# Georgia Sheriffs' Mental Health Transport Study


**Office of Performance Analysis and Quality Improvement**

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## Executive Summary

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) immensely values its relationships with law enforcement partners across the state, so their support in transporting individuals who experience mental health crises is of particular interest to the agency. Mental health transports are an important element of connecting individuals to lifesaving care. Accordingly, DBHDD is appreciative of the opportunity to partner with the Georgia Sheriffs' Association (GSA) to assess the process and consider opportunities for improvement.

This pilot study collected data on 316 transports made by 15 participating counties during the study period of August 1, 2023, to October 31, 2023, and focused on answering the following questions:

- What is the burden on sheriffs' offices (time and money) associated with providing mental health transports?
- Is the transport process working as designed and as socialized with sheriffs' offices?
- What trends are revealed by the data?
- What improvement opportunities exist?

Several different trends emerged from this pilot study, and an important caveat must be disclosed: 113, or 36%, of the reported transports were from Colquitt County. Therefore, the results disproportionately reflect the processes and outcomes of transports performed by Colquitt County deputies.

For the 316 transports, it is estimated that the cost to those 15 sheriffs' offices was $37,838 which annualizes to $151,351 or approximately $119.74 per transport.

Opportunities for improvement were identified in two areas: the transport process and data collection and reporting.

Opportunities for the transport process include:

- Sheriffs' offices and those making referrals should work together to ensure that the Georgia Crisis and Access Line (GCAL) is contacted prior to a transport being initiated. This helps ensure that the GCAL bed board of available male and female crisis beds at each emergency receiving facility (ERF) within the DBHDD network is kept updated, and that transport staff are being directed to the closest available ERF.

- Wait times for deputies at the ERF may vary considerably between transports, but most especially between facilities. For example, the lowest wait time was reported for Turning Point Care Center with an average wait time reported at just under seven minutes; the highest was Phoebe Putney Memorial Hospital's average wait time at twenty-nine minutes; more than four times the lowest time, and more than double the average time of twelve minutes. DBHDD and GSA should consider having a guided discussion that would allow ERFs with longer wait times to benefit from learning about best practices of the ERFs with short wait times.

- Three counties reported having multiple transports refused by an ERF, yet no actionable intelligence was included about the reasons for these refusals. No trends associated with the ERF were noted, as the refusals involved eight ERFs. For these three counties, refusals accounted for 22% to 85% of their total transports. Refusals waste deputies' time and sheriffs' offices' money and delay access to care. DBHDD and GSA should consider working with these sheriffs to determine what barriers exist for them and what steps can be taken to overcome those barriers.

Opportunities related to data collection and reporting include:

- GSA should perform a quality review of the submitted records for accuracy and completeness of information prior to creating the summary reports and providing them to sheriffs. GSA can also use these findings to provide technical assistance and targeted training to sheriffs' staff.

- GSA should explore with their vendor, Eagle Advantage Solutions, how all transports can be automatically sent to GSA, thus reducing the burden on the sheriffs' staff, and reducing the likelihood of record duplication.

- GSA should continue to explore with their vendor the possibility of making all data items of interest required fields. While this was requested by DBHDD's Office of Performance Analysis and Quality Improvement (OPAQI) prior to the beginning of the study, the vendor was unable to complete the task. Much interest has been expressed in understanding the deputies' perceptions of mental health transports. However, by not making the quantitative and qualitative satisfaction items mandatory, these elements were skipped 41% and 94% of the time respectively upon entry. More robust response rates to these items by deputies would have resulted in a more complete picture of deputy satisfaction and may have resulted in actionable intelligence about deputy reasons for satisfaction or dissatisfaction. Additionally, the first and last name of the individual being transported was also not mandatory. Since Seminole County did not include transported individuals' names, no matches were made to any relevant GCAL episodes.

- GSA should explore with their vendor the addition of a drop-down list of ERFs for deputies to choose from when mental health transport data is entered into the portal. Currently the field is free form, which created challenges in interpreting and standardizing the ERF name for analysis. Additionally, 35 transports (11%) contained insufficient information to identify the ERF.

- GSA should create and socialize an expectation that all transport records for a given month be entered by the sheriffs' offices by a specific date, such as the fifth of the following month. During this study, it was noted that transport records for August were still being submitted in November. Allowing such a long lag time between end of month and completed data submission renders the results either untimely or inaccurate if the reports are generated by GSA and returned to sheriffs prior to all data being submitted. OPAQI remains concerned that transports for this study may have been underreported for some counties due to this excessive lag time.

# Introduction

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) immensely values its relationships with law enforcement partners across the state, so their support in transporting individuals who experience mental health crises is of particular interest to the agency. Mental health transports are an important element of connecting individuals to lifesaving care. Accordingly, DBHDD appreciates the opportunity to partner with the Georgia Sheriffs' Association to assess the process and consider opportunities for improvement.

On May 25, 2023, DBHDD Commissioner Kevin Tanner held a meeting in Moultrie, Georgia with representatives from the Georgia Sheriffs' Association (GSA) and thirty sheriffs' offices throughout South Georgia to propose a pilot study and invite the attendees to participate. Shortly thereafter, in partnership with the aforementioned stakeholders, DBHDD initiated a pilot study to further understand how law enforcement expends resources when conducting mental health transports. More specific purposes of the pilot study include determining which types of mental health transports are more burdensome for law enforcement, identifying inefficiencies in current systems, and indicating opportunities for improvement throughout the transport process. This report details the methods by which the pilot study was conducted and presents both collective and county-level findings.

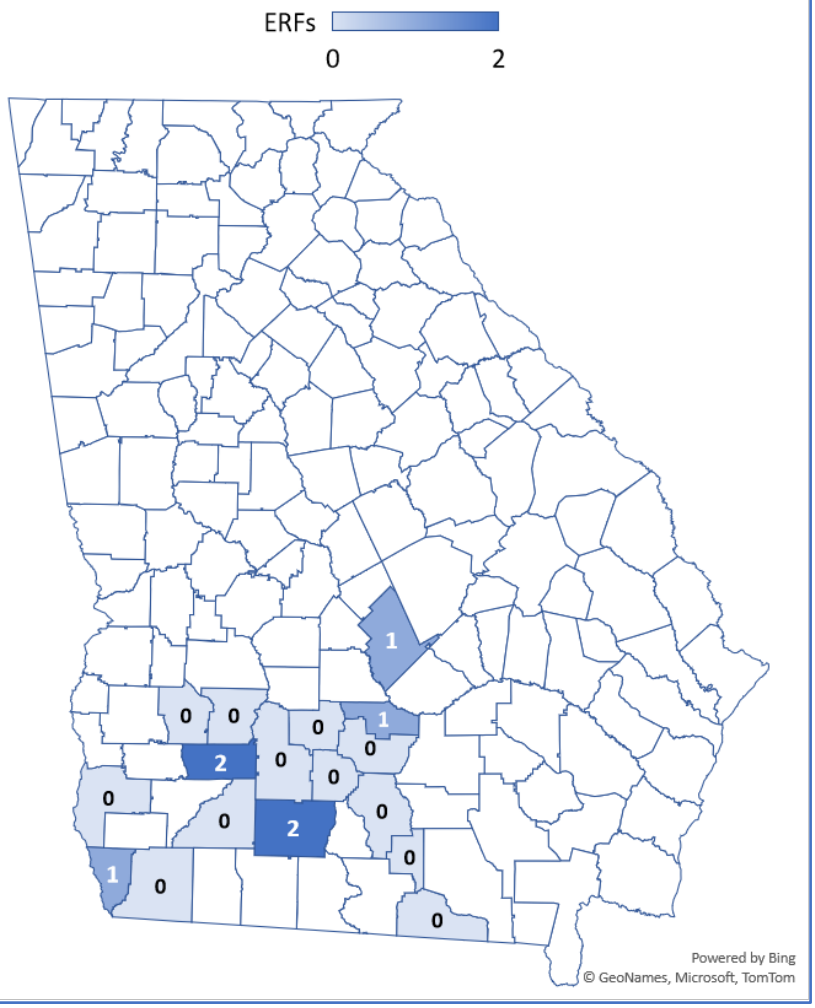
The thirty invited sheriffs' offices are located across DBHDD's regions four (southwest Georgia) and five (southeast Georgia), and they were asked to provide mental health transport records that occurred during the study period of August 1, 2023, through October 31, 2023. Of those thirty invitees, seventeen ultimately participated and fifteen provided mental health transport data for review. Two of those counties, Echols and Terrell, confirmed they performed zero transports during the study period. Table 1 lists the seventeen participating counties. The remaining thirteen counties did not submit transport data for the study period, so they were excluded from analysis. Nine of the fifteen participants were already reporting this data monthly to GSA prior to beginning the study. Those nine are denoted with an asterisk in Table 1 below.

**Table 1. Pilot Study Participants**

| | | | |
|---|---|---|---|
| Ben Hill County* | Dodge County | Irwin County* | Seminole County* |
| Berrien County* | Dougherty County | Lanier County* | Terrell County |
| Colquitt County | Early County | Lee County* | Tift County* |
| Decatur County | Echols County | Mitchell County | Turner County* |
| Worth County* | | | |

Figure 2 shows that there are just seven emergency receiving facilities (ERFs) located in five counties throughout this seventeen-county region. Colquitt and Dougherty Counties are each home to two ERFs, and Ben Hill, Dodge, and Seminole Counties are each home to one. The remaining twelve counties do not have an in-county ERF. Therefore, more often than not, deputies leave their home county to find beds for the individuals they transport. Table 2 names all the ERFs reported from the participating county transports. An asterisk beside the ERF name denotes an ERF located in a participating county.

