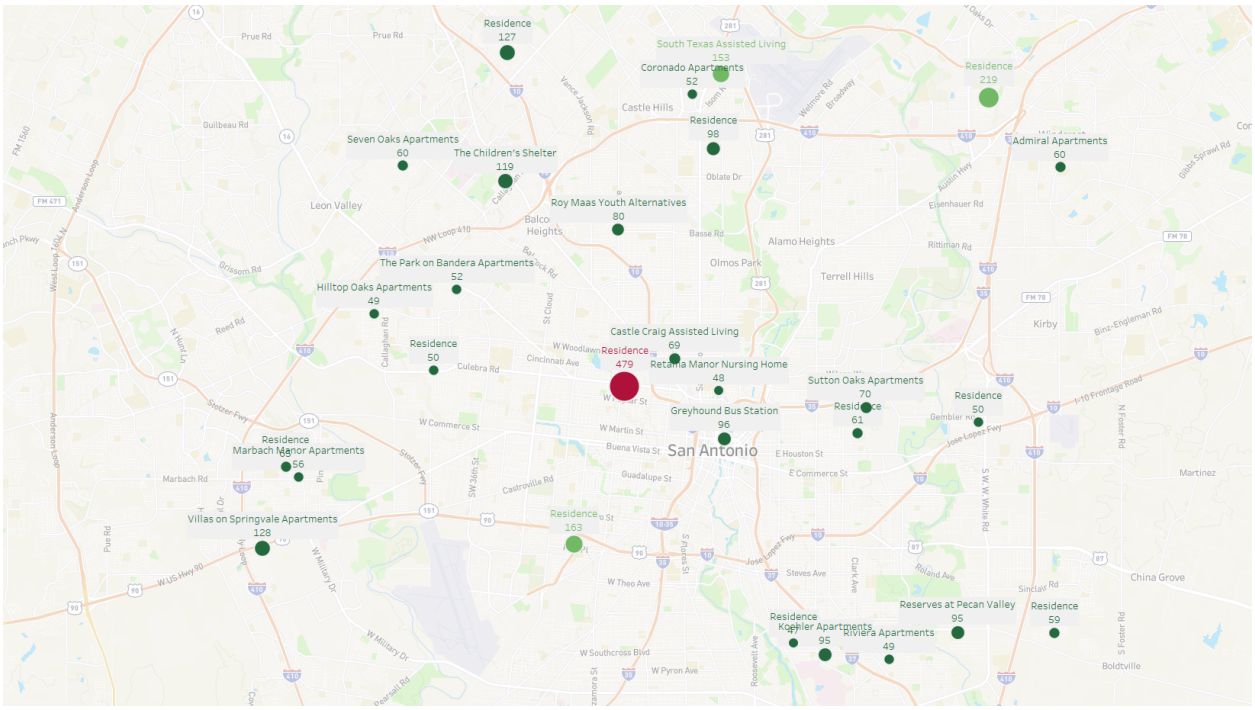




To gain a better understanding of the locations of mental health emergency calls, we identified the top addresses for all mental health calls for service.

These addresses are noted on Map 10, which shows the locations with the most MH calls during the January 2019–April 2021 period. The location with the highest number of calls (479) was a private residence, as was the second highest location (219). The locations are clustered in central San Antonio, southeast San Antonio, and on state highway 151 and loop 401.

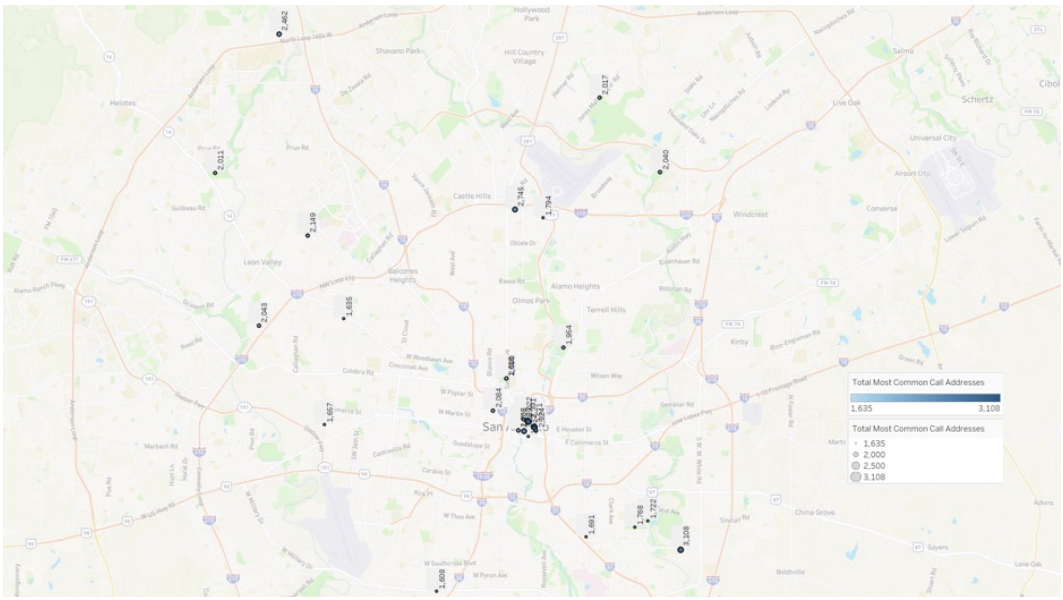
Map 10: Mental Health SAPD Calls (January 2019–April 2021)



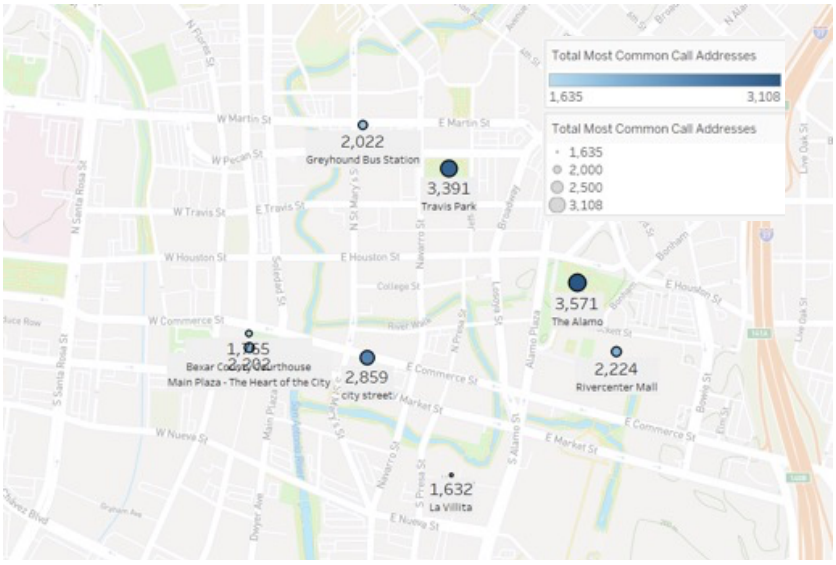
After analyzing trends for the mental health emergency calls identified by dispatch, we then analyzed the most frequent call for service types throughout SAPD and their locations. This allowed us to identify areas where mental health emergency calls have frequent overlap with other calls for service and call type. Through this analysis, and in the absence of a mental health outcome or disposition code, we can better determine the high-need areas of the city and create a correlation between high-frequency call type and mental health emergency call locations.

Map 11 shows the 28 most frequent call locations for SAPD. Some of these 28 locations were dispersed throughout the city, but most were clustered around downtown, similar to our findings for mental health disturbance calls. Map 12 shows the downtown locations for most common addresses for emergency calls. The most common location was the Alamo with 3,571, followed by 3,391 at Travis Park. There were eight locations within the 30 blocks pictured.

Map 11: Most Frequent Call Addresses for SAPD (January 2019–April 2021)



Map 12: Most Frequent Call Addresses for SAPD, Downtown Detail (January 2019–April 2021)



Map 13 shows the four locations where the most common mental health call addresses and the top total emergency call locations overlap. Three of these locations were apartment complexes, including Seven Oak Apartments, Park at Bandera Apartments, and Reserves at Pecan Valley. The Greyhound Bus Station had MH calls making up 5% of the location's total emergency calls.

Map 13: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)

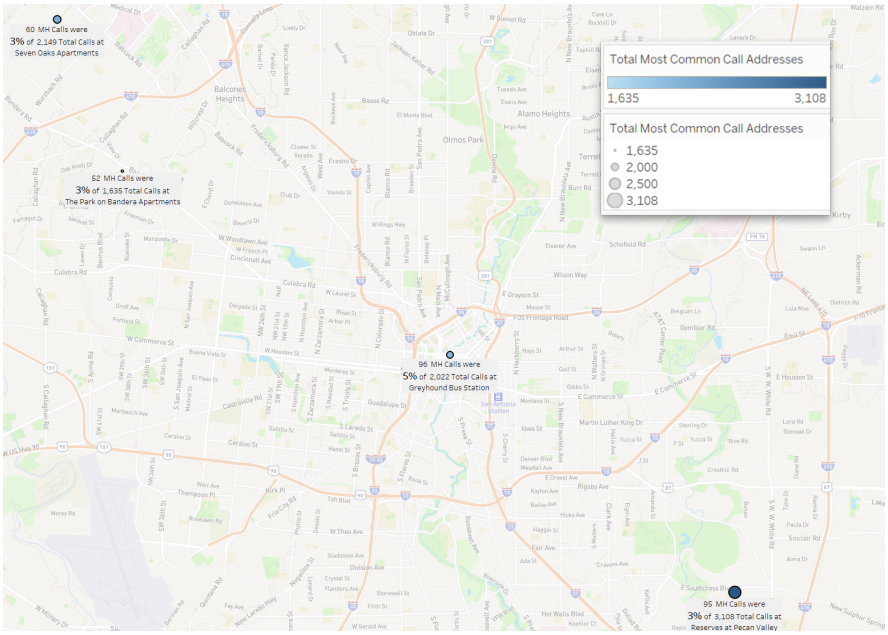


Table 4 reiterates the overlap pictured on the map. The Greyhound Bus Station Terminal had 96 MH calls, which was the highest number of MH calls of these overlapping locations and the highest proportion of total calls. The Reserves at Pecan Valley had 95 MH calls; however, this location also had 3,108 total calls, so the MH calls are a smaller proportion of total calls than the Greyhound Station. However, it is important to reiterate that the mental health calls noted are only those identified at the point of dispatch and may not represent the total of all calls with a mental health emergency response need.

Once we identified high-call overlay areas, we then analyzed the most frequent call type for each area. Through this analysis, we determined the likelihood of public safety risks associated with areas with high resource utilization, including mental health emergency resources. This correlation gave us insight into the intensity, risk level, and co-ocurring call types and events, which is useful in program design and implementation decisions.

Table 4: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)

Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)			
Place	**Total Calls**	**MH Calls**	**MH % of Tot**
Greyhound Bus Station Terminal	2,022	96	5%
Seven Oaks Apartments	2,149	60	3%
Park on Bandera Apartments	1,635	52	3%
Reserves at Pecan Valley Apartments	3,108	95	3%

Table 5 shows the call topics for all calls at the locations above where top MH and top total calls overlap. For each address, Disturbance has the highest number and proportion of MH and total calls.

Table 5: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)[6]

Locations Where Mental Health and Total Calls Overlap			
Greyhound Bus Station			
1	Disturbance	837	41%
2	z-On Site Activity	275	14%
3	911 Hang Up	77	4%
4	Welfare Check	74	4%
5	Patrol By	50	2%
	All Others	709	35%
Seven Oaks Apartments			
1	Disturbance	472	22%
2	911 Hang Up	145	7%
3	Disturbance Family	135	6%
4	Burglary (In Progress)	83	4%
5	z-On Site Activity	81	4%
	All Others	1,233	57%
Park on Bandera Apartments			
1	Disturbance	297	18%
2	Disturbance Loud Music	135	8%
3	Disturbance Family	87	5%
4	911 Hang Up	87	5%
5	Shot Fired/Heard	72	4%
	All Others	957	59%
Reserves at Pecan Valley Apartments			
1	Disturbance	542	17%
2	Disturbance Family	161	5%

[6] San Antonio Police Department (2020). Internal Affairs Annual Report. https://www.sanantonio.gov/Portals/0/Files/SAPD/IAReport_2020.pdf

Locations Where Mental Health and Total Calls Overlap			
3	911 Hang Up	150	5%
4	Shot Fired/Heard	120	4%
5	Miscellaneous	118	4%
	All Others	2,017	65%

After identifying the areas of the city with the highest number of identified mental health emergencies, we examined when these calls result in response to resistance as an additional indicator of call intensity and risk. The most frequent instances of response to resistance occurred in a concentrated geographic area downtown; this is consistent with the area including the highest number of MH Disturbance calls and the highest number of calls for service with public safety risks. Map 14 shows the locations of where response to resistance incidents correlate with MH calls. Each dot represents one incident, and no location had more than one response to resistance incident reported. The arrows indicate three locations that were on the list of most common MH call locations: the Greyhound Bus Station Terminal, the South Texas Assisted Living Facility, and the Park at Bandera Apartment Complex.

