Austin

MEMORANDUM

To: Mayor and City Council

Through: Ramón Batista, Assistant City Manager RB

From: Dr. Mark Escott, Chief Medical Officer MEE
Chief Lisa Davis, Austin Police LD
Chief Robert Luckritz, Austin-Travis County Emergency Medical Services

Date: May 1, 2026

Subject: **Staff Response to Resolution 20250130-080 Regarding Mental Health Response**

The purpose of this memorandum is to provide an update on the implementation of Resolution 20250130-080 to produce a report assessing the City's current mental health response systems and identify resources required to improve protocols and service coordination.

City staff conducted a comprehensive, multi-agency review of mental health response data from 2022 to 2024 as directed by Resolution 20250130-080. This effort builds on the 2019 Meadows Mental Health Policy Institute report and includes a collaborative analysis conducted by the Austin Chief Medical Officer, Austin-Travis County EMS (ATCEMS), Austin Police (APD), and Integral Care.

The review analyzed 9-1-1 and Austin 3-1-1 call data, assessed how mental health-related calls are identified and managed, and evaluated current service models across City and County systems. The analysis identified where improvements in coordination and clinical engagement have already occurred and revealed opportunities to strengthen and expand non-police response options.

Key Findings

Key findings from analysis of mental health response data from 2022 to 2024.

- Between 2022 and 2024, approximately 11% (97,171) of all 9-1-1 calls (867,430) were initially identified as involving a mental health component. Fewer than 1% (7,068) of calls not initially classified this way were later determined to have a behavioral health element.
- Both the total volume and proportion of mental health-related calls have declined year over year across the three-year analysis period.
- Of the calls identified as mental health-related, approximately 16% (15,310) were routed to Integral Care's Crisis Call Center (C3). Among those referred to C3, 86% (13,143) were resolved without requiring law enforcement involvement. Resolution may include:
    - Dispatch of Expanded Mobile Crisis Outreach Team (EMCOT) for in-person response.

  - Follow-up telephone counseling.
  - Referral to Integral Care's treatment team for ongoing care.
  - Referral to outpatient community mental health resources.
  - Referral to Psychiatric Emergency Services (PES) urgent care.
- Of the 86% of calls that were resolved without law enforcement, approximately 3,200 came from unique callers and approximately 9,900 came from repeat callers.
- In cases where EMCOT responded—either alone or with EMS—over 85% (7,039) did not result in arrest or transport to an emergency room.
- C3 was eligible but unavailable to respond to just over 1% (1,514) of mental health-related incidents due to staffing limitations. This percentage has declined annually, indicating improved clinician availability.
- EMCOT's 24/7 availability began on August 11, 2025.

Tiered Model for Mental Health Responses
To improve the services and outcomes for those who experience mental health crises in the community, staff will continue to target enhancements based on the level of acuity involved in calls for service.

Low to moderate acuity calls are those with a decreased risk of immediate danger to the individual in crisis or bystanders and less frequently require immediate intervention. Staff confirm that continued support for 24/7 EMCOT availability and enhancements to triage protocols will better direct appropriate cases to Integral Care's Crisis Call Center (C3). To further enhance triage of mental health related calls, ATCEMS is identifying calls which can be safely transferred to Integral Care's C3 for enhanced triage and alternate disposition.

Currently, responses to low acuity calls may include:
- APD Only
- ATCEMS Only
- Integral Care's C3 Only
- Integral Care's EMCOT Responders via C3 or at the request of APD or ATCEMS
- A combination of ATCEMS, APD, and EMCOT

High-acuity mental health crises have been identified nationally as an area of increased risk for patients and first responders. Best practice models and published research have shown the benefit of a well-coordinated multidisciplinary approach to the care of these patients. Such models have resulted in a decreased risk of adverse outcomes including decreased utilization of involuntary detention.

High-acuity mental health calls are those where a significant mental health episode is accompanied by complicating and often unsafe behaviors that require urgent and coordinated intervention. The Austin FIRST pilot program, a multidisciplinary crisis response team consisting of a paramedic, a mental health clinician, and a mental health-trained police officer, began operations on October 20, 2025, for a period of six months. The pilot phase will conclude on April 20, 2026 followed by an evaluation of the program performance and adjustments based on quality improvement analysis, outcomes, and stakeholder feedback.