## Figure 2. Emergency Receiving Facilities within Study Area




*Counties with ERFs: Ben Hill (1), Colquitt (2), Dodge (1), Dougherty (2), Seminole (1)*

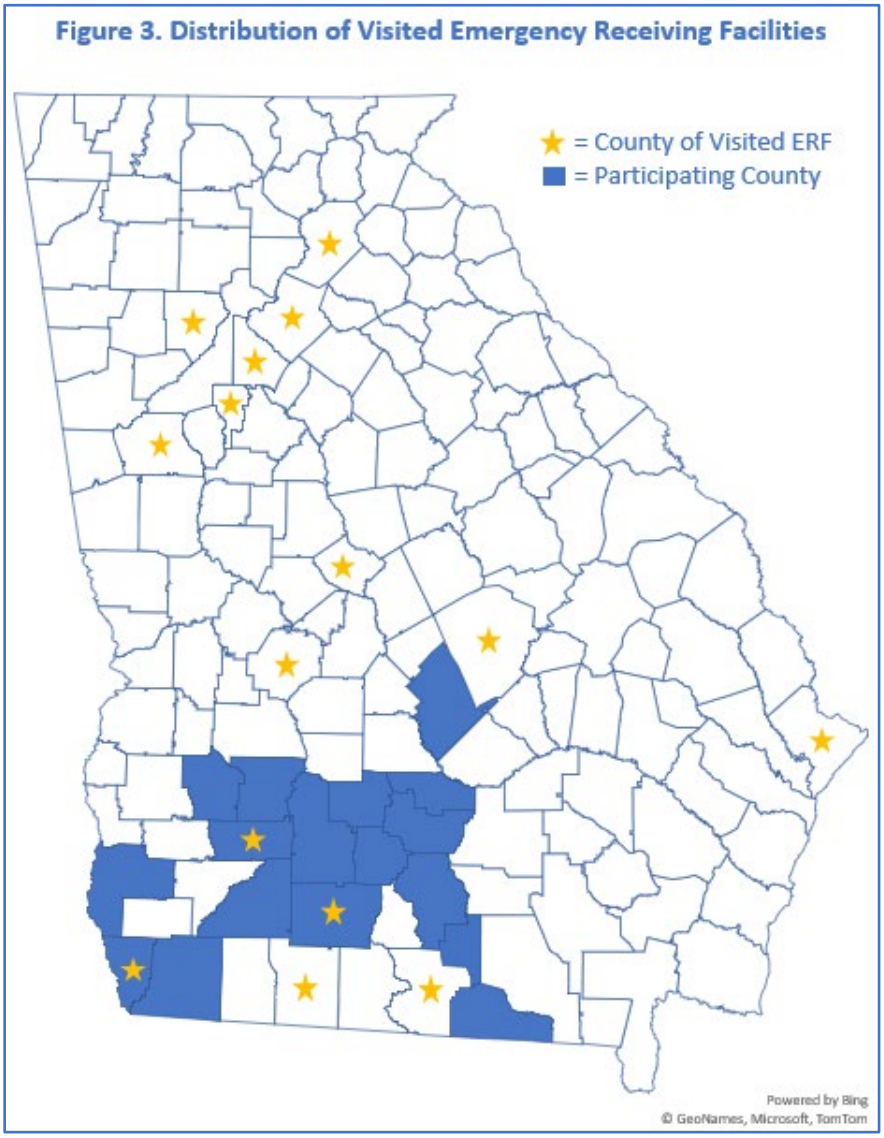
## Table 2. Visited Emergency Receiving Facilities

| | | |
|---|---|---|
| ALBANY ASPIRE* | FLINT RIVER HOSPITAL | PEACHFORD HOSPITAL |
| ANCHOR HOSPITAL | GEORGIA PINES | PHOEBE PUTNEY MEMORIAL HOSPITAL* |
| ARCHBOLD MEDICAL CENTER | GREENLEAF BEHAVIORAL HEALTH | RIDGEVIEW |
| AVITA COMMUNITY PARTNERS | LAKESIDE CENTER | RIVER EDGE BEHAVIORAL HEALTH |
| COLQUITT REGIONAL MEDICAL CENTER* | LAKEVIEW BEHAVIORAL HEALTH | RIVERWOOD BEHAVIORAL HEALTH SYSTEM |
| COSTAL HARBOR | LAUREL HEIGHTS HOSPITAL | SAVANNAH BEHAVIORAL HEALTH |
| CSB OF MIDDLE GEORGIA | LEGACY BEHAVIORAL HEALTH SERVICES | TURNING POINT CARE CENTER* |
| DONALSONVILLE HOSPITAL* | PATHWAYS CHILD AND ADOLESCENT CENTER | VIEW POINT HEALTH |

**ERF located in participating county*

Figure 3 identifies the counties that were visited in this study. Of the transports with known destinations, 80.8% went to ERFs outside of the origin county, and 59.8% went to ERFs in counties outside of the 17-county study area.

**Figure 3. Distribution of Visited Emergency Receiving Facilities**




To explore the mental health transport process as thoroughly as possible, this study considers data from the Georgia Crisis and Access Line (GCAL) because of the integral role it plays in the mental health transport process. GCAL provides two important services: first, triaging an individual to determine what services and supports are needed, and two, for DBHDD network providers, GCAL monitors crisis bed occupancy and can direct law enforcement to the most appropriate ERF with bed availability to admit and evaluate an individual. As such, every individual who is transported for an involuntary evaluation should have a corresponding record in GCAL. No analysis by the Department to date has examined GSA mental health transport data in tandem with GCAL episode data to determine the degree of alignment between the two. The design of this analysis purposefully offers insight into their relationship.

# Methods

## Stakeholder Responsibilities

Responsibilities of the Georgia Sheriffs' Association:

- Liaise with participating sheriff's offices
- Provide technical assistance and training to the sheriffs' offices' staff on using the Eagle Advantage Solutions portal to report transports
- Report mental health transports monthly to DBHDD during study period

Responsibilities of participating sheriffs' offices:

- Timely and accurately enter mental health transport records into GSA portal

Responsibilities of the Georgia Crisis and Access Line:

- Report all GCAL episodes monthly to DBHDD during study period
- Provide GCAL episode data interpretation assistance to DBHDD

Responsibilities of DBHDD's Office of Performance Analysis & Quality Improvement (OPAQI):

- Manage project timeline
- Engage additional stakeholders as needed
- Collect, clean, and analyze datasets rendered by GCAL and GSA
- Produce report of findings and recommendations

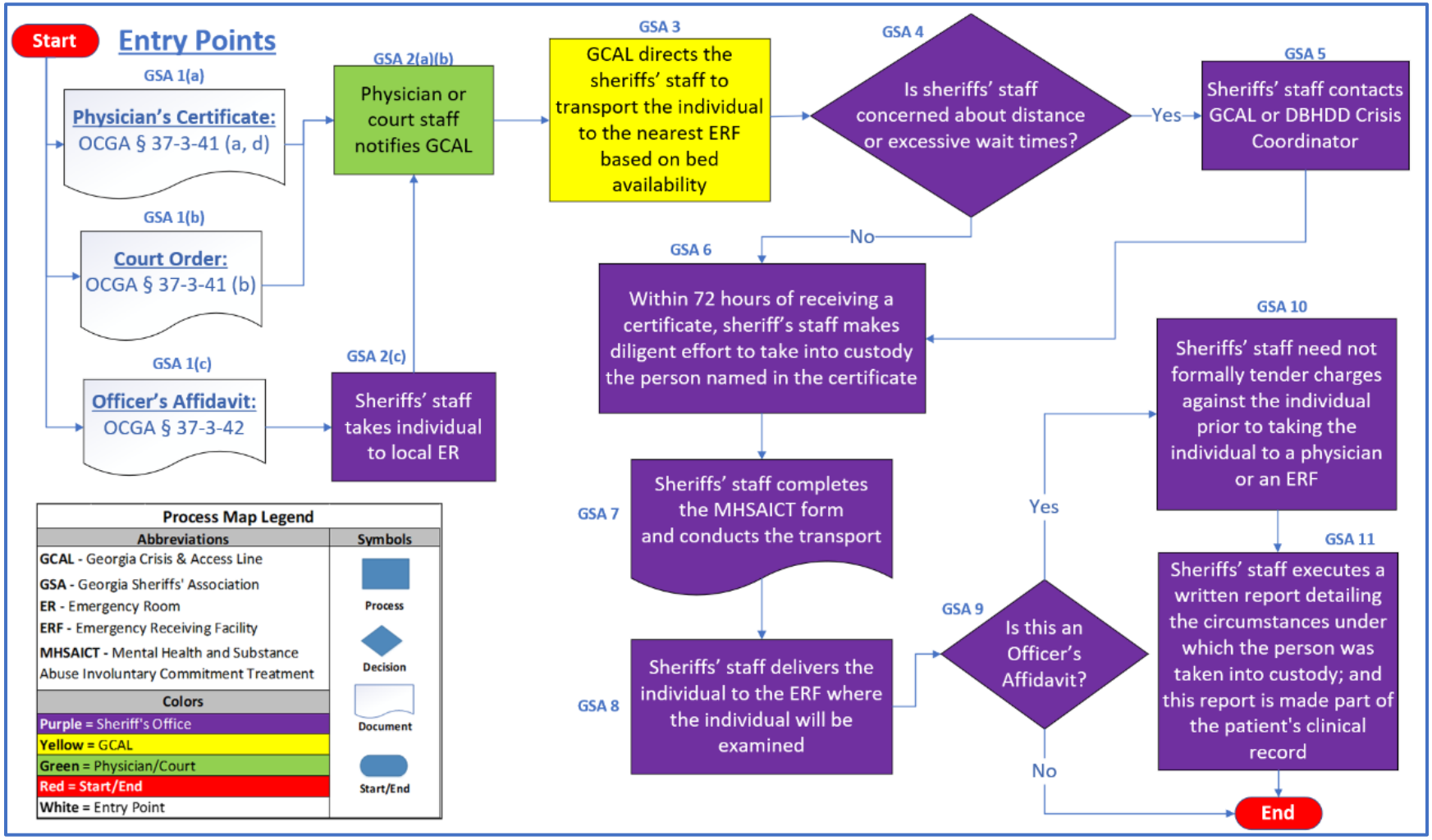
## Early Stages

Pre-study preparation began with an examination of data files from GSA and GCAL to evaluate data point usefulness, ensure compatibility, and facilitate analysis. Concurrently, GSA staff reached out to the thirty identified sheriffs' offices to ensure an understanding of the pilot study process, how to enter transports into the GSA portal administered by Eagle Advantage Solutions, Inc., and answer any technical questions.

## Process Mapping

The study began with the development of a process map that visualizes the steps to carry out a mental health transport from start to finish. The process map is based on a document published by GSA titled "Mental Health & Involuntary Commitment Transport Guide." Last revised in June 2021, the guide summarizes the mental health transport process and describes detailed steps for mental health transport data entry for sheriffs' offices to report their respective transports. It also consists of a generic flow chart and supporting language that informed process map development. The document standardizes transport procedures and is recognized by sheriffs' offices across the state. Subject matter experts from DBHDD were consulted throughout this process as well. Figure 4 shows the finalized, validated process map, which formed the basis of our understanding of the mental health transport process.

## Figure 4. Mental Health Transport Process Map



## Data Collection and Preparation

Following completion of the mental health transport process map, three months of data collection began on August 1, 2023. Relevant data was collected from two sources. One dataset, rendered by GSA, consists of transport records from the fifteen participating counties; the other dataset consists of all GCAL episodes that were created during the study period of August 1, 2023, to October 31, 2023. Analysis was conducted using these two datasets in concert.

