UNIVERSITY OF
GEORGIA
Carl Vinson
Institute of Government

ERET Transportation Study

January 6, 2023

Commissioned by the Governor's Office of Health Strategy and Coordination

Governor's Office of PLANNING AND BUDGET
THE STATE OF GEORGIA

OFFICE OF HEALTH STRATEGY AND COORDINATION

January 6, 2023

Dear Governor Kemp and Members of the Georgia General Assembly,

In my role as Director of the Office of Health Strategy and Coordination (OHSC), I am pleased to submit this report on the transport of individuals to and from emergency receiving, evaluation, and treatment facilities (ERET). This report was developed by OHSC pursuant to O.C.G.A. § 31- 53-3 and the requirements established through House Bill 1013 passed in 2022.

OHSC's work on this transport study began with the effective date of House Bill 1013 on July 1, 2022, and OHSC contracted with UGA's Carl Vinson Institute of Government (Institute) for its development. This report includes the results of a six-week study conducted by the Institute. Of the licensed ERETs, 48 tracked and reported admissions and discharge data and the method of transport used. The study found that numerous transportation methods were used for individuals in crisis. Ambulances, friends and family, law enforcement, and agency vehicles were the most common methods of transport to and from ERETs. The study also evaluated the cost of each transport type based on distance and time.

In addition to collecting data from ERETs, the report includes research conducted on mental health crisis transport systems from states around the Southeast and examines existing programs in Tennessee and Virginia that are meant to help better coordinate transportation of these individuals. The report also examines Georgia's bed coordination efforts and includes recommendations on steps the state can take to improve those efforts.

The scope of this study was defined by HB 1013 to investigate how persons experiencing a mental health crisis are transported to and from ERETs. As a result, transport data to emergency departments or emergency receiving facilities (ERF) that are not licensed as ERETs was not collected. It is important to note that not all individuals who suffer a mental health crisis will be initially transported to an ERET facility. Many will be taken to an emergency department first by sheriffs, family and friends or other means and stabilized before being transported to an ERET facility. For example, this report does not capture cases where a sheriff transports an individual to an emergency department. However, the report does capture an ambulance transport that is used for subsequent transport to an ERET.

A future study that would include a full assessment of mental health crisis transportation to healthcare facilities regardless of ERET classification would address these limitations.

Based on this study, I wanted to highlight some important considerations:

1. Consider ways to shift the number of transports by ambulance to a lower cost alternative. The data shows that the most common method of transport to an ERET is by ambulance which is the most expensive option. Consider ways to use other transportation options to lower the cost to the state and other healthcare providers.

2. Develop methods to collect transportation data through administrative and billing systems and processes. A custom data collection instrument was used to do this study because the data required was not collected in existing intake or discharge administrative or billing systems.

3. Consider a future study that includes transports to all healthcare facilities (ERFs). A follow-up study that provides a longer data collection period and includes transport to ERFs (hospitals that are not ERETs) would provide a more complete picture of the mental health transportation network.

4. Further study grant programs in other states that help offset law enforcement transportation costs. The report provides a scan of how other states in the southeastern United States address the transport of individuals with mental illness. A deeper analysis of the grant program in Tennessee may be helpful in developing policy options for Georgia.

5. With a potential increase in on-site issuance of 1013 Orders now possible under HB 1013, sheriff departments may no longer need to have the person in crisis first evaluated at an emergency department and can instead choose to go directly to a BHCC or CSU. Therefore, law enforcement should be encouraged to utilize the bed registry maintained by DBHDD and accessible to law enforcement through GCAL to find open beds for their transports. Further, local law enforcement and other transport providers should consider prioritizing transport to ERETs instead of general hospital emergency rooms. This will cut out wasted time and get patients to the appropriate healthcare setting sooner.

6. Encourage wider ERET participation in the Bed Registry. A more complete bed registry of not only the BHCC and CSU available beds, but also beds maintained by private providers, would give law enforcement and hospitals (ERFs) more information on where they can place a patient.

7. Consider options for "holding" or "reserving" a bed for 1013 Order transports. This is especially helpful when a sheriff is driving a patient a long distance for an available bed to an ERET facility.

8. Encourage DBHDD to work with GCAL and the Georgia Coordinating Center (GCC) on bed coordination and consider any necessary upgrades or improvements to GCAL technology to improve bed availability information.

While there are limitations in this report, it ultimately better illustrates the scale and variety of resources used in mental health crisis transportation. It is our hope that this report can be used to help inform decision-making when examining methods to improve crisis transportation in Georgia. If you have any questions, please do not hesitate to reach out to me.

Sincerely,

Grant Thomas
Director
Georgia Office of Health Strategy and Coordination

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Introduction

Effectively providing assistance and support to persons with mental illness has been a long-standing objective for the State of Georgia. With the passage of Georgia's Mental Health Parity Act (HB 1013) during the 2022 legislative session, the state made significant strides in this endeavor. As part of HB 1013, the Governor's Office of Health Strategy and Coordination was directed to conduct a study about the methods used to transport persons experiencing a mental health crisis to and from emergency receiving, evaluation, and treatment facilities (ERETs).[1] The law specifically reads as follows:

> The office shall conduct a survey or study on the transport of individuals to and from emergency receiving, evaluation, and treatment facilities pursuant to Chapters 3 and 7 of Title 37. Such survey or study shall identify what method of transport is used in each county of the state, such as the sheriff, a law enforcement agency, a private nonemergency transport provider, or an ambulance service. Such survey or study shall be completed, compiled into a report, and provided to the General Assembly and the Governor no later than January 1, 2023. (O.C.G.A. § 31-53-3(d)(1))

This report shares the research findings by a team of researchers from the University of Georgia's Carl Vinson Institute of Government for the Governor's Office of Health Strategy and Coordination.[2] To learn from Georgia's neighbors, the study also discusses how other states address the critical issue of transporting persons in mental health crisis to treatment centers in Part II of the report. The last section of this report examines bed coordination because this issue and mental health crisis transportation are interconnected for service provision. Further, improved bed coordination may lead to greater efficiencies in emergency transport. Fundamentally, this research offers new information that elected officials and other stakeholders can use as they seek to address this multifaceted and critically important public service challenge for the state.

BACKGROUND

As with most states, Georgia's mental health system has evolved from being highly institutionalized to one that emphasizes community-based care. This integrated system now includes state hospitals, public and private hospitals, behavioral health crisis centers (BHCCs), crisis stabilization units (CSUs), mobile crisis teams, the Georgia Crisis and Access Line (GCAL), and thousands of publicly and privately funded mental health professionals and peer support specialists across the state.

Nationally, the transition to community-based care began in earnest when the US Supreme Court ruled in 1999 (*Olmstead v. L.C.*) that the unnecessary institutionalization of persons with mental illness or developmental disabilities violates the Americans with Disabilities Act and that these persons should be moved into community-based settings.[3] By the late 2000s, the US Department of Justice sought to increase the rate at which Georgia's state mental health hospitals de-institutionalize their patients. The result was a 2010 settlement agreement in which the state, through management by the Georgia Department of Behavioral Health and Development Disabilities (DBHDD), would undertake a series of actions to support the independent living of the chronically mentally ill in their communities.

The specific requirements under the 2010 settlement agreement between the State of Georgia and the US Department of Justice[4] addressed both ongoing outpatient services[5] and crisis services. In regard to crisis services, the state agreed to create and/or expand several alternatives to assist persons in mental health crisis. These include operating the Georgia Crisis and Access Line (GCAL), behavioral health crisis service centers that provide walk-in psychiatric and counseling services 24 hours a day, residential crisis stabilization programs with community partners, funding for at least 35 beds in non-state community hospitals, and mobile crisis units. Mobile crisis units must operate in every county and have a response time of one hour or less. Combined, these services offer the immediate and, if necessary, intensive temporary care that the mentally ill may require, while enabling them to continue to live outside an institutional setting.[6]

As expected, some Georgians with mental health challenges experience temporary crises that require immediate evaluation and treatment, such as through medication and/or a short-term stay in a mental treatment facility. The first challenge in such situations is enabling these individuals to reach a behavioral health facility that can serve them. Georgia code section 7-3-101 provides that the governing authority of the county where the person is found or located is responsible for arranging the initial emergency transport of an individual, giving sheriff departments responsibility for transporting persons deemed to need immediate mental health assistance to an emergency receiving facility (ERF). ERFs are emergency centers or trauma centers that may be a unit within a larger medical facility or a free-standing crisis center.[7] An ERF may or may not be licensed as an ERET. For this reason, people may be transported initially to a local emergency department and then moved to an ERET for subsequent evaluation and treatment.

About ERETs. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) licenses ERETs that provide medically suitable facilities for persons exhibiting mental illness, where they are evaluated, stabilized, and treated. In addition to state-managed hospitals, ERETs can be community-based centers located in local hospitals, private behavioral health hospitals, crisis stabilization units (CSU) or behavioral health crisis centers (BHCC). ERETs are also ERFs. A private facility must attest that it is compliant with the requirements pertaining to emergency receiving, evaluation, and treatment facilities set forth in State of Georgia Rules and Regulations for Hospitals (Georgia Comp. R. & Regs § 111-8-40-.37) and Guidelines for the Design and Construction of Hospitals and Healthcare Facilities. The private facilities must submit their attestation of compliance annually. To be designated an ERET, CSUs must be part of a comprehensive community mental health and substance abuse program that has been certified by DBHDD. A single organization can have multiple ERET units that serve different clienteles, such as adults or minors, and they reported their data separately

- **BHCCs:** Facilities nearly always comprise three treatment elements: crisis service centers, temporary observation units, and crisis stabilization centers. Crisis service centers serve as a 24/7/365 walk-in crisis center where people can voluntarily seek crisis intervention. Temporary observation units provide brief stabilization services for up to 23 hours. Adults can be served in a temporary observation unit on a voluntary or involuntary basis. Crisis stabilization centers provide short-term residential psychiatric stabilization and substance use detoxification services in a community-based setting, then transfer them to community-based services. Individuals served these centers can also be referred to a state hospital for longer stabilization if needed.
- **Crisis Stabilization Units**: These facilities provide short-term residential psychiatric stabilization and substance use detoxification services in a community-based setting. CSUs rapidly stabilize individuals and then transfer them to community-based outpatient services.
- **ERET (Inpatient) Hospitals**: ERET (inpatient) hospitals provide psychiatric stabilization for individuals in a hospital setting. Like BHCCs and CSUs, they have the capacity to serve people short-term but can also provide longer periods of treatment if needed.

Source: Email correspondence with Dawn Peel, DBHDD, November 29, 2022.

The emergency transport is authorized and executed through a Form 1013 "Certificate Authorizing Transport to Emergency Receiving Facility and Report of Transportation," (1013 Order) issued by a physician's certification or probate court order. Additionally, a peace officer is given the authority to initiate an emergency transport if (1) the person is committing a penal

offense; and (2) the officer has probable cause that the person is mentally ill requiring involuntary treatment. Sheriff departments across the state perform a substantial number of transports.

In calendar year 2021, the Georgia Sheriffs' Association reported that county sheriff departments conducted 3,992 transports under the 1013 Order, which equates to a weekly average of 76.77 or a six-week estimate of 461.[8] These may have been to either an emergency department (ED) at a general hospital or a behavioral health facility referred to in this study as an emergency receiving, evaluation, and treatment facility or ERET (see the text box above).

Sheriff's deputies transporting individuals in crisis may select an ED because of concerns that the person needs medical attention or because it is the closest and most convenient facility to safely leave the person for a mental health evaluation. Note that law enforcement must stay with the person until custody has been transferred to the ED or ERET facility. Although sheriff's departments are mandated to transport persons under a 1013 Order, this does not preclude other forms of transport, such as family and friends, ambulance, nonemergency medical transport, and so forth. Furthermore, not all persons in crisis will require a 1013 Order, as many will voluntarily seek assistance but will still need to physically get to a facility. Additionally, persons in crisis may be first transported to an ED for evaluation to ensure they pass a medical check before going to an ERET as not all ERETs have the capacity to medically treat patients. If this occurs, law enforcement or other forms of transport may then move the person from the ED to an ERET if a facility stay is required.

No research to date has been conducted that fully captures the transportation of all persons in mental health crises to ERETs in Georgia. Likewise, little collective information is known about how and where these individuals go after being discharged. This research is an initial effort to better understand these issues. As with most exploratory analyses, this study will likely raise many questions as it seeks to be an information tool for policymakers and stakeholders in the mental health treatment arena.

REPORT FORMAT

This study is a composite of three lines of inquiry that interrelate on the topic of transporting individuals experiencing a mental health crisis to an ERET. The primary research, which is discussed in Part I, focuses on the transport of these persons to and from ERETs across Georgia. More specifically, this part of the report provides an initial examination of the types of transportation used for people arriving at and then departing from an ERET, whether a 1013 Order was issued or not. Information on the counties where these trips originated as well as the counties where patients are transported to after discharge is also presented. The final portion of Part I provides estimates of the expenses associated with the various forms of transportation.

Part II reviews the statutory transportation requirements in states across the Southeast[9] and highlights two states, Tennessee and Virginia that have established differing transportation funding mechanisms to ease the resource burden on local governments that often supply this service. Finally, Part III examines the challenge of coordinating bed availability for people who need inpatient residential treatment in a state-supported ERET and considers options to improve the process over the long term. With improvements, there should also be increased efficiencies in mental health transports. Overall, this report offers wide-ranging information that begins to clarify the challenges and opportunities facing the state in meeting this complex service.

PART I: ERET Transportation in Georgia

A team of researchers from the University of Georgia's Carl Vinson Institute of Government collected data about the transport of patients to and from ERET facilities and then calculated the cost of transporting those patients. Due to high levels of ERET participation in this study, the findings provide insights about the methods of transportation to arrive at and depart from ERETs and origins of the trips to the ERETs as well as the destinations at discharge.

METHODOLOGY

To prepare for the study, the research team held five focus groups in late July and early August 2022 to learn what data ERETs were currently collecting about patient transports to their facilities and how patients left the facilities at discharge.[10] These conversations quickly identified that appropriate data did not exist and that a sampling study would need to be administered to collect the necessary information. ERET representatives then provided guidance about the types of transportation used as well as the most convenient way to collect that data. Dozens of representatives from different ERETs participated in the focus groups.

In the third week of August, all ERETs were sent an Excel data file (i.e., the data instrument) to complete when patients were admitted and discharged from their facilities. The data instrument did not ask for any patient identifying information, so HIPAA rule violations are not a concern.[11] For most of the ERETs, data collection began on August 29, 2022, but a few facilities asked to start a week later. Data collection lasted six weeks (42 days) in order to meet the statutory deadline for a final report. ERET representatives stated during the focus groups that they did not believe that there would be any specific transportation anomalies during this period and that the collection period would be a reasonable representation of the types of transport across a year. ERETs submitted their data weekly to the Institute of Government. A total of 48 ERET units either fully or partially participated in the study, which represents a participation rate of 72.7%. (At the time of data collection, Georgia had a total of 66 ERETs.)[12]

Fully participating ERETs submitted six weeks of admission and discharge data for all the variables.[13] Partial participation meant that less than six weeks of data were collected for either or both patient admissions and discharges or a data variable was only minimally collected or not collected at all. Of the state's 27 BHCCs and CSUs, 26 fully or partially completed the data instrument, with a participation rate of 96.2%. Twenty-two of Georgia's 39 ERET hospital units either fully or partially completed the data instrument, representing a participation rate of 56.4%. See Appendices A and B for the names of the ERETs.

Throughout this study, each ERET unit that reported data is counted separately, even if multiple units are managed by a single entity. A single organization can have multiple ERET units that serve different clienteles, such as adults or minors, and they reported their data separately. For example, River Edge Behavioral Health has both adult and child and adolescent crisis stabilization units. Though both units are under the management of River Edge, they are treated as two separate ERETs for the purposes of data collection and evaluation in this report.

For each admitted patient, ERET staff were asked to report the following information: the date the patient was admitted to the facility, the form of transportation that took the patient to the facility, the county where the trip originated, the amount of time the patient had to wait to be admitted, whether or not the patient was transported under a 1013 Order, and whether the patient was an adult or a minor. Note that a trip may not have originated at a patient's home address, with some patients being transported to the facility from a different location, such as a hospital emergency department, work, or even the side of a road. The data instrument included instructions for how to complete the Excel sheet, and staff were encouraged to attend virtual training sessions or contact the Institute of Government for clarification on data input. A total of 6,759 complete or partially complete records of patient admissions were inputted during the data collection period from all participating ERET facilities.