The tiered response model enables the City of Austin, and partners ensure responses to mental health crises are following best practices while optimizing outcomes and efficiency of resource utilization. Associated work by the multidisciplinary team continues to improve the data integration and communication across agencies necessary to continue providing innovative solutions to those suffering from mental health crises in the Austin community.

Should you have any questions or concerns, please contact Dr. Mark Escott, Chief Medical Officer at mark.escott@austintexas.gov.

cc: T.C. Broadnax, City Manager
Erika Brady, City Clerk
Jason Hadavi, City Auditor
Mary Jane Grubb, Municipal Court Clerk
Judge Sherry Statman, Municipal Court
CMO Executive Team
Department Directors

Attachment: Assessment of Mental Health Response Systems

Assessment of Mental Health Response Systems

April 2026

City staff conducted a comprehensive, multi-agency review of mental health response data from 2022 to 2024. This effort builds on the 2019 Meadows Mental Health Policy Institute report and includes a collaborative analysis conducted by the Austin Chief Medical Officer (ACMO), Austin-Travis County EMS (ATCEMS), the Austin Police Department (APD), and Integral Care.

Summary of Key Findings

Key findings from analysis of mental health response data from 2022 to 2024.

- Between 2022 and 2024, approximately 11% (97,171) of all 9-1-1 calls (867,430) were initially identified as involving a mental health component. Fewer than 1% (7,068) of calls not initially classified this way were later determined to have a behavioral health element.
- Both the total volume and proportion of mental health-related calls have declined year over year across the three-year analysis period.
- Of the calls identified as mental health-related, approximately 16% (15,310) were routed to Integral Care's Crisis Call Center (C3). Among those referred to C3, 86% (13,143) were resolved without requiring law enforcement involvement. Resolution may include:
    - Dispatch of Expanded Mobile Crisis Outreach Team (EMCOT) for in-person response.
    - Follow-up telephone counseling.
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    - Referral to outpatient community mental health resources.
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- Of the 86% of calls that were resolved without law enforcement, approximately 3,200 came from unique callers and approximately 9,900 came from repeat callers.
- In cases where EMCOT responded—either alone or with EMS—over 85% (7,039) did not result in arrest or transport to an emergency room.
- C3 was eligible but unavailable to respond to just over 1% (1,514) of mental health-related incidents due to staffing limitations. This percentage has declined annually, indicating improved clinician availability.
- EMCOT's 24/7 availability began on August 11, 2025.

The following pages detail the data summarized here.

Total number and percentage of 9-1-1 or 3-1-1 calls where the caller requests assistance orprovides information related to mental health;

- From 2022-2024, approximately 10%-12% of 9-1-1 calls were initially identified as mental health related, with a slight year-over-year decline. These calls were classified as mental health related either when the caller explicitly requested mental health services or when the 9-1-1 operator assessed the situation as involving a mental health concern. Over the three-year period, there were a total number of 867,430 calls, with 97,171 calls to 9-1-1 initially identified as mental health (11.20% of the total calls). Austin 3-1-1 transfers all mental health related calls to 9-1-1.
- ATCEMS received a total of 321,195 calls over the three-year period with 12,131 calls (4%) related to mental health. A breakdown of mental health calls per year: 4,165 calls (1%) in 2022; 3,819 calls (1%) in 2023; and 4,147 calls (1%) in 2024.
- The analysis was unable to rule out redundant incidents due to segregation of public safety Computer-Aided Dispatch (CAD) systems.

Total number and percentage of 9-1-1 or 3-1-1 calls where the caller does not request assistance or provide information related to mental health, but the call was later determined to be mental health related.

- Throughout the three-year period, less than 1% of 9-1-1 calls that were not initially identified as mental health related were later determined to involve a mental health component— based on the final problem type, call disposition, or involvement of Integral Care's mental health Call Center Clinicians (C3). A total of 7,068 calls to 9-1-1 (0.81%) were not initially identified as mental health calls over the three-year period.
- Over the three-year period, ATCEMS responded to a total of 8,535 (3%) calls which were determined to have a mental health component after the initial request, with 3,058 calls (3%)in 2022; 2,800 calls (3%) in 2023; and 2,677 calls (3%) in 2024.