### *Mental Health Transport Reports*

DBHDD received reports of mental health transports that GSA collects from its Eagle Advantage Solutions, Inc. software. Counties enter their respective transports into this system which aggregates the data so GSA can disseminate it. The reports list one mental health transport per line item, and the fields relevant to the pilot study include:

- Individuals' first and last names
- County of sheriffs' office
- Basis for emergency admission
- Status of individual to be transported
- Date/time transport order received
- Date/time deputy responded to individual's location
- Date/time individual taken into custody
- Date/time deputy and individual in route to receiving facility
- Date/time of arrival at receiving facility
- Date/time deputy left receiving facility
- Date/time deputy returned to county
- Mileage at time of order receipt
- Mileage at time of departure to receiving facility
- Mileage at time deputy returned to county
- Additional officers assigned to transport
- Destination ERF name
- Admission status of individual at receiving facility
- Self-reported score of deputy's facility interaction
- Self-reported reason for score of deputy's facility interaction

### *GCAL Episode Reports*

DBHDD relied on comprehensive reports of GCAL episodes to identify whether transported individuals had corresponding records in the CGAL episode system. Separate from the system that captures call data, the episode system houses records that are created when call takers deem calls appropriate for GCAL support, such as when an individual's call warrants triage or when calls are made to GCAL locate a bed for an individual. The reports from GCAL list one episode per line item, and the fields relevant to the pilot study include:

- Individuals' first and last names
- County of residence
- Date/time of call

### *Data Testing*

Data testing in the early stages of the study ensured that all necessary fields for analysis were present in GSA and GCAL reports and confirmed what inferences could be made between them. This process was completed in June using data from a ten-day timeframe in May. During this time, the matching criteria to link a transport to a GCAL episode were determined. The test file of mental health transports did not include the names of those transported by deputies, so only the time stamps and counties were used to determine "matches" with GCAL episodes. Those criteria alone did not provide enough evidence of a "match." Therefore, fields for the first and last names of the individuals were included in the mental health transport dataset for transports performed during the three-month data collection period to increase the likelihood that a transport and an episode were truly linked. Manual identification of GCAL episodes that corresponded to transported individuals relied on filtering and searching by name in Excel.

### *Data Collection*

Mental health transport reports and GCAL episode reports were collected monthly from both GSA and GCAL respectively during the study period. Upon receipt of each month's data, the datasets were reviewed, and preliminary cleaning and analysis were performed to ensure no changes or corrections needed to be made to reports requested later in the study. Although data was collected monthly, mental health transport data was aggregated once it was all collected and was not segmented monthly for analysis.

### *Data Cleaning*

From August 1, 2023, to October 31, 2023, GSA reported 396 mental health transports to DBHDD. A total of 76 records consisted of duplicated transport records and were excluded from analysis. When a duplicate record was identified, one was kept in the dataset for analysis and all other duplications of that record were excluded. Four more transport records were excluded due to discrepancies and inconsistencies in data entry that could not be timely resolved. Once the dataset was cleaned, 316 transport records were used to perform calculations and draw subsequent conclusions. Table 3 summarizes the exclusions.

**Table 3. Mental Health Transport Dataset Exclusions**

| | |
|---|---|
| Total mental health transports reported | 396 |
| Duplicate records excluded | 76 |
| Erroneous records excluded | 4 |
| **Total mental health transports analyzed** | **316** |

### *Mental Health Transport and GCAL Episode Alignment Process*

Mental health transport alignment to GCAL episodes was determined in stages as data was received throughout the study period. The data elements that were used to manually match a transported individual to a GCAL episode included:

1) First and last names reported by GSA
2) First and last names reported by GCAL
3) Date/time of transport order receipt reported by GSA*
4) Episode creation timestamp reported by GCAL*
5) Individual's county of residence reported by GCAL**
6) Sheriff's office county reported by GSA**

*To indicate a match, the two timestamps could have a difference of no more than 72 hours. This amount of time was chosen as the constraint because transports for involuntary evaluation must happen within 72 hours of authorization.

**The county fields did not always align between GSA and GCAL records since out-of-county transports are common. County was most often used as a supporting criterium when other fields could not be used alone to determine a match.

## Calculations

The following calculations were performed using the mental health transport dataset exclusively except for the rate at which transported individuals were matched to GCAL episodes and deeper analysis into whether GCAL alignment influenced other variables. Table 4 summarizes the calculations by category.

**Table 4. Pilot Study Calculations**

| |
|---|
| **GENERIC** |
| Total transports performed during study period |
| Total and proportion of transports by basis for emergency admission |
| Total and proportion of transports by order type |
| Average cost per transport |
| **GSA AND GCAL ALIGNMENT** |
| Total and proportion of transports matched to GCAL episodes |
| **TRANSPORT OUTCOMES** |
| Total and proportion of individuals admitted to ERFs |
| Total and proportion of in-county versus out-of-county transports |
| Total transports to most-visited ERFs |
| **TIMELINESS** |
| Total and average time spent on full process |
| Average time spent on full process weighted by number of transporting deputies |
| Total time spent transporting individual |
| Average time spent transporting individual |
| Total wait time at receiving facilities |
| Average wait time at receiving facilities |
| **MILEAGE** |
| Total miles driven to perform reported transports |
| Average miles driven per transport |
| **TRANSPORT PERSONNEL** |
| Total law enforcement involved in transports |
| Average number of deputies per transport |
| **DEPUTY SATISFACTION** |
| Average satisfaction score based on 1-5 Likert scale |
| Thematic trends in free form field |

## Limitations

Thirteen invited counties performed mental health transports during the study period but did not timely report them to GSA, and they were not forwarded to DBHDD. Therefore, the analysis and recommendations only reflect those counties who opted to participate in the pilot study.

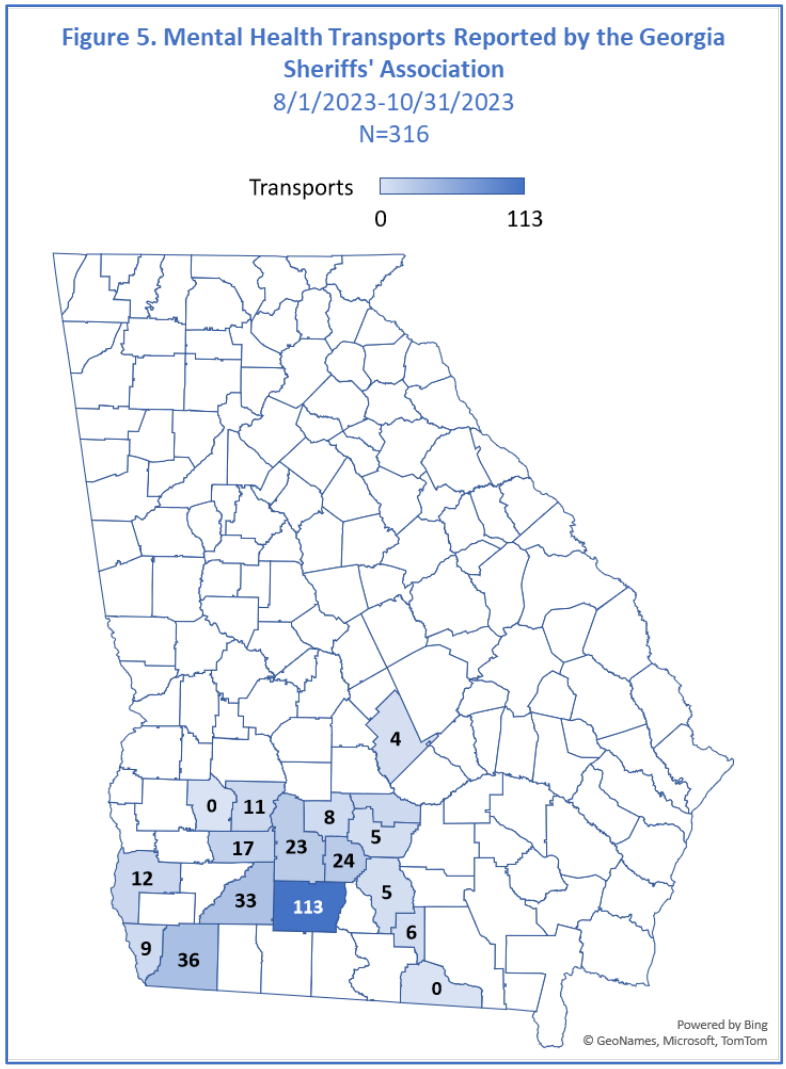
At the onset of the pilot study, findings about the relationship between mental health transports and GCAL calls were highly anticipated. However, connecting GCAL episodes to GCAL calls posed a significant challenge. Since GCAL episodes are housed in a different system from GCAL calls and there are insufficient identifiers to link episodes to their corresponding calls, DBHDD is unable to report on metrics related to speed to answer and talk time of GCAL calls associated with the sample of mental health transports. However, a physician or clinician initiates the GCAL referral. Therefore, for the purposes of this study of the sheriff's process, we are still able to accurately account for sheriff time spent without the GCAL call metrics.

Another important limitation to consider is that of data completeness for certain fields of the mental health transport report. Specifically, deputy satisfaction with the transport process was an important metric to better gauge the burden of mental health transports on sheriffs' offices. However, only 59% of transport records were submitted with the quantitative satisfaction field completed, and only 6% of transport records were submitted with the qualitative satisfaction field completed. Had more records been submitted with completed satisfaction fields, stronger conclusions could be drawn about deputies' unique perspectives on the entire transport process.

## Major Findings

At the conclusion of the study period, seventeen participating counties reported a total of 316 mental health transports with records suitable for analysis. Fifteen of the seventeen counties performed mental health transports. The other two, Echols and Terrell counties, each reported that they performed no transports during the study period of August 1, 2023, to October 31, 2023. The reported transports are also visualized on a county map of Georgia in Figure 5.

**Figure 5. Mental Health Transports Reported by the Georgia Sheriffs' Association**
8/1/2023-10/31/2023
N=316




An important consideration throughout the following discussion of findings and recommendations is that 113, or nearly 36%, of the mental health transports in the study sample were reported by Colquitt County. Each of the other sixteen counties represented in the sample reported 36 or fewer transports. Therefore, the results disproportionately reflect the processes and outcomes of transports performed in Colquitt County. Along with other broad context and findings, the number of transports reported by each participating county during the study period is listed in Table 5. The last row of Table 5 excludes Colquitt County data from the total transports, GCAL matches, average time, average mileage, and average cost.

