

# MULTI-DISCIPLINARY RESPONSE TEAMS

TRANSFORMING EMERGENCY MENTAL  
HEALTH RESPONSE IN TEXAS

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MEADOWS  
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## About Meadows Mental Health Policy Institute

Launched in 2014, the Meadows Institute helps Texas legislators, state officials, members of the judiciary, and local leaders identify equitable systemic solutions to mental health needs and has become Texas's most trusted source for data-driven mental health policy. The Meadows Institute is making a significant impact in multiple areas, helping Texas leaders expand the mental health workforce, improve access to care for veterans and their families, shift the focus of new investments toward early intervention, and address the mental health crisis in our jails and emergency rooms. Learn more at [mmhpi.org](http://mmhpi.org).

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# TRANSFORMING MENTAL HEALTH EMERGENCY RESPONSE: THE TEXAS EXPERIENCE

The Meadows Mental Health Policy Institute (Meadows Institute) is participating in a national effort to transform mental health emergency response and bring that transformation to scale in select communities across Texas and the United States. This transformation focuses on the implementation of a health-driven response to mental health emergency calls through the 911 system and is based on a variation of the Multi-Disciplinary Response Team (MDRT) approach. This paper provides a discussion of the elements of MDRT being implemented in Texas, using as an example the implementation in Dallas of the Rapid Integrated Group Healthcare Team (RIGHT Care). As of the writing of this report, MDRT variations similar to RIGHT Care are being implemented or under consideration with Meadows Institute support in large (Austin, El Paso, San Antonio) and smaller (Abilene, Galveston) Texas communities, and the Meadows Institute is also supporting implementation of the elements of MDRT in large cities across the country.

Traditionally, communities across the United States have primarily relied on law enforcement for the initial response to mental health emergencies, although those same communities do not take this approach in responding to other health emergencies as part of 911 calls. When police do respond, too often they have been forced to choose one of three generally inappropriate, and too often tragic, responses: 1) book the person into jail, 2) transport them to a hospital emergency department, or 3) leave them in the community with no linkage to needed supports or treatments. There have been significant improvements to the criminal justice system's response to people with mental illnesses in the last two decades, including advanced crisis intervention training for law enforcement, laws and initiatives requiring better screening for and treatment of mental illness in jails, the

creation of processes to release people with mental illnesses from jails on personal bond, specialty treatment courts, treatment-oriented probation, and the use of sequential intercept mapping (SIM) as a planning tool.<sup>1</sup>

However, these improvements have occurred primarily within the criminal justice system. For example, as SIM developed, the goal was to divert people with mental illnesses from jail, but the process often failed to include the health systems, particularly hospital emergency departments, that often must play a major role in resolving a mental health emergency. This is an important omission, because people with mental illnesses often stay much longer in hospital emergency departments (ED) than people with other illnesses and linking people to care from an ED is often as difficult as linking people to care from a jail.<sup>2,3</sup>

<sup>1</sup> Munetz, M., Griffin, P. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. <https://pubmed.ncbi.nlm.nih.gov/16603751/>

<sup>2</sup> Ngo, S., Shahsahebi, M., et al. (2018). Evaluating the effectiveness of community and hospital medical record integration on management of behavioral health in the emergency department. *Journal of Behavioral Health Services & Research*, 45(4), 651–658.

<sup>3</sup> Nordstrom, K., et al. (2019). Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *Western Journal of Emergency Medicine*, 20(5), 690.

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<sup>4,5,6</sup> and calls to redesign policing more broadly.<sup>7</sup> 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,”<sup>8</sup> 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.

These national and state efforts aim to improve mental health emergency response.<sup>9</sup> 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 adopting 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. For example, the national 988 number for mental health crisis response<sup>10</sup> 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<sup>11</sup> 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.

A mobile crisis outreach team (MCOT) brings a crisis worker into the community to provide face-to-face assessment and intervention, follow-up, and relapse prevention services for people experiencing mental

health crises.<sup>12</sup> MCOTs may 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 designed to reduce inpatient hospitalizations and intervention with law enforcement. However, MCOTs typically 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.

These efforts are not without merit and there is emerging evidence that increasingly popular models of crisis response can be used to reduce police involvement in subsets of 911 calls. The CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Eugene, Oregon has a proven track record of delivering much needed care to people in situations which do not pose a risk to their

*MDRT is based on a community paramedicine approach that brings together paramedics, licensed mental health professionals, and specialized law enforcement officers within an integrated team with unique potential to transform the response to mental health emergencies through the 911 system from one that relies on either law enforcement or civilians, to one that can address mental health and broader health care and social needs while assuring public safety.*

<sup>4</sup> Meadows Mental Health Policy Institute. (2020, April 28). Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession). <https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpacts.pdf>

<sup>5</sup> 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). <https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpactsVeterans.pdf>

<sup>6</sup> 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. <https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf>

<sup>7</sup> For an example, see: Policing Project. (2020). *Reimagining public safety*. NYU School of Law. <https://www.policingproject.org/rps-landing>

<sup>8</sup> 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>

<sup>9</sup> 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>

<sup>10</sup> National Suicide Hotline Designation Act of 2020 (S. 2661). (n.d.). <https://www.govtrack.us/congress/bills/116/s2661>

<sup>11</sup> Transforming Crisis Services. (2020, November 05). <https://crisisnow.com/>

<sup>12</sup> 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>



non-police civilian response teams.<sup>13</sup> However, while 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 risk to public safety that fall outside the CAHOOTS response parameters. Although people with mental illness have comparable rates of violence to the general public, specific mental illnesses such as untreated psychosis are at much higher risk for violence against others.<sup>14</sup> In addition, members of the public often perceive threats to public safety that do not 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 know in advance which mental health emergencies may pose a public safety risk or otherwise be inappropriate for civilian response teams. In fact, the most tragic outcomes may occur during calls in which a civilian-only response occurs first, and law enforcement comes in only after the initial non-police response has encountered a weapon.<sup>15</sup>

So, communities seeking to reform mental health emergency response face a core dilemma: an emergency response that eliminates police is insufficient to respond to public safety, while a response that relies on police is insufficient to respond to mental 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 the Meadows Institute's work in Texas.