To input their responses, ERET staff chose from drop-down menus except for the date of admission, which the staff typed directly into the data instrument. For form of transport, the drop-down menu included 13 options. ERET staff could also add their own form of transport if they felt it necessary. For example, an ERET included "employee vehicle" as a form of transport as staff felt the "agency vehicle" option included in the menu was inaccurate. The drop-down menu for county of trip origin included all 159 Georgia counties. For patients that came from out of state to be admitted into an ERET, the name of that state, e.g., Alabama or simply "out-of-state" was provided. The instrument used four ranges to record wait times: "less than 15 min.," "15 min. < 1 hr.," "1 < 2 hrs.," and "over 2 hrs." Two questions required a Yes or No response: whether the patient was an adult (18 years or older) and whether the patient arrived under a 1013 Order.

ERET staff also reported data on a separate set of variables when patients were discharged. These patients with discharge information may or may not be the same as those whose information was collected during admission as the data collection period was the same for both. For this analysis, tracking a particular patient from admission to discharge was deemed unnecessary because the goal of the study was to discover how and where persons in crisis were transported to and from an ERET, generally. The following specific discharge facts were collected: the date of discharge from the facility, the form of transport the patient used to leave the facility, what county the patient was going to when discharged, length of stay at the facility, whether the patient was going to a state psychiatric hospital, whether the patient was an adult or a minor, and whether the patient had a 1013 Order at discharge. A total of 5,935 complete or partially complete records for discharged patients were collected over the six-week study period from all participating ERET facilities.

Similar to the admission instrument, the discharge data instrument used drop-down menus to assist ERET staff with reporting data, or staff could type in their own responses. Discharge date, form of transportation, and county destination drop-down menus were the same as those in the admission instrument. Staff could choose from the following drop-down menu options for the length of stay variable: "less than 3 hrs.," "3 hrs. < 6 hrs.," "6 hrs. < 12 hrs.," "12 hrs. < 24 hrs.," "24 < 48 hrs.," and "over 48 hrs." For the questions on whether the patient was going to a state psychiatric hospital, had a 1013 Order during their stay, and was an adult (18 years or older), the selection was either "Yes" or "No."

Because the ERET facility was known, Institute of Government researchers included the name of the facility, whether the facility was a hospital or a BHCC/CSU, and whether it was located within the Atlanta metropolitan region.[14]

Transportation Cost Estimation

An important objective of the research was to better understand the cost to transport individuals in crisis to and from ERETs. This report includes aggregated cost estimates by type of transport. Due to limitations with knowing exactly where a patient was first picked up for admission and dropped off at discharge as well as knowing the exact costs per mile or per hour of every vehicle used to transport patients, the data should be viewed as a general indication of the resources different organizations must deploy to serve these individuals in need.

The cost estimates are based on the distance from the county of trip origin (or destination) to (from) the ERET facility multiplied by the cost per mile and/or per hour for each type of transport. Some types of transport have a single, set cost or a base cost plus a cost per mile. Because multiple counties are associated with each of the ERET facilities and multiple forms of transport, thousands of per-trip cost estimates were calculated. Institute of Government

researchers utilized geospatial analysis to measure the distance, in hours and miles, between the address of each participating ERET and the center point of each county that ERET staff recorded as a county of trip origin at admission or county destination at discharge. Because the exact address of the pick-up or drop-off location was unknown, a county's geographic center was deemed the most reasonable place from which to measure. The assumption was that with many pick-ups and drop-offs across a particular county, the average would result in the center point.

For short-distance transports, such as within the same county, relying solely on mileage or hours to travel could severely underestimate costs. Therefore, the cost estimates use a minimum time of 30 minutes for hourly-based travel. The cost of transport excludes transport personnel waiting with patients at a facility until they are admitted to the ERET. Finally, only cost estimates for the trip to the facility (or to the discharge destination) are included as vehicles may or may not directly return to the place of trip origin. For example, after transporting a person to an ERET, law enforcement may immediately begin responding to calls for service; therefore, the return trip is really a trip for a new purpose.

Costs for each type of transport are as accurate as possible. When the types of transport were less uniform or vague, researchers contacted each ERET to learn more about the type of vehicle or whether a known cost for the transport existed, such as a specific reimbursement rate or hourly contract expense. When the form of transportation did not provide sufficient specificity, the research team tried to collect the following information about vehicle types: the body type of a vehicle (e.g., van, sedan), the installation of special equipment (plexiglass, radios), and whether the driver had any special training (crisis intervention training, first aid).

When operational costs for a method of transport were generally uniform, researchers contacted reliable service providers for a cost estimate such as for an ambulance.

Calculating the Cost per Trip

The list below details the methodology applied to determine the cost per trip for each type of transport method recorded for the study.[15]

Agency-Owned Vehicle. This general category for vehicles owned by the ERET includes passenger vehicles, such as sedans or minivans, without special equipment or drivers with special training. The research team used an hourly cost estimate,[16] and assumed a minimum of 30 minutes of travel time.

Ambulance. The calculation uses a per-trip base cost-plus a per-mile cost.[17] The base cost includes having one paramedic and one emergency medical technician (EMT) riding in the vehicle, all supplies, equipment, and the replacement cost for the ambulance, and the company being accredited. The per-mile cost includes employee costs and fuel. The operating cost for

ambulances has increased substantially post-COVID due to salaries rising to attract and retain qualified medical personnel. Local government-owned and privately-owned ambulances are assumed to have the same per-trip costs because local governments generally offer higher levels of benefits to employees than the private sector but also often pay lower salaries.

Co-responder. As this form of transport typically involves law enforcement, the cost per trip is based on those for police outside the Atlanta metropolitan area. See below.

Georgia Department of Human Services (DHS) Contracted Provider. The estimate is based on an hourly cost[18] and assumes a minimum of 30 minutes of travel. This vehicle cost is paid by the ERET.

Employee Vehicle. The research team used the base cost for reimbursing the employee to drive their vehicle plus an average hourly employee cost for staff who transport patients.[19] This vehicle cost is paid by the ERET.

Family/Friend. This category is used when a family member or friend either took the patient to the facility or picked them up at discharge. The form of transport varies and could be a personal vehicle or some other form of transportation. For this study, no costs are associated with this form of transport.

Interfacility Transfer. No costs are associated with this transport method because the patient was moved from one department to another within the facility, such as from an emergency department to an inpatient psychiatric department.

Nonemergency Medical Transport. The calculation uses a per-trip base cost plus a per-mile cost.[20] The base cost includes having one driver with crisis intervention training and first aid, equipment, and the cost of the vehicle with specially installed equipment such as plexiglass between the driver and the passenger, and the company being accredited. The per-mile costs are for staff and fuel. The operating cost for nonemergency medical transport (NEMT) has increased post-COVID due to salaries rising to attract and retain qualified personnel.

Nonemergency Medical Transport - Simple. The calculation is based on the cost per mile only. This vehicle would be similar to a small bus and have a wheelchair ramp installed. While the driver would likely have some first aid training, there is no expectation that the person be an EMT or have specialized mental health crisis training.[21]

Other-institution Owned Vehicle. This general category includes passenger vehicles, such as sedans or minivans, without special equipment or drivers with special training and is based on

an hourly cost.[22] The calculation assumes a minimum of 30 minutes of travel. Applies to vehicles not owned or funded by the ERET completing the data instrument.

Police – Atlanta Metropolitan Area. For all law enforcement transportation options, personnel costs[23] are measured on an hourly basis, and the vehicle costs use a mileage basis. The patrol officer hourly salary is based on an average of hourly salaries from 28 departments located within the Atlanta metropolitan area. Benefits are measured as a percentage of the hourly salary. Vehicle operating costs include the purchase price of a new, fully equipped patrol vehicle divided by its estimated lifespan of 125,000 miles, insurance, maintenance, and fuel.[24] The calculation assumes that only one officer performs the transport and that it takes a minimum of 30 minutes of his or her time.

Police – Outside Atlanta Metropolitan Area. Costs are calculated the same as for Police – Atlanta Metropolitan Area but using salaries from 75 departments outside the Atlanta metro area.

Public Transit. The calculation uses the base cost for a single fare charge to ride MARTA. This category is used when the patient, family, or friend is not paying for the transportation.

Self-Transport. Patients arrive at the facility by their own means, either by driving or walking. For this study, no costs are associated with this form of transport.

Sheriff – Atlanta Metropolitan Area. The same methodology is used as described for Police – Atlanta Metropolitan Area, including the same vehicle per-mile costs. For hourly personnel costs, the benefit ratio to salaries is the same as with police. Salaries are based on sheriff's deputy salaries within the Atlanta metropolitan area.[25]

Sheriff – Outside Atlanta Metropolitan Area. The same methodology is used as described for Sheriff – Atlanta Metropolitan Area, only using an hourly salary provided by the Georgia Sheriffs' Association.

Taxi or Rideshare. The cost for a taxi was found for the 26 counties that recorded taxis as being a source of transport at admission or discharge.[26] These taxi fares were found by researching city and county ordinances, websites, and calling taxi companies. The taxi fares from these counties were averaged to create a base plus a per-mile cost for taxis and rideshare companies. This category is used when the patient, family, or friend is not recorded as paying for the transportation (i.e., self-transport or family/friend).

Limitations of the Data

As with any preliminary research and data collection process, this study has several limitations that could be addressed through a longer and more thorough analysis. One of the most significant challenges to this research was completing it within the statutory deadline. The timeframe resulted in data only being collected for six weeks. Although this time period was not considered unusual, a longer data collection time frame, such as a year, would ensure a fuller picture of transportation demand and type and, thus, cost. With over 70% of ERETs participating in the data collection, the response rate is high for this type of research. Of course, a higher response rate from hospitals would have provided a more nuanced understanding of transportation for these larger facilities. As with all data collection instruments completed by people, there are bound to be a small number of random data input errors, particularly because ERET staff were busy serving patients. Researchers attempted to minimize such errors by consulting with ERET staff about data that appeared to be unusual.

The reader is also cautioned to evaluate the costs associated with the different types of transport as general estimates. A driver's salary and benefits can only be measured at a general, occupational level. Likewise, vehicle expenses will vary considerably by age, make, and model. Expecting ERET staff to have detailed knowledge about the hourly or per-mile cost for many different types of transportation to and from their facilities is unrealistic.

Perhaps the most significant limitation of this study is not knowing the type of transports for persons in crisis who were initially transported to a non-ERET emergency department (ED). Based on outreach to the participating ERETs, it appears that many patients first arrived at an ED and then, after being evaluated, were sent to the ERET. This appears to be true for many of the patients arriving at BHCCs and CSUs. By limiting the study to only ERETs as specified by HB 1013, likely many transports, including those by law enforcement or self-transport, are not counted.

In contrast, including all ERFs would provide a more complete picture of how individuals in mental health crisis are transported and to what types of facilities. Such a study would require significant planning as it would likely involve a substantial effort by hospitals and crisis centers to amend electronic admission and discharge software. Despite these data limitations, several interesting findings and patterns can be seen. These are discussed in the next section, Findings.

FINDINGS

This section presents the findings for admission cases and discharge cases separately as they are essentially two different datasets. To meet the study timeline and privacy requirements, the Institute of Government collected data on admissions and discharges separately but during the same six-week data collection period. Thus, patients who were admitted and their information

shown in our admission data may or may not be the same individuals who were discharged. Likewise, the discharge data during the initial days of data collection would include patients who had been admitted prior to the data collection start date. Though the admission and discharge data cannot be compared, they each shed light on the patterns of transportation to and from ERETs throughout the state.

Admissions Data

As discussed in the Methodology Section, the data instrument included additional variables in order to permit a more thorough understanding of the key variable of interest, transportation method. These additional variables included the type of ERET that collected the data, either a BHCC/CSU or a hospital; whether the person in crisis arrived at the ERET under a 1013 Order; whether the person in crisis was an adult (18 years or older) or a minor; and the county of trip origin. This section first presents the frequencies for these descriptive variables to provide context when they are applied to the transportation method variable.

Figure 1 shows the location of all licensed ERETs in Georgia. Clearly, ERETs are located across the state, with the greatest concentration in the Atlanta metropolitan area. ERETs are also concentrated in counties with higher populations (i.e., counties with larger cities), such as Bibb, Chatham, Muscogee, Richmond, and the like. In contrast, fewer ERETs exist in rural areas, particularly in the mid-eastern part of the state. Rural areas, with their smaller populations, naturally have concomitantly less demand for mental health crisis services. However, the challenge of longer transport distances arises when someone from a less-populated area needs assistance at an ERET. Balancing a reasonable transport distance for persons experiencing a mental health crisis with efficiently locating ERETs is an ongoing public policy challenge.

Figure 1. All Licensed ERETs in Georgia

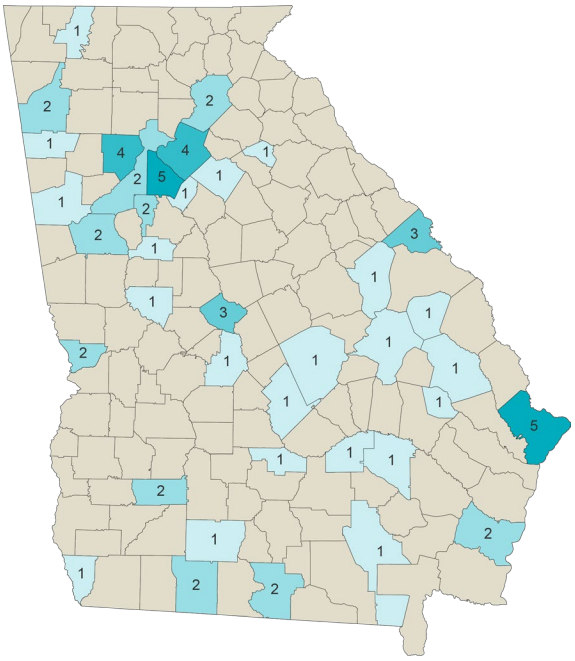
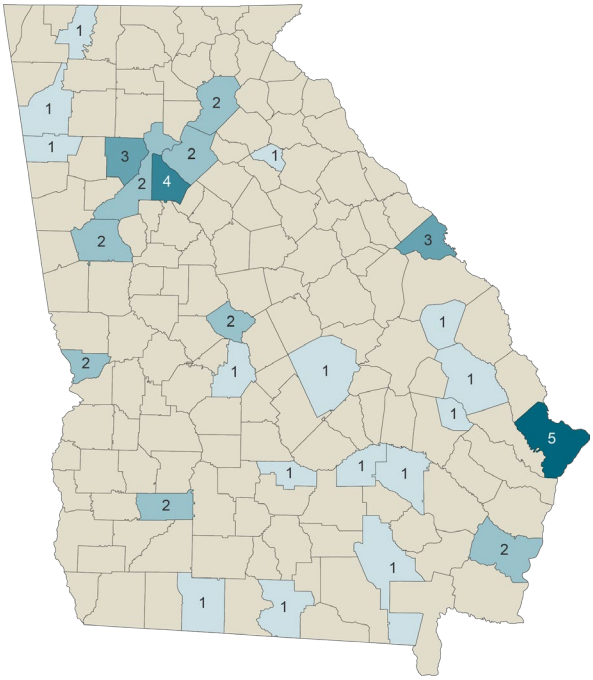


Figure 2. Licensed Participating ERETs – Admissions



A total of 48 ERET units located across the state completed or partially completed the admission data instrument. As Figure 2 shows, of all the ERETs in the sample, 55% are located outside the Atlanta metropolitan area, and 45% are located within it.

Table 1 shows the total number of admissions by type of ERET: 38.6% of the admissions were to BHCCs/CSUs, and the remaining admissions (61.4%) were to hospitals.

Table 1. Admissions by ERET Facility Type

Type of Facility	Frequency	Percent
BHCC/CSU	2,607	38.6%
Hospital	4,152	61.4%
Total	**6,759**	**100.0%**

Note: Missing data = 0 cases

The sample shows sizeable variation among the ERETs in the number of admissions over the six-week data collection period. Of the 46 ERETs in this dataset, Grady Hospital had the most admissions, accounting for 15.9% of all admissions and over one-fourth of the hospital admissions (26.7%). In contrast, the ERET with the fewest admissions was West Central Georgia

Regional Hospital, which reported only five admissions during the six weeks of data collection due to limited capacity. The mean (i.e., average) number of admissions was 147, and the median was 102. The substantial difference between the mean and median was because Grady's 1,077 recorded admissions raised the average.