**Table 5. County-Level Mental Health Transport Findings**

| County | Reported Transports | Transports Matched to GCAL Episodes | Average Time per Transport (hh:mm)[1] | Average Miles per Transport[2] | Average Cost per Transport[3] |
|---|---|---|---|---|---|
| **Ben Hill*** | **10** | 9 (90%) | 05:55 | 226.3 | $291.52 |
| **Berrien** | **5** | 2 (40%) | 02:22 | 65.6 | $100.15 |
| **Colquitt*** | **113** | 47 (42%) | 01:40 | 60.5 | $79.92 |
| **Decatur** | **36** | 14 (39%) | 02:50 | 118.6 | $146.31 |
| **Dodge*** | **4** | 3 (75%) | 05:08 | 174.8 | $238.24 |
| **Dougherty*** | **17** | 13 (76%) | 01:32 | 18.9 | $49.22 |
| **Early** | **12** | 9 (75%) | 03:30 | 154.3 | $186.04 |
| **Echols** | **0** | - | - | - | - |
| **Irwin** | **5** | 1 (20%) | 04:49 | 235.0 | $270.80 |
| **Lanier** | **6** | 4 (67%) | 02:37 | 106.7 | $133.43 |
| **Lee** | **11** | 7 (64%) | 02:00 | 16.5 | $58.74 |
| **Mitchell** | **33** | 14 (42%) | 02:29 | 107.8 | $130.95 |
| **Seminole*** | **9** | - | 03:23 | 167.6 | $192.07 |
| **Terrell** | **0** | - | - | - | - |
| **Tift** | **24** | 14 (58%) | 02:35 | 109.9 | $134.69 |
| **Turner** | **8** | 8 (100%) | 03:23 | 119.4 | $159.94 |
| **Worth** | **23** | 13 (57%) | 02:31 | 88.9 | $119.17 |
| **Total** | **316** | **158 (50%)** | **02:27** | **92.6** | **$119.74** |
| **Total Excluding Colquitt County** | **203** | **111 (55%)** | **02:52** | **110.5** | **$141.91** |

**At least one in-county ERF*

[1]Average Time per Transport = (∑Weighted Full Process Time)/316 Transports. Accounts for time of additional deputies assigned to transports.
[2]Average Miles per Transport = (∑Total Miles Driven)/316 Transports.
[3]Average Cost per Transport used the following figures for calculation: State of Georgia mileage reimbursement rate @$0.665/mile. State Accounting Office. Accessed 12.22.2023. Cost of deputy time @$23.81 per hour 50th percentile salary for sheriffs' deputies in Georgia. Police and Sheriff's Patrol Officers (bls.gov). Accessed 12.12.2023.

# Results

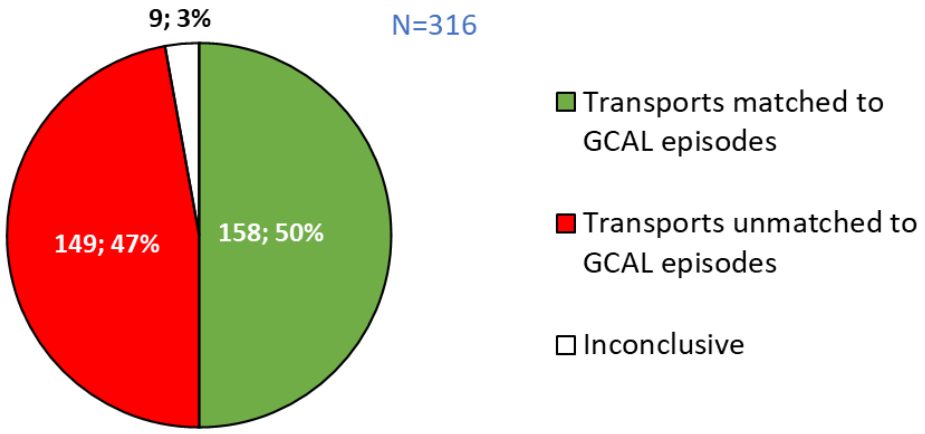
## Introduction

Since the inception of the pilot study, certain metrics related to mental health transports have remained at the forefront of the analysis. Categories for these metrics include transport entry points, timeliness, mileage, personnel use, deputy satisfaction, transport outcomes, and alignment with GCAL. This section summarizes findings that fall in each of these categories and draws attention to relevant and insightful findings uncovered in later stages of the study. All the following elements of analysis are intended to inform conclusions of the present study and serve as useful evidence for further study and recommendations.

## GSA and GCAL Alignment

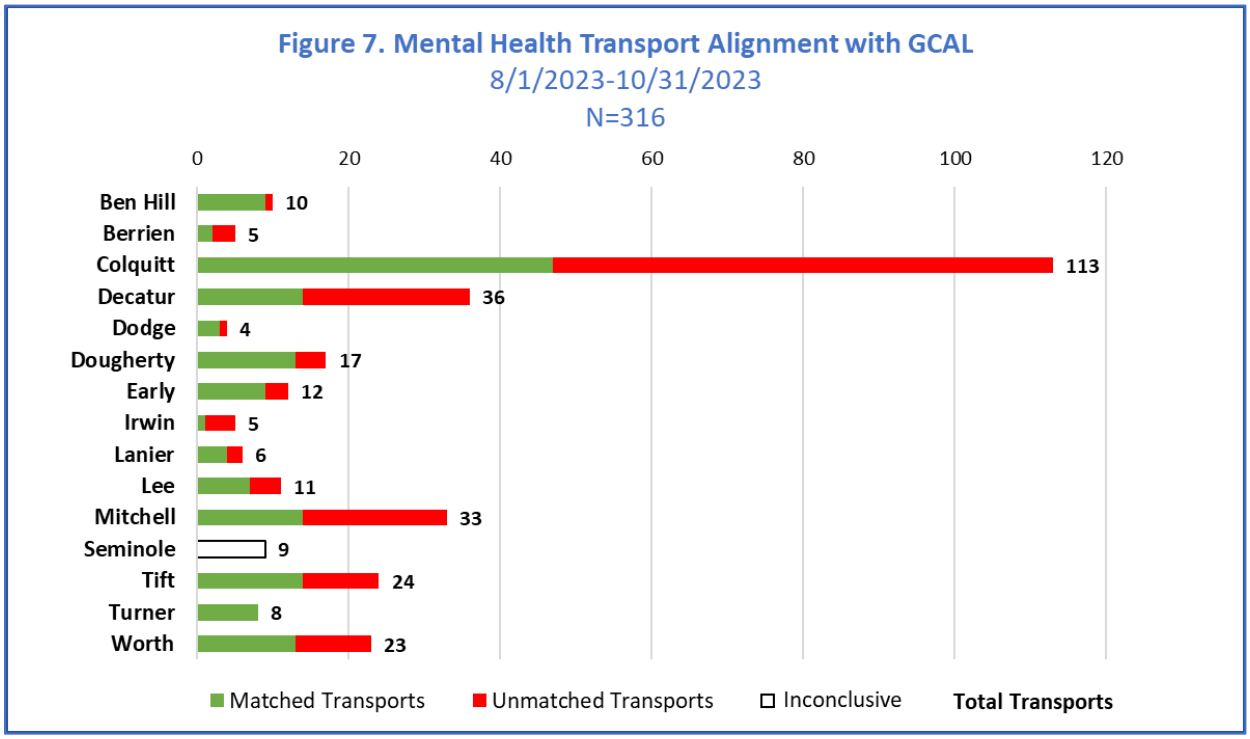
The manual process for matching a transported individual to a corresponding episode in GCAL revealed a matching rate much lower than established procedures suggested. Figure 6 shows that only 158 transported individuals (50%) were identified throughout GCAL episode reports. As a result of the collaborative nature of the pilot study, DBHDD learned from GCAL partners that it is common for providers and hospitals to place calls to GCAL in lieu of the deputy. Because of the important role GCAL plays in directing the transport destination, GCAL alignment will be examined through lenses of the remaining study metric categories, too.

**Figure 6. Mental Health Transports Matched to GCAL Episodes**
8/1/2023-10/31/2023
N=316




At the county level, the rate of matching transported individuals to GCAL episodes varied considerably. Corresponding GCAL episodes were identified for all eight transports reported by Turner County. In addition to Turner County, at least 75% of the transports reported by Ben Hill, Dodge, Dougherty, and Early Counties were matched to GCAL episodes. Conversely, fewer than 50% of the transports reported by Berrien, Colquitt, Decatur, Irwin, and Mitchell Counties were matched to GCAL episodes. Figure 7 illustrates the alignment outcomes for each participating county.

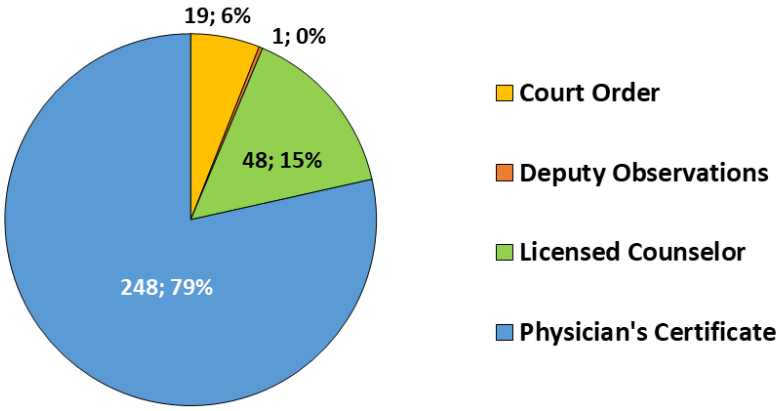
Notably, mental health transports reported by Seminole County did not include transported individuals' names, so matches to GCAL episodes could not be made with enough confidence to include in the analysis. The inconclusive results are indicated with a colorless bar for Seminole County in applicable figures.




## Transport Entry Points

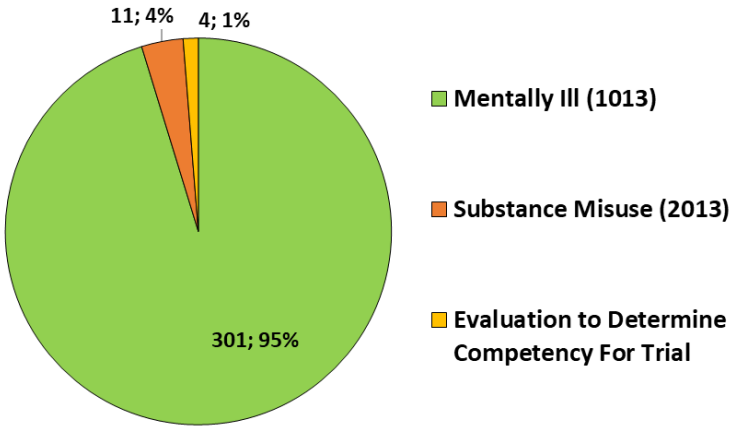
The findings indicate there are four sources for emergency admission regarding mental health transports within the sample of 316 transports. A physician or licensed counselor (e.g., MD, LPC, LCSW, etc.) can certify that, upon examination, an individual is mentally ill and requires involuntary treatment. In the transport dataset, the type of provider is specified, so the category is split between physicians and licensed counselors. Together, these admission sources account for 296 mental health transports (94%) in the study sample. Transports can also be initiated by court order when a court mandates that a peace officer take an individual into custody to transport them to either an ERF or to a provider who can issue a physician's certificate. In the study sample, 19 transports (6%) were initiated by a court order. The last possible emergency admission source is an officer's affidavit or deputy observation, and only one reported transport was initiated this way. This admission source allows a peace officer to transport an individual to an ERF or to a certifying physician if individual is committing a penal offense and the officer has probable cause to believe that the individual requires involuntary treatment. Figure 8 visualizes the distribution of the four emergency admission sources in the study sample.