The Texas MDRT model provides an integrated, health-driven approach based on best-practice responses to medical emergencies proven effective for other emergency 911 responses to people with chronic and complex illnesses. MDRT is based on a community paramedicine approach that brings together paramedics, licensed mental health professionals, and specialized

law enforcement officers within an integrated team with unique potential to transform the response to mental health emergencies through the 911 system from one that relies on either law enforcement or civilians, to one that can address mental health and broader health care and social needs while assuring public safety.<sup>16</sup> The Texas MDRT model provides a comprehensive response that recognizes that people with emergency mental health needs often have multiple needs, and those needs are best met outside of a jail or hospital emergency department, even when they exceed the capacity of mental health crisis systems.

### The Texas MDRT Model: Examining Dallas's RIGHT Care Program

The Meadows Institute is working in multiple communities across Texas to assist in the transformation of emergency response systems that are overly reliant on either police or specialty mental health response. The Meadows Institute has developed a specialized MDRT framework for that work that addresses the public safety, mental health, and broader health and resource needs (including substance use and homelessness) that often present in a single emergency response call. The Institute is working with local stakeholders in communities that are diverse in population and ethnic and racial makeup, including the cities of Abilene and Austin, as well as Bexar (working jointly with the city of San Antonio), El Paso, Galveston, and Lubbock counties.

While the core components of the Texas MDRT model examined in this report focus on Dallas, they are also the central elements being developed in the other communities the Meadows Institute is assisting. In addition, many of these communities are looking at additional features that may add value. For example, in addition to developing a core three-system MDRT approach similar to Dallas (paramedic, mental health specialist, police), the Austin 911 system has developed the capacity to use telehealth to augment the paramedic response with a virtual mental health clinician in situations where there is no public safety risk (similar to the CAHOOTS model). In Bexar

<sup>13</sup> For more information, see: Eugene Police Department. (n.d.). CAHOOTS. <https://www.eugene-or.gov/4508/CAHOOTS>

<sup>14</sup> 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>

<sup>15</sup> 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. Avancier, 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/>

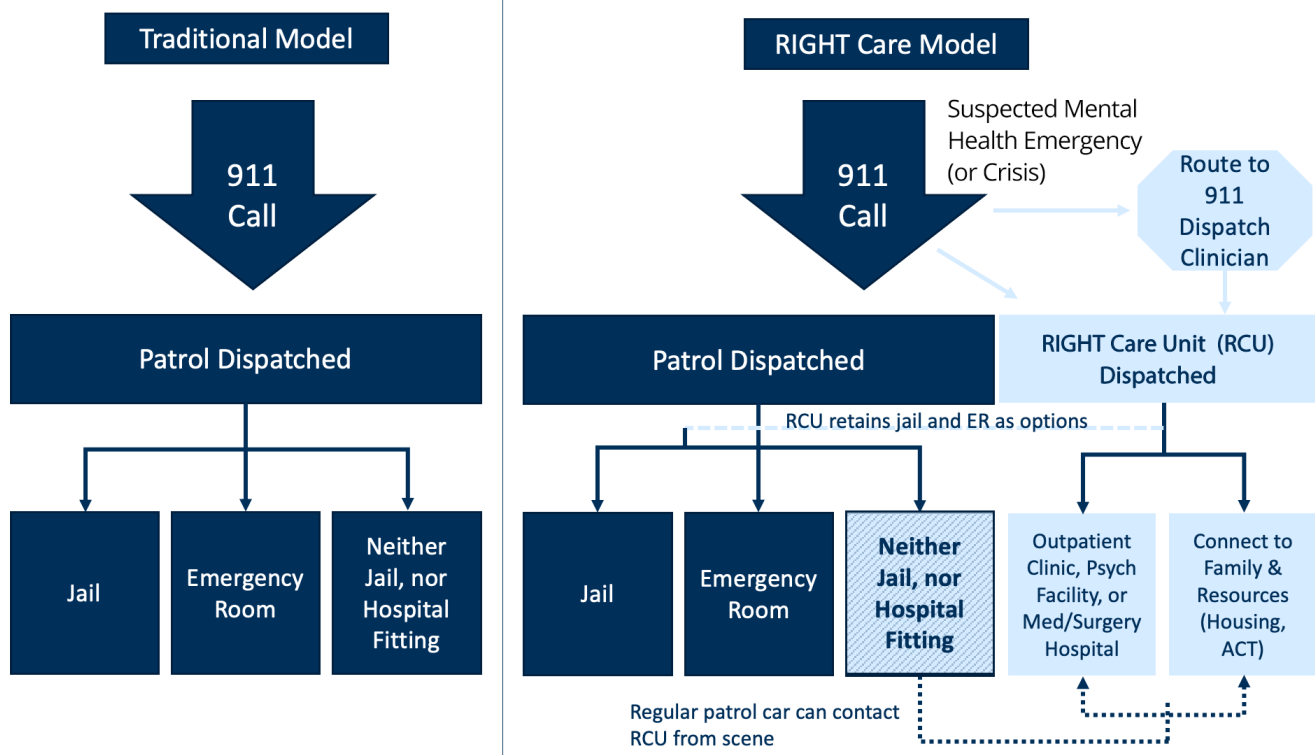
<sup>16</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration. (2012). Community paramedicine evaluation tools. <https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/paramedicevaltool.pdf>

County, a peer support specialist with lived experience has been added to the team. In Abilene, telehealth is used to provide access to a mental health clinician in the 911 dispatch center. Over time the Meadows Institute hopes to help communities both determine variations important to their local systems and stakeholders, as well as to determine the cost-benefits of these additional features.

In Dallas, community leaders and stakeholders have 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 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 of 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 (see Figure 1), something that will be critically important in any MDRT effort and particularly as integration of 911 with 988 becomes a priority. 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 is able to manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs. This allows the 911 call center to make a determination to dispatch the RIGHT Care team as the appropriate response. The team provides a health-driven medical response first and foremost while assuring public safety, as is necessary within the 911 emergency response system. In Dallas, there were 912,300 calls made to 911 from January 1, 2019 through June 30, 2020. Of these, 24,087 calls were classified as code 46 calls (2.6%) and 3,360 were classified as code 46A calls (less than 1%). Code 46 and 46A calls are mental health emergency calls to 911, with and without a request for an ambulance, respectively and are the types of calls RIGHT Care is designed to address.