Total number and percentage of 9-1-1 calls diverted to a mental health call center employee and percentage of such diverted calls that were resolved without a police response and the total number and percentage of such calls that were unable to be routed to a mental health call center employee because no employees were available, with the data differentiated between call center clinicians and Collaborative Care, by shift, and by whether requested by a caller or transferred by another 9-1-1 dispatcher;

- Over the three-year period, a total of 15,310 calls to 9-1-1 were handled by Integral Care's Mental Health Call Center Clinicians (C3), representing 15.76% of all mental health 9-1-1 calls during this period. Of these, 13,143 calls (85.85%) were resolved without the need for police involvement.
- The percentage of calls resolved without police has steadily increased from 83.05% in 2022 to 87.97% in 2024, demonstrating growing effectiveness of the C3 model.
- This data reflects only C3's involvement, as APD does not track responses from other mental health providers. Furthermore, due to inconsistencies in shift structures across dispatchunits, shift-level data could not be included. While some data exists regarding whether callers requested mental health support or whether dispatchers identified such needs, it is not consistently linked to C3-specific interventions and therefore excluded from this analysis.

Total number and percentage of police interactions, both in response to calls for service or officer initiated, involving mental health, including an analysis of APD time and resources for individuals with the highest frequency of mental health interactions versus one-time callers;

- A similar trend was observed when officer self-initiated calls were included. From 2022 to 2024, approximately 9% to 11% of all CAD incidents, including both 9-1-1 calls and officer self-initiated calls, involved a mental health related component, with a slight decline observed year over year. Please note that data on the frequency of individual callers is not available. The total number of CAD incidents was 1,218,549 and the total number of incidents involving mental health was 120,218 (9.87% of the total number of incidents).
- It is important to clarify that a CAD incident is classified as mental health related if it meets one or more of the following criteria:
    - the initial problem is related to mental health
    - the final problem is related to mental health
    - the caller specifically requested mental health services, or the 9-1-1 operator determined the situation involved a mental health concern
    - the call disposition is related to mental health
    - C3 responded to the call. This definition of mental health-related CAD incidents aligns with the mental health call data published by APD on its open data portal.

Total number and percentage of police hours devoted to mental health related activity;

- Consistent with the data on the percentage of mental health related CAD incidents, approximately 9% to 11% of total officer hours logged across all CAD incidents were dedicated to mental health related calls, showing a slight decrease over the three-year period.
- The total number of officer hours spent on mental health incidents is 231,886.83 hours over the three-year period, 9.76% of the total number of officer hours for all CAD incidents (2,376,787.35 hours).

Total number and percentage of City responses to incidents or service requests involving mental health where mental health workers responded together with police, as well as the total number and percentage of City responses where mental health workers responded (including call center-only responses) instead of police, differentiated between call center clinicians, Collaborative Care, Expanded Mobile Crisis Outreach Team (EMCOT), or Community Health Paramedic Mental Health Responders and by shift;

- From 2022-2024, approximately 15% of mental health related CAD incidents were responded to by C3 without police involvement, while only 2% involved a joint response by both EMCOT and APD (1,581 incidents). EMCOT additionally responded to 5,318 (5.47%) incidents withoutpolice, either solo or requested by EMS or CHP. The C3-only response percentage has slightlyincreased over the three-year period, while in-person response has slightly declined whether with or without police. This information cannot be further broken down by mental health service provider or by shift due to the previously mentioned limitations. There was a total of 19,783 mental health related CAD incidents where either C3 or EMCOT supported without police. For calls when EMCOT responded without police, when requested by EMS, or co-responded with CHP, the outcome data

on dispositions shows that over 85% (7,039) of these calls did not result in a transport to the ER or an arrest. Additionally, these individuals did not experience another crisis episode 30 days post intervention.

Total number and percentage of City responses to incidents or service requests involving mental health where mental health workers were requested to respond together with or instead of police (including call center-only responses), but no such workers were on duty or were otherwise unable to respond, differentiated between call center clinicians, Collaborative Care, EMCOT, or Community Health Paramedic Mental Health Responders and by shift;

- The total number of mental health related CAD incidents (9-1-1 plus officer-initiated calls) where C3 was eligible but either was unavailable or not referred (officer-initiated calls) was 1,514 (1.26% overall).
- A total of 714 calls were identified as eligible for C3 response but could not be routed due to C3 staff unavailability, representing 4.45% of eligible 9-1-1 calls over the three-year period.
- EMCOT hours of operation during this time period were Monday-Friday 6 a.m. - 10 p.m. and Saturday and Sunday 10 a.m. - 8 p.m. and therefore EMCOT staff were unable to respond tocalls that may have been eligible for a mental health response.