**Figure 8. Mental Health Transports by Emergency Admission Source**
8/1/2023-10/31/2023
N=316




Another way to examine entry points for mental health transports is categorization by transport type or reason for transport. Among the study sample, the vast majority (95%) of individuals transported were considered mentally ill and an involuntary evaluation was authorized. The remaining individuals were transported because of substance use (4%) or to determine their competency for trial (1%). Figure 9 visualizes the distribution of these three categories in the study sample.

**Figure 9. Mental Health Transports by Transport Type**
8/1/2023-10/31/2023
N=316




## Transport Outcomes

Every transport is intended to result in an individual's admission for evaluation, but in practice, that is not always the case. In the study sample of 316 transports, 282 individuals were admitted when they reached their destination, and 34 were not. In other words, 89% of transports resulted in admissions. Figure 10 visualizes the distribution of admission outcomes. For those transports that did not result in admissions,

free form space was given for deputies to indicate why they were turned away. However, very little actionable information was provided. Reasons why deputies may have been turned away include lack of medical clearance prior to transport or lack of an available male or female bed.

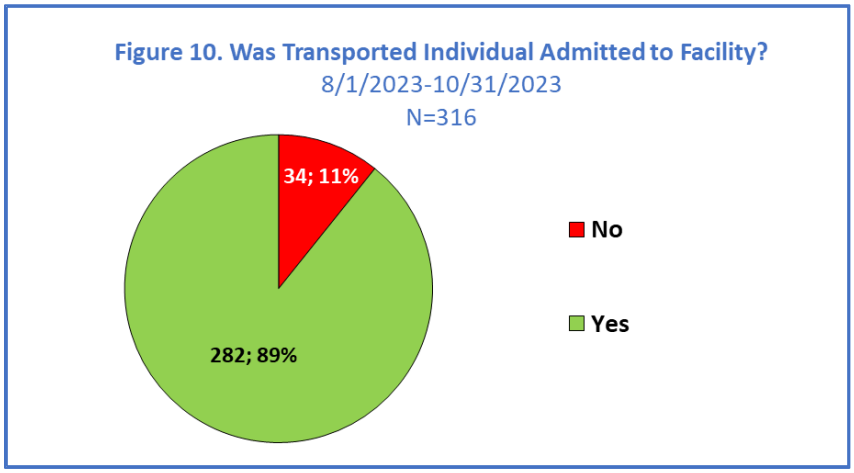
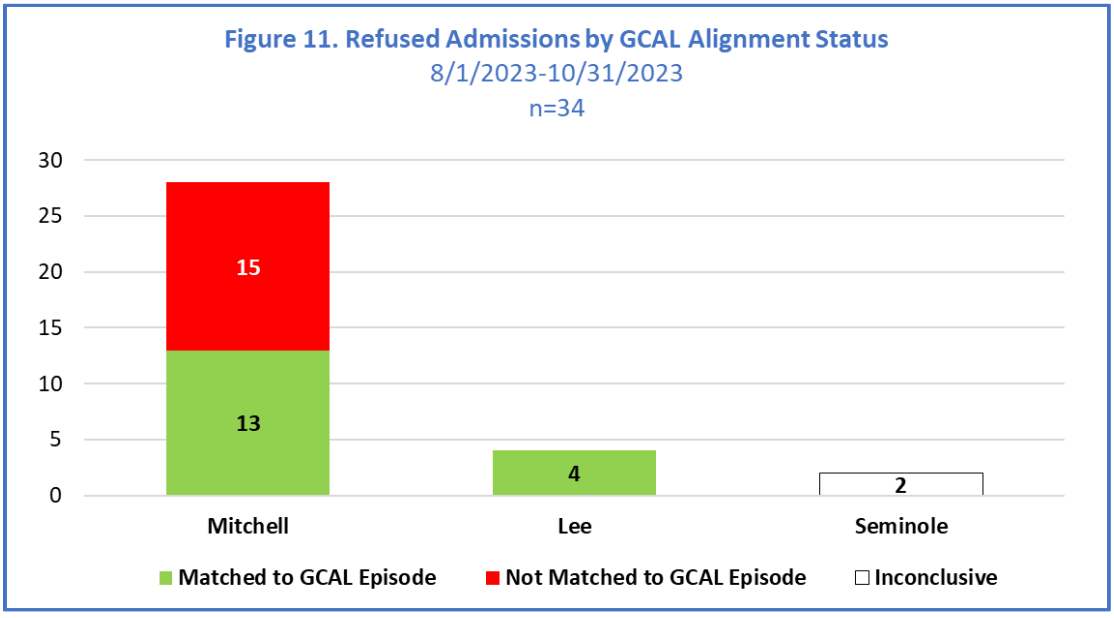
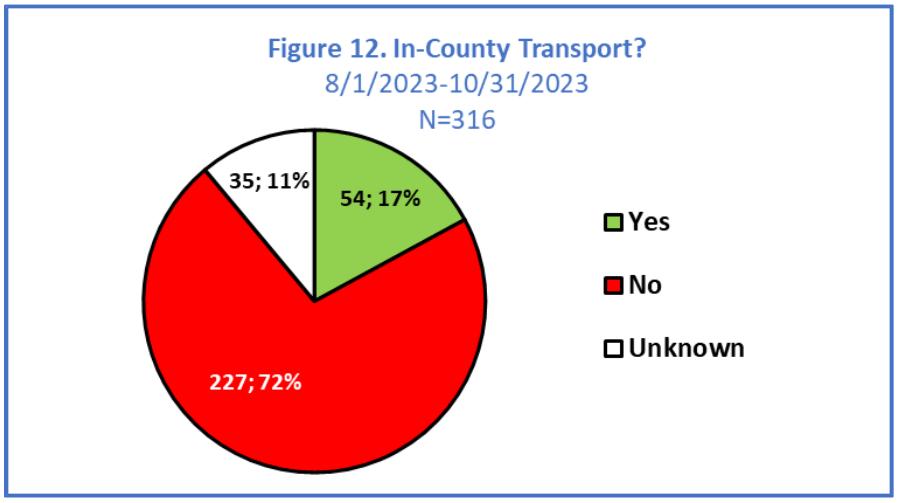


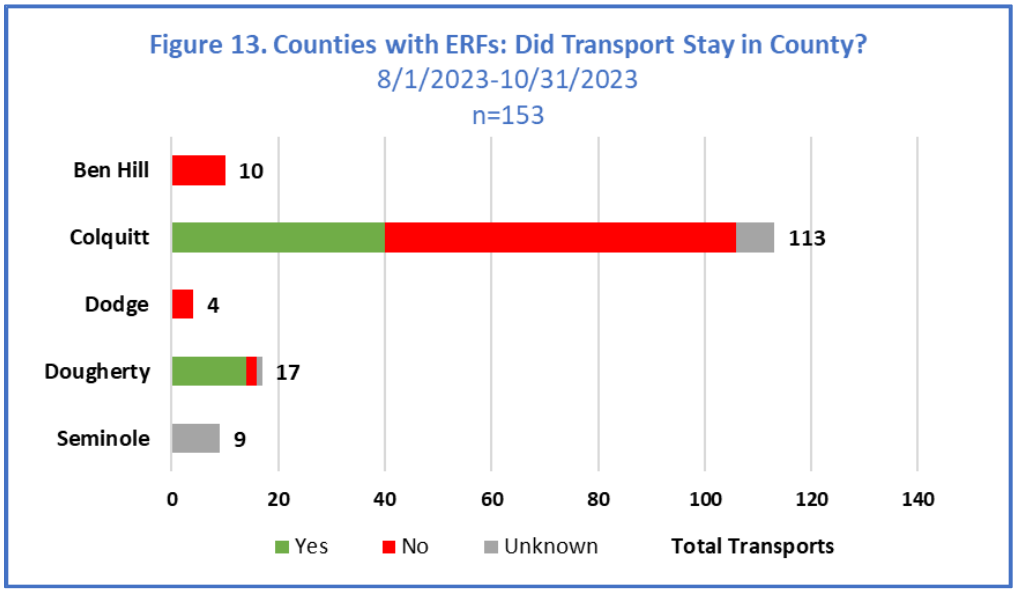

Figure 11 visualizes whether GCAL episodes were matched to the transported individuals who were refused admission to ERFs. Of the 34 transports with that admission status, only half had corresponding GCAL episodes. There is no trend in this data that could explain whether contacting GCAL influences the admission outcome. As noted above, admission refusals could stem from lack of medical clearance or bed availability. While bed availability may seem counter intuitive as a source of refusal, especially in instances when GCAL was contacted, it remains a concern due to the timing issues it may create. Since GCAL was not contacted prior to transport 47% of the time, a lag is left between an individual occupying a bed and GCAL being notified that a bed is occupied. Therefore, GCAL may sometimes provide inaccurate information about bed availability because the transport process, which includes the step of obtaining a bed assignment through GCAL, has been bypassed.



Since only five of the seventeen participating counties have at least one in-county ERF, most transports require deputies to travel outside their home county. In the study sample, this was true for 227 (72%) of reported transports. Figure 12 shows the distribution of where deputies traveled.

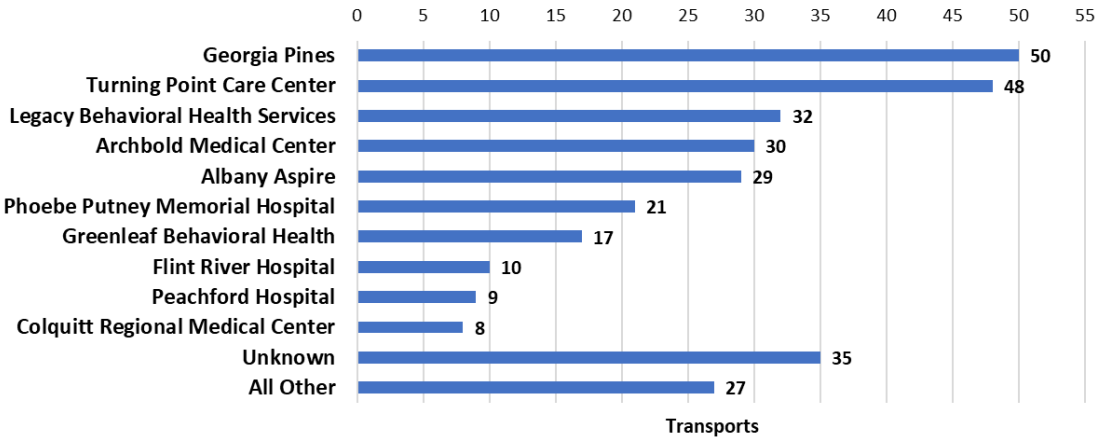



Although Ben Hill, Colquitt, Dodge, Dougherty, and Seminole Counties have in-county ERFs, not all their transports stay in-county. Figure 13 visualizes transports from those counties required travel to an ERF outside of their own county. Neither Ben Hill County nor Dodge County reported any in-county transports despite having an in-county ERF. Seminole County did not provide sufficient information to determine transport destinations. The ten individuals transported by the Ben Hill County Sheriff's Office were evaluated at Anchor Hospital (1), Archbold Medical Center (1), Greenleaf Behavioral Health (2), Legacy BHS (3), Peachford Hospital (1), and Riverwood Behavioral Health System (2). The four individuals transported by the Dodge County Sheriff's Office were evaluated at Coastal Harbor (3) and CSB of Middle Georgia (1).