Figure 1: Traditional 911 Response Model Compared to RIGHT Care Model, as Implemented in Dallas, Texas



# CREATING THE PROTOTYPE: DEVELOPING AND IMPLEMENTING THE RIGHT CARE PROGRAM IN DALLAS, TEXAS

## Rationale for Developing RIGHT Care

RIGHT Care was developed as a data-driven emergency response embedded in a multi-million-dollar, multi-year Dallas County Smart Justice Project grant from the W.W. Caruth, Jr. Fund at the Communities Foundation of Texas. It developed through a partnership between the City of Dallas, the North Texas Behavioral Health Authority (the local mental health authority), the Parkland Health and Hospital System (the county hospital serving uninsured people), and other community agencies and stakeholders. The program is operated by the Dallas Fire-Rescue Department and administered by the City of Dallas Office of the City Manager. The Meadows Institute has played a major consultative role in planning and implementing RIGHT Care from its beginning.

RIGHT Care was developed between 2017 and 2018. Part of the rationale for creating the Dallas County Smart Justice Project and the RIGHT Care program was that more than 6,000 people in Dallas County with long-term mental health needs routinely cycled between jails, emergency rooms, and inpatient care. Fewer than one in seven were under care for their condition and many had a high recidivism rate, which affected jail bed usage. When Dallas police responded to a mental health call from the 911 call center, its policies required that four officers and a supervisor respond.<sup>17</sup>

RIGHT Care became operational in Dallas on January 28, 2018, and started in the South-Central Patrol Division in Dallas, chosen because that district generated the most 911 mental health calls, is significantly affected by poverty, and traditionally had high arrest rates (including for minor offenses).

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<sup>17</sup> Meadows Mental Health Policy Institute. (2016, March 3). Caruth Smart Justice Planning Grant. Phase I Community Assessment – Funder Version. Unpublished.

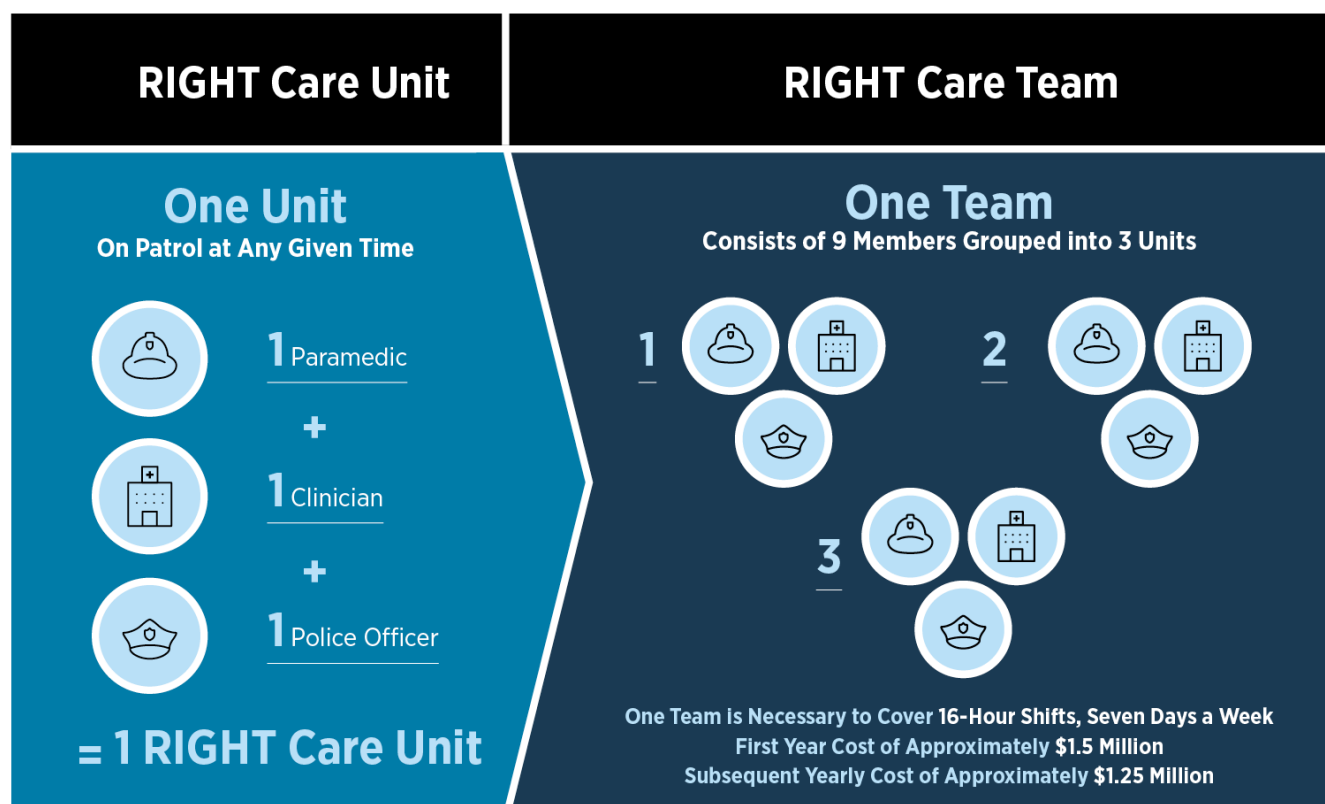
## The Essential Elements of RIGHT Care

RIGHT Care provides three types of care that go beyond the limited options of a response that relies solely on law enforcement or specialty mental health systems:

- **911 emergency response:** In the pilot district, the team has shifted the primary mental health emergency response from law enforcement to community paramedicine, the anchor to the emergency response system that is used for other medical emergencies for people with chronic illnesses.
- **Post-emergency follow-up:** For people who are stabilized in or are returning to the community, RIGHT Care's community paramedic component provides follow-up and linkages to care for comorbid health conditions, which may contribute to ongoing emergencies, while the licensed mental health clinician manages community mental health service connections. These community resources include same-day prescriber access, so the person suffering the medical emergency (or other need) does not have to be taken to an emergency room or jail as part of the response unless essential for either health or law enforcement purposes that cannot be met otherwise.
- **Outreach and prevention:** The team can proactively reach out to people who chronically use emergency services and help them access mental health and other needed health care services to reduce the use of emergency medical services for preventable conditions as well as the risk of law enforcement and criminal justice system involvement.