The ERET group with the most admissions during the data collection period was hospitals. Table 2 shows that after Grady Hospital, the ERET hospitals with the next-most admissions were Wellstar Cobb Hospital's Emergency Department (9.1% of all admissions),[27] and SummitRidge Hospital (8.5% of all admissions). The fact that hospitals generally had more admissions than BHCCs/CSU is indicative of their relative capacity to serve more patients. The following ERETs saw the fewest admissions during the data collection period: West Central Georgia Hospital (0.1%), Dorminy Medical Center (0.2%), and Evans Memorial Hospital (0.2%). Table 2 lists the ERETS with the most and fewest admissions in our sample. Not surprisingly, the three ERETs with the highest number of admissions are located within the Atlanta metropolitan area, while those with the fewest admissions during the data collection period were outside the metropolitan area, reflecting the populations they serve.

Table 2. ERETs with the Most and Fewest Admissions

ERET	Frequency	Percent of Total Admissions
Most Number of Admissions		
Grady Memorial Hospital	1,077	15.9%
Wellstar Cobb ED	614	9.1%
SummitRidge Hospital	576	8.5%
The Bradley Center – St. Francis Emory Healthcare	315	4.7%
St. Simon's By-The-Sea	303	4.5%
Fewest Admissions		
West Central Georgia Regional Hospital	5	0.1%
Dorminy Medical Center Silver Lights Care Center	11	0.2%
Evans Memorial Hospital	12	0.2%
Pineland Behavioral Health –John's Place	22	0.3%
Middle Flint CSB – Phoenix Place	25	0.4%

Note: Missing data = 0 cases

Knowing the number of 1013 Orders in the sample is important for appreciating the types of transport used for persons in crisis to reach an ERET. State law (§ 37-3-101) allows for methods other than a sheriff to take a person with a 1013 Order to a facility (e.g., family members,

NEMTs, ambulance). Additionally, one would expect fewer law enforcement officials transporting persons in crisis to an ERET when a 1013 Order has not been issued. Table 3 shows that more patients in the sample were admitted with a 1013 Order (53.3%) than without one (46.7%). Patients admitted to a BHCC or CSU were almost as likely to not arrive under a 1013 Order as with one (22.0% vs. 21.2%); in contrast, those in the sample being admitted to a hospital were more likely to have a 1013 Order.

Table 3. Percentage of 1013 Orders by ERET Facility Type

	No 1013 Order	1013 Order in Place	Total
BHCC/CSU	22.0%	21.2%	43.2%
Hospital	24.7%	32.1%	56.8%
Total	**46.7%**	**53.3%**	**100.0%**

Note: Missing data: 731 cases

Whether a patient is an adult, or a minor is an important distinction for ERET transport as minors require special care. Presumably, it would be far more likely for a minor (under the age of 18) in mental health crisis to be driven by a family member or medical transport rather than by law enforcement.

The sample had a much higher proportion of adults (81.3%, n = 5,443) than minors (18.7%, n = 1,256). According to Mental Health America, in 2021, 13.75% of Georgia youth (age 12–17) had at least one major depressive episode in the prior year, and 9.0% had experienced severe major depressive episodes.[28]

Of the 1,256 minors in the sample, Table 4 shows that 67.0% were admitted to hospitals and 33.0% to BHCCs/CSUs. The high proportion of minors being admitted to hospitals reflects the higher capacity of these ERETs to serve minors, either through specialized longer-term treatment or by admission at emergency departments. Adults were also more likely to be admitted to a hospital (60.8%) than to a BHCC/CSU (39.2%).

Table 4. Adults and Minors Admitted to Hospitals and BHCCs/CSUs

Adults		Minors	
Hospitals	BHCCs/CSUs	Hospitals	BHCCs/CSUs
60.8%	39.2%	67.0%	33.0%

Note: Missing data: 60 cases

Table 5 shows adult and minor admissions, broken down by whether the individual was under a 1013 Order. Similar percentages of adults were admitted with and without a 1013 Order (49.8% and 50.2%, respectively). In contrast, two-thirds of minors were admitted with a 1013 Order (66.6% vs. 33.4% with no 1013 Order). These results suggest that either adults were more apt to voluntarily transport themselves or that when minors required admission to an ERET, the situation was very serious.

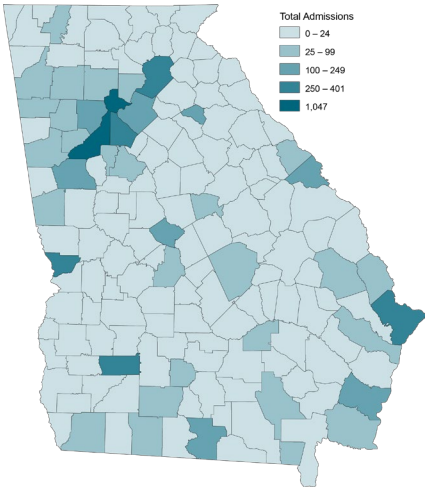
Table 5. Adults and Minors Admitted to ERETs under 1013 Order or Not

Adults		Minors	
1013 Order: Yes	1013 Order: No	1013 Order: Yes	1013 Order: No
49.8%	50.2%	66.6%	33.4%

Note: Missing data: 789 cases

Knowing where persons in mental health crisis were transported *from* is essential to fully understanding where demand for services exists. The analysis uses the term "transport origination" to indicate where a person was picked up to be transported to an ERET. During the six-week data collection period, individuals were reported to have come from 150 different counties, plus Alabama and South Carolina.[29] This wide distribution of transport originations, highlighted in Figure 3, indicates the widespread need for mental health services across the state. There were 812 admissions without an identified county of transport origination, 89.2% of which were either for the Wellstar Atlanta Emergency Department or Wellstar Cobb Emergency Department.[30] Therefore, these cases of unidentified counties of trip origin likely took place within the Atlanta metropolitan area.

Figure 3. Number of Transport Originations by County



The number of transports coming from each of the 150 identified counties varied widely. Not surprisingly, Fulton County, one of the most populous counties in the state, had the most trips to an ERET at 1,047. However, many counties only had a handful of trips. In fact, nearly one-third of the counties (48) had five or fewer transports (trips). The mean number of transports per county was 40, yet the median was just nine. The difference between the two can be explained by the large number of trips beginning from just a handful of counties. The 10 counties with most transits, listed in Table 6, represent 59% of all the identified trips (i.e., admissions).

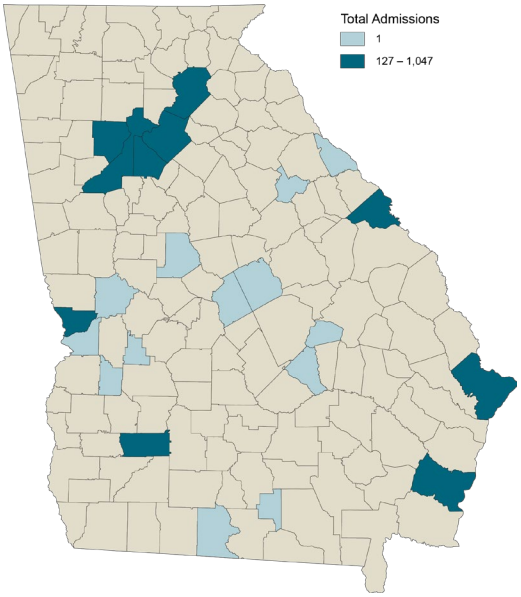
Table 6. Top 10 Counties for Transport Origination

County	Trip Frequency	Percent of All Transport Originations
Fulton	1,047	17.6%
Chatham	401	6.8%
DeKalb	361	6.1%
Muscogee	319	5.4%
Hall	316	5.3%
Dougherty	284	4.8%
Cobb	243	4.1%
Gwinnett	217	3.7%
Richmond	195	3.3%
Glynn	127	2.1%

Note: Missing data: 812 cases and excludes out-of-state transport originations

Figure 4 displays the counties with most and fewest admissions. Sixty-six percent (65.7%) of the transports originated within the Atlanta metropolitan area. Of the 10 counties with greatest number of transits, four are within the Atlanta metropolitan area.[31] This finding simply corresponds to Fulton and the surrounding counties being the largest population center in the state. The other most commonly recorded counties represent other large population centers in the state. At the other end of the spectrum, 13 counties had a single admission during the data collection period. There were nine counties with no admission transports in the sample.

Figure 4. Counties with Most and Fewest Admissions



Knowing the relative demand for mental health services is also important for stakeholders to fully appreciate where services are most needed. Relative demand is measured here by the originating transports per capita for counties in the sample. If relative demand were equal across the state, every county would have the same number of transports per capita. Due to the short data collection timeframe, this measure is not definitive but can indicate if some counties appear to have greater demand than their total populations would indicate.

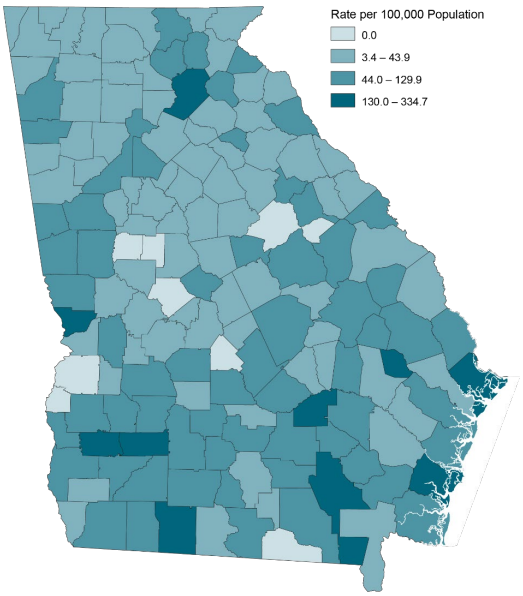
The data show a wide range of trips per capita by county. Monroe County had the fewest transports per capita, just 3.48 trips per 100,000 residents, and Dougherty County had the most per capita, at 334.7 per 100,000. The mean and median for trips per capita are much closer, 52.7 and 42.3 per 100,000 population, respectively, than was the case with the aggregate number of trips. Table 7 shows the 10 counties with the highest per capita admission rate during the study period.

Table 7. Counties with the Highest per Capita Admission Rates

County	Total Population	Admission Rate (per 100,000 pop.)
Dougherty	84,844	334.7
Evans	10,672	215.5
Jeff Davis	14,872	215.2
Ware	36,033	202.6
Thomas	45,842	181.1
Muscogee	205,617	155.1
Hall	207,369	152.4
Glynn	84,739	149.9
Calhoun	5,509	145.2
Chatham	296,329	135.3

Figure 5 presents a visualization of county admissions per capita. As can be seen, the counties with the highest admission rates are not exactly the same as those with greatest number of total admissions. The reasons why some counties have a higher per capita admission rate than others may simply be due to the data collection period or could be related to other factors. Learning the answer would require further study.

Figure 5. Transports per Capita by County



Even though the data set contains far fewer minors than adults, 1,256 minors versus 5,443,[32] minors were transported to ERETs from 124 different counties, reflecting the broad demand for services for this special population. Adults were transported from 143 counties. The counties with the most transports were nearly the same for the two groups, though their rankings in the top 10 vary (see Table 8). Of note is Fulton County's high percentage of transports, relative to its overall population. Fulton County had 20.8% of all adult transports, yet it contains 10.2% of the state's population. For minors, the counties with the most transports can likely be explained because of their large total populations, but it is also worth pointing out that Hall, Chatham, Gwinnett, Richmond, DeKalb, Muscogee, and Coweta counties all have crisis stabilization units specifically for children and adolescents.

Table 8. Counties with the Most Transports for Adults and Minors

Adult (18 years and older)			Minors		
County	Percent of Transports	Percent of State Adult Pop.[1]	County	Percent of Transports	Percent of State Minor Pop.[1]
Fulton	20.8%	10.2%	Hall	9.2%	2.0%
Chatham	7.0%	2.8%	Chatham	6.3%	2.4%
DeKalb	6.6%	7.1%	Gwinnett	5.6%	10.1%
Muscogee	5.7%	1.9%	Fulton	5.3%	8.9%
Dougherty	5.3%	0.8%	Richmond	5.0%	1.9%
Hall	4.5%	1.9%	DeKalb	4.4%	6.8%
Cobb	4.3%	7.2%	Muscogee	4.1%	2.0%
Gwinnett	3.2%	8.6%	Cobb	3.4%	6.9%
Richmond	2.9%	1.9%	Coweta	3.2%	1.4%
Glynn	2.1%	0.8%	Dougherty	2.8%	0.8%

Note: Missing data: 690 cases for adults and 121 cases for minors (have designation of adult or minor but no county for that case); excludes out-of-state transports
1. Equals a county's total population as a percentage of the state's total population
Source: Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP) County as percentage of the state population

Figures 6 and 7 present the per capita rate of admissions by county for adults and minors statewide. The counties with the highest rate of adult and minor admissions were Dougherty and Clay, respectively, while the counties with the lowest rates of admission were Monroe for adults and Clayton for minors at 6.2 per 100,000. For adults, the mean and median admission rates were 55.1 per 100,000 and 39.1 per 100,000. For minors, the mean and median rates were 69.7 per 100,000 and 51.2.

Figure 6. Adult Admission Rate by County

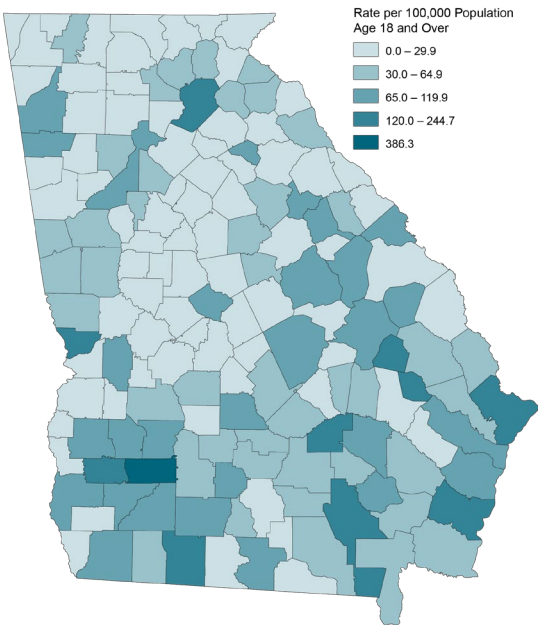
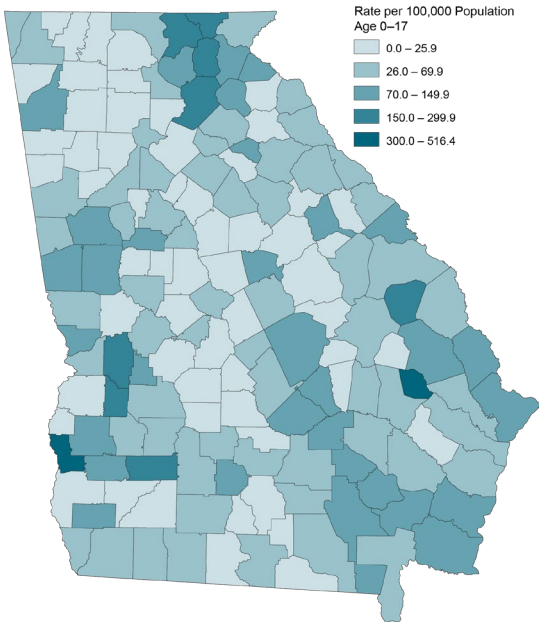


Figure 7. Minor Admission Rate by County



Method of Transport

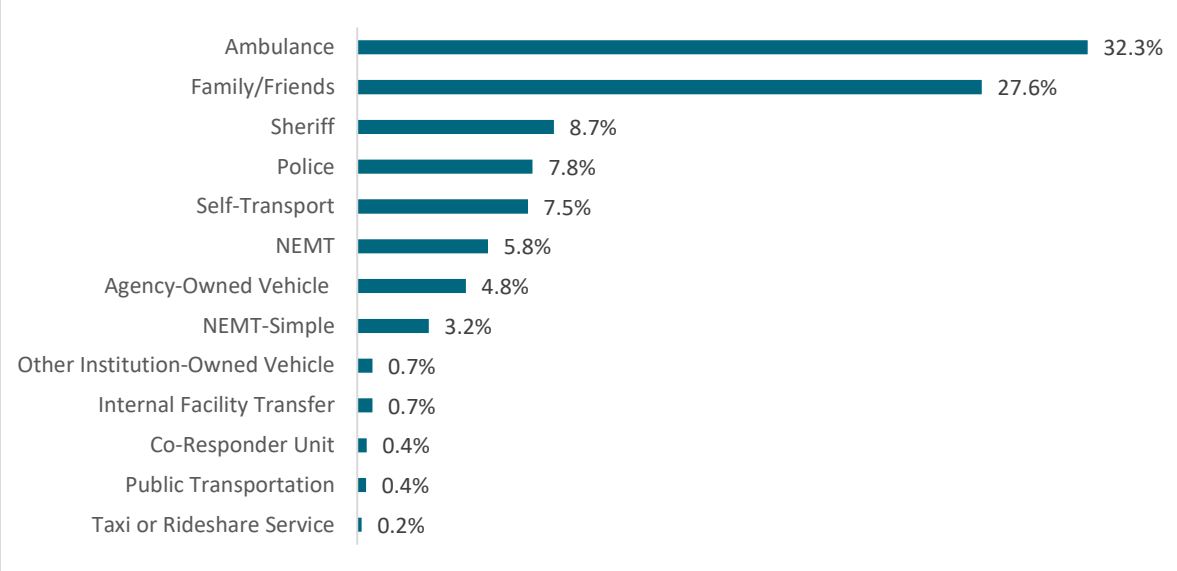
For all ERETs, several methods of transportation were used for patients to reach an ERET but their frequency varied substantially. Ambulances (32.3%) and family or friends (27.6%) brought the most patients during the data collection period and constituted 59.9% of all the recorded transports. At the other end of the spectrum, just 0.2% of patients arrived at an ERET via taxi or rideshare service. Overall, medical transport, either by ambulance, NEMT, or NEMT-Simple, played a critical role in transporting people in mental health crisis to an ERET, accounting for 41.3% of all transports. As Table 9 and Figure 8 show, in total, 13 different types of transportation were recorded, including one medical flight.