Certain ERFs received more individuals for evaluation than others. Figure 14 lists the ERFs beginning with the facility that was frequented most. For 35 transport records, the receiving facility was either not reported or unclear. The "All Other" category consists of ERFs that were visited seven or fewer times.

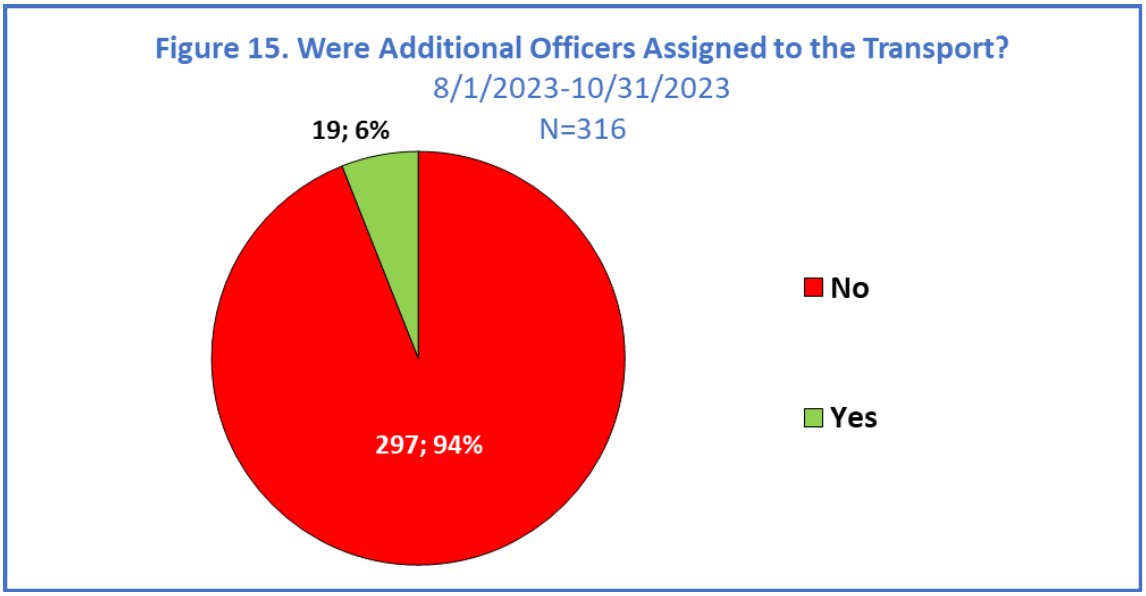
**Figure 14. Mental Health Transports by ERF**
8/1/2023-10/31/2023
N=316




## Transport Personnel

Since the primary purpose of the pilot study is to gain an understanding of how resources are expended to perform mental health transports, it is important to explore how human capital is used in addition to time, mileage, and other factors that make transports possible. In the case of 297 transports (94%), no additional deputies were assigned to transports, but 19 transports (6%) required the assignment of additional deputies to safely complete the transport. These results are visualized in Figure 15.

In the study sample, 358 personnel were required to perform 316 transports. The average number of deputies present for each transport was 1.13. The maximum number of deputies present for any transport was three. As an annualized figure, the time spent on mental health transports can be distilled to 1.48 full-time equivalent personnel.




## Transport Timeliness

Understanding the time sheriffs' offices devote to mental health transports was one of the top priorities for the pilot study. Based on the timestamps provided by GSA, there are different ways to look at the time a deputy spends on a transport. The timestamps that drove the pilot study calculations include:

A. Date/time of transport order receipt
B. Date/time deputy responded to individual's location
C. Date/time deputy took individual into custody
D. Date/time deputy and individual in route to facility
E. Date/time deputy and individual arrive at facility
F. Date/time deputy departs from facility
G. Date/time deputy returns to county

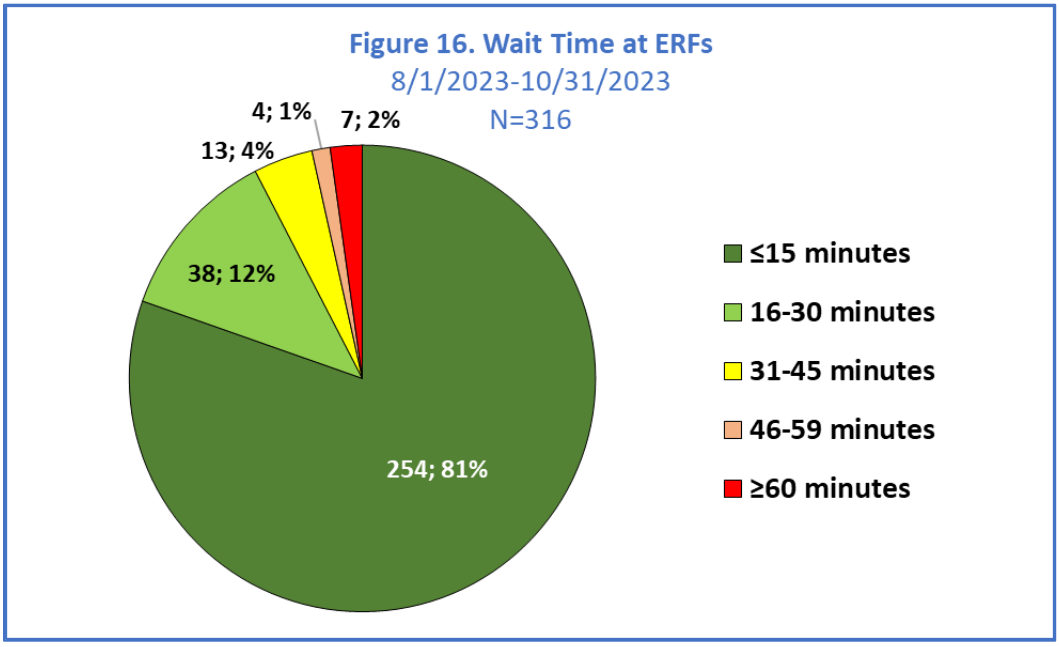
There are several ways to examine time as it relates to the transport process. The transport time refers to the elapsed time between the time an individual is taken into custody and when the deputy returns to county from the ERF. The average transport time for the study sample was 2 hours and 1 minute. The full process time includes both the time it takes a deputy to take an individual into custody after responding to their location and the transport time. The average full process time for the study was 2 hours and 13 minutes. The personnel and timeliness categories are intertwined because, in 19 instances, more than one deputy was assigned to the transport, and the time each deputy devoted to the transport must be accounted for. The weighted full process time considers both the full process time and the number of deputies assigned to a transport and increases the average full process time to 2 hours and 27 minutes. Table 6 lists these findings in more detail.

Table 6. Transport Timeliness

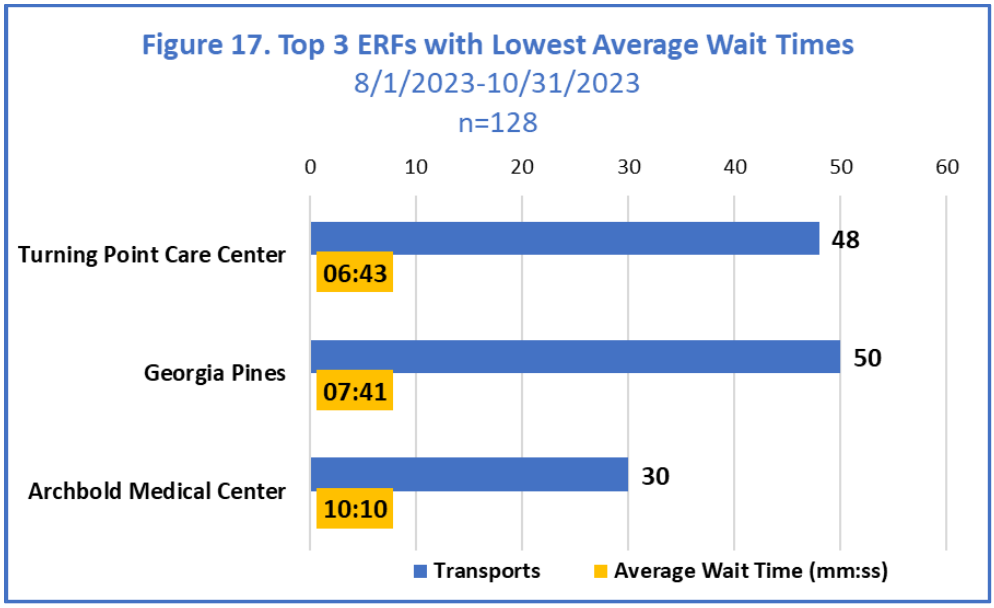
| | FORMULA | TOTAL TIME (hh:mm) | AVG. TIME (hh:mm) | MIN. TIME (hh:mm) | MAX. TIME (hh:mm) |
|---|---|---|---|---|---|
| **Transport Time** | G-C | 638:45 | 02:01 | 00:05 | 10:14 |
| **Full Process Time** | G-B | 701:18 | 02:13 | 00:08 | 10:15 |
| **Weighted Full Process Time** | (G-B)*# Deputies | 771:42 | 02:27 | 00:08 | 15:26 |
| **ERF Wait Time** | F-E | 61:14 | 00:12 | 00:00 | 02:01 |

As annualized figures, deputies would spend 3,087 hours performing mental health transports which would cost an estimated $73,497 in salaries.