The composition of the RIGHT Care team is critical. As noted above, each team is comprised of distinct but integrated components, including law enforcement, a licensed mental health clinician, and emergency medical services (typically a community health paramedic). Collectively, this multi-disciplinary approach is a core component of the MDRT response and permits a coordinated and integrated approach to people experiencing a mental health emergency (see Figure 2 for the definition of the RIGHT Care team).

Figure 2: RIGHT CARE Team Definition and Composition





The composition of the team in Dallas also illustrates that this is a joint city-county venture:

- The City of Dallas provides the team's community health paramedic through the Dallas Fire-Rescue Department,
- The Dallas County health system provides a licensed master's level mental health clinician with extensive emergency mental health care delivery experience through the Parkland Health and Hospital System (Parkland), and
- The City of Dallas provides a tenured law enforcement officer with advanced crisis intervention training through the Dallas Police Department.

In addition, Parkland also provides licensed mental health professionals to assist with triage in the 911 call center.

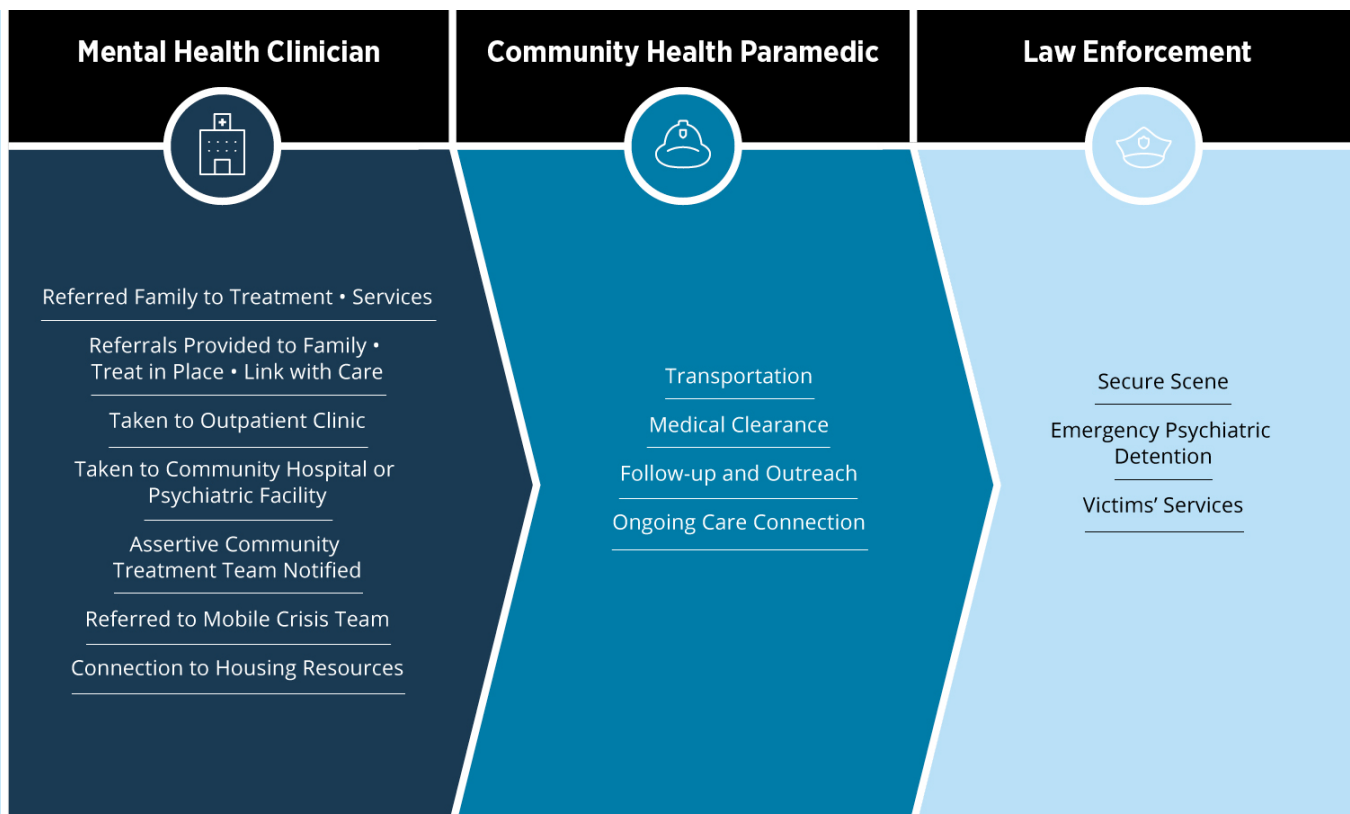
The role of team members, beyond their professional identity, is also critical (see Figure 3). The team operates on the principles of community paramedicine, which entails functioning as a single integrated unit, relying on shared knowledge and experience, and responding as a team.

The role of each member is described in more detail below:

The lead paramedic is a **community health paramedic (CHP) who has special training to provide individualized care** to patients who are at risk for preventable hospital admission or re-admission based on chronic care needs. A CHP receives training on patient navigation, referral to resources, and identification of health-related risk factors for hospital or emergency care recidivism. This level of training and focus on individualized patient care is a departure from the typical acute stabilization and transport training a medic receives, and is vital to successful triage, treatment, care linkage, and preventative care services. In Dallas, the RIGHT Care team paramedic continues to monitor care of the individual and assess significant changes to the person's physical condition on the scene and after a transfer of care.

The **licensed master's level mental health clinician** provides clinical assessment and mental health treatment recommendations and is credentialed to provide definitive diagnostic input. By ensuring the clinician has at least five years of emergency medical care delivery experience, preferably in a combined community and hospital setting, this position brings extensive mental health and substance use disorder training, knowledge, and clinical expertise that enables a full and immediate assessment of a person's social and mental health needs on the scene.

Figure 3: Role of RIGHT Care Team Members, as Implemented in Dallas, Texas



This combined hospital and community-based experience also facilitates social interventions intended to prevent future 911 involvement for people with chronic hospital and jail recidivism by helping address factors such as lack of housing, food insecurity, transportation to clinical care, and access to other social service resources.