Map 14: Response to Resistance Locations on Mental Health Calls by Response to Resistance Incident Type[7] (January 2019–April 2021)

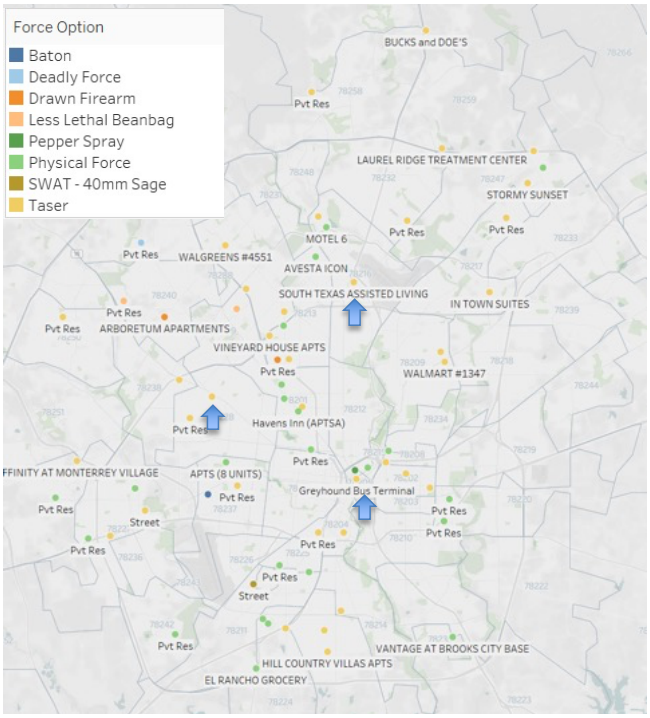


Table 6 lists the locations where MH calls and response to resistance incidents correlate. The Park at Bandera Apartments had 52 mental calls, which were 3% of 1,635 total calls to that

[7] Map 10 accounts for 68 total incidents.

location, and one incident involving a response to resistance incident. The Greyhound Bus Station Terminal had 2,022 total calls, 96 mental health calls, and one response to resistance incident. The South Texas Assisted Living facility had 153 mental health calls and one response to resistance incident; however, it was not on the list of top overall emergency calls.

Table 6: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)

Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)				
Locations	**Total Calls**	**MH Calls**	**MH % of Total**	**Response to Resistance Incidents**
South Texas Assisted Living[8]		153		1
Greyhound Bus Station Terminal	2,022	96	5%	1
The Park at Bandera Apartments	1,635	52	3%	1

Local Program Inventory and Analysis

Our inventory functions within the context of the ideal system of care and the framework of SIM mapping.

The Ideal System of Care

The guiding principle for our work in the San Antonio community and throughout Texas is that the traditional approach of treating the mind and body separately has led to inadequate and often inappropriate care for people with mental illnesses and substance use disorders; an overuse of jails, emergency departments, and hospital beds; and treatment of adults with serious mental illnesses and children and youth with serious emotional disturbances that stands in sharp contrast to the integrated care provided to people with complex physical health needs. Care for mental illness and substance use disorder should be the same as care for physical illness, unless clinical needs or public safety warrants a specialty approach, with integration of care the norm and not simply a goal. For more details on transforming mental health care please see the publication, *A Unified Vision for Transforming Mental Health & Substance Use Care*.[9]

There are several principles that flow from this guiding principle. The principles used to guide this report include:

- Identification and treatment of mental illnesses and substance use disorders should occur at the earliest stage in the illness, just as with all other physical illnesses.

[8] Although South Texas Assisted Living was included in the locations for highest volume mental health calls, it was not included on the list for the locations with highest volume of all types of calls received by SAPD.
[9] MMHPI. (2020, December 16). *A unified vision for transforming mental health & substance use care*. https://mmhpi.org/topics/announcements/unified-vision-launch/

Additionally, treatments should be provided, whenever possible, in the general health care system, from the initial response to a crisis using outpatient and inpatient care, with specialty care reserved for those whose needs cannot be addressed by the general health care system. In practice, this means that traditional reliance on law enforcement response to behavioral health crises should be shifted, to the degree possible, to the medically facing response used for all other health crises.

- It is particularly important to identify and provide treatment for children, youth, and families at the earliest possible point because untreated mental illnesses, emotional disturbances, and substance use disorders can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.
- Many people with diagnoses of mental illnesses and substance use disorders have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses, such as depression or substance dependence, that can compromise care. Given this, emergency assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and treat both physical and mental health conditions, including medically supervised detoxification and medication-assisted treatment. Cross-system efficiencies that target navigation and coordination of treatment need to incorporate trauma-informed responses, beginning in the least restrictive settings, and include capabilities to identify acute physical and behavioral health needs at each entry point. When more intensive treatment is necessary, coordination should be person centered, with the transferring systems – not the person – assuming responsibility for communicating details about the crisis and coordinating transitions between levels of care. Lastly, communities should prioritize the expansion and evolution of existing intensive community-based services to reduce the need for hospitalizations, incarceration, and crisis services, with the ultimate goal of improving health, well-being, and quality of life for those in need.
- We use the term "behavioral health" to include mental illnesses and substance use disorders, both separately and as co-occurring health care needs. It is important that mental health and substance use disorder services are integrated into an ideal behavioral health system. Specific substance use disorders treatment protocols, such as medically supervised detoxification and medication-assisted treatment, need to be developed within the broader context of integrated physical and behavioral health care.

No community in Texas or the nation has a system that seamlessly incorporates all of these principles. In many instances, behavioral health care delivery is fragmented and segregated from the health care system.

Crisis Response within the Ideal System of Care

The Texas Administrative Code defines "crisis" as a situation in which (a) a person presents an immediate danger to self or others, (b) a person's mental or physical health is at risk of serious deterioration, or (c) a person believes that they present an immediate danger to self or others or that their mental or physical health is at risk of serious deterioration.[10] Common examples of a mental health emergency include (1) thoughts or plans to commit suicide; (2) a person's existing mental health disorder deteriorates, creating severe symptoms; (3) someone whose current functioning restricts their ability to go school or work, maintain healthy relationships, or successfully engage in activities of daily living; or (4) major changes in mood that affect functioning.

From a system intervention perspective, individual mental health emergencies exist on a spectrum, with some crises requiring immediate intervention in a safe and secure place such as an emergency room, whereas others are best resolved and treated in a community-based setting, such as a school, office, via telehealth, or in a home environment. Both ends of the crisis system spectrum require a significant response; however, the challenge lies in ensuring treatment occurs in the most appropriate setting.

The need to refocus community response to mental health emergencies from a primarily law enforcement response has assumed new urgency with the COVID-19 pandemic[11,12,13] and calls to redesign policing more broadly.[14] There are now renewed efforts to provide law enforcement agencies with models to shift their role as "default first responders to numerous social issues that they are neither trained nor equipped to properly handle,"[15] to more effective responses that provide access to needed medical care and resources rather than criminalizing behaviors related to mental illnesses and other health and social needs.

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[10] Texas Administrative Code, Title 25, Part 1, Chapter 416, Subchapter a, Rule §416.3 (2014). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3

[11] Meadows Mental Health Policy Institute. (2020, April 28). Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession). http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpacts.pdf

[12] Meadows Mental Health Policy Institute. (2020, June 15). Projected COVID-19 MHSUD impacts, volume 2: Effects of COVID-induced economic recession (COVID recession) on veteran suicide and substance use disorder (SUD). http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpactsVeterans.pdf

[13] Meadows Mental Health Policy Institute. (2020, August 6). Projected COVID-19 MHSUD impacts, volume 3: Modeling the effects of collaborative care and medication-assisted treatment to prevent COVID-related suicide and overdose deaths. http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf

[14] For an example, see: Policing Project. (2020). *Reimagining public safety.* NYU School of Law. https://www.policingproject.org/rps-landing

[15] Neusteter, R. S., et al. ((2019). Gatekeepers: The role of police in ending mass incarceration. Vera Institute of Justice. https://www.vera.org/downloads/publications/gatekeepers-police-and-mass-incarceration.pdf

These national and state efforts aim to improve mental health crisis response.[16] However, they generally center on the mental health sector rather than health systems more broadly while ignoring the justice system, and they also tend to focus on resolving the immediate need rather than a more systemic approach. Response models such as 988, crisis response centers, the Crisis Now framework, and mobile crisis outreach teams are designed to respond outside of the 911 system used for general health emergencies. The national 988 number for mental health crisis response[17] explicitly seeks to create routes to crisis care separate from, not just police, but the entire 911 emergency response system. Similarly, the full-service crisis response centers and comprehensive mental health crisis systems based on the Crisis Now framework[18] seek to maximize the number of people with mental illness served within mental health systems and minimize those coming to the attention of law enforcement.

The ideal crisis continuum is based on the fundamental principle that people have the greatest opportunity for healthy development when they maintain their ties to community and family while receiving help. The Substance Abuse and Mental Health Services Administration practice guidelines provide an overview of the ideal continuum of crisis services and outline essential values for crisis services. These values and guidelines emphasize:

- rapid response,
- safety,
- crisis triage,
- active engagement of the person in crisis, and
- reliance on natural supports.[19]

In this section of the report, we focus on the San Antonio first response system and local programs and services within that system as part of the current crisis continuum. It is important to remember that the ideal crisis continuum exists within a broader system of care that identifies and responds to the behavioral health needs of the individual in a community. Without the availability of and coordination with community-based behavioral health services that address needs ranging from mild to severe, the crisis end of the services spectrum, especially the first response system, becomes the default point of entry for care. In the ideal system, most people would have their behavioral health needs identified prior to reaching a point of crisis.

Developing a strong community-based services continuum that people can access prior to being in crisis is critical to preventing crises and maximizing efficient use of the available crisis

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[16] Substance Abuse and Mental Health Services Administration. (2020). *National guideline for behavioral health crisis care: Best practice toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[17] National Suicide Hotline Designation Act of 2020 (S. 2661). (n.d.). https://www.govtrack.us/congress/bills/116/s2661

[18] Transforming Crisis Services. (2020, November 05). https://crisisnow.com/

[19] Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Office of Consumer Affairs, Center for Mental Health Services. https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf

services. When meaningful community-based alternatives to inpatient treatment are absent, many people in crisis have nowhere to turn but to the most restrictive, disruptive, and expensive care.

Inventory of Local Programs

There is an existing foundation of effective services and programs within the COSA first response system. The collaboration among COSA, Bexar County, CHCS, STRAC, service providers, and other community stakeholders is impressive and will support efforts to improve the local system.

Table 7: Inventory of Local Programs

Inventory of Local Programs	
San Antonio Police Department Programs	
Crisis Intervention Team (CIT) Training	All SAPD patrol officers receive the state-approved, 40-hour CIT training as well as regular refresher trainings on topics related to crisis intervention, de-escalation, and mental health. Staff at the 911 Call Center also receive training on crisis event call recognition.
Mental Health Unit (MHU)	SAPD has a dedicated Mental Health Unit staffed with a supervisor, two detectives, 10 patrol officers, and three clinicians. The Mental Health Unit is not dispatched by the 911 Call Center as a first response but supports officers in the field when requested and follows up after a crisis is resolved to ensure connection to community treatment and support.
Partner Program Collaboration Support	SAPD provides officers from the Mental Health Unit to support other community partner cross-system programming for other targeted interventions discussed.
Bexar County Sheriff's Office Programs	
Mental Health Deputies	BSCSO has mental health deputies which are assigned from 8:00AM to 12:00AM. They are preparing to incorporate another unit into the SMART team.
Partner Program Collaboration Support	BCSO provides officers to support other community partner cross-system programming for other targeted interventions discussed.
San Antonio Fire Department (SAFD) Programs	
Crisis Intervention Team (CIT) Training	The department has made efforts to increase the number of firefighters, especially high-ranking ones, who receive CIT training. Currently, all fire cadets are receiving three days of CIT training.

Inventory of Local Programs	
Mobile Integrated Healthcare Program (MIH)	The MIH program extends the SAFD's reach into the community by allowing emergency medical service (EMS) responders to play an expanded role in proactive, non-emergent capacities, such as the PICC.[20]
Partner Program Collaboration Support	SAFD provides paramedics to support other community partner cross-system programming for other targeted interventions discussed.
Southwest Texas Regional Advisory Council Programs	
Program for Intensive Care Coordination (PICC)	PICC was developed in partnership with the SAFD's MIH program, SAPD's Mental Health Unit, and CHCS. The team works to reduce emergency detentions and the subsequent use of emergency and inpatient services by providing ongoing engagement and by meeting patients where they are. PICC sees the people who are the highest utilizers of emergency services throughout Bexar County and carries a caseload of around 100. To be eligible, a person must have six or more emergency detentions in a 12-month timeframe. The PICC roster is fluid, as it is reviewed each month to deem consumers active or inactive. Examples of why someone may become inactive include a reduction in emergency service use, a long-term incarceration, or a relocation out of Bexar County. Those who are inactive may be activated immediately when needed, such as in the case of a new engagement with law enforcement. PICC collaborates with SMART to help determine how they can best serve residents.[21]
Chronic Crisis Stabilization Initiative (CCSI)	The CCSI is a multidisciplinary team consisting of two licensed master's level mental health professionals, one credentialed case manager, and SAPD Fusion Mental Health Officers. The team works together to get people linked up to the appropriate level of care. The overall goal of the initiative is to aid people in need and prevent avoidable use of the 911 system. The team mostly responds to referrals made by city officials and SAPD, including the PICC program.