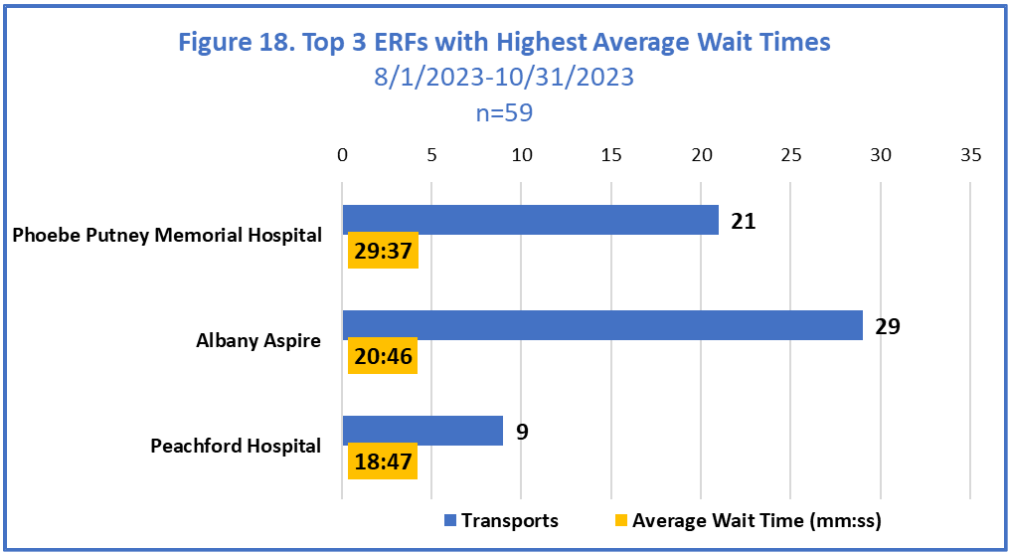
Table 6 also lists how much time deputies spend waiting at ERFs during the transport process. On average, deputies spend 12 minutes waiting before they leave the ERF to return to county. Figure 16 shows the distribution of ERF wait times in 15-minute increments. It is notable that 81% of the reported transports showed that deputies waited fifteen minutes or less at the receiving facility. However, there was significant variation in the amount of time spent, on average, at different ERFs.




The data revealed that certain ERFs had significantly shorter wait times than others. Turning Point Care Center, Georgia Pines, and Archbold Medical Center all had average wait times of ten minutes or less. Figure 17 shows how many transports went to each of those ERFs and the corresponding average wait times.




The data also revealed that certain ERFs had longer wait times than others. Phoebe Putney Memorial Hospital, Albany Aspire, and Peachford Hospital all had average wait times of 19 to 29 minutes. Figure 18 shows how many transports went to each of those ERFs and the corresponding average wait times.

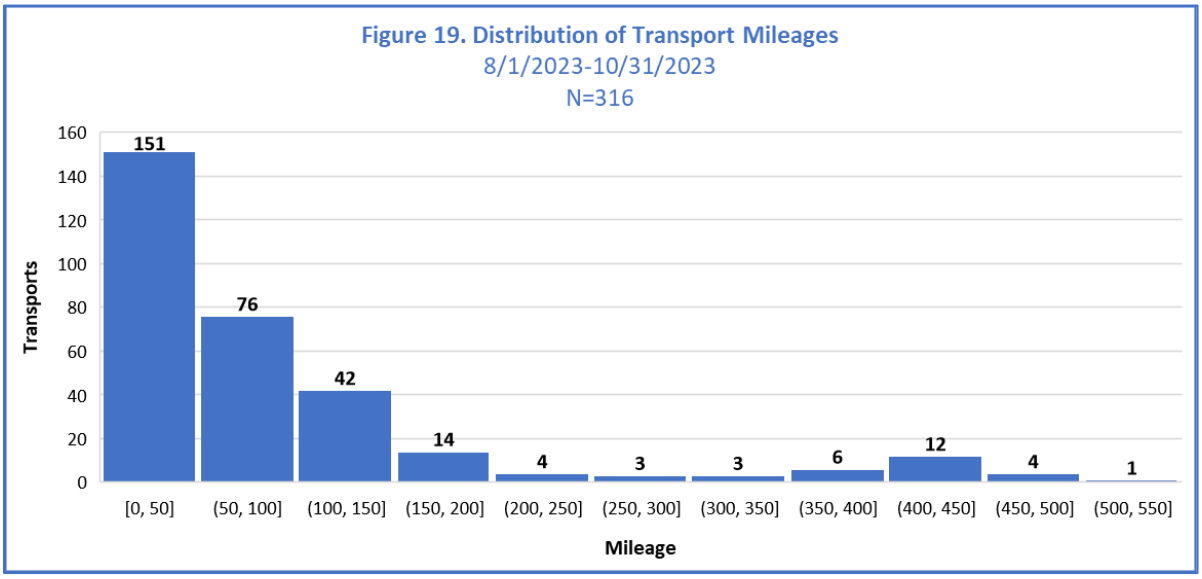



Regardless of whether the transport time or the full process time is considered, the average times are lower among transports without a corresponding GCAL episode. Although contacting GCAL during the transport process may increase the length of time it takes to complete a transport, there is a positive correlation between GCAL contact and deputy satisfaction with the transport process.

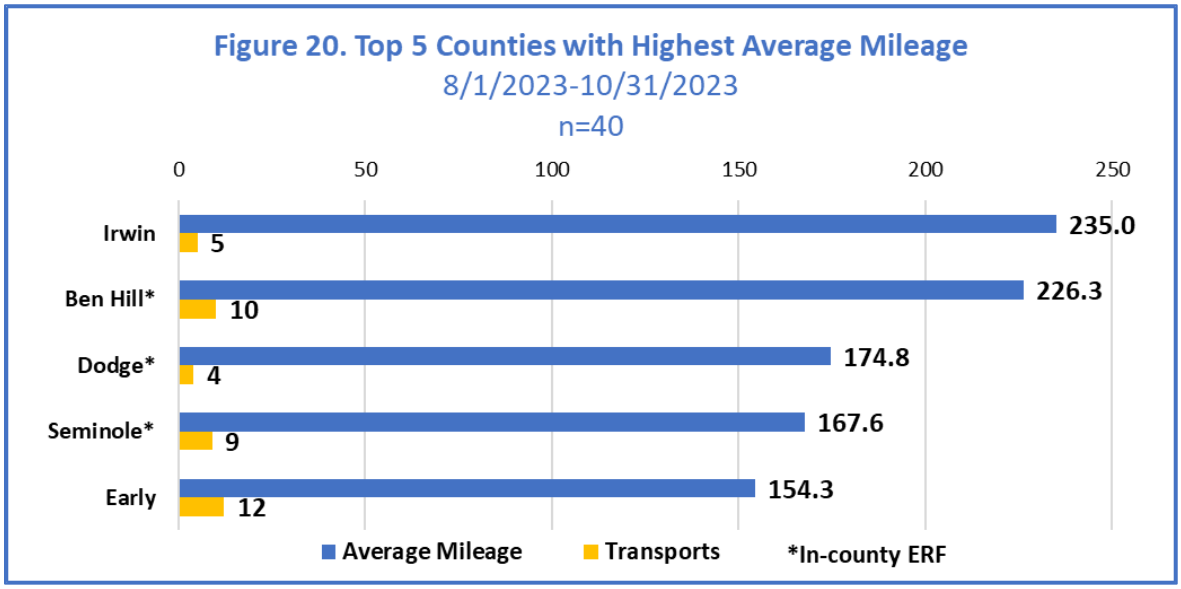
## Transport Mileage

Deputies drove a total of 29,271 miles to perform the 316 reported mental health transports. On average, each transport required a deputy to drive 92.6 miles. The mileage range reported was 0 to 511 miles. As

annualized figures, it is estimated that deputies would drive 117,084 miles which equates to $77,861 using Georgia's mileage reimbursement rate to account for fuel and vehicle wear and tear. See Figure 19 below for a histogram showing the distribution of transport mileage.



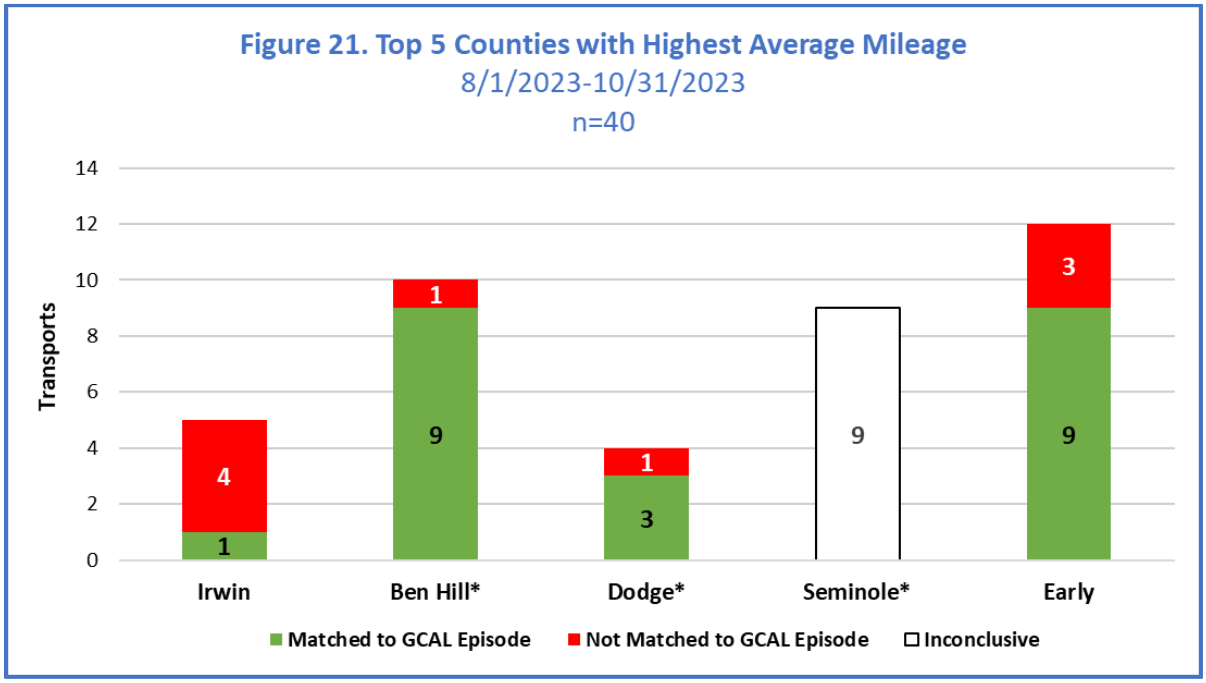

In descending order, Irwin, Ben Hill, Dodge, Seminole, and Early County deputies logged the highest average miles per transport. Despite having in-county ERFs, Ben Hill, Dodge, and Seminole County deputies drive considerable distances. Figure 20 depicts how far deputies drove on average per transport in each county.




**At least one in-county ERF*

Among the same five high-mileage counties, few conclusions can be drawn regarding the impact of contacting GCAL on traveled distance. Results from Seminole County are inconclusive for this analysis

because insufficient data were provided to match individuals to GCAL records. These results are visualized in Figure 21.