The **tenured law enforcement officer with advanced crisis intervention and mental health peace officer training** is primarily responsible for assessing the safety of the scene as well as any risk for victimization on the part of the person being served (an often overlooked piece of the emergency call response despite the fact that people with unaddressed trauma have a significantly increased risk of mental health needs, physical health chronic diseases, substance use disorders, and earlier deaths).<sup>18</sup> Texas law also only allows peace officers to order emergency psychiatric detention, so the officer is also required for this function, when needed.<sup>19</sup> Although the officer's primary role on the MDRT is to ensure the security of the team and the person being served, including assessing for victimization, the officer's job is not limited to these traditional law enforcement functions. Advanced crisis intervention training allows the officer to respond directly if the person in need of emergency medical care finds it easier to build rapport or communicate with the officer rather than other team members. This training can also support communication with family members and others who may be at the scene. While some programs across the nation have eliminated the use of law enforcement in responding to some types of mental health emergencies, the Meadows Institute believes that law enforcement is essential to the response, not only to secure the scene but also to play other roles as previously described.

### Costs of Establishing and Implementing the Original RIGHT Care Program

Each RIGHT Care team consists of nine staff members (three paramedics, three police officers, and three clinicians). One unit from that team is on patrol at any given time with one paramedic, one police officer, and one clinician (as illustrated in the prior section in Figure 2).

The RIGHT Care program as originally established in the South-Central Patrol Division in Dallas consists of one team, with its three staffed units each operating in one

shift for 16 hours a day, seven days a week. The decision to have the teams available for 16 hours rather than 24 hours was based on an analysis of mental health calls to the 911 call center, which recommended the allocation of limited resources during the hours when the majority of calls were received.

Based on the Dallas experience, the Meadows Institute estimates that the first-year cost of setting up an MDRT team of three community health paramedics (CHP), three licensed masters-level mental health clinicians, three police officers, a program coordinator, and necessary vehicle and administrative support would be approximately \$1.5 million with estimated subsequent yearly costs of \$1.25 million. This cost is only for the team and does not include other potential costs related to mission support health components that may be needed in some localities to increase the effectiveness of the RIGHT Care team, as discussed below.

### Planning and Resource Needs

MDRT teams can work only with careful advance planning and RIGHT Care is no exception. Below are descriptions of necessary elements of planning for and creating these teams.

First, RIGHT Care was developed from a careful planning process that included an inventory of available data, such as 911 mental health emergency call volume and service gaps in responding to such calls. In Dallas, this involved focus groups with more than 400 law enforcement officers as well as a data analysis of 911 calls. Both efforts were part of the larger system assessment funded by the Caruth Foundation.<sup>20</sup>

Second, securing resources through multiple sources was essential, not only to fund personnel but also to cover associated costs of equipment and vehicles. In Dallas, funding came from philanthropic and governmental resources and as noted, both city and county resources were brought to bear.

Third, important administrative issues needed to be addressed. For example, it is essential to secure agreement on identifying the entity that will manage the project. Although multiple parties are involved, there needs to be a single point of responsibility; in Dallas, that was

<sup>18</sup> Substance Abuse and Mental Health Services Administration. (2016). *Justification of estimates for appropriations cost*. U.S. Department of Health and Human Services. [https://www.samhsa.gov/sites/default/files/samhsa-fy2016-congressional-justification\\_2.pdf](https://www.samhsa.gov/sites/default/files/samhsa-fy2016-congressional-justification_2.pdf)

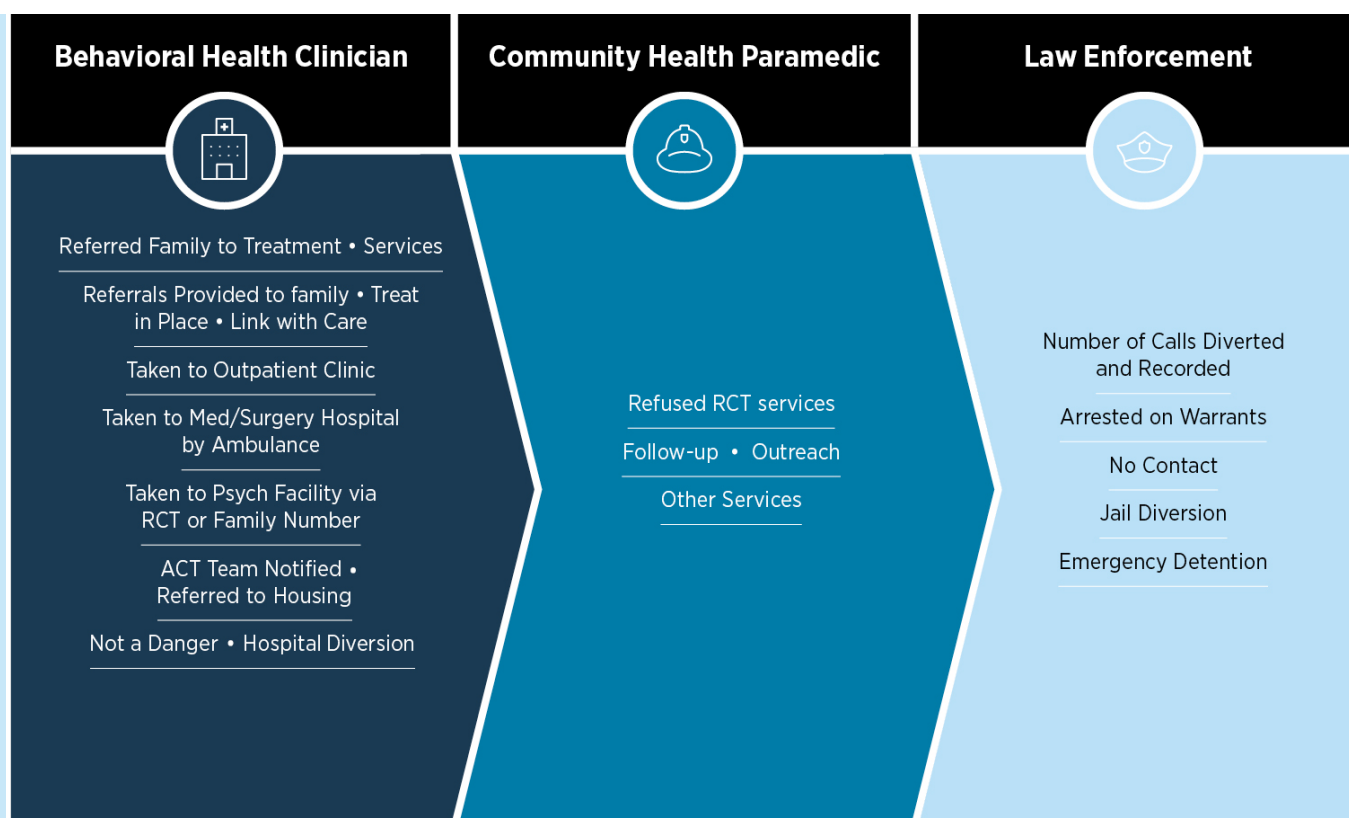
<sup>19</sup> Texas Health and Safety Code, Title 7, Subtitle C, Chapter 573.001, Apprehension by Peace Officer without Warrant. <https://mmhpi.org/wp-content/uploads/2018/11/MMHPI-violence-trends.pdf>