[20] For more information on the MIH program, please visit https://www.sanantonio.gov/SAFD/About/Divisions/Emerency-Medical-Services/MobileHealthcare#286043926-picc

[21] For more information on PICC, please visit https://www.strac.org/stcc-picc

Inventory of Local Programs	
MEDCOM Law Enforcement Navigation	The MEDCOM program allows for law enforcement officers to transport behavioral health patients to the most appropriate place rather than transporting them to the closest emergency room. The program includes a protocol on which resources (EMS, Fire, MEDCOM) are appropriate for a patient prior to transport. This protocol can be found in Appendix C. If a patient has no acute medical issues and is medically stable, then MEDCOM can be contacted for transport.[22]
The Specialized Multidisciplinary Alternative Response Team (SMART)	SMART is a collaborative team which operates under Bexar County's Department of Behavioral Health. The collaboration requires paramedics from Acadian Ambulance Services, clinicians from CHCS, and mental health deputies from the Bexar County Sheriff's office. Each unit consists of one paramedic, one clinician, and two mental health deputies who all serve to provide the least restrictive treatment they can offer a patient. SMART operates in both response and follow-up capacities. As a response team, SMART works to deescalates immediate crises, conduct assessments, and connect the person with appropriate services, including SMART follow-up. When following up, SMART engages or re-engages people into services with time and attention that is not always available in the field.[23]
Local Mental Health Authority – The Center for Health Care Services (CHCS) Programs[24,25]	
Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) Program	ACT and FACT teams are multidisciplinary teams consisting of licensed specialists and care managers who work together within one comprehensive, holistic team to meet the needs of people living with SMI. CHCS provides intensive services to people with complex needs who routinely cycle between jails, emergency rooms, and inpatient care and are most in need of intensive, community-based wraparound services. These services include ACT, FACT, Coordinated Specialty Care for first episode psychosis treatment, and Permanent Supportive Housing.[26]

[22] Miramontes, D., & Winckler, C. J. (2017). *Law enforcement navigation of behavioral health patients*. Southwest Texas Regional Advisory Council. https://strac.org/files/Education/2018_conference/Presentations/Mental_Health_Miramontes-Winckler_STRAC%20Leo%20Nav%202018.pdf

[23] For more information on SMART, please visit https://www.bexar.org/3330/Mental-Health-First-Response-SMART

[24] CHCS operates 19 offices throughout San Antonio that provide integrated care to people with mental health conditions, substance use challenges, and intellectual or developmental disabilities. The organization offers a wide array of services and resources, and those most relevant to San Antonio's first response system are included.

[25] For more information on CHCS and its programming, please visit https://www.bexar.org/DocumentCenter/View/27621/CHCS--Presentation

[26] The Center for Health Care Services (2021). *Program directory*. https://chcsbc.org/program-directory/

Inventory of Local Programs	
Mobile Crisis Outreach Team (MCOT)	CHCS's MCOT is designed to send crisis workers into the community to provide face-to-face assessments and interventions, follow-up, and relapse prevention services. Services are designed to reduce inpatient hospitalizations and intervention with law enforcement. Additionally, MCOT provides mental health assessments in emergency rooms and can recommend appropriate care.
The Restoration Center	The Restoration Center is law enforcement's first option to divert people with behavioral health needs from jails and emergency rooms. It is a one-stop shop to treat those in crisis and includes a Crisis Care Center, a Minor Medical Clinic, and a Substance Use Public Sobering Unit. The Crisis Care Center provides assessments and interventions 24 hours a day, the clinic can provide minor medical clearance for people brought in by SAPD, allowing for much quicker access than traditional medical settings, and the sobering unit provides a treatment alternative in lieu of arrest for public intoxication.
Partner Program Collaboration Support	CHCS provides clinicians to support other community partner cross-system programming for other targeted interventions discussed.

Analysis of Local Programs

Our inventory and analysis have focused primarily on services that provide or directly support first responders. These services are part of the SIM Intercepts 0 and 1, community services that can avoid detention (Intercept 0) and emergency department transport and law enforcement responses to 911 (Intercept 1). These initial interaction points are the starting point for a comprehensive review of the local continuum of services from incarceration to court action and return to the community. Our interviews with stakeholders and review of program protocols and reports have identified community strengths that can be leveraged to implement the recommendations from this report. Below, we discuss these strengths and challenges that must be considered to transform the local response system.

Effective Collaboration and Leadership

The San Antonio community has a strong foundation of effective collaboration among stakeholders, including community leadership, service providers and advocates. The Southwest Texas Regional Advisory Council (STRAC) supports community efforts through its Southwest Texas Crisis Collaborative (STCC), which focuses on ending ineffective utilization of services at the intersection of mental illness, homelessness, and high utilization.[27] STRAC has driven much of the collaboration around improving first response and has promoted a data-driven approach to implementing new programs, and STCC represents a national best practice unrivaled in any major metropolitan area. CHCS, the local mental health authority, provides many of the

[27] https://www.strac.org/stcc

services that make up the local continuum of care. Our interviews with stakeholders found strong collaborations among those providing direct services. Providers meet regularly, in some cases multiple times per week, to coordinate their efforts.

The Behavioral Health Committee is composed of behavioral health care providers, public safety, homeless services providers, and advocacy groups. The goal of the Committee is to convene cross-system staffing regarding the behavioral health system of care, with the goal of achieving overall system performance improvement. The execution arm of the STCC oversees the Behavioral Health Committee. Additionally, STCC oversees the Southwest Texas Crisis Collaborative Steering Committee, which is made up of top executive health system and safety net leadership who are tasked with creating a strategic vision for the overall system. Individuals involved in the Behavioral Health Committee provide day-to-day clinical operations and work together to make decisions targeted at more efficient and enhanced behavioral care in San Antonio and Bexar County.[28] A comprehensive list of organizations represented in this committee can be found in Appendix B.

Growing Experience in Transforming First Response Options

The local programs discussed in our inventory provide experience that can be leveraged in further transforming first response options. The PICC, CCSI, and SMART programs all contain many features of the MDRT model and can be the foundation for a more comprehensive first response to behavioral health crisis. SAPD's dedicated Mental Health Unit also has a history of collaborating with clinicians and promoting connections to community treatment. SAFD's experience in community health through their MIH program provides a foundation for expanded partnerships in first response. We found that most of the programs are collecting and reporting on output and outcome measures and using that data for program management, quality improvement, and cross-system coordination.

Data Sharing

The online platform Signify Community, a product of Signify Health, is a cloud-based technology platform designed to address a patient's social determinants of health (SDoH). STRAC is deploying Signify Community to members to better address patients who are the highest utilizers of crisis services. This collaborative platform aids clinicians across the system in understanding the person and their individual challenges to build a relationship based on care, concern, and compassion. It connects social, financial, and local community resources to identify and address SDoH. This leads to decreased risk factors, ensuring successful transitions from one phase of a person's health journey to the next.

Challenges

The current continuum in San Antonio supports transport to an emergency department for evaluation as a primary response to people in a mental health emergency. The MEDCOM Law

[28] Kellie Burnam, Southwest Texas Crisis Collaborative Program Manager (personal communication, July 2021).

Enforcement Navigation system managed by STRAC allows for law enforcement officers to transport behavioral health patients to the most appropriate place rather than transporting them to the closest emergency room. In 2019 and 2020, SAPD reported 29,039 emergency detentions, which is 64% of the 45,672 reported mental health calls.[29] Although not all emergency detentions come from mental health calls, emergency detention is SAPD's primary response to people in a mental health emergency. As first responses are developed that promote treatment in place and connection to less restrictive services, community education on the efficacy of community-based treatment will be important to shift the expectations of law enforcement and service providers.

It is especially important in developing a more comprehensive continuum of crisis care that there should be no wrong door to treatment. Services should be coordinated so that appropriate assessments, connections to services, and follow up as needed happen regardless of which program, team, or provider makes first contact. It can be confusing to the person in crisis as well as first responders if program criteria or process do not promote warm hand-offs and engagement in community treatment.

Emerging Best Practices in Texas

The Institute is part of a growing national effort to implement a health-driven response to mental health emergency calls through the 911 system. In May 2021, we released *Multi-Disciplinary Response Teams: Transforming Emergency Mental Health Response in Texas,*[30] which surveys available research and describes the work to date.

Multi-Disciplinary Response Teams

Although SAPD has CIT trained officers and a Mental Health Unit, this is still fundamentally a law-enforcement-driven response without prevention, intervention, and medically forward community connections to care. Even though CITs have some level of mental health training, their primary skill set remains law enforcement. They do not have the capacity, nor should they be asked, to assess mental health conditions in the field and make care decisions.

The need to refocus the default response to mental health emergencies from a primarily law enforcement response has assumed new urgency with the COVID-19 pandemic[31,32,33] and calls to

[29] Data provided by SAPD via e-mail.

[30] Meadows Mental Health Policy Institute (2021, May). *Multi-disciplinary response teams: Transforming emergency mental health response in Texas.* https://mmhpi.org/wp-content/uploads/2021/06/MDRT_PEW_Report_05282021.pdf

[31] Meadows Mental Health Policy Institute. (2020, April 28). *Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession)*. http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpacts.pdf

[32] Meadows Mental Health Policy Institute. (2020, June 15). Projected COVID-19 MHSUD impacts, volume 2: Effects of COVID-induced economic recession (COVID recession) on veteran suicide and substance use disorder (SUD). http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpactsVeterans.pdf

[33] Meadows Mental Health Policy Institute. (2020, August 6). Projected COVID-19 MHSUD impacts, volume 3: Modeling the effects of collaborative care and medication-assisted treatment to prevent COVID-related suicide and overdose deaths. http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf

redesign policing more broadly.[34] There are now renewed efforts to provide law enforcement agencies with models to shift their role as "default first responders to numerous social issues that they are neither trained nor equipped to properly handle"[35] to more effective responses that provide access to needed medical care and resources.

Although these national and state efforts aim to improve mental health crisis response,[36] they generally center only on the mental health sector rather than on ignoring the justice system and instead focusing on health systems more broadly. For example, response models such as 988 and MCOT are designed to respond outside of the 911 system used for general health emergencies. In Bexar County, the current MCOT brings a crisis worker into the community to provide face-to-face assessment, intervention, and linkage to appropriate community treatment consistent with state requirements.[37] MCOTs can be dispatched to a person's home, place of work, community setting, hospital, or school for assessment and connection to care. Services are coordinated with community organizations and are designed to reduce inpatient hospitalizations and intervention with law enforcement. As in most Texas communities, CHCS's MCOT is dispatched solely through calls received by their crisis line. Therefore, CHCS's MCOTs operate on a parallel track to police response, leaving law enforcement to provide the primary response to all other mental health emergencies dispatched through 911.

There is emerging evidence that MCOT expansion can reduce police involvement in subsets of 911 calls and deliver much-needed care to people in situations that do not pose a risk to their non-police civilian response teams.[38] However, although such programs can reduce the role of police response, they cannot eliminate it given the subset of calls that involve use or suspected use of a weapon or other risks to public safety that fall outside MCOT response parameters. Although people with mental illness have comparable rates of violence to the public, specific mental illnesses such as psychosis are at much higher risk for violence against others.[39] In addition, members of the public often perceive threats to public safety that do not actually exist, but that 911 dispatch cannot rule out. As a result, law enforcement remains an essential element of mental health emergency response because it is not possible in all circumstances to

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[34] For an example, see: Policing Project. (2020). *Reimagining public safety.* NYU School of Law. https://www.policingproject.org/rps-landing

[35] Neusteter, S. R., Subramanian, R., Trone, J., Khogali. M., & Reed, C. (2019). *Gatekeepers: The role of police in ending mass incarceration*. The Vera Institute of Justice. https://www.vera.org/downloads/publications/gatekeepers-police-and-mass-incarceration.pdf

[36] Substance Abuse and Mental Health Services Administration. (2020). *National guideline for behavioral health crisis care: Best practice toolk*it. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[37] Texas Health & Human Services Commission. (2020, April 2020). Information item V – crisis service standards. https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/community-mh-contracts/info-item-v.pdf

[38] For more information, see: Eugene Police Department. (n.d.). *CAHOOTS. https://www.eugene-or.gov/4508/CAHOOTS*

[39] Meadows Mental Health Policy Institute. (2019, November). *Mental illness and violence: Current knowledge and best practices*. https://mmhpi.org/wp-content/uploads/2018/11/Mental-Illness-and-Violence-November-2019-FINAL.pdf

know in advance which mental health emergencies may pose a public safety risk or otherwise be inappropriate for civilian response teams.[40]

So, communities seeking reform face a core dilemma: an emergency response that eliminates police is insufficient to respond to public safety, whereas a response that relies on police is insufficient to respond to mental health and broader health care needs. What is needed is a response that can assure public safety, ensure rapid identification and assessment of acute mental health and broader health care needs (including substance use), and provide access to needed assessment, treatment, and broader resources (such as housing). Multi-Disciplinary Response Teams (MDRT) can provide such a response and have become the model for our work in Texas.

The Texas MDRT model is based on a community paramedic approach and includes paramedics, licensed mental health professionals, and specialized law enforcement officers. The integrated team is organized around three core activities: first response to a 911 emergency call, provision of post-emergency follow-up to community treatment and support resources, and proactive outreach to people who chronically use emergency services to promote care in the community. The core components of the Texas MDRT model were developed through our support to leadership in Dallas in implementing the Rapid Integrated Group Healthcare Team (RIGHT Care) program in Dallas. The Institute is working in multiple community across the state to develop MDRT programs that include the core elements from RIGHT Care, with adaptations and augmentation based upon individual community needs and capacity for change.

911 Call Center Support

Staffing 911 call centers with clinical support is critical to an effective MDRT program. A clinician embedded in the call center, or available via telehealth, can assess the presence of a mental health emergency and dispatch a MDRT unit instead of a traditional patrol unit. Clinical support at the 911 call center can also connect first responders in the field to appropriate community services, provide consultation, and link to area resources to avoid jail detention or transport to an emergency department.