Table 9. Method of Transport to ERETs

Transportation Method	Frequency	Percent of Total
Ambulance	2,174	32.3%
Family/Friends	1,859	27.6%
Sheriff	585	8.7%
Police	522	7.8%
Self-Transport	508	7.5%
Nonemergency Medical Transport	389	5.8%
Agency-Owned Vehicle	323	4.8%
Nonemergency Medical Transport-Simple	213	3.2%
Internal Facility Transfer	45	0.7%
Other-institution Owned Vehicle	45	0.7%
Co-Responder Unit	28	0.4%
Public Transportation	26	0.4%
Taxi or Rideshare Service	13	0.2%
Total[1]	**6,730**	**100.1%**

Note: Missing data: 28 cases. See following page for definitions. Sum exceeds 100% due to rounding. 1. Excludes medical flights, as there was only one case.

Figure 8. Method of Transport to ERETs



Note: Missing data: 28 cases; 1. Excludes medical flights, as there was only one case.

A significant finding from this study is the wide variety of transport methods people used to get to an ERET. Sheriff departments drove 8.7% of the patients to ERETs even though they are legally obligated to transport all people with a 1013 Order to an ERET if requested. When asked about the data for their facilities, ERET staff said that many of their patients were driven from an emergency department, where they had been evaluated and determined to need the services of a crisis stabilization unit, to their facilities by agency-owned vehicles, other-institution owned vehicles, and NEMTs. While sheriff departments could transport these patients, staff said it was often faster or easier to manage moving the patients themselves or with a hospital vehicle as sheriff departments were busy responding to calls for service. Data collected by the Georgia Sheriffs' Association during the same six-week time period[33]34recorded 317 1013 Order transports compared to the 424 1013 Order transports identified in this study. Note that not all sheriff departments participate in the Georgia Sheriffs' Association 1013 Order survey.

Family and friends and self-transport comprised over one-third of all transportation cases. Family and friends transporting patients to ERETs most likely occurred in situations not involving a 1013 Order, which is nearly half (46.7%, see Table 3) of all cases in the sample and hence explains its large percentage. The fact that over 500 people in our sample transported themselves to an ERET, even when in crisis, is also a testament to their determination to seek help.

Definitions of Transportation Methods to ERETs

Ambulance. This category comprises transport via a medical ambulance that may be owned by a local government, hospital, or private company. Ambulance was coded as the form of transport regardless of whether the situation was an "emergency" or not, as long as the vehicle was an ambulance with medical equipment and staffed with medical professionals, such as paramedics or emergency medical technicians (EMT).

Agency-Owned Vehicle. This category includes any form of transport paid by the ERET. The vehicles could include a sedan or van owned by the ERET and driven by staff, employees driving their personal vehicles and reimbursed by the ERET, or a contracted vehicle that is not an ambulance, nonemergency medical transport, or taxi/rideshare service.

Co-Responder Unit. The patient is transported by personnel whose organization(s) have a law enforcement and mental health professional partnership.

Family/Friends. The patient is transported by a family member or friend.

Internal Facility Transfer. The patient arrived at the unit from another department located at the same facility, such as transferring from an emergency department to a crisis stabilization unit.

Nonemergency Medical Transport (NEMT). The patient is transported by a vehicle with some specialized equipment but not an ambulance, and the driver has some specialized training in mental health, such as crisis intervention training and first aid but is not a certified EMT.

Nonemergency Medical Transport-Simple (NEMT-Simple). The patient is transported by a vehicle, typically a small bus without specialized medical equipment beyond a wheelchair lift. The driver lacks specialized training in mental health.

Other-institution Owned Vehicle. The patient is transported by a vehicle not owned or funded by the ERET, and the admissions staff did not classify the vehicle as an ambulance or nonemergency medical transport. This category would include a sedan or van driven by nonmedical personnel.

Police. The patient arrives in a police patrol vehicle driven by a police officer.

Public Transportation. The patient arrives unaccompanied by a family or friend via public transportation such a bus or MARTA.

Self-Transport. A person either walks to the facility or drives themselves to the facility.

Sheriff. This category includes transport via any type of vehicle owned by a sheriff department and driven by a sheriff department employee. This could be an unmarked vehicle.

Taxi or Rideshare Service. The patient arrives unaccompanied by a family or friend in a taxi or rideshare vehicle such as an Uber or Lyft.

To clarify the circumstances surrounding transportation to ERETs, the research team analyzed the data further. When considering transportation method by ERET facility, it is important to appreciate differences beyond the proportion of patients admitted to a BHCC/CSU or a hospital. If transportation methods were proportional between the two types of ERETs, then for each transportation method, approximately 40% would go to a BHCC/CSU and approximately 60% would go to a hospital. In fact, the data collected showed 38.6% of all patients went to BHCC/CSUs and 61.4% went to hospitals. With this qualification, distinct differences emerge regarding which types of transport are used to take patients to the two types of ERETs. Ambulances are far more likely to take patients to a hospital (88.8%) than to a BHCC/CSU (11.2%), while agency-owned vehicles (86.4%) and other- institution owned vehicles (80.0%) are more likely to transport patients to BHCCs/CSUs. For law enforcement agencies, sheriff departments take patients to BHCCs/CSUs 69.1% of the time but police departments drive them to hospitals 73.9% of the time. Police departments may transport patients to hospitals more frequently than BHCCs/CSUs because hospitals are typically located in cities which would be within their jurisdictions. Friends and family transport their loved ones to BHCCs/CSUs and hospitals relatively proportionally, 41.3% and 58.7% respectively.

Table 10. Transportation Method Used to Reach BHCCs/CSUs or Hospitals

Transportation Method[1]	Facility Type				Total Frequency
	BHCCs/CSUs		Hospitals		
Agency-Owned Vehicle	279	86.4%	44	13.6%	323
Ambulance	243	11.2%	1,931	88.8%	2,174
Co-Responder Unit	28	100.0%	0	0.0%	28
Family/Friend	767	41.3%	1,092	58.7%	1,859
Internal Facility Transfer	36	80.0%	9	20.0%	45
Nonemergency Medical Transport	317	81.5%	72	18.5%	389
Nonemergency Medical Transport-Simple	34	16.0%	179	84.0%	213
Other-institution Owned Vehicle	36	80.0%	9	20.0%	45
Police	136	26.1%	386	73.9%	522
Public Transportation	14	53.8%	12	46.2%	26
Self-Transport	281	55.3%	227	44.7%	508
Sheriff	404	69.1%	181	30.9%	585
Taxi/Rideshare	9	69.2%	4	30.8%	13
Total	**2,584**	**38.4%**	**4,146**	**61.6%**	**6,730**

Note: Missing data: 28 cases
1. Excludes one medical flight case

Because Grady Memorial Hospital represented such a large percentage of all cases in the dataset, its sources of transport are reviewed separately. For Grady's 1,077 cases, six forms of transportation are recorded, but three—internal facility transfer (3), NEMT (1), and public transportation (1)—are only cited a combined total of five times. Rather, ambulance (39.1%), family or friends (37.8%), and police (22.7%) represent nearly all (99.6%) of the transports to this facility. Furthermore, the 244 police transports to Grady represent nearly half (46.7%) of all recorded police transports (522) to ERETs.

The research team next assessed transportation methods based on whether the ERETs are located inside or outside the Atlanta metropolitan area.[35] This distinction is made in case the Atlanta area has unique factors that influence the type of transport used for patients. Slightly over half (55%) of patients arrived at an ERET outside the Atlanta metropolitan area, while 45% arrived at an ERET within the Atlanta metropolitan area. Table 11 shows that patients arriving by ambulance were more likely (68.3%) to be taken to an ERET inside the Atlanta area than to one outside the Atlanta area (31.7%). Similarly, when patients used public transportation, they

went to an ERET inside the Atlanta area 73.1% of the time. This finding makes intuitive sense as the Atlanta metro area has a large public transportation network. In contrast, 79.3% of agency-owned vehicle transports and 95.6% of other-institution owned vehicle transports were to ERETs outside the Atlanta area. Likewise, 81.9% of NEMTs drove patients to ERETs outside the Atlanta area. Due to the lack of infrastructure in rural areas, one might think that sheriffs would need to drive patients from rural areas to an ERET. The data support this assumption, as sheriff personnel drove patients to ERETs outside the Atlanta area far more frequently (91.6%) than to ERETs inside the Atlanta area (8.4%).

Table 11. Transportation Method Used to Reach ERETs Located Inside Versus Outside the Atlanta Metropolitan Area

	ERET Location				Total Frequency
Transportation Method[1]	**Outside Atlanta Metro**		**Inside Atlanta Metro**		
Agency-Owned Vehicle	256	79.3%	67	20.7%	323
Ambulance	690	31.7%	1484	68.3%	2,174
Co-Responder Unit	22	78.6%	6	21.4%	28
Family/Friend	1,038	55.8%	821	44.2%	1,859
Internal Facility Transfer	35	77.8%	10	22.2%	45
Nonemergency Medical Transport	280	72.0%	109	28.0%	389
Nonemergency Medical Transport-Simple	213	100.0%	0	0.0%	213
Other-institution Owned Vehicle	43	95.6%	2	4.4%	45
Police	224	42.9%	298	57.1%	522
Public Transportation	7	26.9%	19	73.1%	26
Self-Transport	348	68.5%	160	31.5%	508
Sheriff	536	91.6%	49	8.4%	585
Taxi/Rideshare	10	76.9%	3	23.1%	13
Total	**3,702**	**55.0%**	**3,028**	**45.0%**	**6,730**

Note: Missing data: 28 cases
1. Excludes medical flights as there was only one case.

To better understand specifically where transporters drove patients, those with the greatest number of trips are examined in greater detail: agency-owned vehicle, ambulance, family or friend, police, self-transport, and sheriff.

Agency-Owned Vehicle. Twenty-two ERETs directly provided transportation to bring 323 patients to their facilities over the data collection period. St. Francis – The Bradley Center

represented over half (53.3%) of all agency-owned vehicle transports. The remaining facilities used this method of transport anywhere between one and 36 times.

Ambulance. Ambulances were used to transport patients to 31 different facilities, but over half of these trips (55.0%) were to just three facilities: Grady Memorial Hospital in Fulton, SummitRidge Hospital in Gwinnett, and WellStar Cobb ED in Cobb. Since Grady Memorial and Wellstar Cobb ED only include emergency department data, ambulances appear to be used more for initial transport, i.e., evaluation, rather than to transport patients from one medical facility to a mental health crisis stabilization unit.

Family/Friend. Forty ERETs reported family or friends transporting a patient to their facility for services. The ERETs with the most overall transports such as Grady Memorial and Wellstar Cobb ED also had the greatest number of family/friend transports. However, the ERETs with the highest proportion of family/friend transports to total transports were Albany Area CSB – Aspire (81.7%), Pathways Center C&A (60.0%), and Gateway Crisis Center – Savannah (56.6%).

Police. Nearly half (46.7%) of all police transports were attributed to Grady Memorial Hospital. Beyond that facility, police drove patients to 27 other ERETs. Police transports to a particular ERET ranged from one to 40.

Self-Transport. Individuals were recorded as self-transport when they arrived at an ERET by walking or driving themselves. DeKalb Regional Crisis Center and Laurelwood Behavioral Health Hospital had the most instances of patients transporting themselves. Staff at DeKalb Regional Crisis Center said that such a large number of patients self-transport to this facility because they walk from a nearby MARTA station. The remaining cases of self-transport are distributed across 18 additional ERETs.

Sheriff. Of the 46 facilities represented in the admissions data, 33 had at least one transport by a sheriff's department. Of the 585 transports by a sheriff department, the facilities with the most were East Central State Hospital with 78 transports, Legacy (68), and Georgia Pines (66). For East Central State Hospital, 85.7% of all its transports were by a sheriff department. As these three facilities are all located outside the Atlanta metropolitan area, the previous finding that 91.6% of sheriff department transports were outside the Atlanta area is mostly explained through these findings.

Legacy receives so many of its patients via sheriff transport in part because of a long-standing relationship between the Lowndes County Sheriff Department and the South Georgia Medical Center in Valdosta. The two entities jointly fund transports of individuals experiencing a mental health crisis to the hospital for medical clearance and from the hospital to an ERET if necessary. Off-duty officers voluntarily sign-up to conduct these transports. The hospital pays the officers

a transport fee for their time, and the officers drive county patrol cars. The officers are required to transport patients within an hour of the call from the hospital. For 1013 Orders, the sheriff department works closely with Legacy to ensure the person in crisis can receive assistance efficiently and with minimal trauma.

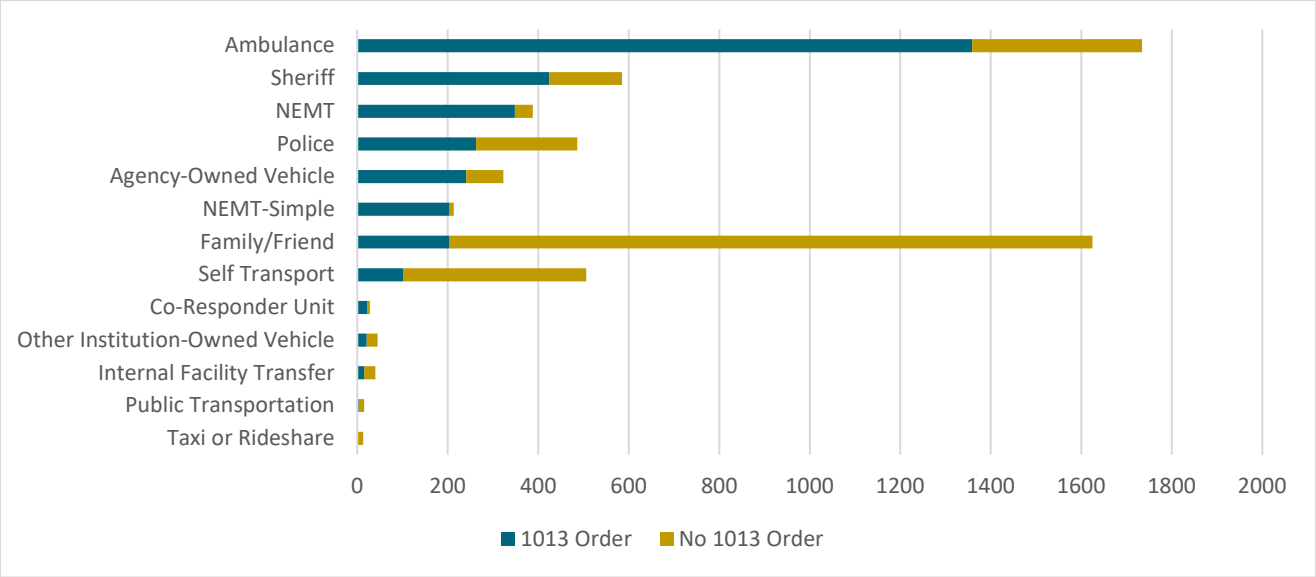
The method of transport varies substantially depending on whether the patient arrived at the facility with a 1013 Order or not. Tables 12 and 13 show the transportation method for those with and without a 1013 Order, respectively.[36] For individuals coming to an ERET under a 1013 Order, the most common form of transport was an ambulance (42.4%). The need for some level of medical transport would be expected to occur more frequently under a 1013 Order than without one. Likewise, a sheriff's deputy would more likely drive individuals with a 1013 Order to an ERET than without a 1013 Order. In contrast, those individuals without a 1013 Order arrived half of the time with a family member or friend (50.8%). The few people who used public transportation or taxi/rideshare services generally did not have a 1013 Order, which would be expected. However, police officers transported the same proportion of 1013 Order and non-1013 Order individuals.