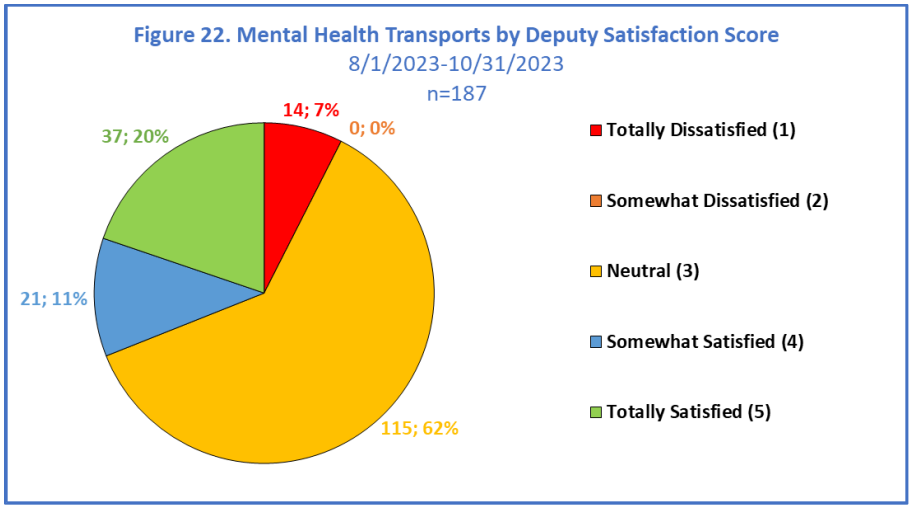



**At least one in-county ERF*

## Sheriff Staff Satisfaction

To better understand how sheriffs' staff feel about performing mental health transports, GSA added two fields to the software into which counties enter their respective transport data to gauge their satisfaction. One field consisted of a Likert scale with five choices to indicate their satisfaction level, and the other allowed deputies to freely enter additional details and impressions about each transport.

The response rate for the satisfaction Likert scale field was 59.1%. Of the 187 transports with reported satisfaction scores, the average score was 3.36. Figure 22 shows the distribution of scores within the study sample. The most reported score was a 3 which indicates neutral feelings; this score was reported 115 times (62%). Deputies indicated they were "totally satisfied" with 37 transports (20%), "somewhat satisfied" with 20 transports (11%), and "totally dissatisfied" with 14 transports (7%). The "somewhat dissatisfied" choice was never reported in the sample. Although the "totally dissatisfied" choice was reported 14 times, the free response field to provide additional feedback was only populated three times. One of the three responses was "none."

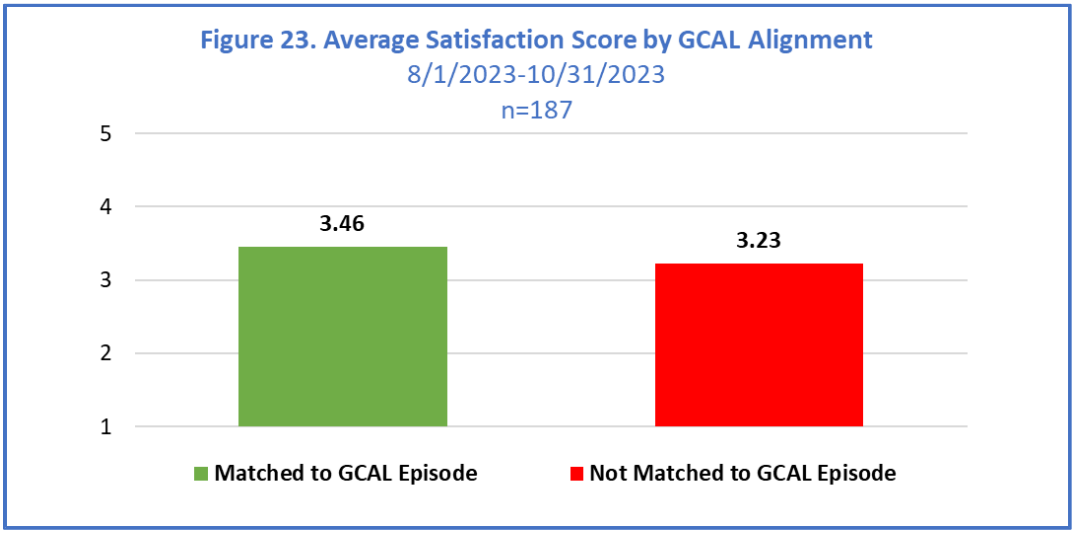



Of the 187 satisfaction scores provided, only 19 were accompanied by interpretable text in the open response satisfaction field, so the response rate for that field was approximately 10%. About 90% of these responses were categorized as positive feedback (neutral-totally satisfied), and about 10% of them were categorized as negative feedback (totally dissatisfied). Examples of positive and negative feedback are shown in Table 7.

**Table 7. Qualitative Transport Feedback**

| POSITIVE FEEDBACK EXAMPLES | | |
|---|---|---|
| "Everything was smooth." | "Everything went well." | "Great." |
| "In and out." | "Patient was cooperative." | |
| **NEGATIVE FEEDBACK EXAMPLES** | | |
| "Subject not medically cleared." | "Subject was not cooperative." | |

When segmented by matches to GCAL episodes, there is a slight difference in average deputy satisfaction scores, with deputies reporting slightly higher satisfaction when GCAL was contacted. Figure 23 shows how similar the scores are whether the transports were matched or not.



## Conclusions & Recommendations

The following list summarizes key takeaways of the pilot study based on the 316 mental health transports suitable for analysis:

- Colquitt County reported nearly 36% of the transports in the sample
- Roughly half the transports were matched to a corresponding GCAL episode although established processes indicate that step should happen every time
- 95% of transports were authorized on a 1013 order
- Clinicians deemed involuntary evaluation necessary for 94% of transported individuals
- Nearly three-quarters of the transports required deputies to travel to an out-of-county ERF
- 11% of transported individuals were denied admission to the ERF
- Counties with in-county ERFs still have to travel to out-of-county ERFs
    - Ben Hill and Dodge Counties reported no in-county transports
- 19 transports required additional deputies to be present
- Average transport time is 2 hours and 1 minute
- Average weighted full process time is 2 hours and 27 minutes
- Over 80% of the ERF wait times were under 15 minutes
    - Average wait time was approximately 12 minutes
- Cannot conclude whether contacting GCAL impacts traveled distance
- The satisfaction field response rates were low, but deputy satisfaction with the transport process was considered "positive" (neutral to totally satisfied) for 93% of the responses
- Deputies reported being slightly more satisfied with transports where GCAL was contacted than those where GCAL was not contacted

Table 8 summarizes the costs incurred by sheriffs' offices to perform mental health transports as annual figures.

**Table 8. Annualized Figures**

| METRIC | ANNUALIZED FIGURES |
|---|---|
| Total miles driven | 117,084 |
| Cost to drive total miles | $77,861 |
| Total hours worked | 3,087 |
| Cost to work total hours | $73,497 |
| Total transport cost | $151,358 |
| Full-time equivalent | 1.48 |

Based on these conclusions from the pilot study, DBHDD can offer several recommendations to eliminate existing insufficiencies and facilitate the mental health transport process and associated inquiries in the future.

## Improvement Opportunities

### *Transport Process*

One of the major learnings from this study is that sheriffs' offices most often do not have responsibility for reaching out to GCAL to obtain a bed assignment for an individual. That outreach is generally done prior to the deputy apprehending the individual and is performed by whomever (usually physicians, clinicians, or court personnel) refers the individual for evaluation and transport. An important finding of this study is how infrequently GCAL is contacted (only 50% of the time) prior to an individual being transported. Recommendations for improvement to the transport process include:

- Sheriffs' offices and those making referrals should work together to ensure that GCAL is contacted prior to a transport being initiated. This helps ensure that the GCAL bed board of available male and female crisis beds at each ERF is kept updated, and that transport staff are being directed to the closest available ERF. Additionally, ERF staff are alerted that a transport is on the way, and this can help pave the way for deputies to have a positive transport experience once they arrive.

- As previously noted, wait times for deputies at the ERF may vary considerably between transports, but most especially between facilities. DBHDD and GSA may consider having a guided discussion that would allow ERFs with longer wait times to benefit from learning about best practices of the ERFs with short wait times.

- As noted earlier, three counties reported having multiple transports refused, yet no actionable intelligence was included about the reasons for these refusals. No trends associated with the ERF were noted, as the refusals involved 8 of the receiving facilities. For these three counties, refusals accounted for 22% to 85% of their total transports. Obviously, refusals waste deputies' time and sheriffs' offices' money, and delay access to needed evaluation and treatment. DBHDD and GSA may want to consider working with these sheriffs to determine what barriers exist for them, and what steps can be taken to overcome those barriers.

### *Data Collection and Reporting*

Currently, GSA collects information on mental health transports from participating counties, aggregates the information, and returns summary reports to the participating counties. During this study, DBHDD determined that of the 396 transports submitted by GSA, 80 (20.2%) were either duplicated or contained erroneous data that rendered them unsuitable for inclusion in the study. Ongoing collection of this data and collaboration between GSA and DBHDD could further inform process improvements. As such, the following opportunities are recommended for consideration:

- GSA should perform a quality review of the submitted records for accuracy and completeness of information prior to creating the summary reports and providing them to sheriffs. GSA can also use these findings to provide technical assistance and targeted training to sheriffs' staff.

- GSA should explore with their vendor, Eagle Advantage Solutions, how all transports can be automatically sent to GSA, thus reducing burden on the sheriffs' staff, and reducing the likelihood of record duplication.

- GSA should continue to explore with their vendor the possibility of making all data items of interest required fields. While this was requested by OPAQI prior to the beginning of the study, the vendor was unable to complete the task. Much interest has been expressed in understanding the deputies' perceptions of mental health transports. However, by not making the quantitative and qualitative satisfaction items mandatory, these elements were skipped 41% and 94% of the time respectively upon entry. More robust response rates to these items by deputies would have resulted in a more complete picture of deputy satisfaction and may have resulted in actionable intelligence about deputy reasons for satisfaction or dissatisfaction. Additionally, the first and last name of the individual being transported was also not mandatory. Since Seminole County did not include transported individuals' names, no matches were made to any relevant GCAL episodes.

- GSA should explore with their vendor the addition of a drop-down list of ERFs for deputies to choose from when mental health transport data is entered into the portal. Currently the field is free form, which created challenges in interpreting and standardizing the ERF name for analysis. Additionally, 35 transports (11%) contained insufficient information to identify the ERF.

- GSA should create and socialize an expectation that all transport records for a given month be entered by the sheriffs' offices by a specific date, such as the fifth of the following month. During this study, it was noted that transport records for August were still being submitted in November. Allowing such a long lag time between end of month and completed data submission renders the results either untimely or inaccurate if the reports are generated by GSA and returned to sheriffs prior to all data being submitted. OPAQI remains concerned that transports for this study may have been underreported for some counties due to this excessive lag time.

## Final Thoughts

To support its relationships with law enforcement partners across the state, DBHDD led this inquiry into how sheriffs' offices expend resources to perform mental health transports. While the findings of the study are particularly insightful and establish a baseline understanding of the transport process, they also invite additional inquiries that will be made more feasible with implementation of the recommendations. DBHDD welcomes the opportunity to continue collaboration alongside the GSA to support efficient and safe transport of the individuals we serve. These may include process improvements, county-specific partnerships, and additional data collection and study.