Telehealth Services

Telehealth, including both video and voice-only systems, can facilitate 24-hour access to medical and psychiatric staff, clinicians, and other staff for crisis evaluations and ongoing treatment. Telehealth can greatly reduce waiting time and time to initiate treatment. Increasingly, telehealth technology can support crisis interventions in the field by facilitating

[40] Consider: 1. Herrera, I. (2020, August 26). *Man, 31, killed in deputy-involved shooting on far west side, Bexar County sheriff says*. KSAT.COM. https://www.ksat.com/news/local/2020/08/26/watch-live-sky-12-over-scene-of-officer-involved-shooting-on-far-west-side/; 2. Sellars, F. S., Shepherd, K., Witte, G., Ewing, M., & Berman, M. (2020, October 27). *Protests grip Philadelphia, leaving officers injured and stores damaged, after police kill a black man.* The Washington Post. https://www.washingtonpost.com/nation/2020/10/27/philadelphia-police-shooting-walter-wallace/; and, 3. Avanier, E. (2020, September 2). *Body cam: Knife-wielding woman killed after stabbing Jacksonville officer.* News4Jax. https://www.news4jax.com/news/local/2020/09/01/body-cam-knife-wielding-woman-killed-after-stabbing-jacksonville-officer/

direct psychiatric evaluations via secure tablet platforms. Using this technology significantly improves the reach of mobile crisis services. The use of telemedicine during the COVID-19 pandemic has been well established with considerable satisfaction noted by clients and providers.[41]

Critical Program MDRT Elements

To date, the Meadows Institute has identified six essential conditions for MDRT success, one of which is adding a clinician to the 911 call center. The other five are noted below, and each is present in San Antonio currently or could be added, but they will need to be augmented and aligned with MDRT implementation, if that implementation is to be successful.

Same-Day Walk-In Clinic and Prescriber Services. Relationships with providers who will accommodate same-day walk-in clinic and prescriber services are essential. One of the great advantages of the multi-disciplinary team is that it is designed to address emergencies on site, affording people the opportunity to stay in their homes with little to no disruption of their lives and support systems. However, some people will need to be taken elsewhere to ensure their safety or for prescriber services, respite, or other supports. Walk-in clinic staff have adequate time to complete a thorough assessment and provide access to prescribers and prescription services, without the chaos often experienced in jails and emergency departments. There are a variety of ways in which this coordination can occur. Community mental health clinics with designated walk-in and priority appointments for the MDRT program serve a uniquely valuable role in emergency services by enhancing continuity of care and providing long-term community-based services in a familiar and consistent setting.

Crisis Intervention and Other Training for Officers, Clinicians, and Paramedics. Crisis Intervention Team (CIT) training for law enforcement officers began in response to an incident that occurred in Memphis, Tennessee in 1987.[42] Although CIT was intended to reduce lethal encounters between police and people with mental illnesses, it has grown to become a program expectation, replacing mobile crisis outreach team response with a law enforcement team. However, CIT remains a critical component to law enforcement training and is a prerequisite to MDRT implementation. When based on research and presented with high quality, CIT training has been shown to increase officers' confidence in responding to mental health emergency calls, improve their knowledge base, and reduce their perceived stigma of

[41] Group for the Advancement of Psychiatry. (2021, March). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. National Council for Behavioral Health. https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56

[42] Police encountered 27-year-old Joseph Dewayne Robinson in the street outside his mother's house as they responded to a 911 emergency dispatch called in by Mr. Robinson's mother. Mr. Robinson's mother called police to report that her son, who had a reported history of mental illness and substance abuse, had been using cocaine and was cutting himself and threatening people. According to reports, Mr. Robinson did not respond to verbal requests and "lunged" at the officers, who shot him multiple times.

mental illnesses.[43] However, as recent tragedies noted above show, CIT training is not enough to ensure an adequate response. Even communities with long histories of CIT training such as Houston, Texas can still put police in situations where that training is not sufficient to prevent a tragic outcome.[44] Additionally, 40 hours of CIT training does not provide law enforcement officers with the necessary medical training to differentiate needs that can be managed by a next day urgent care appointment versus those requiring emergency medical care, so people continue to be taken unnecessarily to emergency departments for that needed triage and, too often, to jail if the officers decide that detention is preferable.

With community health paramedics taking a lead role in the MDRT response, it is vital that they, too, receive CIT training. In addition, MDRT staff should receive training on policies and procedures as a group, so each member understands the responsibilities of the others. Ideally, the officers, mental health clinicians, and community health paramedics should receive all of their training together as a team to enhance shared learning, knowledge, and experiences.

Twenty-Four Hours a Day, Seven Days a Week Community Hospital Bed Capacity. Often, communities debate the need for "more beds" without considering whether there are programs in place that can reduce the need for those beds and that, in many instances, can have an impact on jail bookings as well. These programs also can provide treatment options for the MDRT program, assuring that the teams do not operate in a vacuum. One option that is central to the MDRT program success is to provide short-term hospitalization or extended observation services as an essential element of the transformed system.

Crisis Medical Care Capacity for People Under the Influence of Intoxicants. People who experience frequent mental health emergencies often have primary or comorbid substance use treatment needs. When emergency response systems are not equipped to respond to people who are under the influence of intoxicants, they are often limited to law enforcement responses, which can result in arrests. An essential element of the MDRT program is its capacity to provide effective emergency medical interventions for people who are under the influence of alcohol or other intoxicants.

Housing Referral Network. Not every person experiencing a mental health emergency struggles with homelessness; there are times when a person who already has shelter is in need of a place for respite. While only a small proportion of calls have resulted in direct linkages to housing in the Dallas RIGHT Care program (approximately 3% of calls to date), in order to ensure that people lacking safe housing do not inappropriately end up in a jail or hospital bed, a housing referral network was established prior to the launch of the RIGHT Care project and has proven to be critical to the program's success, especially when MDRT staff need to find rapid housing,

[43] Rogers, M. S., McNiel, D. E., & Binder, R. L. (2019). Effectiveness of police crisis intervention training programs. *The journal of the American Academy of Psychiatry and the Law*, *47*(4), 414–421.
[44] Blakinger, K., & Hixenbaugh, M. (2020, June 19). *"It was an execution": Nicolas Chavez was on his knees when Houston police killed him. His father wants answers.* https://www.texastribune.org/2020/06/19/nicolas-chavez-houston-police/

shelter, or shelter referrals for people in need. This network also supports effective collaboration to secure successful housing and shelter connections in times of urgent need.

Emerging Best Practices for MDRT Staffing

Two additional staffing practices are emerging: the role of peers and the optimal MDRT clinician credential.

The Bexar County SMART program employs peers, and there is a strong research base showing the value of peer support. However, incorporating peers into the SAPD's response must weigh the following factors:

- Peers cannot replace the clinician, as diagnostic authority is key, and it is not within the scope of practice of a peer specialist.
- It is not clear whether it is most cost effective to embed a peer in the MDRT response (that must respond within minutes) or in a follow-up support response (that could still fill essential peer roles, but could be more efficiently staffed).

There are also questions regarding the optimal MDRT clinician credential. Texas programs draw on both community mental health clinicians (SMART, Austin Police Department) and experienced emergency room social workers (RIGHT Care). The key is optimal credibility within the system in general, and with the law enforcement agency in particular, regarding diagnosis and judgment as to whether the individual can remain safely in the community or requires a more structured setting.

Texas Communities: Efforts to Improve Emergency Response

Dallas RIGHT Care

Dallas has implemented a MDRT program known as RIGHT Care (the Rapid Integrated Group Healthcare Team). RIGHT Care is an integrated, health-driven approach based on best practice responses to medical emergencies that have proven effective for other emergency 911 responses to people with chronic illnesses. RIGHT Care, like MDRT generally, is based on the community paramedicine approach described above and relies on carefully chosen multi-disciplinary teams of a paramedic, a licensed master's level mental health professional with at least five years' experience in providing mental health emergency care, and a tenured law enforcement officer with advanced crisis and mental health peace officer training. The team and its characteristics are described in more detail below.

The RIGHT Care model also includes a different approach to the 911 call center (Figure 1), something that will be critically important in any MDRT effort and particularly as integration of 911 with 988 becomes a priority. Normally, when someone calls 911 and reports a mental health emergency, the absence of clinical triage in the call center plays a role in dispatching law enforcement as the first response. As RIGHT Care was implemented in Dallas, the 911 call center added a mental health clinician who could manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs. This practice allows 911 call centers to decide to dispatch RIGHT Care teams as the appropriate response to

mental health emergencies. First and foremost, the team provides a health-driven medical response while also assuring public safety, both of which are critical to emergency response.

Figure 1: Traditional 911 Response Model Compared to RIGHT Care Model (Dallas, TX)

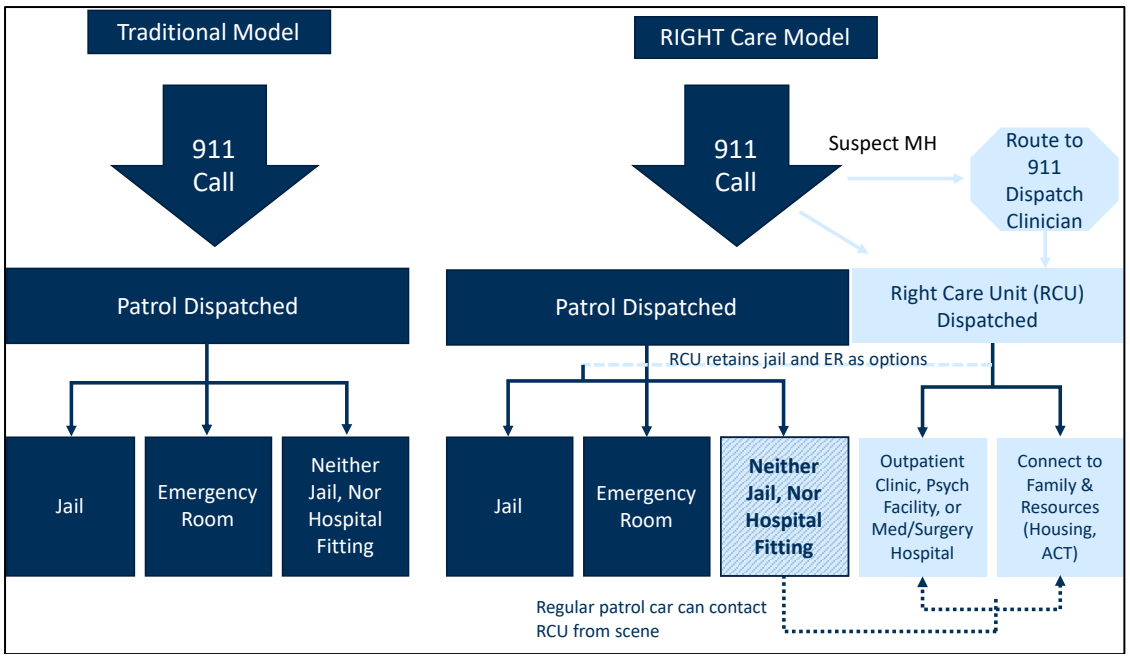
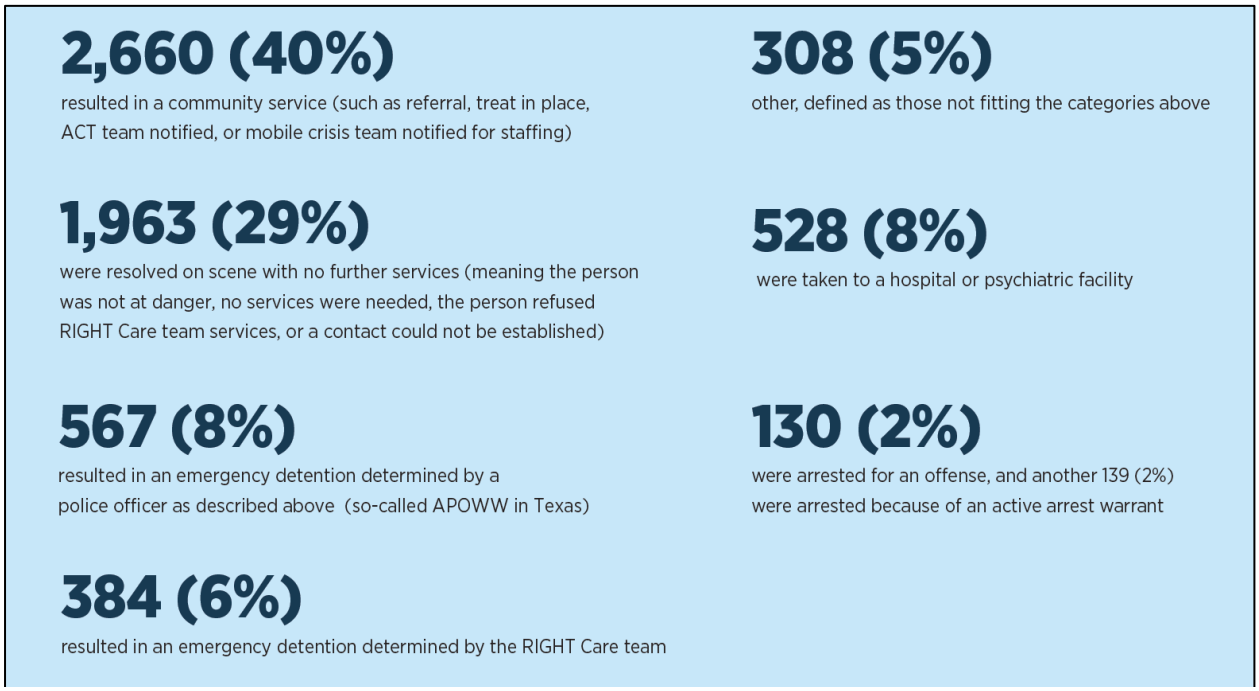


Figure 2 below shows the Institute's analysis of the last available metrics report of June 7, 2020, showing the cumulative program metrics from program start date of January 29, 2018– June 7, 2020, for the pilot in the South-Central Division of the Dallas police department. During this period, there were 6,679 total responses by the RIGHT Care team.