Data comparing the response times and outcomes (e.g., arrest, emergency mental health detention, citation, referral to mental health or other services, serious bodily injury or death, etc.) of mental health calls with a police-only response to calls with a mental health worker response (including call center-only responses) or joint police and mental health worker response, differentiated between call center clinicians, Collaborative Care, EMCOT, or Community Health Paramedic Mental Health Responders including a breakdown of misdemeanor, non-violent felony, and felony arrests made by APD for people with mental health issues;

- This data request requires integration of multiple databases within and outside of the City of Austin and is not currently available to requested level of detail. Collaboration is currently underway to improve the coordination and integration of the data sources related to mental health crises. An analysis similar to the above request has been performed by two academic institutions related to the City of Austin.
- Researchers at The University of Texas at Austin, Cornell University, Integral Care, and the Austin Police Department are estimating the impact of Integral Care's Center Crisis Clinicians (C3) Program on the likelihood that a diversion-eligible call results in a peace officer emergency detention (POED), arrest, use of force, as well as the average officer time on scene. Using an observational study with comparison group research design and data on all diversion-eligible 9-1-1 calls between December 2019 and February 2025 (n = 21,222), preliminary results show that the C3 Program significantly reduced the likelihood of a Police Ordered Emergency Detention (POED) by 44-62% and an arrest by 37-58%, as well as the average officer time on scene by 51-66%. Evidence of the program's impact on instances of use of force was mixed, with three out of four showing models a significant and substantial reduction and the fourth model showing no significant impact. Overall, embedding behavioral health professionals in Austin's 9-1-1 call center appears to provide important public health and public safety benefits.

- For interactions involving individuals experiencing a mental health crisis, APD only documents mental health status if force has been used during the encounter, through an optional entry. For interactions with individuals experiencing homelessness, APD collects address information; however, it is currently not feasible to provide an accurate count of the homeless population due to the wide variety of addresses entered – such as shelters, encampments, and other temporary locations as well as changing housing circumstances over time.
    - ATCEMS provided care a total of at least 15,188 mental health emergencies, including 2,338 (16%) to persons experiencing homelessness (PEH) over the three-year period. Tracking of PEH by ATCEMS began in 2023 with at least 802 encounters and 1,536 encounters in 2024. The overall three-year demographic percentage estimates of individuals experiencing a mental health crisis by gender, race, age, (in order of highest percentage to lowest) are as follows:
        - Gender: 55% male, 45% female, 0% other preferred gender identification
        - Race: White: 50%, Black/African-American: 25%, Hispanic/Latino: 23%, and other/unknown: %
        - Age: highest concentration (81%) from 21-60 years of age (21-30: 22%; 31-40: 28%; 41-50: 20%; 51-60: 11%); 11-20: 8%; 61-70: 6%; 71-80: 2%; 81-90:1%; 0-10: 1%, 91-100 and N/A: less than 1%)
    - Break down per year:
        - 2022:
            - Gender: 55% male, 45% female, 0% other preferred gender identification
            - Race: White: 49%, Black/African-American: 27%, Hispanic/Latino: 22%, and other: 2%
            - Age: highest concentration (81%) from 21-60 years of age (21-30:23%; 31-40: 29%, 41-50: 19%; 51-60: 10%); 11-20: 8%; 61-70: 6%;71-80 and 81-90: 2%; 0-10: 1%; 91-100 and N/A: 0%)
        - 2023:
            - Gender: 56% male, 43% female, <1% other preferred gender identification
            - Race: White: 49%, Black/African-American: 25%, Hispanic/Latino: 23%, and other/unknown: 2%
            - Age: highest concentration (81%) from 21-60 years of age (21-30:21%; 31-40: 28%, 41-50: 20%; 51-60: 12%); 11-20: 8%; 61-70: 7%;71-80: 2%; 0-10 and 81-90: 1%; 91-100 and N/A: 0%)
        - 2024:
            - Gender: 55% male, 44% female, 1% other preferred gender identification
            - Race: White: 50%, Black/African-American: 24%, Hispanic/Latino: 23%, and other/unknown: 3%
            - Age: highest concentration (82%) from 21-60 years of age (21-30: 21%; 31-40: 28%, 41-50: 21%; 51-60: 12%); 11-20 and 61-70: 7%; 71-80: 2%; and 0-10 and 81-90: 1%; 91-100 and N/A: 0%)