Table 12. Transportation Method for Individuals with 1013 Order

Transportation Method	Percent
Agency-Owned Vehicle	7.5%
Ambulance	42.4%
Co-Responder Unit	0.7%
Family/Friend	6.4%
Internal Facility Transfer	0.5%
Nonemergency Medical Transport	10.9%
Nonemergency Medical Transport-Simple	6.4%
Other-institution Owned Vehicle	0.7%
Police	8.2%
Public Transportation	0.1%
Self-Transport[1]	3.2%
Sheriff	13.2%
Taxi/Rideshare	0.0%
Total Transports (n = 3,206)	**100.1%**

Note: Missing Data: 6 cases; Sum exceeds 100% due to rounding;
1. Ten ERETs reported having a person with a 1013 Order arriving by self-transport. This could be due to the person receiving this designation when evaluated at the facility. Of the 102 people who transported themselves and had a 1013 Order, 61.7% were from Memorial Health University Medical Center.

Figure 9. 1013 Orders at ERET Admission



Note: Missing data: 731 cases

As shown in Figure 9, ERETs reported that persons under 1013 Orders were most commonly transported to ERETs by ambulances, NEMT, NEMT-Simple, and law enforcement.

For a person not under a 1013 Order, a family member or friend was the most common method of transport to an ERET. Self-transport or an ambulance were the second and third most common transport methods for persons not under a 1013 order.

Table 13. Transport Method for Individuals without a 1013 Order

Transportation Method	Percent
Agency-Owned Vehicle	2.9%
Ambulance	13.4%
Co-Responder Unit	0.2%
Family/Friend	50.8%
Internal Facility Transfer	0.9%
Nonemergency Medical Transport	1.4%
Nonemergency Medical Transport-Simple	0.3%
Other-institution Owned Vehicle	0.9%
Police	8.0%
Public Transportation	0.4%
Self-Transport	14.5%
Sheriff	5.8%
Taxi/Rideshare	0.5%
Total Transports (n = 2,795)	**100.0%**

Note: Missing Data: 21 cases

While any person suffering from severe mental illness is vulnerable, minors are especially so. However, the data do not show striking differences in the transportation methods between adults and minors overall (see Tables 14 and 15).[37] Minors were less likely to be transported by law enforcement, which would support wanting to limit any trauma or stigma to this group. In turn, they had a higher percentage of transports via medical vehicle (i.e., ambulances, NEMT, and NEMT-Simple) and family or friends. Nearly all instances of transport by self, public transportation, or taxi/rideshare were done by adults.

Table 14. Transport Method for Adults (18 years and older) to an ERET

Transportation Method	Percent
Agency-Owned Vehicle	4.9%
Ambulance	31.0%
Co-Responder Unit	0.4%
Family/Friend	26.9%
Internal Facility Transfer	0.8%
Nonemergency Medical Transport	5.7%
Nonemergency Medical Transport-Simple	1.7%
Other-institution Owned Vehicle	0.7%
Police	9.0%
Public Transportation	0.5%
Self-Transport	8.6%
Sheriff	9.7%
Taxi/Rideshare	0.2%
Total Transports[1] (n = 5,429)	**100.0%**

Missing Data: 13 cases
1. Excludes one medical flight case

Table 15. Transport Method for Minors to an ERET

Transportation Method	Percent
Agency-Owned Vehicle	4.5%
Ambulance	38.4%
Co-Responder Unit	0.3%
Family/Friend	30.9%
Internal Facility Transfer	0.0%
Nonemergency Medical Transport	6.5%
Nonemergency Medical Transport-Simple	9.9%
Other-institution Owned Vehicle	0.5%
Police	2.9%
Public Transportation[1]	0.1%
Self-Transport	3.1%
Sheriff	2.7%
Taxi/Rideshare[1]	0.1%
Total Transports (n = 1,241)	**99.9%**

Missing Data: 15 cases; Note: Sum is less than 100% due to rounding
1. Only a single case

Beyond driving individuals to an ERET, resources are also required when official personnel must wait with their charges until they are admitted to the facility. The data instrument asked ERET staff to estimate the amount of time the person who transported the individual in crisis is stayed with the patient during the admissions process. By generally knowing the length of time law enforcement or medical transport personnel must wait with a patient, stakeholders can work to increase efficiencies where necessary. Several of the larger emergency departments, such as Grady Memorial and Wellstar Cobb have established protocols to limit the amount of time patients in mental health crisis have to wait before being admitted. As shown in Table 16, these effort to limit wait times can be seen in the data as those who arrived at an ERET waited very little time overall. Nearly 79% waited 15 minutes or less to be admitted while 4.3% waited over two hours.

Table 16. Wait Times for Individuals to be Admitted at ERETs

Time Frame	Percent
Less than 15 minutes	78.6%
15 minutes to 1 hour	13.7%
1 to 2 hours	3.3%
Over 2 hours	4.3%
Total (n = 5,232)	**99.9%**

Note: Missing data: 1,527 cases; Sum is less than 100% due to rounding

Table 17 presents the amount of time patients waited to be admitted by the transport method used to take them to their respective ERETs. Family or friends had to wait the longest of all transport types, representing 83.6% of all cases with over two-hour wait times. Fifteen percent of all family or friends waited two hours or more. Police and Sheriff personnel were reported as waiting 15 minutes or less 87.4% and 84.1% of the time, respectively. In contrast, only three police transports and one sheriff transport waited over two hours. Ambulance transports showed similar wait times to law enforcement with just two waiting over two hours and 84.6% waiting 15 minutes or less. Similarly, 99.7% of NEMT and 99.5% of NEMT-Simple transport waited less than an hour for their charges to be admitted.

Table 17. Wait Times by Method of Transport

Transportation Method	Less than 15 min.	15 min. < 1 hr.	1 hr. < 2hrs.	Over 2 hrs.	Total
Agency-Owned Vehicle	301	22	1	3	327
Ambulance	1447	259	2	2	1710
Co-Responder	26	2	0	0	28
Family/Friend	739	147	152	189	1227
Internal Facility Transfer	11	6	0	0	17
Nonemergency Medical Transport	273	106	1	0	380
Nonemergency Medical Transport-Simple	211	1	0	1	213
Other-institution Owned Vehicle	26	7	1	4	38
Police	401	53	2	3	459
Public Transportation	5	1		1	7
Self-Transport	239	44	7	22	312
Sheriff	433	76	5	1	515
Taxi/Rideshare	9	1	0	0	10
Total (n=5,226)	**4,110**	**719**	**171**	**226**	**5,226**
	78.6%	**13.8%**	**3.3%**	**4.3%**	**100.0%**

Note: Missing data: 1,533 cases

Additional variables were also examined with the wait time data. Minors did not appear to receive special treatment when it came to wait times. Nearly 10% (9.3%) of minors had to wait over two hours to begin the admissions process, while only 3.1% of adults did. Very few people who were transported under a 1013 Order, and thus presumed to be under severe distress, waited over two hours to be admitted (0.8% of all 1013 Orders).

Cost of Transport

As explained in the Methodology Section, the Institute of Government research team estimated the cost to transport patients to an ERET for several of the methods. No estimates of transportation costs for the family/friends and self-transport categories are provided due to the myriad of possible vehicles used to drive a person to an ERET as well as the value of the transporter's time. Additionally, there are no costs associated with internally transporting a person within a facility, so this category also lacks cost estimates.

Costs could only be estimated for cases that included the form of transport, county of trip origin, and ERET. Because each ERET submitted its own data, there were no unknown ERETs.

However, hundreds of cases did not identify the county, leading to an underestimation of the aggregate cost for some of the transportation methods.[38] Over 80% of the missing cases can be attributed to ambulance transport to either Wellstar Atlanta Medical Center or Wellstar Cobb ED.

A key variable in estimating transportation costs is miles travelled from the centerpoint of the county where the transport originated to the ERET. Table 18 presents the miles travelled by transport method. Forty-one percent of transports were less than 15 miles. For Sheriffs, 34.4% of transports were less than 15 miles and an additional 40.3% were between 15 and 50 miles. Police officers had far more shorter trips with 80% of them being less than 15 miles. This is to be expected as police would be less likely to transport patients outside their municipal jurisdiction.[39] For the recorded data, ambulances had the greatest number of transports equaling at least 100 miles (307 or 17.6% of all ambulance transports), including 11 exceeding 300 miles. While NEMT-Simple had far fewer transports than ambulances overall, 49.8% were at least 100 miles.

Table 18. Miles Driven at Admission by Transport Method

Transportation Method	< 15 Miles	15 < 50 Miles	50 < 100 Miles	100 < 150 Miles	150 < 200 Miles	200 < 250 Miles	250 < 300 Miles	> 300 Miles
Agency-Owned Vehicle	259	38	15	8	0	2	0	1
Ambulance	799	448	191	211	42	26	17	11
Co-Responder	24	4	0	0	0	0	0	0
Nonemergency Medical Transport	97	191	68	39	1	0	1	1
Nonemergency Medical Transport-Simple	23	29	53	45	30	21	5	3
Other-institution Owned Vehicle	25	8	9	2	0	0	0	0
Police	390	72	16	7	0	0	0	0
Public Transportation	15	0	0	0	0	0	0	0
Sheriff	201	236	94	41	8	2	0	3
Taxi/Rideshare	9	3	1	0	0	0	0	0
Total (n=3,845)	**1,842**	**1,029**	**447**	**353**	**81**	**51**	**23**	**19**
	41.4%	**26.8%**	**11.6%**	**9.2%**	**2.1%**	**1.3%**	**0.6%**	**0.5%**

Note: Missing Data: 27. Excludes data for Family/Friends and Self-Transport as cost estimates were excluded for these two transportation methods.

Table 19 shows the cost estimates for each form of transport to an ERET. The cost data indicate that reliance on ambulances can lead to high transportation costs relative to the other methods. This method was by far the most expensive in total cost and on an average, per-trip basis. It has the highest median cost as well at nearly $800. This finding is to be expected as ambulance was the most frequently used type of transport in the data and generally considered to be the most expensive. The six ERETs that had the most admissions by ambulance[40] accounted for 70% of all ambulance trips, and all of them were hospitals. NEMT and NEMT-simple were the next-most expensive transport methods in aggregate and on a per-trip basis, yet they were still only about a third of the per-trip cost of an ambulance. Even though NEMT-simple has a fairly low per-mile cost when compared to the other methods of transport, its per trip average was nearly $334 due to approximately half of its trips exceeding 100 miles. Similarly, sheriff transports were more expensive than police transports because the former included several very long trips as shown in the previous table.

Table 19. Estimated Cost of Transportation

Transportation Method	6-week Aggregate Cost	Average Cost per Trip	Median Cost
Agency-Owned Vehicle[1]	$6,979	$21.61	$14.44
Ambulance	$2,074,556	$1,188.86	$799.99
Co-Responder	$529	$18.91	$17.87
Nonemergency Medical Transport	$153,446	$385.54	$336.76
Nonemergency Medical Transport-Simple	$69,749	$333.72	$301.50
Other-institution Owned Vehicle	$933	$21.21	$14.44
Police	$13,644	$28.13	$24.19
Public Transportation	$38	$2.50	$2.50
Sheriff	$26,716	$45.67	$29.66
Taxi/Rideshare	$400	$30.74	$7.86

Note: Missing data: 28 cases
1. Combines cost data for three agency-related forms of transport: agency-owned vehicle, Department of Human Services contracted transport, and employee vehicle
2. Excludes one medical flight as there was only one case

Discharge Data

When patients were discharged from an ERET, staff recorded the following information: the type of ERET facility (BHCC/CSU or hospital), whether the person in crisis at the ERET was under a 1013 Order or not, whether the person admitted to an ERET was an adult (18 years or older) or a minor, county of trip destination, and method of transport. The data on discharges include one additional variable: patient's length of stay at the ERET. This discussion of the discharge data will follow the same format as the admission data.

As shown in Figure 10, 47 of Georgia's 66 ERET units fully or partially completed the discharge data collection instrument over the six-week recording period. Of these, 22 were hospital units[41] and 25 were BHCC/CSU units. Furthermore, 43% of the ERETs are located within the Atlanta metropolitan area and 57% outside the area. This density of ERETs in the Atlanta area reflects the higher demand associated with the state's largest population center. Finally, Table 20 shows that BHCCs/CSUs discharged 34% of all patients in the dataset while hospitals discharged the remaining 66%.

Figure 10. Licensed Participating ERETs – Discharges

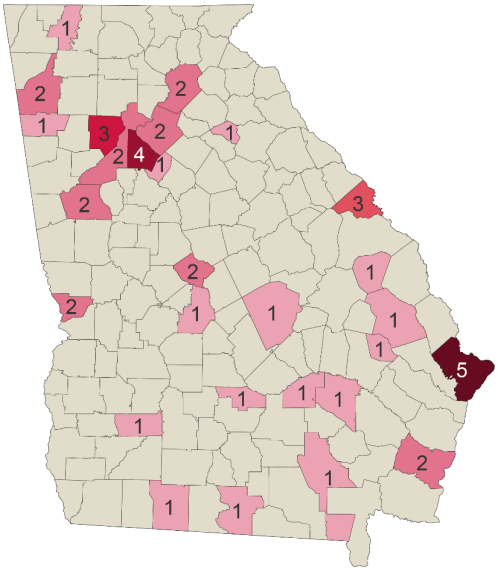


Table 20. Discharges by ERET Facility Type

	Frequency	Percent
BHCC/CSU	2,015	34.0%
Hospital	3,919	66.0%
Total	**5,934**	**100.0%**

Note: Missing data = 0 cases

As with the admissions data, a sizeable range of discharges occurred among the participating ERETs. Grady had the most with 1,077, followed by Wellstar Cobb Emergency Department (638), and Floyd Behavioral Health (382). At the other end of the spectrum, ViewPoint Health's Autism Unit and West Central Georgia Regional Hospital each only recorded three discharges. For ViewPoint, the low number was due to the facility being closed for four of the six weeks during which data were collected while West Central Georgia Regional Hospital's patients have been staying for weeks rather than days as is typical for ERETs. The mean (average) and median discharges were 126 and 80, respectively. The mean is much larger than the median because a few ERETs with large case numbers skew the average upward. Table 21 presents the frequencies for the ERETs with the most and fewest discharges. Several of the ERETs listed in the table also had the most and fewest admissions, respectively. Although the patients counted in the two datasets are unlikely to be exactly the same, having the same ERETs represented in the two tables indicates their relative capacity.

Table 21. ERETs with the Most and Fewest Discharges

ERET	Frequency	Percent of Total Discharges
Most Discharges		
Grady Memorial Hospital	1,077	18.1%
Wellstar Cobb Emergency Department	638	10.8%
Floyd Behavioral Health	382	6.4%
The Bradley Center – St. Francis Emory Healthcare	294	5.0%
Laurelwood Behavioral Health	243	4.1%
Fewest Discharges		
ViewPoint Rockdale Autism	3	0.1%
West Central Georgia Regional Hospital	3	0.1%
Dominy Medical Center Silver Lights	12	0.2%
Evans Memorial Hospital	12	0.2%
Pineland Behavioral Health – John's Place	18	0.3%

Note: Missing data = 0 cases, includes out-of-state discharges

The discharge data instrument included a question on whether patients had a 1013 Order during their stay at the ERET. Table 22 shows that slightly over half the patients had a 1013 Order while at the ERET (55.1%). For those discharged from BHCCs/CSUs, about the same

percentage had a 1013 Order as did not (17.9% versus 17.7% of all ERET patients), while more patients in hospitals had a 1013 Order while staying at this type of facility.