Figure 2: South-Central Dallas Division RIGHT Care Team Outcomes (January 2018–June 2020)



Austin

The Institute is currently supporting the city of Austin in implementing recommendations from our 2019 assessment of their first response to mental health calls for service.[45] Our recommendations were:

- Establish an advisory role to the chief of police within the Behavioral Health Criminal Justice Advisory Committee.
- Develop mental health crisis call identification and management training for 911 call takers and dispatchers within Austin Police Department's call center.
- Integrate Integral Care crisis clinicians into the Austin Police Department's call center for mental health triage of 911 calls and support for officers tasked with answering crisis calls in the field.
- Fund the Extended Mobile Crisis Outreach Team, including a telehealth expansion which emphasizes integrated care while working collaboratively with community stakeholders to create a long-term sustainability plan for the program.
- Integrate the Austin Police Department's CIT follow-up functions into the Homeless Outreach Street Team, including use of telehealth.
- Create Spanish language community education addressing how to effectively communicate crisis needs to first responders, in collaboration with National Alliance on Mental Illness Austin, for Latino communities identified as having high rates of response to resistance during a crisis call for service.

[45] Meadows Mental Health Policy Institute. (2019). Recommendations for First Responder Mental Health Calls for Service, May 15, 2019. https://www.austintexas.gov/edims/document.cfm?id=364576

El Paso

Emergence Health Network (EHN) – the local mental health authority – and the city of El Paso partnered to implement CIT at El Paso Police Department (EPPD) in December 2019. The partnership was made possible with funds from Texas Senate Bill 292 and the long-standing collaborative relationship between EHN and EPPD. The CIT team is a traditional co-responder model that partners a specially trained EPPD officer with a masters-level licensed mental health clinician from EHN. As a co-responder unit, the team deploys on patrol together to conduct prevention outreach, provide intervention services, and answer mental health emergency calls from 911, as well as respond as a backup unit to patrol officers across the city on mental health emergency calls. This unit lacks a community paramedic, which is a key deviation from the MDRT model.

In August 2019, Emergence Health Network (EHN) engaged the Institute to evaluate the CIT program. Our report was issued in June 2021 and included an analysis of the outcomes to date and recommendations for improvement. EHN is currently considering our core recommendation to adopt an integrated health approach, which includes paramedicine and telehealth services to explore prevention-oriented and community-based care solutions for the population they serve and to make immediate care connections to an EHN clinician when a clinician is not available for deployment.

Houston

Houston Police Department and the Harris Center initiated a collaborative Crisis Call Diversion (CCD) program in 2015. Since that time, the program has demonstrated strong efficacy in diverting non-emergent CIT calls away from police and EMS to CCD clinicians embedded in the call center. The clinicians, who are employed by the Harris Center, link the caller to needed services rather than dispatching a police unit or ambulance to the scene. The CCD program has provided cost savings, and, more importantly, significant cost avoidance to Houston first responder agencies. Initial research estimated the program provided Houston agencies with over $1.3 million in cost avoidance, netting first responder agencies over $860,000 in cost savings in the first year of operations[46] while connecting thousands of Houston area residents to mental health care services during times of crisis.

Program Recommendations

The Institute's recommendations were developed based on our analysis of available data, program reports and protocols, and interviews with key informants and stakeholders. The recommendations provide a roadmap for COSA to follow that will transform the first response to people in behavioral health crisis, ensuring that individuals receive appropriate clinical care as quickly as possible while also protecting public safety.

[46] For more information, see: https://www.houstoncit.org/boarding-homes/

Data-Driven Program Design

We recommend that COSA follow a data-driven public safety model as system transformation is developed and implemented. Data-driven public safety is the use of data to inform decision making and increase actionable program development and intelligence for all personnel within an agency. When establishing a data-driven public safety strategy, specificity to the mission is critical to success.

Recommendation: Close identified gaps in data reporting to improve COSA's ability to manage the crisis first response system. There is a strong need for a disposition, outcome, or secondary call code that can indicate a behavioral health need that was identified by the first responder. The use of this code should be mandatory for officers to ensure all emergency calls with mental health care needs are identified in the data.

Reviewing and revising data collection is an ongoing activity in a data-driven public safety model. Additional codes and other data may need to be added as work progresses. The review of the current public safety data system should also include opportunities for data sharing with collaboration partners. Providing data on prior services and treatment can support triage and assessment in the field. System data on engagement in services, subsequent use of crisis services, and cost of service delivery are important to determine the effectiveness of programs and interventions.

Recommendation: Add licensed clinical support to the 911 Call Center. Licensed clinicians should be added to the 911 Call Center to support identification and response to behavioral health issues. Clinicians can also provide consultation support to first responders in the field to determine appropriate community care. Call data will identify which times the volume justifies having a clinician physically embedded in the 911 Call Center and when remote access via telehealth can meet the need. Developing training protocols for clinical support will be critical to program success.

Recommendation: Adopt the Multi-Disciplinary Response Team Model. We recommend that COSA and its public safety partners adopt the Multi-Disciplinary Response Team (MDRT) model. Existing collaborations and services can be leveraged so that the MDRT model is implemented based upon identified needs and service utilization patterns. Initial MDRT deployment should be in those areas and during those times that the data show have the highest needs. We recommend multiple MDRT teams between the hours of 7:00 AM and 10:00 PM in the 78207 ZIP Code. The data also show the need for a single MDRT team between the hours of 8:00 AM and 8:00 PM for ZIP Codes 78208 and 78229.

Data analysis will drive next steps in MDRT implementation. Our data analysis identified several locations with a history of high volumes of 911 calls. Additional analysis, including information from service providers and other data sources, may identify the root causes of the high call volumes. A response to those specific calls in those areas can be developed and may include a MDRT team dedicated to high-need areas. This may be especially true in the 78229 area code

given the number of requests for officers to respond to area hospitals to conduct an emergency detention.

A fully functioning and effective MDRT program has availability whenever needed, covering 24 hours a day, seven days a week, 365 days a year. Telehealth can be an effective way to maximize resources, and local planning for MDRT should include expanded use of and access to telehealth services.

Initial and ongoing training is critical to sustaining a successful MDRT program. Training should be provided before launching a team or adding staff to an existing team.

Recommendation: Align and enhance all six essential conditions of MDRT success with the program roll out in San Antonio. To date, the Meadows Institute has identified six essential conditions for MDRT success, one of which is adding a clinician to the 911 call center (as recommended above). The other five are noted below, and each is present in San Antonio currently or could be added, but they will need to be augmented and aligned with MDRT implementation, if that implementation is to be successful:

- Same-day walk-in clinic and prescriber services,
- Crisis intervention and other training for officers, clinicians, and paramedics,
- Twenty-four hours a day, seven days a week community hospital bed capacity,
- Crisis medical care capacity for people under the influence of intoxicants, and
- A housing referral network.

Recommendation: Assess optimal clinical deployment for diagnostic credibility and the role of peers. The Bexar County SMART program employs peers, and there is a strong research base showing the value of peer support. However, incorporating peers into the SAPD's response must weigh the following factors:

- Peers cannot replace the clinician, as diagnostic authority is key, and it is not within the scope of practice of a peer specialist.
- It is not clear whether it is most cost effective to embed a peer in the MDRT response (that must respond within minutes) or in a follow-up support response (that could still fill essential peer roles, but could be more efficiently staffed).

There are also questions regarding the optimal MDRT clinician credential. Texas programs draw on both community mental health clinicians (SMART, Austin Police Department) and experienced emergency room social workers (RIGHT Care). The key is optimal credibility within the system in general, and with the law enforcement agency in particular, regarding diagnosis and judgment as to whether the individual can remain safely in the community or requires a more structured setting.

Strategy and Initial Workplan for Improving First Response System

The Institute recommends that the COSA adopt a data-driven public safety model as first response system improvements are implemented to meet the goal of a first response system

that connects people in mental health crisis to appropriate care as quickly as possible. Our specific recommendations should be implemented along with a data-driven evaluation of the entire local crisis continuum in collaboration with other community stakeholders. This initial workplan address the ongoing collaboration as well as the implementation of our core recommendations: closing gaps in data reporting for mental health calls and responses, providing clinical support to the 911 call center, and adopting the MDRT model.

1. **Gain consensus from leadership and key stakeholders.**
    - Establish a Steering Committee for reviewing information in this report and developing a consensus for action on the recommendations.
    - Adopt a process for the Steering Committee to determine how to leverage existing community processes to share implementation plans and progress, including outcome metrics, to ensure continued collaboration.

2. **Designate an Implementation Workgroup and identify currently available resources that can be leveraged for system transformation.**
    - Identify or designate the staff resource within COSA who will be responsible for managing implementation of the recommendations for first response system improvements and the ongoing collaboration with key partners and stakeholders.
    - Identify within SAPD, SAFD, CHCS, and STCC leadership a single point of contact in each organization for this first response system improvement project to ensure efficient communication around processes and outcomes.
    - Agree upon the process and staff support for the above identified contacts to form the Implementation Workgroup responsible for implementation activities and coordination with the Steering Committee.
    - Inventory existing resources and begin the process of shifting to the MDRT model, including realignment of staff and resources.
    - Determine if existing resources can be leveraged to begin integration of clinical support into the 911 Call Center.
    - Identify an oversight structure and consider mutual aid and support agreements for the MDRT model.

3. **Determine additional funding needs and develop a community plan to secure implementation and ongoing funding.**
    - The inventory of existing services that might be leveraged will help identify additional funding that is needed to provide clinical support to the 911 Call Center and to provide MDRT access wherever and whenever needed, as identified by data.
    - The Implementation Workgroup must develop an initial budget for COSA to consider for FY 2022 funding to begin work.

- The Implementation Workgroup should identify funding options for implementation and sustainability and provide written recommendations to the Steering Committee.

4. **Continue to refine and review data from the City of San Antonio and key partners to identify gaps in data and explore data sharing to support service delivery and program evaluation.**
   - Our review identified the need for a disposition, outcome, or secondary call code that can indicate a behavioral health need that was identified by the first responder but not initially indicated as a mental health call. This should be quickly added to the service code options.
   - In consultation with the Steering Committee, determine if an existing group can be leveraged for a broader review of the current public safety data or if a specific workgroup is needed. Reviewing and revising data collection is an ongoing activity in a data-driven public safety model and a formal mechanism to enable this review is needed.
   - The review of the current public safety data system should also include opportunities for data sharing with collaboration partners. A review of data sharing should start with an inventory of current data shared among all partners, but at a minimum must include SAPD, SAFD, CHCS, and the Signify Community platform managed by STRAC.
   - Identify outcome measurements and agree on a pre- and post-deployment analysis plan.

5. **Develop training to support new programs and protocols.**
   - Specific training is required for clinical support at the 911 Call Center. There are models in other cities to follow, but the training must be within the context of the overall 911 Call Center operations.
   - A team approach to training on the MDRT model has proven most effective. Implementation planning must include significant initial training and include an ongoing training and support component.
   - Curriculum should be developed as should a plan for providing the training upon implementation and ongoing for new hires and continuing education.

Appendices

Appendix A: Stakeholder List

Stakeholder List		
Name	**Organization**	**Position**
Emily Kidd	Acadian Ambulance	Texas Medical Director
Steven Cope	Acadian Ambulance	Operations Manager
Brian Hearn	Acadian Ambulance	Paramedic
Kellie Burnam	Bexar County Department of Behavioral Health	SMART Program Manager
Angela Freveletti	Bexar County Sheriff's Office	Lieutenant Mental Health Unit
Sergeant Esteban Lopez	Bexar County Sheriff's Office	Mental Health Unit Supervisor
Sergeant Benjamin Olvera	Bexar County Sheriff's Office	Mental Health Unit Supervisor
Alice Lopez	Bexar County Sheriff's Office – Mental Health Unit	Sergeant
Omar Qassom	The Center for Health Care Services	Vice President of Operations
Erik Walsh	City of San Antonio	City Manager
María Villagómez	City of San Antonio	Deputy City Manager
Jenny Hixon	City of San Antonio	Public Health Administrator Violence Prevention
Kevin Orton	City of San Antonio	Executive Management Assistant
Joe Frank Picazo	City of San Antonio	Assistant to the Director
Jesse Salame	San Antonio Police Department	Deputy Chief of Staff
William McManus	San Antonio Police Department	Chief

Stakeholder List		
Name	**Organization**	**Position**
Karen Falks	San Antonio Police Department	Deputy Chief – Oversees Mental Health Unit
Robert Blanton	San Antonio Police Department	Deputy Chief – Chief of Staff
Jon Sabo	San Antonio Police Department – Mental Health Unit	Patrol Officer
Sarah Hogan	Southwest Texas Crisis Collaborative	Division Director of STCC
Carmen Goode	The Center for Health Care Services	Clinical Practitioner III
Jesse Peralez	The Center for Health Care Services	Vice President for Restoration and Transformation
Amanda Miller	The Center for Health Care Services	Clinical Administrator
Dr. Shawna Corley	The Center for Health Care Services	Behavioral Health Supervisor: Outpatient Competency Restoration, Court-Ordered Treatment, and ACCESS