<sup>20</sup> Meadows Mental Health Policy Institute. (2016, March 3). Caruth Smart Justice Planning Grant. Phase I Community Assessment – Funder Version. Unpublished.

the Dallas Fire-Rescue Department originally, and more recently the Dallas City Manager’s Office has taken on administrative oversight. In addition, it is important to identify and agree on “points of engagement” prior to implementation (recognizing that these may change over time as the program is implemented). For example, what documentation is required at different points of the encounter with the person with the emergency medical needs? Where are the drop-off points for the team? Do information sharing agreements need to be negotiated in advance? These are some, but not all, of the questions that need to be addressed prior to implementation. Standard operating procedures also need to be developed to govern these processes.

In addition, outcomes and metrics need to be specified and agreed upon, and the types and sources of data that will be used to measure outcomes need to be determined (Figure 4). Creating a data system to link data across various systems has also been a part of the Dallas project. The Meadows Institute is currently collaborating with the City of Dallas to carefully review the initial metrics and data elements constructed for RIGHT Care. The need for ongoing assessment suggests that there needs to be an infrastructure to do this. To address this need, the Meadows Institute has played an active role since the program’s implementation by providing consultation to the parties operating RIGHT Care.

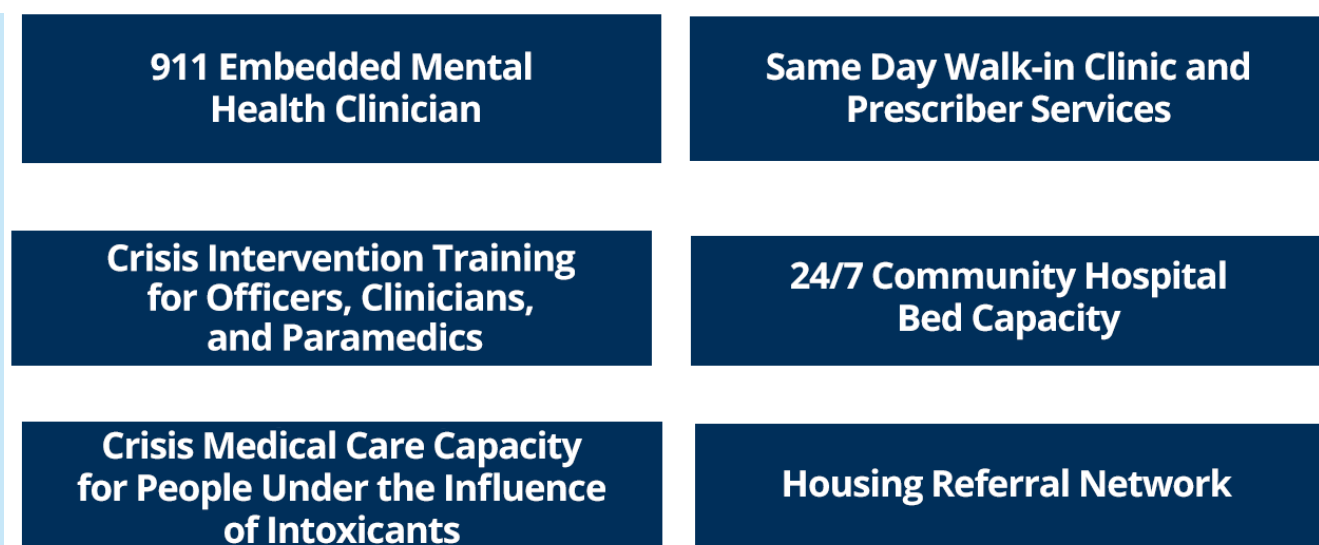
**Figure 4: Key RIGHT Care Metrics Gathered by Clinicians, Law Enforcement Officers, and Community Health Paramedics, as Designed in Dallas, Texas**



## RIGHT CARE SYSTEMWIDE SUPPORT ELEMENTS

Transformation of an emergency medical response and treatment system requires more than transformation of the point of initial response. No program exists in a vacuum. This is particularly true with the MDRT response, since the MDRT team is equipped to provide rapid identification of acute mental health and broader health and social needs, and the team requires options for connecting people with additional assessment, treatment, and resources beyond the emergency room or jail. In the Meadows Institute's view, certain features will significantly enhance the prospects for success of the transformed system. These features are presented briefly below (see Figure 5 and discussion that follows).

Figure 5: Key Care Systemwide Support Elements for RIGHT Care Teams



### 911-Embedded Mental Health Clinician

One critical element of the RIGHT Care model is to staff 911 call centers with a mental health clinician who can manage calls with clinical expertise. This clinician can effectively assess the presence of a medical emergency related to mental health needs and inform decisions to dispatch the RIGHT Care team instead of a traditional law enforcement unit. When someone calls 911 with a mental health emergency, typically the only option available is to send law enforcement officers to answer the call. This is due in part to the lack of clinical triage available in a 911 call center. A 911 call center needs to include a mental health clinician who can provide clinical expertise for effectively assessing the presence of a medical emergency related to mental health needs. This clinical expertise will enable the call center to identify any additional needs and coordinate connections to additional support based on the clinician's 911 call assessment, perhaps eliminating any unnecessary contact with law enforcement. As 988 call lines are developed, the integration of calls to 911 and 988 will become a critically important issue to avoid further fragmenting the emergency response.