Table 22. Number of 1013 Orders by ERET Facility Type

	1013 Order at Discharge		
	No	**Yes**	**Total**
BHCC/CSU	17.7%	17.9%	35.6%
Hospital	27.2%	37.2%	64.4%
Total	**44.9%**	**55.1%**	**100%**

Note: Missing data: 317 cases

Knowing whether the patients being discharged are adults (18 years older) or minors can help ERETs and policymakers more fully understand potential transportation needs for these two groups. Of all the patients being discharged in the dataset,[42] 82.1% were adults and 17.9% were minors. In comparison, Georgia's statewide population has 76.6% adults and 23.4% minors.[43] Adults and minors were discharged from hospitals and BHCCs/CSUs at approximately the same rate. The fact that far more adults and minors were discharged from hospitals than BHCCs/CSUs reflects the hospitals' higher capacity.

Table 23. Adults and Minors Discharged from Hospitals and BHCCs/CSUs

Adults		**Minors**	
Hospitals	BHCCs/CSUs	Hospitals	BHCCs/CSUs
65.3%	34.7%	69.6%	30.4%

Note: Missing data: 3 cases

The dataset includes the destination counties where patients were discharged, providing a fairly good indicator for where they permanently reside, whether it be at a private residence or an institution. Some patients were likely discharged to longer-term behavioral health facilities as well. Patients were transported to 149 counties across the state, and 32.9% specifically went to counties within the Atlanta metropolitan area.[44] An additional 30 patients travelled out of state at discharge.[45] The county recorded as the most frequent destination for discharged patients was Fulton County, with 20.4%[46] of in-state transports. Similar to the admissions data for transport origination, many counties received just a few patients. The mean and median number of transports to a particular county was 34 and 7, respectively. The difference between these two statistics can be attributed to the large number of transports to a few counties (e.g., Fulton, DeKalb, Muscogee, Chatham), which skewed the average upard.

Table 24 lists the counties as the destination for the most patients when discharged. These 10 counties collectively represent nearly 59% of all the recorded transports in the data. Since most are also the counties with the largest populations, it seems reasonable they should have received the most patients when these patients were discharged from the ERETs.

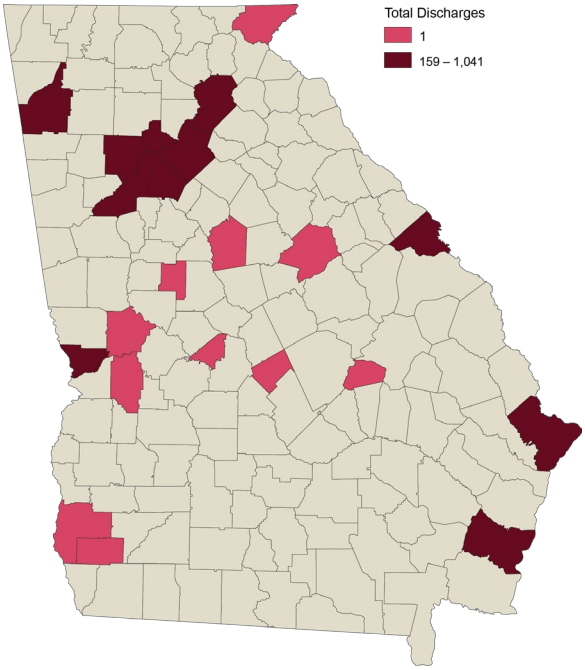
Table 24. Top 10 Counties for Transport Destination after Discharge

County	Trip Frequency	Percent[1]
Fulton	1,041	20.4%
DeKalb	301	5.9%
Muscogee	264	5.2%
Chatham	247	4.8%
Floyd	228	4.5%
Gwinnett	210	4.1%
Cobb	191	3.7%
Hall	184	3.6%
Glynn	171	3.4%
Richmond	159	3.1%

Note: Missing data: 804 cases
1. Excludes transports to destinations out of state

Figure 11 presents the counties recorded as being the destination the most and least times. Ten counties received only one discharged patient during the study period.

Figure 11. Counties Recorded Most and Least as Destinations



In addition to being transported back to their permanent residences, some patients require inpatient care for a longer period of time than typically provided at the crisis centers studied for this report. Thus, the data instrument also asked whether a patient was being discharged to a state psychiatric hospital. Only 4.1% of patients were recorded as such.[47]

As with admissions, knowing the per capita rate of discharges to a county may indicate the relative demand for mental health services for that community. The data show a large spectrum of rates for counties across the state. The low was just 2.9 discharges per 100,000 population[48] in Catoosa County, while the high was in Floyd County at 230.8 per 100,000 population. The mean rate equaled 45.6 discharges per 100,000, and the median rate was 29.4 discharges per 100,000.

Figure 12. Counties as Destinations per 100,000 Population

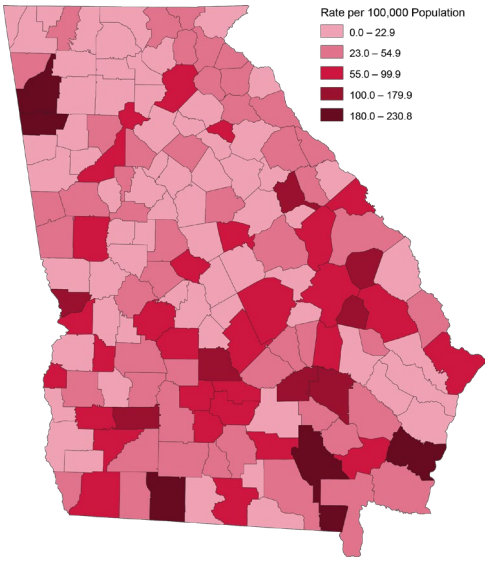


Table 25 lists the 10 counties with the highest per capita rate (per 100,000) for transports at discharge. Those included in the table vary in overall population, ranging from 5,240 in Warren County to 98,771 in Floyd County.

Table 25. Top 10 Counties for Transport Destination per 100,000 Population

County	Total Population	Discharge Rate (per 100,000 pop.)
Floyd	98,771	230.8
Ware	36,033	227.6
Glynn	84,739	201.8
Polk	43,496	193.1
Thomas	45,842	183.2
Jeff Davis	14,872	161.4
Candler	11,037	154.0
Wilcox	8,739	137.3
Dougherty	84,844	134.4
Warren	5,240	133.6

Note: Missing data: 804 cases
Source: US Census Bureau, 2021 population estimates

The data are further differentiated to present discharges for adults and minors in order to discern whether one group has a substantially higher demand for services in certain counties. Knowing this information would allow ERETs and policymakers to ensure the appropriate level of care is available in those areas. Though there were only 1,062 minors in the dataset, they were discharged to 110 different Georgia counties, demonstrating a widespread need for mental health services. Adults were discharged to 144 counties. Table 26 presents the counties recorded most frequently as the destination at discharge for adults and minors. Generally, the counties with the most discharges are also the state's population centers. That said, a few counties had discharges disproportionate to their relative statewide population, having discharge rates that were substantially higher or lower than total population would indicate, such as Fulton County for adults and Richmond and Chatham Counties for minors. For Fulton County, Grady Memorial Hospital appears be to the reason for the high number of adult discharges.

Table 26. Counties Receiving the Most Adult and Minor Discharge Transports

Adult (18 years and older)			Minors		
County	Percent of Transports[1]	Percent of Adult State Pop.[2]	County	Percent of Transports[1]	Percent of State Minor Pop.[2]
Fulton	23.7%	10.2%	DeKalb	7.7%	6.8%
DeKalb	5.5%	7.1%	Richmond	7.2%	1.9%
Muscogee	5.3%	1.9%	Chatham	6.8%	2.4%
Floyd	5.1%	0.9%	Gwinnett	6.6%	10.1%
Chatham	4.3%	2.8%	Fulton	5.6%	8.9%
Cobb	3.6%	7.2%	Hall	4.8%	2.0%
Gwinnett	3.5%	8.6%	Cobb	4.4%	6.9%
Hall	3.3%	1.9%	Muscogee	4.4%	2.0%
Glynn	3.3%	0.8%	Glynn	3.5%	0.7%
Bibb	2.4%	1.4%	Coweta	2.8%	1.4%

Note: Missing data: 708 cases for adults and 95 cases for minors (have designation of adult or minor but no county for that case)
1. Percent of total includes out-of-state transports
2. Equals a county's total population as a percentage of the state's total population
Source: Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP), county as percentage of state population

Figures 13 and 14 present the per capita rate of discharges by county for adults and minors statewide. The counties, as a percentage of the population, that were listed the most as the discharge destination for adults and minors were Floyd and Quitman, respectively, while the counties with the lowest per capita destination rates were Gordon (2.2 per 100,000) for adults

and Rockdale (4.5 per 100,000) for minors. For adults, the mean and median discharge destination rates were 46.9 and 31.7 per 100,000, respectively. For minors, the mean and median destination rates were 56.8 and 42.2 per 100,000.

Figure 13. Adult Discharge Destination Rate

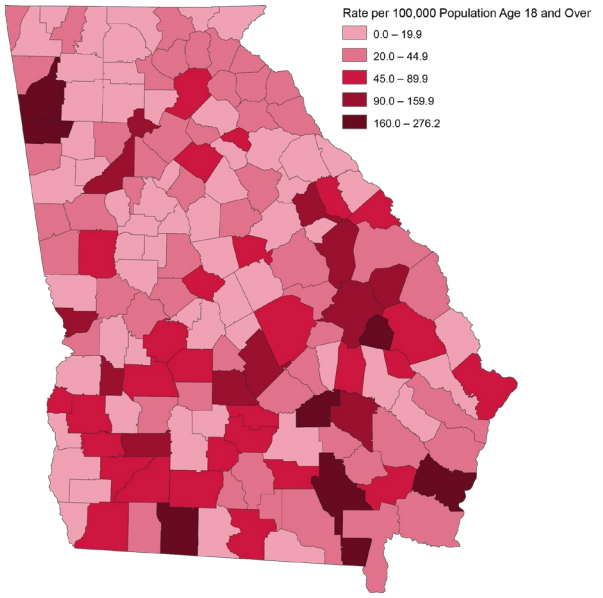
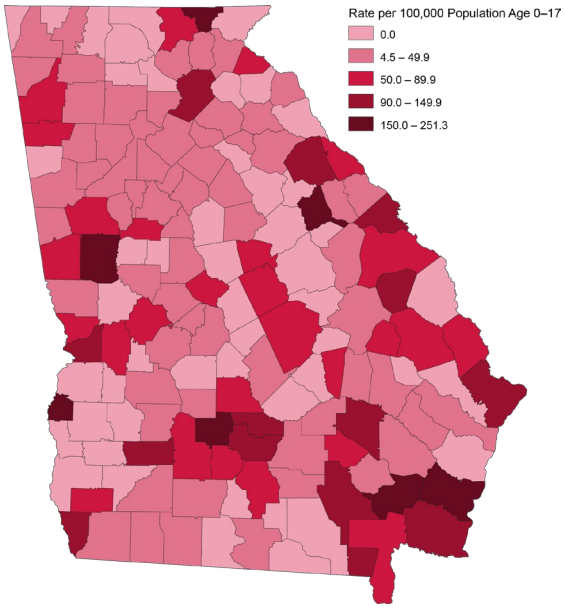


Figure 14. Minor Discharge Destination Rate



Transportation Methods

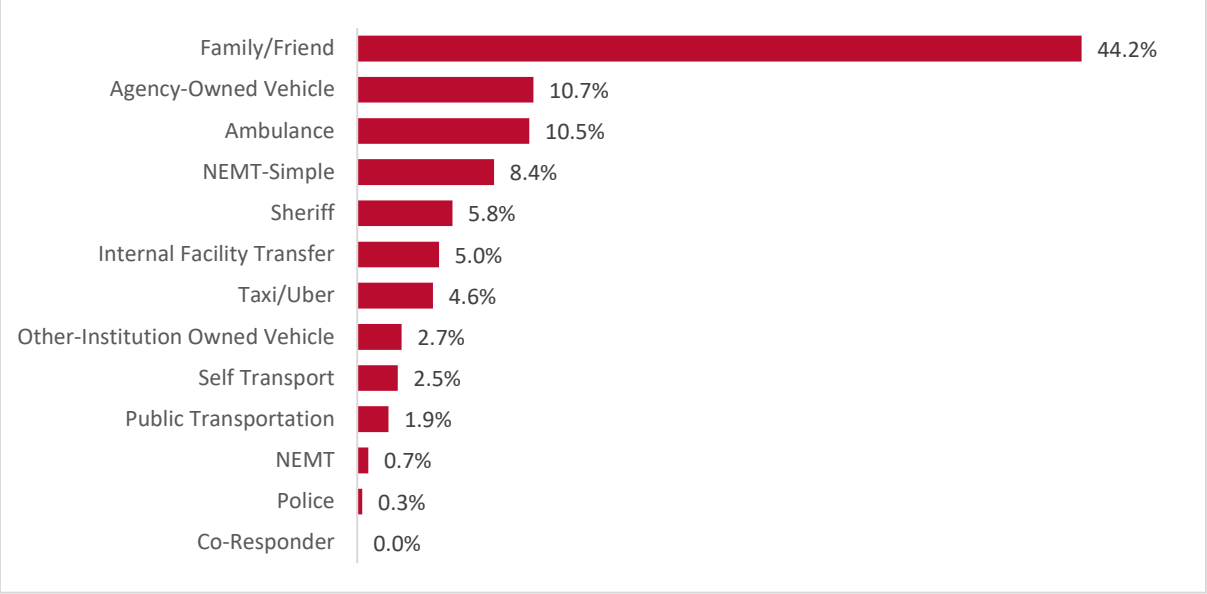
Transportation methods that could be considered "nonemergency" were utilized far more frequently for patients being discharged than emergency-related transportation methods (i.e., ambulance, law enforcement). As the method with the greatest number of transports, family and friends served a critical role in picking up patients when they were discharged from ERETs. The ERETs themselves also took on this responsibility. Five percent of patients were internally transferred, which means that they were discharged from the reporting unit and admitted to another department within the same ERET facility. Table 27 notes that 1,803 cases are missing (30% of total cases) because Grady Memorial Hospital, Wellstar Atlanta Medical Center ED, and Wellstar Cobb ED did not record the method of transport (or only did so a handful of times) for discharged patients. The impact of these omitted data can be seen in the tables that follow.

Table 27. Method of Transport from ERETs

Transportation Method	Frequency	Percent of Total
Family/Friends	1,826	44.2%
Agency-Owned Vehicle[1]	554	13.4%
Ambulance	434	10.5%
Nonemergency Medical Transport-Simple	345	8.4%
Sheriff	240	5.8%
Internal Facility Transfer	206	5.0%
Taxi or Rideshare Service	191	4.6%
Other-institution Owned Vehicle	112	2.7%
Self-Transport	102	2.5%
Public Transportation	79	1.9%
Nonemergency Medical Transport	28	0.7%
Police	13	0.3%
Co-Responder Unit	1	0.0%
Total	**4,131**	**100.0%**

Note: Missing data: 1,803 cases
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Figure 15. Method of Transport from ERETs



Note: Missing data: 1,803 cases

1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Based on reported transports, BHCCs/CSUs had close to the same number of transports at discharge as hospitals (48.6% versus 51.4%). Yet, the two types of ERETs differed substantially in how patients left their respective facilities. Table 28 shows that BHCCs/CSUs were far more likely to utilize agency-owned vehicles, other-institution owned vehicles, and public transportation to transport patients from their facilities. Family and friends transported patients from BHCCs/CSUs in somewhat greater numbers than hospitals.

In contrast, hospitals were far more likely to have patients transported via ambulance, NEMT-simple vehicles, law enforcement, and taxis or rideshare services. Floyd Behavioral Health and Memorial Hospital accounted for 73.8% of all ambulances used. Over half of all recorded sheriff transports (55.4%) were affiliated with Floyd Behavioral Health Hospital as well. Half of all NEMT-simple transports came from Laurelwood Hospital.