Appendix B: Behavioral Health Committee Representation

Behavioral Health Committee Representation	
Organizations	
San Antonio Behavioral Health Hospital	National Alliance on Mental Illness San Antonio
The Center for Health Care Services	Methodist Healthcare
Haven for Hope	Bexar County Sheriff's Office/MHU
STRAC/MEDCOM	UHS (Bexar County Jail)
San Antonio Police Dept/MHU	University Health
San Antonio State Hospital	UT Health Transitional Crisis Clinic
Baptist Health System	Community First Health Plans
Hill Country MHDD	Laurel Ridge Treatment Center
UTHSCSA/Office of Medical Director	Veterans Affairs
Clarity Child Guidance Center	San Antonio Military Medical Center
Crosspoint	Children's Hospital of San Antonio
Bexar County Mental Health Department	South Alamo Regional Alliance for the Homeless
Texas Rio Grande Legal Aid	City of San Antonio DHS
Alamo Area Council of Governments	Acadian Ambulance
Christus Healthcare	Alternative Transport Solutions
Bexar County Judge Probate Court 1	Kendall County Sheriff's Office
Texas Vista Medical Center	San Antonio Fire Department

Appendix C: Law Enforcement Navigation of Behavioral Health Protocol

STRAC MEDCOM
Southwest Texas Regional Advisory Council

Law Enforcement Navigation of Behavioral Health Protocol

CALL EMS **and** FIRE (manpower) for ***EMERGENT*** response if:

- Excited delirium, severe agitation or violent behavior
- Mental status changes or confusion (change from baseline)
- Recent trauma, ingestion or overdose

Call EMS **only** Evaluation for ***URGENT*** response if:

- Officer impression indicates patient needs medical assessment
- Patient complains of medical illness
- Patient requests a medical evaluation

If patient has ***no acute medical issues and is medically stable***, contact MEDCOM for Navigation to the appropriate psychiatric facility by Law Enforcement:

- Provide Patient Name and DOB
- Provide location
- Is patient pregnant? Gestation greater than 20 weeks?
- Call MEDCOM (24/7) for navigation to the appropriate psychiatric facility

MEDCOM (24/7): (210) 233-5933

Rev 9_21_17

Appendix D: Data Tables

Table 8: Mental Health Calls by Type (January 2019–April 2021)

Mental Health Calls by Type (January 2019–April 2021)				
Call Type	**2019**	**2020**	**January–April 2021**	**Grand Total**
Mental Health Routine	8,869	9,648	3,444	21,961
Mental Health Disturbance	8,732	10,300	4,185	23,217
Mental Health in Progress	3,897	4,226	1,631	9,754
Total	21,498	24,174	9,260	54,932

Table 9: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)

Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)			
Place	**Total Calls**	**MH Calls**	**MH % of Tot**
Greyhound Bus Station Terminal	2,022	96	5%
Seven Oaks Apartments	2,149	60	3%
Park on Bandera Apartments	1,635	52	3%
Reserves at Pecan Valley Apartments	3,108	95	3%

Table 10: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)[474849]

Locations Where Mental Health and Total Calls Overlap			
Greyhound Bus Station			
1	Disturbance	837	41%
2	z-On Site Activity	275	14%
3	911 Hang Up	77	4%

[47] San Antonio Police Department (2018). Internal Affairs Annual Report. https://www.sanantonio.gov/Portals/0/Files/SAPD/OpenData/2018%20IA%20Annual%20Report%20Final.pdf?ver=2019-06-17-143505-473

[48] San Antonio Police Department (2019). Internal Affairs Annual Report. https://www.sanantonio.gov/Portals/0/Files/SAPD/IAReport_2019.pdf

[49] San Antonio Police Department (2020). Internal Affairs Annual Report. https://www.sanantonio.gov/Portals/0/Files/SAPD/IAReport_2020.pdf

Locations Where Mental Health and Total Calls Overlap			
4	Welfare Check	74	4%
5	Patrol By	50	2%
	All Others	709	35%
Seven Oaks Apartments			
1	Disturbance	472	22%
2	911 Hang Up	145	7%
3	Disturbance Family	135	6%
4	Burglary (In Progress)	83	4%
5	z-On Site Activity	81	4%
	All Others	1,233	57%
Park on Bandera Apartments			
1	Disturbance	297	18%
2	Disturbance Loud Music	135	8%
3	Disturbance Family	87	5%
4	911 Hang Up	87	5%
5	Shot Fired/Heard	72	4%
	All Others	957	59%
Reserves at Pecan Valley Apartments			
1	Disturbance	542	17%
2	Disturbance Family	161	5%
3	911 Hang Up	150	5%
4	Shot Fired/Heard	120	4%
5	Miscellaneous	118	4%
	All Others	2,017	65%

Table 11: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)

Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)				
Locations	**Total Calls**	**MH Calls**	**MH % of Total**	**Response to Resistance Incidents**
South Texas Assisted Living[50]		153		1
Greyhound Bus Station Terminal	2,022	96	5%	1
The Park at Bandera Apartments	1,635	52	3%	1

[50] Although South Texas Assisted Living was included in the locations for highest volume mental health calls, it was not included on the list for the locations with highest volume of all types of calls received by SAPD.

Appendix E: Maps

Map 15: All Mental Health Calls (January 2019–April 2021)

Hour	Day of Week						
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	213	193	226	220	262	235	258
1.00	193	188	197	197	223	200	222
2.00	194	142	166	164	179	181	178
3.00	172	150	140	136	144	155	172
4.00	126	137	123	138	128	152	163
5.00	119	120	118	140	111	124	137
6.00	102	151	150	136	138	132	117
7.00	163	203	246	204	236	204	138
8.00	164	282	314	342	316	282	270
9.00	237	345	490	413	410	396	348
10.00	283	442	513	501	494	428	430
11.00	301	501	511	489	509	482	440
12.00	358	450	587	583	522	484	418
13.00	336	498	560	577	520	473	430
14.00	352	511	549	586	535	459	375
15.00	337	420	440	439	483	413	346
16.00	343	429	479	449	421	483	394
17.00	341	472	458	504	427	410	343
18.00	377	448	424	527	443	379	388
19.00	356	453	444	524	445	393	354
20.00	402	434	397	464	382	410	363
21.00	336	390	365	431	411	334	330
22.00	299	322	332	342	333	294	312
23.00	244	285	285	238	291	270	298

Map 16: All Mental Health Calls by Type (January 2019–April 2021)

Hour	Problem / Day of Week																								
	Mental Health Disturbance							Mental Health In Progress ^							Mental Health Routine										
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat				
0.00	96	89	108	92	120	104	126	34	30	38	39	36	38	33	83	74	80	89	106	93	99				
1.00	68	81	97	89	111	101	118	29	37	35	23	42	30	37	96	70	65	85	70	69	67				
2.00	91	63	87	76	72	79	84	29	29	22	32	34	29	23	74	50	57	56	73	73	71				
3.00	81	66	58	46	67	80	88	18	26	19	31	19	21	22	73	58	63	59	58	54	62				
4.00	47	66	52	61	69	76	82	23	16	17	20	20	21	25	56	55	54	57	39	55	56				
5.00	46	43	51	57	47	64	62	26	29	18	24	20	19	18	47	48	49	59	44	41	57				
6.00	43	72	71	55	66	61	51	19	27	27	23	23	25	20	40	52	52	58	49	46	46				
7.00	67	89	118	93	106	81	56	33	30	42	30	34	33	20	63	84	86	81	96	90	62				
8.00	73	112	129	143	138	104	97	33	51	55	59	48	39	47	58	119	130	140	130	139	126				
9.00	119	120	188	134	166	133	97	52	52	59	56	48	59	47	66	173	243	223	196	204	204				
10.00	139	168	198	179	186	158	127	57	74	56	62	61	55	47	87	200	259	260	247	215	256				
11.00	129	201	182	187	172	154	136	75	78	75	70	86	94	74	97	222	254	232	251	234	230				
12.00	165	179	202	211	207	204	132	83	75	78	88	76	70	77	110	196	307	284	239	210	209				
13.00	156	195	194	218	190	177	154	78	81	83	107	99	81	92	102	222	283	252	231	215	184				
14.00	162	216	242	211	221	189	134	71	86	74	95	91	89	84	119	209	233	280	223	181	157				
15.00	151	198	201	164	187	174	140	64	72	67	84	83	81	69	122	150	172	191	213	158	137				
16.00	137	221	212	208	173	197	173	83	69	102	71	93	112	73	123	139	165	170	155	174	148				
17.00	158	231	223	207	176	182	138	60	97	94	102	96	92	82	123	144	141	195	155	136	123				
18.00	170	222	217	203	188	176	184	83	72	79	111	96	71	75	124	154	128	213	159	132	129				
19.00	156	224	220	233	203	171	141	84	94	92	101	88	81	72	116	135	132	190	154	141	141				
20.00	180	211	184	213	171	186	167	85	82	79	97	68	84	70	137	141	134	154	143	140	126				
21.00	138	195	187	221	180	133	141	84	78	58	74	79	74	63	114	117	120	136	152	127	126				
22.00	126	146	131	154	156	132	141	64	59	79	67	75	63	64	109	117	122	121	102	99	107				
23.00	93	136	115	107	139	129	128	49	45	53	31	47	40	54	102	104	117	100	105	101	116				

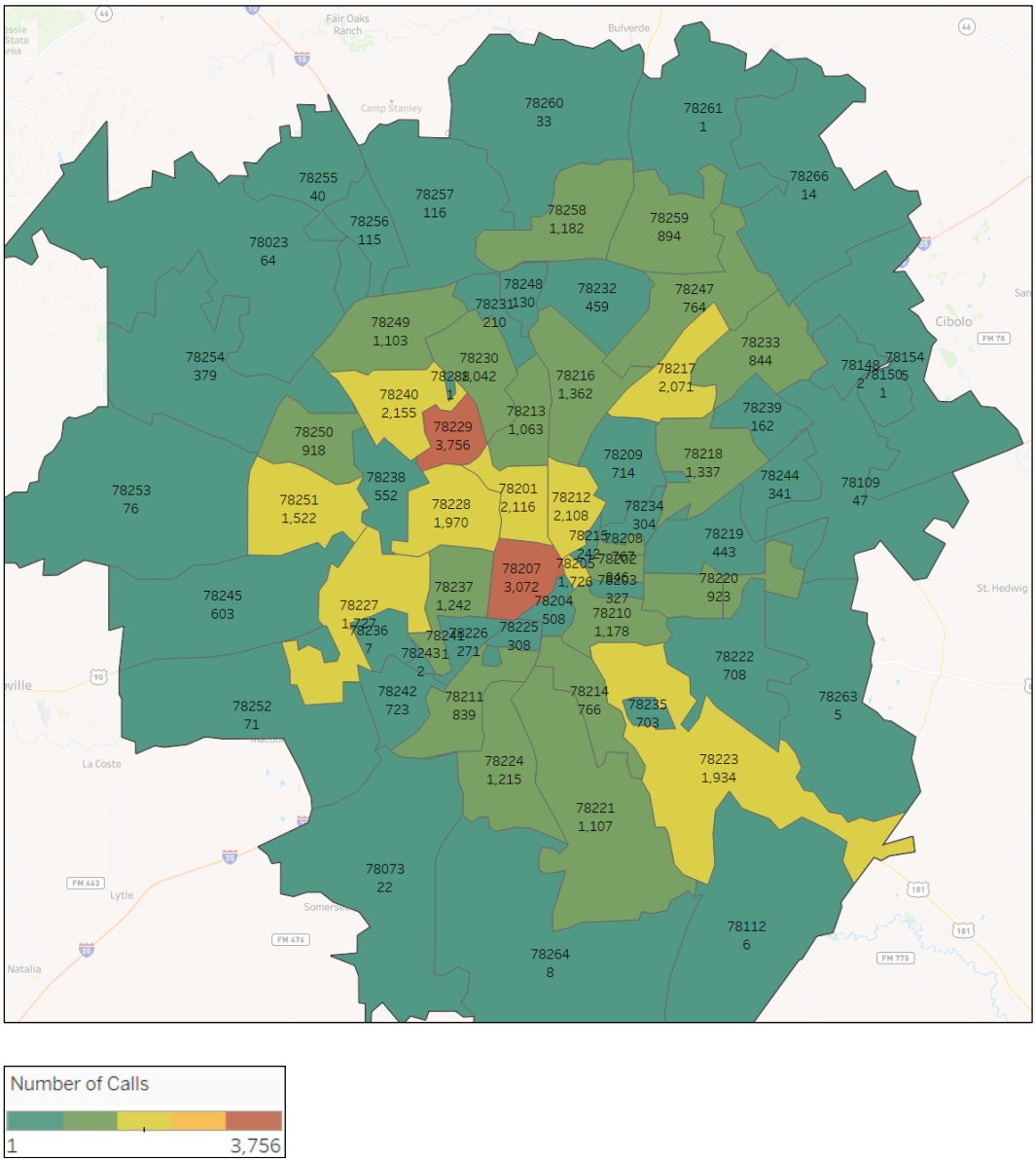
Map 17: Mental Health Calls by Day of Week, Hour, and Battalion (Central, East, North) (January 2019–April 2021)