Current policies related to the transport of individuals with mental health needs to hospitals, the Sobering Center, or other medical facilities by APD versus alternatives, such as basic life support ambulances

- APD Policy found in General Order, Handling Publicly Intoxicated Persons and General Order, Mental Health Response.
- ATCEMS does not regularly staff any basic life support ambulances but can transport patients or provide courtesy rides to alternative destinations such as those described abovein ambulances or via single responder unit vehicles.

Current policies concerning when 9-1-1 calls are routed to call center clinicians and Collaborative Care employees when callers choose the "mental health" option at the beginning of the call, and how other 9-1-1 dispatchers are trained and instructed to identify when a call is to be transferred to mentalhealth triage when the "mental health" option is not selected by the caller;

- APD currently serves as the Public Safety Answering Point (PSAP) for all 9-1-1 calls within the city of Austin and provides the initial triage and call routing to other partner agencies (ATCEMS, AFD, Integral Care). APD 9-1-1 Call Takers receive extensive instruction during their initial 5-week classroom training about appropriately transferring callers that request mental health assistance in the same way that they are trained to triage calls to Austin Fire and Austin-TravisCounty EMS. They also receive training on the department's standard operating protocols to differentiate between mental health calls that are eligible for Call Center Clinician (C3) transfer, and those that require a patrol response. During their 4–6-week on-the-job training, they are evaluated on their ability to effectively title calls and transfer eligible calls to the C3.
    - APD policy found in CCD/Councilor Info sheet attached. 9-1-1 Operator responsibilities found in Crisis Call Diversion Program sheet attached.

The current number of APD officers with mental health-specific training or certifications, thetypes of training and/or certifications received, percentage of shifts where one or more such officers are available, policies regarding how police officers with mental health training are used and deployed, and policies regarding when and how to request joint response with mental health workers; and

- All APD officers are required to complete Crisis Intervention Team (CIT) and de-escalation training, beginning at the Cadet level. Training includes 40 hours of CIT and 8 hours of de-escalation training—there are no other mental health specific certifications that are recognized by the Texas Commission on Law Enforcement (TCOLE), the licensing agency for peace officers. As all commissioned police officers at APD currently have the same standard training, 100% of all APD shifts have officers with mental health-specific training available. Currently, 757 APD officers have completed an updated 16 hours of continued de-escalation training through the Integrating Communications, Assessment and Tactics (ICAT) program bythe Police Executive Research Forum (PERF), and all officers have completed a previous 8-hour version of this training. APD has a total of 1,482 sworn police officers employed as of the date of this report.
- For historical context, TCOLE has a course, 4201: Mental Health Officer Course, which

previously was used to certify officers as a Mental Health Officer (MHO). This certification ended 2017-2018 as the materials in the 4201 course were rolled into the Basic Peace Officer Course (BPOC) taught at APD's Police Academy. This training allows any officer to complete a mental health commitment for those in need of services instead of a select few officers. Following this change in training and department protocols, the MHO pay stipend was removed from the meet and confer agreement (contract) negotiated with the City.

- The policies regarding how police officers with mental health training are used and deployed, and the policies regarding when and how to request joint response with mental health workers can be found in attached documents, General Order regarding Handling Publicly Intoxicated Persons and Crisis Call Diversion Program sheet.

Current police academy curriculum or other training required for all APD cadets and officers related to handling incidents and encounters related to mental health.

- APD has two BPOC courses and one Advanced Education course focused on mental health: BPOC 27 – De-escalation (8 hours), BPOC 29 – Crisis Intervention Training (40 hours), and Integrating Communications, Assessment, and Tactics (16 hours). APD has identified 16 other courses that include a mental health component through curriculum, role plays, or both.
- Integral Care has been providing mental health training to first responders in the Austin community for over 10 years. As subject matter experts, Integral Care provides up to 21 hours of mental health training through APD's Cadet Training and Advanced Education programs. Additionally, Integral Care provides mental health training to Austin Travis County EMS Community Health Paramedic Responders.