Table 28. Transportation Method Used at Discharge from BHCCs/CSUs or Hospitals

	Facility Type				Total
Transportation Method[1]	**BHCCs/CSUs**		**Hospitals**		**Frequency**
Agency-Owned Vehicle[1]	482	87.0%	72	13.0%	554
Ambulance	19	4.4%	415	95.6%	434
Co-Responder Unit	1	100%	0	0%	1
Family/Friend	1,013	55.5%	813	44.5%	1826
Internal Facility Transfer	145	70.4%	61	29.6%	206
Nonemergency Medical Transport	27	96.4%	1	3.6%	28
Nonemergency Medical Transport-Simple	18	5.2%	327	94.8%	345
Other-institution Owned Vehicle	70	62.5%	42	37.5%	112
Police	1	7.7%	12	92.3%	13
Public Transportation	59	74.7%	20	25.4%	79
Self-Transport	60	58.8%	42	41.2%	102
Sheriff	44	18.3%	196	81.7%	240
Taxi/Rideshare	67	35.1%	124	64.9%	191
Total	**2,006**	**48.6%**	**2,125**	**51.4%**	**4,131**

Note: Missing data: 1,803 cases
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Because of the large number of missing transportation cases from ERETs within the Atlanta metropolitan area, Table 29 presents data only for ERETS outside the Atlanta area. These facilities relied mostly on family and friends to transport patients at discharge. The next-most frequently used transportation methods were agency-owned vehicles and ambulances. Overall, the distribution of transportation methods resembles the data for all ERETs.

Table 29. Transportation Method Used at Discharge: ERET Located Outside the Atlanta Metropolitan Area

Transportation Method	Frequency	Percent of Total
Agency-Owned Vehicle[1]	481	14.3%
Ambulance	421	12.5%
Co-Responder Unit	1	0.0%
Family/Friend	1,349	40.1%
Internal Facility Transfer	184	5.5%
Nonemergency Medical Transport	19	0.6%
Nonemergency Medical Transport-Simple	326	9.7%
Other-institution Owned Vehicle	79	2.3%
Police	11	0.3%
Public Transportation	26	0.8%
Self-Transport	99	2.9%
Sheriff	223	6.6%
Taxi/Rideshare	143	4.3%
Total	**3,362**	**99.9%**

Note: Missing data: 1,803 cases; sum is less than 100% due to rounding
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Individuals transported to an ERET under a 1013 Order are not discharged until they are stabilized. Thus, their transportation method at discharge should not differ substantially from patients without a 1013 Order. Table 31 shows discharge transportation method, broken down by whether the patient had a 1013 Order while admitted. Overall, the table shows that this supposition generally holds true except for a couple of categories. The most striking difference is for ambulances, as patients with a 1013 Order were transported by them 14.6% more often than patients who did not have a 1013 Order. Patients without a 1013 Order were also more likely to be transferred to another department within an ERET than patients with one. This

action may be a reflection of non-1013 Order patients first being evaluated at an emergency department and then being admitted to an inpatient behavioral health unit within the same facility.

Table 30. Transportation Method at Discharge for Individuals with and without a 1013 Order

	With 1013 Order		Without 1013 Order	
Transportation Method[1]	**Frequency**	**Percent**	**Frequency**	**Percent**
Agency-Owned Vehicle[1]	289	11.5%	261	16.5%
Ambulance	408	16.2%	25	1.6%
Co-Responder Unit	0	0.0%	1	0.1%
Family/Friend	1,054	41.8%	758	47.9%
Internal Facility Transfer	53	2.1%	147	9.3%
Nonemergency Medical Transport	18	0.7%	10	0.6%
Nonemergency Medical Transport-Simple	230	9.1%	114	7.2%
Other-institution Owned Vehicle	64	2.5%	48	3.0%
Police	7	0.3%	6	0.4%
Public Transportation	14	0.6%	64	4.0%
Self-Transport	55	2.2%[2]	45	2.8%
Sheriff	191	7.6%	48	3.0%
Taxi/Rideshare	136	5.4%	55	3.5%
Total Transports	**2,519**	**100.0%**	**1,582**	**99.9%**

Note: Missing Data: 1,833 Cases; Sum does not equal 100% due to rounding
1. Combines the transport categories: agency-owned vehicle and DHS contracted provider as these are funded by the ERET
2. In 55 cases, people with a 1013 Order while at an ERET left the facility by self-transport. This could be due to these individuals receiving this designation when they were evaluated at the facility.

For discharge-related transportation, adults and minors varied considerably in the methods used (see Table 32).[49] Family and friends overwhelmingly transported minors (69.9%), which makes sense as these patients were likely going home at discharge. For the seven ERETs in our dataset that only served minors (or only submitted data about minors),[50] 82.4% to 100% of their patients were transported by family or friends. Minors also rode in ambulances 16.2% of the time. Yet, they relied very little on law enforcement, public transportation, taxis, or rideshare companies for transport. In contrast, adults used a wide variety of transportation, with family and friends being the most popular but only about half the percentage of minors who were transported by this method (36.0%). Agency-owned vehicles and sheriff's departments were two other important sources of transport for adults.

Table 31. Transport Method for Adults (18 years and older) and Minors (under age 18)

Transportation Method	Adult Percent (n=3,127)	Minor Percent (n=1,002)
Agency-Owned Vehicle[1]	17.1%	1.8%
Ambulance	8.7%	16.2%
Co-Responder Unit	0.0%	0.0%
Family/Friend	36.0%	69.9%
Internal Facility Transfer[2]	6.6%	0.1%
Nonemergency Medical Transport	0.6%	0.9%
Nonemergency Medical Transport-Simple	9.1%	6.1%
Other-institution Owned Vehicle	3.0%	1.6%
Police	0.2%	0.6%
Public Transportation	2.5%	0.0%
Self-Transport[2]	3.2%	0.1%
Sheriff	7.1%	1.7%
Taxi/Rideshare	5.8%	1.0%
Total Transports (n = 4,129)	**99.9%**	**100.0%**

Note: Adult Missing Data: 1,742 cases (known an adult but transport is unknown); Sum does not equal 100% due to rounding
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET
Note: Minor Missing Data: 60 cases (known minor but transport is unknown)
2. Equals a single minor case

Although having data on the length of stay for patients at ERETs does not specifically concern transport, it is critical for ensuring sufficient resources (i.e., beds and staff) for patients after they have been admitted to an ERET. (See Part III of this report for a more in-depth discussion of bed coordination for Georgia's ERETs) Tables 32 and 33 show the length of stay at ERETs for the patients in the sample being discharged. Nearly half (46.4%) of the discharged patients in the sample stayed at an ERET for more than 48 hours. The high percentage of longer visits reflects the exclusion of general hospital emergency departments in the dataset. There would likely be a much higher proportion of short-term stays (i.e., less than 24 hours) if these facilities were included in the analysis.

Table 32. Length of Stay at ERETs

Length of Stay	Frequency	Percent
Less than 3 hours	767	13.0%
3 hours < 6 hours	448	7.6%
6 hours < 12 hours	699	11.9%
12 hours < 24 hours	905	15.3%
24 hours < 48 hours	339	5.7%
Over 48 hours	2,739	46.4%
Total	**5,897**	**99.9%**

Note: Missing data: 37 cases; Sum does not equal 100% due to rounding

Table 33 and Figure 16 further break down length of stay by type of facility. BHCCs/CSUs were far more likely to have patients stay over 48 hours at their facilities than hospitals. BHCC/CSU staff explained to Institute of Government researchers that many of their patients remain at their facilities for an average of five to seven days. It may be that patients are first evaluated at emergency departments and then transferred to BHCC/CSUs for more intensive care.

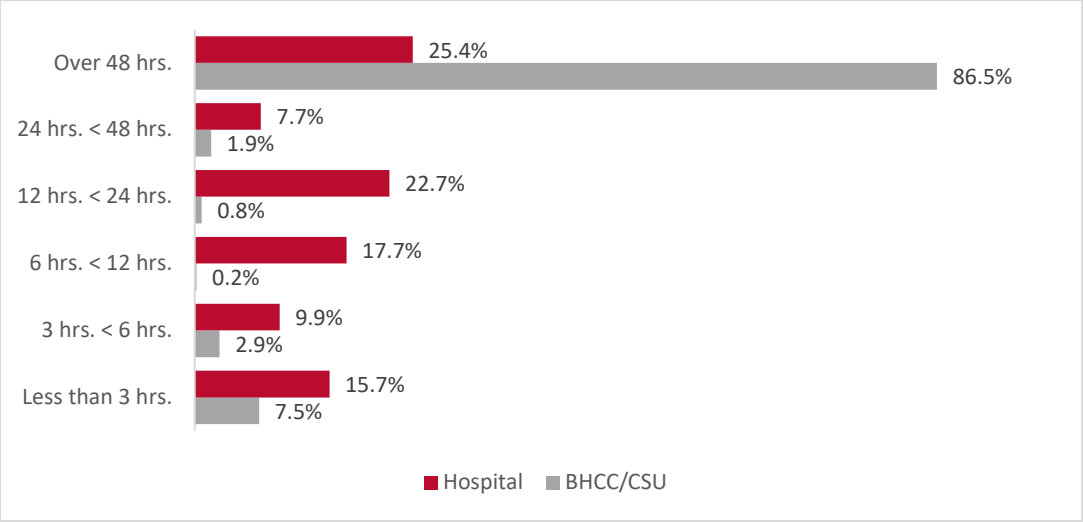
The reported shorter stays for hospitals also demonstrate the goals of emergency departments to quickly evaluate and stabilize patients so they can be discharged from the hospital or transferred to an inpatient behavioral health unit. The hospital data include a subset of emergency departments.[51] Of 2,525 patients helped specifically at ERET hospital emergency departments, only 100 (4.0%) stayed over 48 hours at those facilities. For all hospitals in the sample, 25.4% of patients in the sample stayed over 48 hours.

Table 33. Length of Stay by Type of ERET

	Type of Facility	
Length of Stay	BHCC/CSU	Hospital
Over 48 hours	86.5%	25.4%
24 hours < 48 hours	1.9%	7.7%
12 hours < 24 hours	0.8%	22.7%
6 hours < 12 hours	0.2%	17.7%
3 hours < 6 hours	2.9%	9.9%
Less than 3 hours	7.5%	15.7%
Total	**99.8%**	**99.1%**

Note: Missing data: 37 cases; Sum does not equal 100% due to rounding

Figure 16. Length of Stay by Type of ERET



Note: Missing data: 37 cases

Cost of Transport

The cost estimation for the transportation of patients when discharged followed the same methodology as for admissions. Similar to the admissions dataset, the discharge data have a very large number of missing cases (1,925) related to estimating the cost of transport. Grady (1,077), Wellstar Atlanta Medical Center (119), and Wellstar Cobb ED (590) account for 92.8% of these cases as these facilities did not collect information on the method of transport for all or nearly all their patients when discharged. The cost estimates also exclude out-of-state transports.

The estimated costs to transport patients are a function of the time and/or miles travelled for each transport. As shown in Table 34, over 64 percent of transports were less than 50 miles while 15.0% were at least 100 miles to the county destination. Ambulances had the most transports that were at least 100 miles which equaled 22.7% of all ambulance transports. Agency-owned vehicles had the most transports and 51.1% were under 15 miles. Since agency-transports are paid by the ERETs, to the extent transports are lengthy their costs will rise. This group had 46 trips (8.5%) over 100 miles

Table 34. Miles Driven at Discharge by Transport Method

Transportation Method	Less than 15 Miles	15 < 50 Miles	50 < 100 Miles	100 < 150 Miles	150 < 200 Miles	200 < 250 Miles	250 < 300 Miles	Greater than 300 Miles
Agency-Owned Vehicle[1]	277	142	77	31	6	1	4	4
Ambulance	176	20	134	50	15	20	8	4
Co-Responder	0	1	0	0	0	0	0	0
Nonemergency Medical Transport	3	12	4	11	0	0	0	5
Nonemergency Medical Transport-Simple	102	96	102	29	9	5	1	1
Other-institution Owned Vehicle	49	25	17	16	1	0	0	1
Police	4	2	2	2	2	0	0	0
Public Transportation	52	19	1	3	0	2	0	0
Sheriff	87	84	49	16	2	1	0	1
Taxi/Rideshare	67	50	24	25	14	5	1	1
Total (n=1,975)	**817**	**541**	**410**	**183**	**49**	**34**	**14**	**17**
	41.4%	**22.8%**	**20.8%**	**9.3%**	**2.5%**	**1.7%**	**0.7%**	**0.9%**

Note: Missing data: 1,117 cases. Miles travelled is only to the county destination. Excludes data for Family/Friends and Self-Transport as cost estimates were excluded for these two transportation methods.
1. Combines the transport categories: agency-owned vehicle, DHS contracted provider, and employee vehicle as these are all funded by the ERET

Table 35 shows cost estimates for each type of transportation at discharge. Figure 17 shows the average cost per trip at discharge as well. The average cost per trip is a function of the aggregate cost over the six-week data collection period divided by the number of trips using that form of transport. The most expensive form of transport is an ambulance followed by a nonemergency medical transport vehicle, which costs approximately one-third of an ambulance trip. Like the estimates for admissions, the discharge cost estimates show ambulances as the most expensive in total cost and on an average per-trip basis. NEMT-simple was the second-most costly transport method in aggregate because of utilization and third overall on a per-trip basis. NEMT was over three times more expensive than NEMT-simple on an average per-trip basis. The taxi/rideshare per-trip cost estimate was relatively high due to dozens of trips exceeding 100 of miles each. For all the methods, the extent to which median costs exceed average per-trip cost estimates is due to longer trips, skewing the averages upward. Note that the table does not

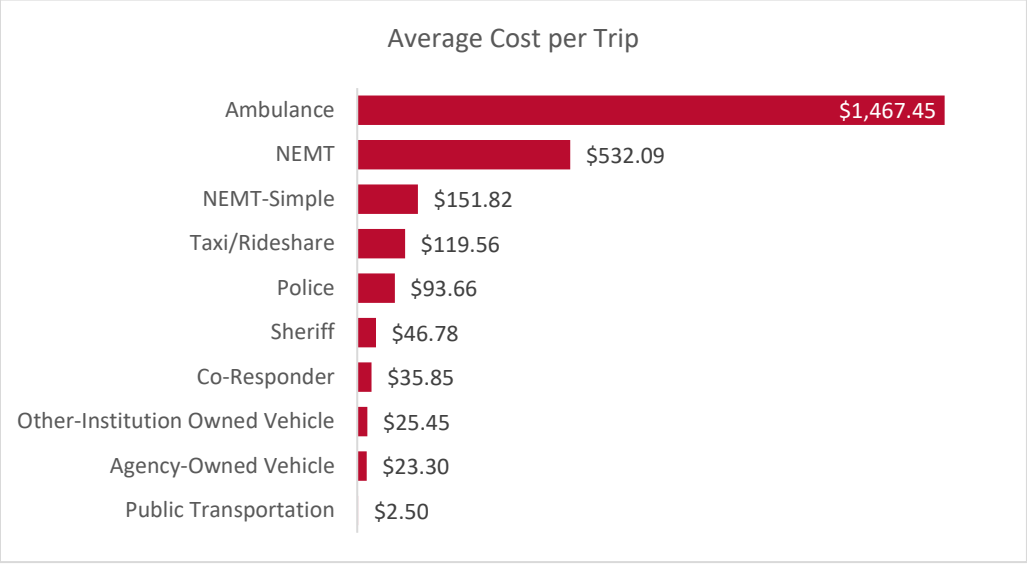
show the cost of transportation borne by family and friends. This group transported at least 44% of all patients in the sample at discharge, so the combined cost would be substantial.

Table 35. Estimated Cost of Transportation at Discharge

Transportation Method	6-week Aggregate Cost	Average Cost per Trip	Median Cost
Agency-Owned Vehicle[1]	$12,630	$23.30	$14.44
Ambulance	$626,600	$1,467.45	$1,267.98
Co-Responder	$36	$35.85	$35.85
Nonemergency Medical Transport	$18,623	$532.09	$563.90
Nonemergency Medical Transport- Simple	$52,379	$151.82	$120.14
Other-institution Owned Vehicle	$2,775	$25.45	$14.44
Police	$1,120	$93.30	$74.89
Public Transportation	$193	$2.50	$2.50
Sheriff	$10,879	$45.33	$26.23
Taxi/Rideshare	$22,357	$119.56	$67.06

Note: Missing data: 1,925 cases
1. Combines cost data for three agency-related forms of transport: agency-owned vehicle, Department of Human Services contracted transport, and employee vehicle.

Figure 17. Average Cost of Transportation at Discharge



Note: Missing data: 1,925 cases
1. Combines cost data for three agency-related forms of transport: agency-owned vehicle, Department of Human Services contracted transport, and employee vehicle.

CONSIDERATIONS

The following considerations for Part I are offered based on the data collected about ERET transports for admissions and discharges and taking into consideration the study's limitations.

1. **Shift ERET transports from ambulance service to other lower cost options**. The sample data collected for this study indicate a high number of transports by ambulance to ERETs which is one of the most expensive transport methods. Consider ways to use other transportation options to lower the cost to the state and other healthcare providers.