	CENTRAL							EAST							NORTH						
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	37	36	47	39	47	48	55	21	24	36	32	35	29	20	39	29	33	25	52	41	50
1.00	34	37	42	37	41	43	40	22	31	30	21	28	24	34	23	20	32	38	33	36	46
2.00	35	33	32	34	37	43	43	19	20	23	20	20	17	24	40	19	25	25	29	24	28
3.00	35	47	34	28	33	24	32	20	16	13	15	11	20	27	27	13	22	26	19	34	24
4.00	34	32	31	22	19	30	33	12	13	18	21	20	23	21	16	21	18	29	24	22	21
5.00	34	30	24	37	25	25	28	15	14	15	22	14	17	13	12	20	19	23	14	17	22
6.00	24	16	31	18	29	28	23	19	15	20	16	12	14	17	10	21	14	18	26	16	9
7.00	28	46	47	43	48	35	28	21	29	24	42	41	29	16	29	31	44	28	34	35	28
8.00	31	69	72	89	75	69	67	28	38	44	40	47	27	30	25	33	47	57	54	45	42
9.00	46	61	89	88	91	70	80	35	50	62	50	58	50	55	38	60	86	63	61	65	47
10.00	57	83	100	86	120	84	58	27	63	65	77	72	62	58	41	61	93	67	70	70	62
11.00	64	107	106	101	108	110	56	43	73	60	60	70	69	58	33	69	84	66	74	77	77
12.00	60	80	114	117	97	89	69	52	76	89	74	77	63	66	71	76	91	85	72	83	66
13.00	70	74	99	85	82	98	70	45	63	75	76	66	54	65	58	95	82	94	91	59	63
14.00	58	78	105	98	111	93	73	50	65	72	73	71	54	50	65	83	86	92	70	78	71
15.00	54	67	81	84	87	90	82	28	53	48	58	69	54	48	72	70	78	66	87	64	59
16.00	56	64	77	84	85	86	72	35	66	74	57	57	71	47	69	74	91	74	61	87	71
17.00	61	83	81	85	66	62	57	50	60	59	66	47	58	40	50	72	76	80	75	70	67
18.00	66	72	67	85	77	70	73	47	54	60	64	57	48	43	59	80	73	73	74	61	76
19.00	51	74	76	83	78	81	84	44	51	58	51	57	52	48	70	86	79	90	73	75	62
20.00	75	76	67	88	64	81	70	49	69	54	54	48	55	40	60	72	72	87	71	71	60
21.00	64	73	71	72	67	56	67	50	52	40	58	62	47	40	58	63	75	61	68	50	62
22.00	49	70	51	54	56	53	58	36	35	36	45	49	42	45	52	55	54	68	49	41	44
23.00	51	57	61	43	57	54	57	38	32	30	36	25	33	38	34	61	41	39	47	36	46

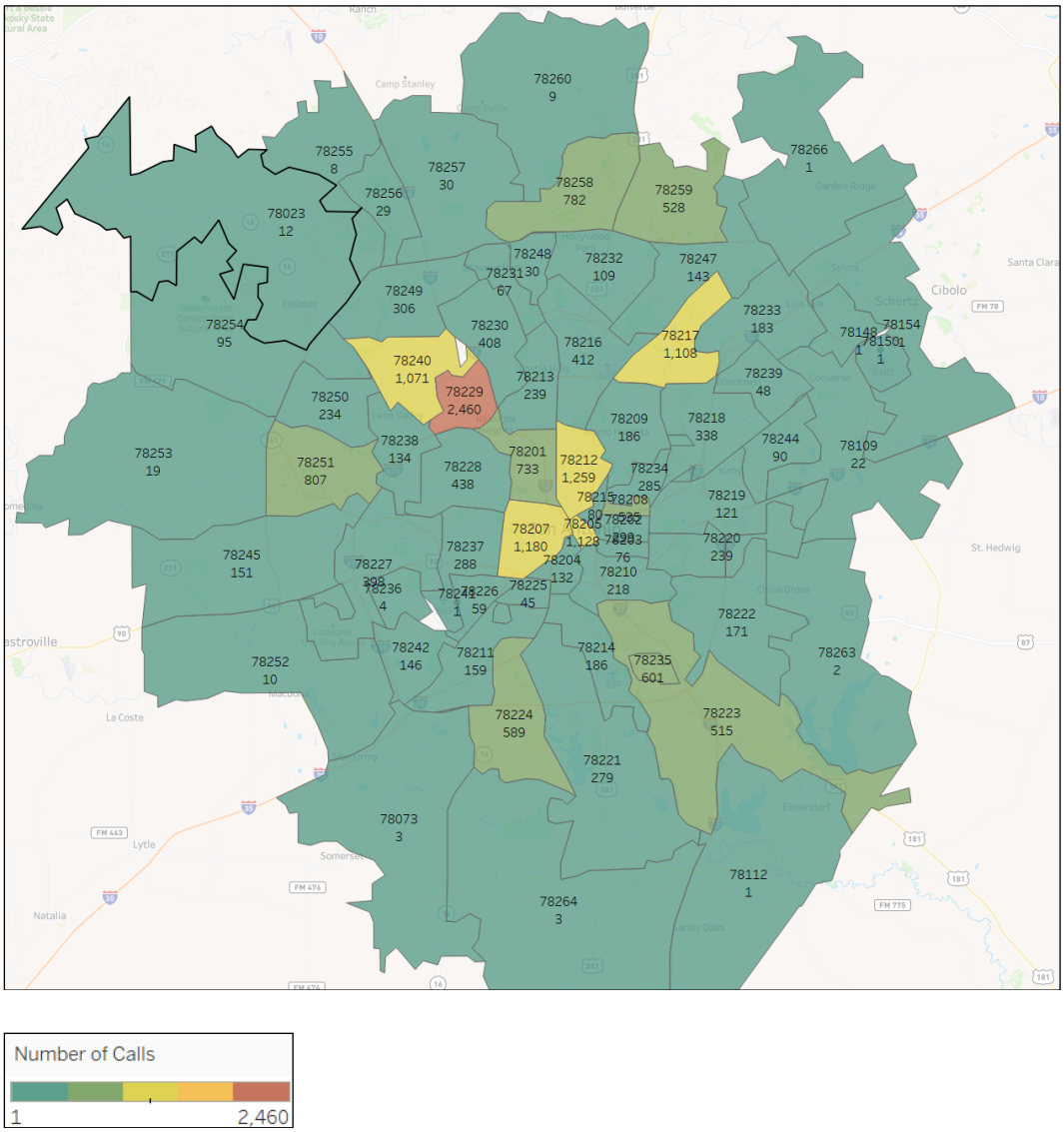
Map 18: Mental Health Calls by Day of Week, Hour, and Battalion (Prue, South, West) (January 2019–April 2021)

	PRUE							SOUTH							WEST						
Hour	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
0.00	45	27	38	47	51	31	47	35	38	48	31	50	41	42	35	38	24	43	22	42	42
1.00	43	40	35	42	37	37	28	36	33	26	33	43	33	37	34	24	27	25	37	25	34
2.00	39	30	30	25	35	29	25	34	27	29	32	31	39	27	26	13	25	27	25	28	30
3.00	31	32	33	21	30	24	27	29	19	22	19	21	25	30	26	20	13	27	29	22	29
4.00	24	33	20	31	19	28	37	19	18	17	18	24	29	25	20	19	17	17	20	17	22
5.00	21	21	29	24	24	28	31	24	18	15	18	17	24	24	13	15	14	15	15	12	19
6.00	16	30	39	32	24	22	28	19	38	26	23	27	26	23	13	29	20	26	16	24	16
7.00	35	35	42	36	31	33	27	26	33	40	34	43	31	19	24	25	43	21	35	38	20
8.00	34	44	44	51	49	51	47	26	50	51	54	38	40	39	18	44	46	40	37	32	29
9.00	41	49	88	72	61	54	44	42	42	60	53	61	62	39	33	61	66	43	51	60	43
10.00	60	75	76	77	76	76	68	44	70	71	65	67	56	53	51	72	77	72	60	42	52
11.00	54	77	80	91	104	77	81	46	68	70	73	69	60	65	59	78	83	79	60	55	67
12.00	64	75	119	109	92	103	70	57	62	64	86	61	55	50	51	58	73	70	86	67	65
13.00	60	99	99	107	92	101	81	62	75	75	65	71	67	58	40	67	82	110	77	69	59
14.00	55	106	89	108	105	101	67	50	82	77	84	61	58	48	71	63	75	88	85	64	40
15.00	80	92	79	98	87	82	67	56	68	78	60	72	56	36	42	61	59	49	61	55	40
16.00	71	94	87	92	88	86	75	56	66	68	64	63	85	72	48	64	75	64	55	59	47
17.00	76	107	104	99	91	103	70	57	79	58	80	71	62	61	47	68	74	70	63	48	47
18.00	78	96	80	92	93	84	73	59	69	68	73	69	59	54	67	73	74	76	67	54	65
19.00	63	105	85	100	80	76	69	64	59	80	87	78	45	50	61	74	63	64	68	60	37
20.00	87	72	75	78	75	84	72	68	62	67	87	62	57	52	57	75	58	66	58	59	64
21.00	63	81	71	89	87	72	59	44	53	49	71	63	54	63	52	65	53	74	60	48	34
22.00	48	59	81	62	61	58	65	54	53	58	59	55	42	54	58	48	46	51	56	55	40
23.00	42	50	56	45	59	54	62	40	39	45	37	57	60	47	37	43	50	36	46	31	45

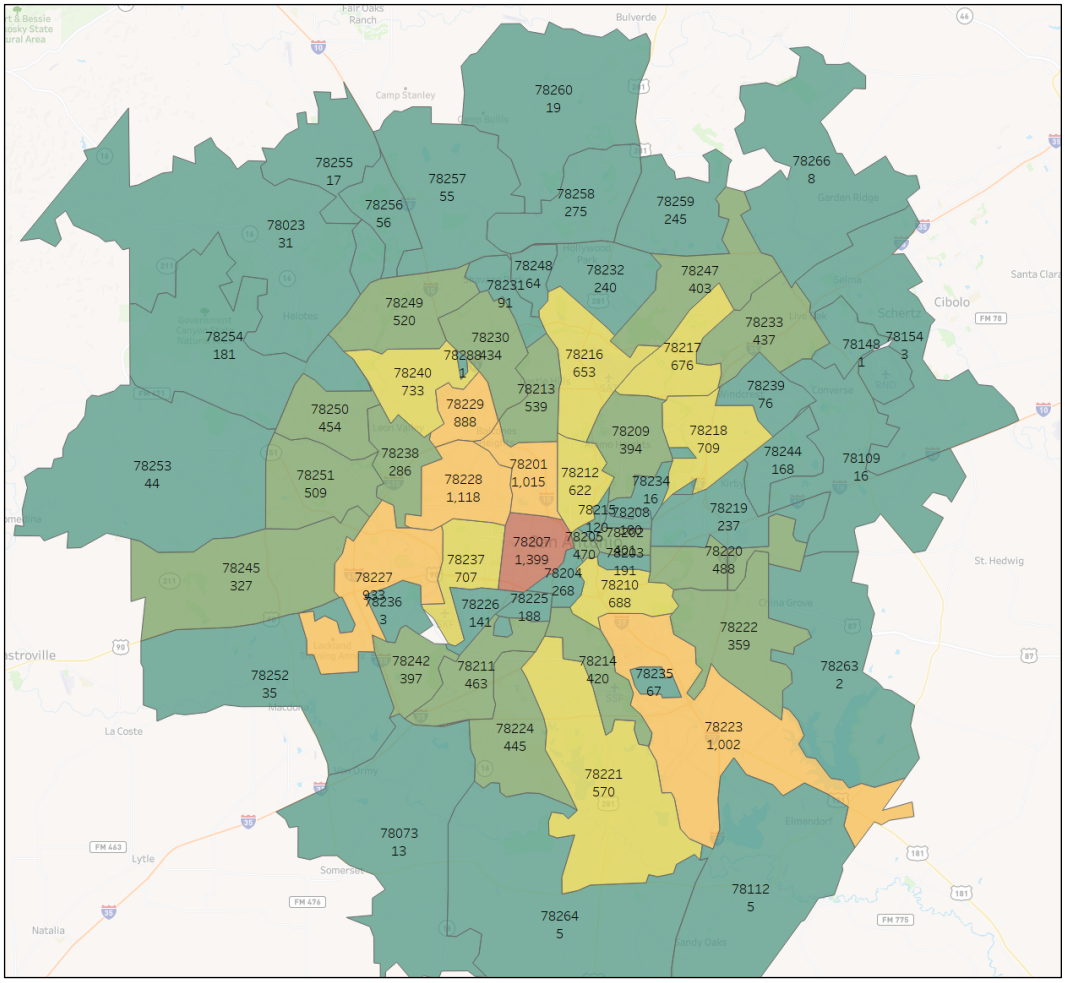
Map 19: SAPD Mental Health Calls (January 2019–April 2021)



Map 20: SAPD MH Routine Calls (January 2019–April 2021)