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to staff 911 call centers with a mental health clinician who can manage  
calls with clinical expertise.*

### **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 RIGHT Care team 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.<sup>21</sup> 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 participating in RIGHT Care. 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 mental illnesses.<sup>22</sup> 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.<sup>23</sup> 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 RIGHT Care response, it is vital that they, too, receive CIT training. In addition, RIGHT Care team members should receive training on policies and procedures as a group, so each member understands the responsibilities of the others. Further training requirements should include team building activities, emergency response vehicle and radio use orientation for civilians, and preventing and managing aggressive behavior in close quarters (such as SAMA<sup>24</sup>). 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 RIGHT Care teams, assuring that the teams do not

<sup>21</sup> 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.

<sup>22</sup> 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.

<sup>23</sup> 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/>

<sup>24</sup> For more information, please see: SAMA Training. (n.n). *Satori alternative to managing aggression*. <https://samatraining.com>



operate in a vacuum. One option that is central to the MDRT/RIGHT Care program success is to provide short-term hospitalization or extended observation services as an essential element of the transformed system.

In partnership with the Parkland Health and Hospital System (Parkland), the City of Dallas increased extended observation unit (EOU) capacity to relieve pressure on its emergency departments and to permit more thorough assessment and stabilization of psychiatric emergencies. Extended observation units are usually attached to a hospital emergency department and provide capacity for more in-depth assessment and stabilization than typically can be achieved in a crowded emergency room. Parkland provides progressive, intensive, acute care with an expanded emergency room, extended observation unit, and expanded inpatient care capacity, which increased from 14 beds in May 2016 to 25 beds in December 2019. In smaller communities, inpatient hospitals such as county hospitals can provide this service.

### **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 RIGHT Care 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. However, 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 results in direct linkages to housing (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 in Dallas prior to the launch of the RIGHT Care project and has proven to be critical to the program's success, especially when RIGHT Care teams need to find rapid housing, shelter, or shelter referrals for people in need. Having an established and trusted network of housing services means that Dallas (and other communities adopting the MDRT approach) does not need to develop new or additional housing resources. This network also supports effective collaboration to secure successful housing and shelter connections in times of urgent need.

More broadly, the ongoing collaboration among the RIGHT Care partners informed the Dallas community's response to increased housing instability due to the COVID-19 pandemic. RIGHT Care was part of two projects funded and coordinated by the United Way of Metropolitan Dallas that were implemented in early 2019. This included funding to place specialists in housing at key points within the local crisis system (Parkland Hospital, the Dallas County Jail, a separate walk-in crisis clinic, and other sites) to connect people in need of emergency housing. In addition, a "connector" project provides transportation on an established route of service providers. Both projects have been important resources for the RIGHT Care teams during the pandemic. The United Way of Metropolitan Dallas leveraged the partnerships developed through these two programs and RIGHT Care to organize the Dallas community's rapid deployment of COVID-19 relief funding targeted for housing and eviction prevention. Funds allocated to the City of Dallas and Dallas County were initially disbursed through agreements with existing housing agencies, which already had application and payment mechanisms in place. This coordination of efforts led to establishing a formal Eviction Prevention Task Force to prevent evictions, mitigate impacts on tenants and landlords, stabilize households for the benefit of public health, and develop a long-term eviction prevention plan for the Dallas community.

## EARLY RESULTS FROM RIGHT CARE AND PLANS FOR EXPANSION

The Dallas Police Chief identified the expansion of RIGHT Care as a key part of the department's violence reduction plan of 2020 because expansion would support "violent crime reduction efforts by linking residents with appropriate mental health services, providing comprehensive care, and preventing future crisis events from occurring."<sup>25</sup> Local officials also saw RIGHT Care as a success and in late 2019 recommended expansion of RIGHT Care citywide in 2021.<sup>26</sup> As a result, in 2021, the City of Dallas expanded RIGHT Care to five active RIGHT Care teams (as noted, each team includes units of three working to cover shifts), working citywide and designed to meet the City's goal of having sufficient RIGHT Care capacity to respond to 40% of all mental health calls. Dallas has also budgeted expansion funds for FY 2022 and anticipates the deployment of 5 additional teams in

FY 2022 for a total of ten teams citywide, with the goal of answering at least 80% of all mental health calls.

Early development of RIGHT Care and the decision to expand it has been based on performance metrics. Performance metrics<sup>27</sup> for the program are compiled by program administrators in each participating agency and are reported to local officials for aggregation and analysis.<sup>28</sup>

Figure 6 shows the data reported to the Meadows Mental Health Policy Institute by the City of Dallas, from the last available metrics report from June 7, 2020, showing the cumulative program metrics from program start date of January 29, 2018, to June 7, 2020, for the pilot in the South-Central Division of the Dallas police department.<sup>29</sup> The Institute is now working with the City to refine and update these metrics and their reporting.

*From program inception on January 29, 2018, through June 7, 2020, only 130 (2%) of 6,679 RIGHT Care team responses resulted in arrests for new offenses.*

<sup>25</sup> Dallas Police Department. (2020). Violent crime reduction plan. <https://www.dallaspolice.net/Shared%20Documents/violent-crime-reduction-plan.pdf>

<sup>26</sup> Oden, K. (2019, December 9). RIGHT Care expansion [PowerPoint slides]. City of Dallas Public Safety Committee. [https://dallascityhall.com/departments/pnv/resilient\\_dallas/DCH%20Documents/RIGHT%20CARE%20Expansion-Presentation-9-Dec-2019.pdf](https://dallascityhall.com/departments/pnv/resilient_dallas/DCH%20Documents/RIGHT%20CARE%20Expansion-Presentation-9-Dec-2019.pdf)

<sup>27</sup> A report provided by Parkland Health and Hospital System shows weekly aggregate counts of patients served and includes a cumulative total from program launch for 15 outcomes. Outcomes include, for example, counts on the number of people arrested; the number of people arrested under an emergency detention (in Texas referred to as APOWW, Apprehension by the Police Officer Without a Warrant); and the number of people taken to outpatient clinics, psychiatric treatment facility, or referred to community services, family, or staffed by a mobile crisis team. These metrics are defined in the RIGHT Care Weekly Report, RIGHT Care Team Weekly Report Definitions, Parkland Health and Hospital System. Another important metric is whether the clinician on the scene considered the outcome as a "hospital diversion" or a "jail diversion". Hospital diversions are determined by the clinicians on the scene who use the following criteria: "Were it not for RIGHT Care's intervention and clinical services, the person would have presented to a hospital." Jail diversions are determined by the officers on the scene who use the following criteria: "Were it not for RIGHT Care's intervention, an arrest would have taken place."