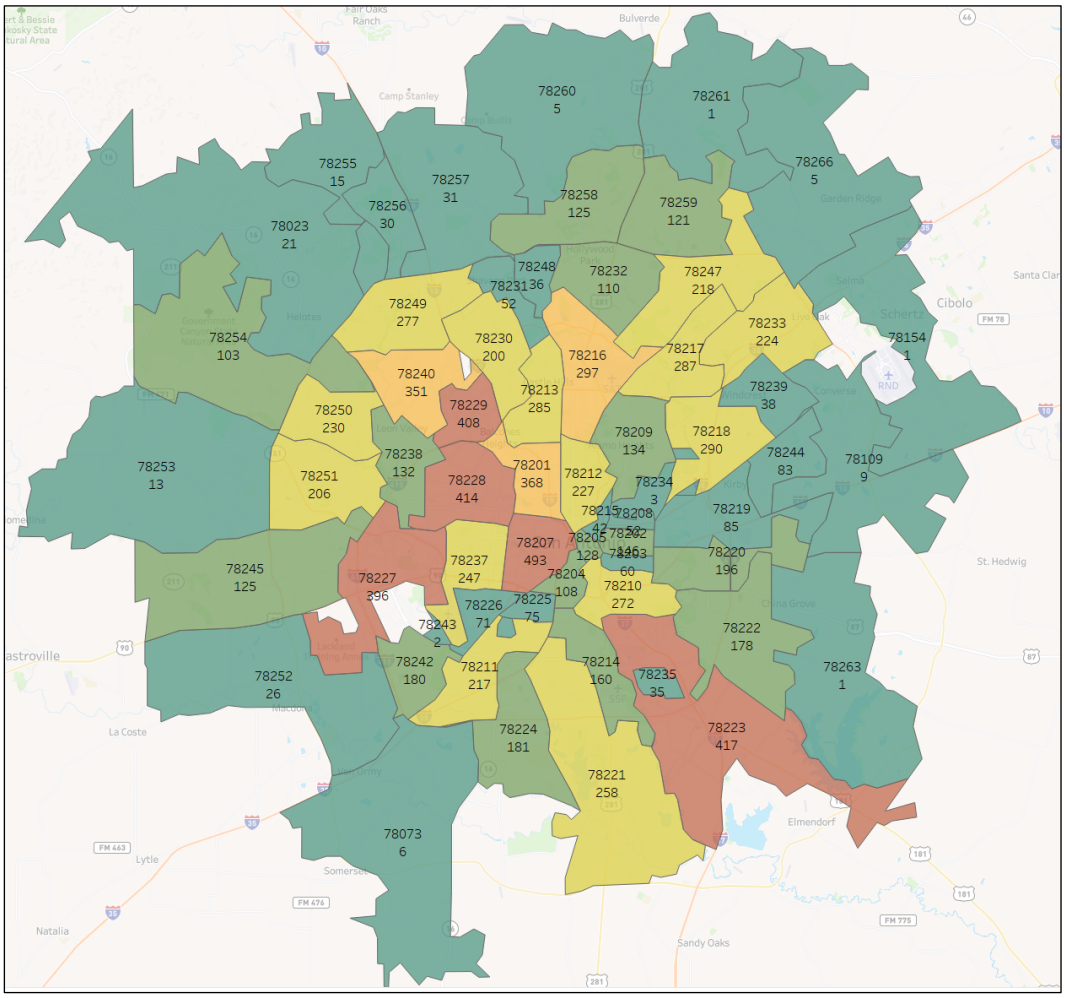
Map 21: SAPD MH Disturbance Calls (January 2019–April 2021)



Number of Calls

1 — 1,399

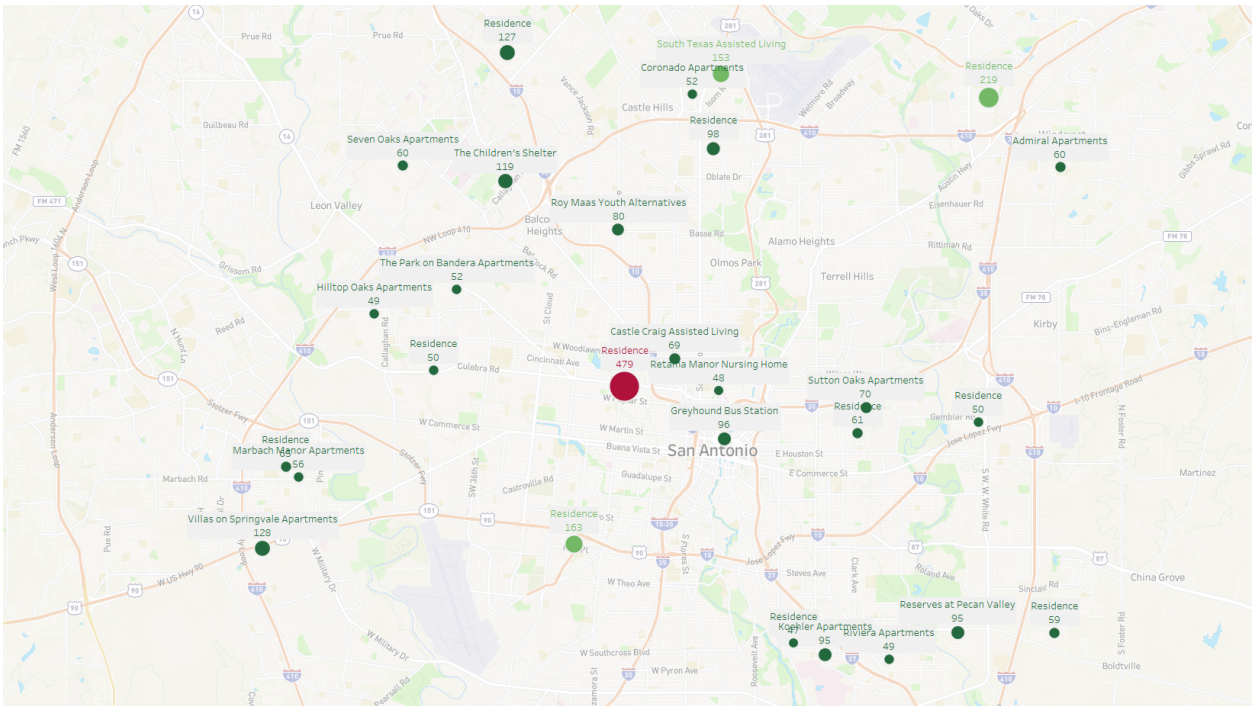
Map 22: SAPD MH in Progress Calls (January 2019–April 2021)



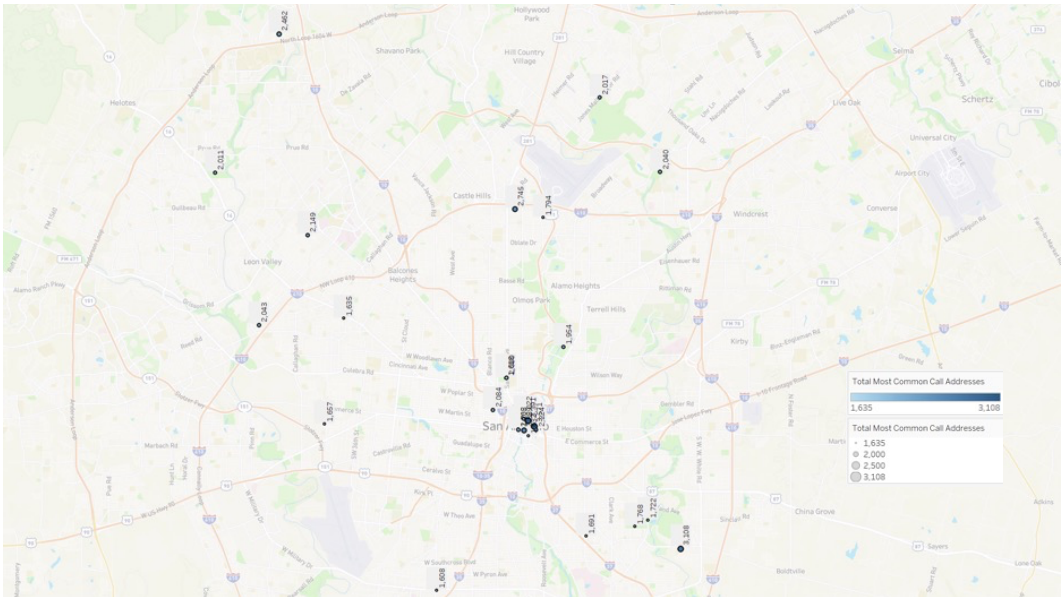
Number of Calls

1.0 493.0

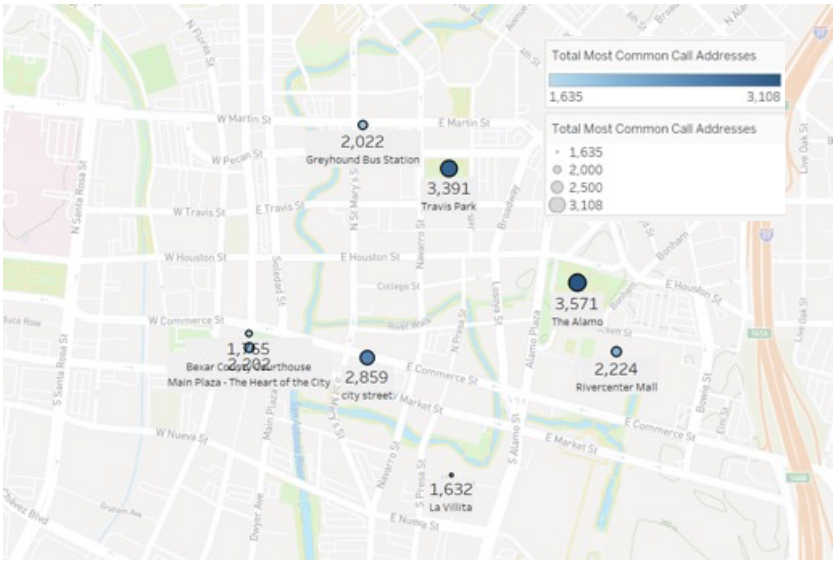
Map 23: Mental Health SAPD Calls (January 2019–April 2021)



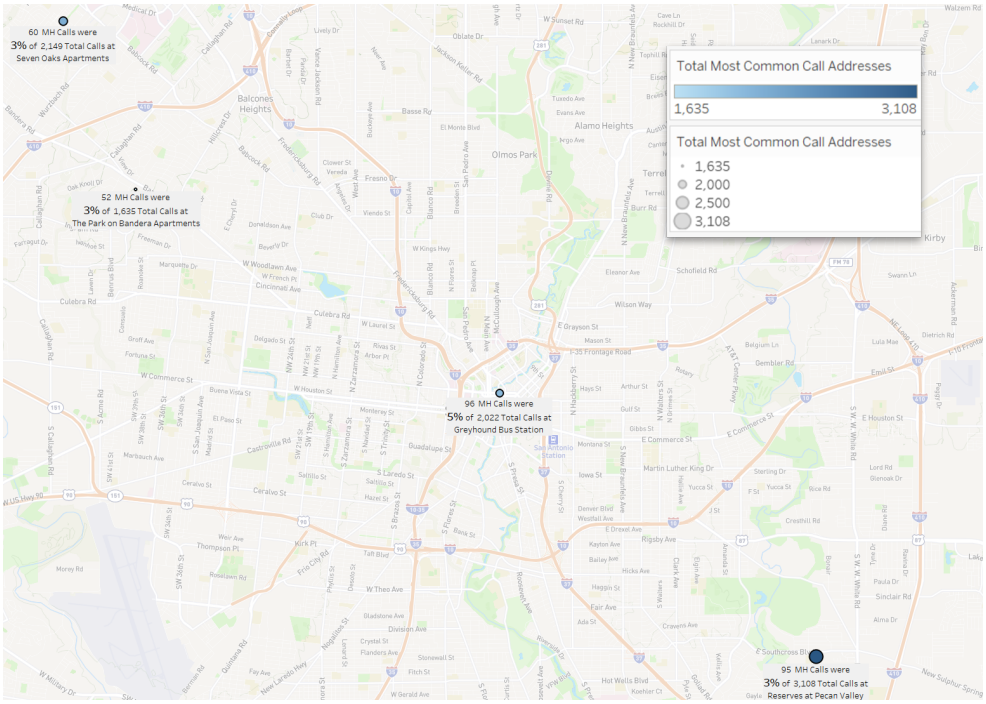
Map 24: Most Frequent Call Addresses for SAPD (January 2019–April 2021)



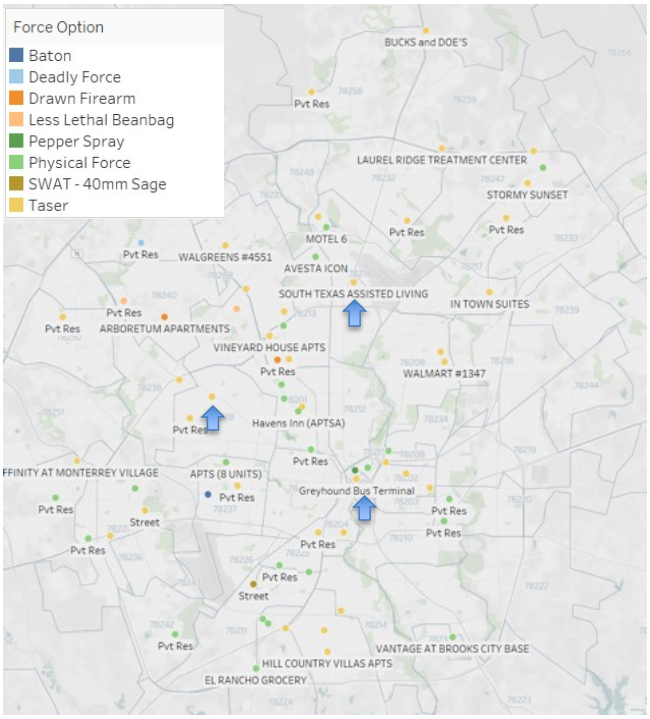
Map 25: Most Frequent Call Addresses for SAPD, Downtown Detail (January 2019–April 2021)



Map 26: Locations Where Mental Health and Total Calls Overlap (January 2019–April 2021)



Map 27: Response to Resistance Locations on Mental Health Calls by Response to Resistance Incident Type[51] (January 2019–April 2021)



[51] Map 10 accounts for 68 total incidents.