<sup>28</sup> During the initial pilot period that ended in May 2020, the program metrics were reported by Parkland Health and Hospital System. The metrics are now collected and reported by the Dallas Office of the City Manager.

<sup>29</sup> RIGHT Care Weekly Report, RIGHT Care Team Weekly Report Definitions, Parkland Health and Hospital System.

From January 29, 2018 through June 7, 2020, there were 6,679 total responses by the RIGHT Care team.<sup>30</sup>  
Of those responses:

**2,660 (40%)**

resulted in a community service (such as referral, treatment provided on the scene, ACT team linkage, or mobile crisis team linkage)

**1,963 (29%)**

were resolved on scene with no further services (meaning the person was not at danger, and did not need or refused additional services)

**567 (8%)**

resulted in involuntary inpatient detention determined by a non-RIGHT Care police officer on the scene (so-called APOWW in Texas) and transport to a hospital

**384 (6%)**

resulted in involuntary inpatient detention determined by the RIGHT Care team and transport to a hospital

**528 (8%)**

were taken to a hospital or psychiatric facility voluntarily

**130 (2%)**

were arrested for a new offense, and another 139 (2%) were arrested because of an active arrest warrant

**308 (5%)**

other, defined as those not fitting the categories above (most commonly, the person who was subject of the 911 call could not be located)

**Figure 6: RIGHT Care Calls for Service and Call Outcome Statistics, South-Central Division of the City of Dallas Police Department, Reported by Program Administrators, January 20, 2018, to June 7, 2020**

Call Outcomes	Number	% Total
Connections to Care	4,139	62%
Community Service	2,660	40%
Resolved on Scene/No Services	1,963	29%
Involuntary Inpatient Care Initiated – Not Determined by RIGHT Care*	567	8%
Involuntary Inpatient Care Initiated – Determined by RIGHT Care*	384	6%
Taken to Hospital or Psych Facility	528	8%
Arrested for Offense	130	2%
Arrested for Warrants	139	2%
Other**	308	5%
Total	6,679	100%

\* APOWW (Apprehension by the Police Officer Without a Warrant)

\*\* "Other" is defined as "any disposition that does not fit into the other categories."

<sup>30</sup> Some of these 6,679 total responses may not all be unique individuals, as the responses may include multiple outcomes for the same person. For example, a person may be counted in the category of "referrals provided to family/treat in place/link with care" and in "ACT team notified." The most recent metrics reported by the City of Dallas in a "public safety dashboard" show that from program inception to December 2020, RIGHT Care served 8,051 clients, representing 4,663 unduplicated clients served. This dashboard does not capture the metrics as in the earlier reports, with the call outcomes tracked along the dimensions above. The latest dashboard states that from program inception to December 2020, there were 1,836 hospital diversions and 914 jail diversions as defined above in the current metric report (see footnote 28 for definitions). The Meadows Institute is working with Dallas officials to determine if the dashboard can integrate the more detailed metrics being collected and to assure greater precision in determining outcomes for unduplicated individuals, including differentiating the number of calls per individual.

*The next step in program sustainability, therefore, would be to design an evaluation that would document long-term outcomes of a multi-disciplinary response team model and determine the ultimate efficacy of the model in reducing the utilization of hospital emergency department services and rates of incarceration.*

Cumulatively, 4,139 calls of the 6,679 total responses (or 62%) resulted in a connection to care (community service, or voluntary or involuntary hospitalization). When the 1,963 cases (29% of the total) who needed no additional services are deleted from the total, 88% of the remaining calls (4,139 out of 4,716) resulted in a connection to care. Most notably, only 130 calls (2% of the total) resulted in an arrest for a new offense, illustrating that at least based on these preliminary data, RIGHT Care teams use arrests as a disposition very sparingly.

Although these metrics provide a positive early indicator of success, readers should keep in mind that the program has not been formally evaluated and would benefit from deeper analysis. For example, have individuals who received a RIGHT Care intervention reduced their utilization of hospital emergency rooms or rates of incarceration over time? Have jail bookings declined? These are the types of questions that a formal evaluation would answer.

Conducting a long-term evaluation in Dallas will require a careful design and significant investment of resources, as it would in any jurisdiction that adopts this model. For example, at present, there are insufficient unique identifiers to match people served by the RIGHT Care team with other medical or criminal justice data systems which makes it difficult to capture the experiences of individuals across the various systems that provide care and supports.<sup>31</sup> Also, the research design would need to address agencies' claims that the Health Insurance Portability and Accountability Act (HIPAA) prevents them from sharing information, through use of the various data sharing agreements explicitly provided in HIPAA. The next step in program sustainability, therefore, would be to design an evaluation that would document long-term outcomes of a multi-disciplinary response team model and determine the ultimate efficacy of the model in reducing the utilization of hospital emergency department services and rates of incarceration.

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<sup>31</sup> Unique identifiers are markers that allow correct identification of a person across data systems. Texas has a unique identifier for people who are arrested (a State Identifier Number), which is assigned after fingerprint identification to verify a person's identity. The state does not have a unique identifier for people receiving medical or mental health services. Any evaluation attempting to track outcomes over time in the health, mental health, and criminal justice systems will require that client records from each of these systems are matched.

## SUMMARY

### **The RIGHT Care program is an exemplar of the emerging Texas MDRT model to transform mental health emergency response.**

Emergency medical response system transformation using MDRT as its core depends on careful, data-driven planning, the creation of a well-trained multi-disciplinary response team, the ability to triage calls in a call center, and the creation of supports that permit the team to link people to care quickly and effectively when a mental health emergency cannot be resolved “on the ground.” Early results from RIGHT Care are very promising. As the Meadows Institute works with communities across Texas, individual variations are emerging and RIGHT Care is just the most carefully examined exemplar to date to approach a transformed mental health emergency response system. However, the essential elements discussed in this paper are being prioritized in all of the Texas MDRT sites the Meadows Institute is helping to implement. Without those elements, even the best emergency response team will struggle to break the cycle of inappropriate — and too often tragic — emergency department and jail use that marks so many mental health emergency responses across the United States.