2. **Study transports to and from ERFs**. The scope of this study as outlined in HB 1013 focused on the transport of individuals to and from an ERET. A follow-up study that provides a longer data collection period and includes transport to and from ERFs (Hospitals that are not ERETs) would provide a more complete picture of the mental health transportation network.

3. **Collect more data from ERFs about mental health admissions and discharges**.

    a. Gather more information from ERFs on the number of admissions related to mental illness as the sole diagnosis versus co-occurring problems such as substance abuse, physical injury, or physical health problem. Understanding the proportion of cases that present at the emergency department that are solely mental health related will provide needed information on potential opportunities to redirect these cases directly to an ERET.

    b. To more fully understand the flow of persons to and from ERFs, more data is needed about ERF admissions that are mental health related. Knowing how many people stay overnight (24 hours) in the emergency department, how many are admitted to the hospital, how many are discharged to go home from the ERF, and how may are transferred to an ERET would greatly inform future decisions.

4. **Develop ways to collect transportation data through administrative and billing systems and processes.** A custom data collection instrument was used to do this study because the data required was not collected in existing intake or discharge administrative or billing systems.

CONCLUSION

Overall, the admission data indicate that a wide variety of methods were used to transport individuals experiencing a mental health crisis to an ERET. The most common methods were medical, both ambulance and NEMT, and family/friends. The former category was more likely utilized for patients with a 1013 Order and the latter when no such order was not executed.

Ambulances and police departments were more likely to transport those experiencing a mental health crisis to hospitals, whereas agency-owned vehicles, other-institution owned vehicles, and sheriff departments transported more such individuals to BHCCs and CSUs. Family and friends transported their loved ones to both hospitals and BHCCs/CSUs at close to the same rate. Minors were transported more frequently by ambulance and family and friends and less by law enforcement or self-transport than adults. Finally, the data did not reveal a large number of cases with exceedingly long wait times. For 78% of patients in the sample, the wait time was 15 minutes or less. Data collected on miles traveled indicate that the large majority (75%) of trips are less than 49 miles one way with almost half of the reported admissions being a trip of less than 15 miles in distance.

Like the admissions data, the discharge dataset showed that patients travel by many types of transport when leaving a facility. Family and friends provided the most support by far. Agency-owned vehicles were the next most common forms of transportation at discharge. Advanced medical transport, i.e., ambulances and NEMTs, were used somewhat but not extensively. This finding makes intuitive sense as patients would not need the level of support that comes from advanced medical transport when they have been deemed sufficiently stable to leave the facility. Sheriff departments continued to transport patients, but over half were from a single hospital, indicating a special relationship between this hospital and one or more sheriff departments.

Nearly half of the patients in the dataset stayed at an ERET for more than 48 hours. Those that did were far more likely to be at BHCCs/CSUs than hospitals, but this finding is probably due to hospitals serving so many of their patients in emergency departments, which by definition are meant for brief stays. One consideration for a future study would be to include all emergency receiving facilities, not just the licensed ERET facilities. Because this study only focuses on ERETs, our understanding of length of stay is limited.

The cost estimates to transport patients to and from ERETs revealed a wide divergence in aggregate and per-trip costs. Medical transports, including ambulances and NEMT providers, were the most expensive on an average, per-trip basis. The shortage of drivers with appropriate training to transport persons in crisis have increased outlays and could cause additional stress to the ERET system. Other forms of transport, such as agency-owned vehicles and other-institution owned vehicles (both of which are vans or sedans), appear to be a cost-effective alternative when possible.[52] Law enforcement also had lower per-trip costs, but their personnel are very limited, and reliance on this group for transport can cause unintended consequences for public safety. While taxis and rideshare companies are a relatively affordable option for shorter trips, the cost can rise substantially for very long distances, as evidenced by the $120 per-trip average for discharge transport. One challenge elucidated by the data is the need to

find an efficient transportation method when trips are over 100 miles. With the information presented in this report, stakeholders and policy makers can begin to consider optimal transport alternatives that can efficiently and safely assist patients when family members or friends are unable to do so.

A more comprehensive transportation dataset that includes the entirety of ERFs would provide a clearer picture of how all individuals experiencing a mental health crisis are initially transported. Furthermore, having data from all ERFs would shed more light on how many patients are first transported to an ERF for evaluation and then to an ERET for treatment. One option for collecting transport data by facility for 1013 Orders would be to include destination "check boxes" (i.e., BHCC, CSU, ERET hospital, non-ERET hospital) on the peace officer transport report and then have these reports submitted to a central data repository for tracking. Currently, the name of the receiving facility is included on the form, but recording this additional information would be more resource intensive. Of course, this administrative change would still not provide information on non-1013 Order transports.

The strong participation of ERETs in this study allowed for informative data analysis regarding the transport of persons in mental health crisis to an ERET and then from that facility when discharged. However, the limited timeframe for data collection inhibits the research team from extrapolating the results to the entirety of ERET transport across the state. This research should be viewed as providing guidance for a longer-term project that can capture the full breath of transports to and from all types of emergency facilities.

PART II: Multi-State Review of Emergency Mental Health Involuntary Transport

Part II looks broadly at the policies of Georgia and nine additional southeastern states regarding mental health involuntary transportation. It also reviews the innovative programs used by Tennessee and Virginia for transporting individuals experiencing a mental health crisis. In six of the nine states reviewed a law enforcement agency has primary responsibility to transport individuals to a mental health evaluation center, and most also explicitly mandate law enforcement to transport individuals in mental health crisis from an evaluation center to another facility that can treat them for an extended time. Three states (North Carolina, Texas, and Virginia) make provision for non-law enforcement transport under certain conditions. These states generally have oversight requirements in place such as not allowing male officers to transport an unaccompanied female in mental health crisis, but these requirements are varied and inconsistent across states. Although law enforcement officers are mandated to conduct this

transportation, many states do not provide funding for this task. A handful of states fund the transportation through grants or through third-party transportation programs.

METHODOLOGY

This report is based on a review of state statutes and regulations, written reports generated by various governmental agencies, and interviews conducted with officials administering mental health transportation programs. Due to the rapidly developing nature of mental health transportation policy in several states, interviews with administrators of these programs were particularly rich sources of information for this report.

MULTI-STATE SUMMARIES

Alabama

An officer may decide, in conjunction with a mental health officer, to transport an individual "likely to pose a real and present threat of substantial harm to self or others." When this is done, the officer and mental health officer are required to transport the individual together to a designated mental health facility. If upon arrival at the mental health facility, a determination is made by the facility staff that the individual does not require admission, the transporting officer is mandated to deliver the individual to their abode within the county unless the officer has another legal cause to detain the individual.[53]

Alabama law states that no county shall bear the cost of mental health transportation. Instead, this cost is to be paid from the state general fund if the transported individual is indigent or from the transported individual if they are not indigent.[54]

Arkansas

Arkansas mandates that if an individual is a danger to them self or others, including for mental health reasons, the law enforcement agency exercising jurisdiction over the physical location of the individual will transport the individual to an evaluation facility.[55]

In 2019, the Arkansas General Assembly created a task force to analyze the issue of mental health transportation across the state.[56] This task force conducted in-depth analysis of the situation in Arkansas to identify potential issues with future mental health transportation plans and to make recommendations. This task force identified issues such as custody, liability, and the creation of a statewide mental health resource map.[57] Despite the mandate to transport individuals in mental health crises and the creation of this task force, the State of Arkansas has not funded transportation at a state level for individuals in mental health crises.

Florida

Each county is required to designate a single law enforcement agency to transport individuals for involuntary examination by authorized professionals. Law enforcement officers can only decline to transport individuals under the following circumstances: (1) the county has contracted with a private transport service to fulfill this need, and (2) the law enforcement agency and private transport service both agree that a law enforcement officer is not necessary for safety reasons.[58]

Although law enforcement officers are mandated to transport individuals or to secure alternative transportation, funding for such transport is to be sought from the transported individual. The county is mandated to seek reimbursement from the following sources in the following order: (1) a private or public third-party source if the person receiving transportation has applicable coverage, (2) from the person receiving transportation, or (3) from a financial settlement accruing to the transported individual. No state funding is provided.[59]

Georgia

In Georgia, a physician may execute a certificate known as a Form 1013 stating that he or she has personally examined a person within the preceding 48 hours and found that, based upon observations set forth in the certificate, such person appears to be a mentally ill person requiring involuntary treatment. In such instances, a peace officer must make diligent efforts to take a person into custody and transport them to the nearest ERF for an emergency evaluation. (O.C.G.A. 37-3-41(a).) A county court can also issue an order commanding a peace officer to take such person into custody and deliver them for examination at the nearest ERF within the county in which they are found. (O.C.G.A. 37-3-41(b).) Any officer who takes a person into custody and delivers them for examination pursuant to a physician's certificate or a court order must execute a written report detailing the circumstances under which such person was taken into custody. The report and either the physician's certificate or court order authorizing such taking into custody becomes part of the patient's clinical record. (O.C.G.A. 37-3-41(c).)

Georgia law also gives a peace officer decision-making authority to initiate the transport of a person if certain criteria are met. In cases where the person is committing a penal offense, the officer may decide to transport the person to an ERF if there is probable cause the person is mentally ill requiring involuntary treatment. (OCGA 37-3-42 (a)(1)). The peace officer need not formally tender charges against the individual prior to taking the individual to a physician or an ERF, and must execute a written report detailing the circumstances under which the person was taken into custody that then becomes part of the patient's clinical record. Absent the commission of a penal offense, a peace officer may decide to transport a person if: (1) there is probable cause that the person is mentally ill requiring involuntary treatment; and (2) the peace

officer has consulted in-person or via telephone or telehealth with a physician who then authorizes such transport by issuing a Form 1013. (O.C.G.A. 37-3-42(a)(2).)

The governing authority of the county where the person is found or located is responsible for arranging the initial emergency transport of an individual, giving sheriff departments the ultimate responsibility for transporting persons deemed as needing immediate mental health assistance to an ERF. (O.C.G.A. 37-3-101(a).) In cases involving initial transports initiating by a peace officer, the ERF is responsible for coordinating all subsequent transports with the law enforcement agency employing such peace officer or a qualified private nonemergency transport provider or ambulance service. (O.C.G.A. 37-3-101(b).)

Mississippi

The sheriff is mandated to transport individuals in mental health crisis and against whom there is a writ to take them into custody for treatment.[60]

When a sheriff transports an individual to a mental health facility, the sheriff is entitled to expenses for commitment and transportation.[61] Mississippi law regulating these expenses states that "the county where a person in need of treatment is found is authorized to charge the county of the person's residence for the costs incurred while the person is confined in the county where such person was found."[62]

North Carolina

Each county or city is required to determine who is mandated to transport individuals in mental health crises. The city has a duty to arrange transportation for its residents and those taken into custody in the city limits. The county has the duty to arrange transportation for residents outside of the city limits. The cities and counties may determine individually who will transport individuals. They may "designate law enforcement officers, volunteers, or other public or private personnel" to do the transport.[63]

To the extent that costs of transport are not reimbursed by a third-party insurer, costs of transportation are the responsibility of the county of residence of the individual being transported. This county may seek to recover these costs from (1) the transported individual, (2) any entity liable for the transported individual's support, (3) anybody contractually responsible for the cost, or (4) any entity otherwise liable under any law.[64]

South Carolina

For an emergency admission due to a mental health crisis that requires transportation, a licensed physician must write a certification stating the reason for such admission and authorize

a state or local law enforcement officer to conduct such transportation. The officer would preferably be in civilian clothes and have crisis intervention training. [65]

Transportation of individuals in mental health crisis in South Carolina is unfunded. A bill to amend this failed in the South Carolina House of Representatives in 2019. It would have created a Therapeutic Transport Fund.[66]

Texas

Texas prioritizes the party responsible for mental health transport in the following order: (1) special officers for mental health under Section 1701.404 Occupations Code, (2) a facility administrator of the designated mental health facility, (3) a representative of the local mental health authority, (4) a qualified transportation service under Section 574.0455, (5) a sheriff or constable, and (6) a relative or other interested and responsible party.[67]

Although the mandate for transportation is unfunded, Texas does designate that the county in which the mental health transportation procedures are initiated is responsible for the costs of transportation. The county is entitled to reimbursement from the transported individual or their estate. However, if transport is conducted by another party, the county must reimburse the transporting agency up to $50 for transporting within the same county and reasonable costs for transporting outside of the county.[68]

CASE STUDIES

While many states have an unfunded transportation mandate, several states have sought alternative ways to provide mental health transportation in recent years. Tennessee and Virginia have both recently initiated programs to improve mental health transportation. Tennessee has implemented a grant program that allows sheriffs, mandated to conduct mental health transport, to apply for grant funding that can defray their own transportation costs or to hire secondary transport agents.[69] Virginia has taken a different approach to the same problem by contracting with a third-party transport company to create a statewide system of non-law enforcement transport agents that aims to conduct a percentage of all mental health transports.[70] Both plans are designed to accomplish the dual goals of alleviating burdens on law enforcement officers and providing better care for individuals in mental health crises.

Tennessee

Introduction and Background

As of July 2021, Tennessee has an estimated population of 6,975,218.[71] Although the current population requiring mental health support is dispersed throughout the state, Tennessee expects that in the coming decades, the majority of population growth will occur in the geographic region of Nashville and surrounding communities, thereby condensing the need for

services.[72] Against this backdrop of expected growth in the urban center of Tennessee, at the end of the state legislative session in 2019, a Republican-controlled House, Senate, and governorship amended the Tennessee code[73] to create a grant system that would provide funding for mental health transportation.[74]

Historically, as is the case in most states, Tennessee has mandated sheriffs to transport "people with mental illness who are determined to be a danger to themselves and in need of physical restraint or vehicular security."[75] This mandate persists under the new grant system, but Tennessee now also permits sheriffs to designate a secondary transport agent to conduct such transportation if these agents meet various requirements.[76]

Under this grant system, Tennessee sheriffs remain mandated to transport individuals in mental health crisis to be evaluated by a physician.[77] The grant system sets transportation requirements and a funding mechanism for sheriff departments to be reimbursed for the cost of transportation. Sheriffs must remain at the evaluation facility for 1 hour and 45 minutes or until the evaluation is complete.[78] Once this timeframe expires, the evaluating facility bears the burden of custody and further transportation of the patient.[79] However, if during this timeframe the patient is determined to need continued treatment but does not require physical or vehicular restraint, sheriffs may designate a secondary transportation agent to transport the patient from the evaluation facility to a longer-term care facility. If a physician determines during this timeframe that a patient requires physical or vehicular restraints, then the duty of transporting the patient remains with the sheriff. In both cases, the evaluating physician must provide the transporter with a certificate of need before the patient is transported to a hospital or treatment resource.

This grant system terms allow sheriffs to either contract with a secondary transportation agent or to fund their own officers to conduct these mandated transports to an evaluation facility and then to a treatment facility. This system aims to allow non-law enforcement officers to conduct transports when it is safe to do so.[80] Currently, sheriffs in 44 of Tennessee's 95 counties have chosen to participate in the grant program.[81]

Initial Implementation and Goals

In 2019, the legislature amended current law to create a grant that provides funding for sheriff departments, or their designated transportation agents, to transport persons in mental health crisis to "a hospital or treatment resource for emergency mental health" treatment.[82] The creation of this grant was completed through substantial input from multiple stakeholders, including the Tennessee Department of Finance and Administration, the Tennessee Department of Mental Health and Substance Abuse Services, Tennessee's Medicaid program, the Tennessee Sheriffs' Association, and the Tennessee Hospital Association.[83] Together, these stakeholders

contributed their input, resulting in the legislature allocating substantial funds to support the direct expenditures by sheriff departments or for these agencies to contract with transportation agents. Because sheriff departments are allowed to contract out transportation, the expectation is that they can partially relieve sheriffs of the burden of mental health transports while better serving patients.[84]

This grant functions as an annual appropriation awarded to sheriffs' offices determined by the total number of mental health crisis transportations conducted by each department in the prior fiscal year.[85] There is base award of $25,000 for any sheriff that opts to participate in the grant program and meets its requirements. In addition to the base award, there is a variable award which is calculated by totaling the number of transports throughout the state in the prior year and dividing that number by the total available funding to determine a per transport value. The state awards grants to each participating sheriff department based upon that department's total transports in the prior year (base award plus variable award).[86] Transports may occur directly, i.e., with personnel from the sheriff's office, or through a private transport company contracted by the sheriff's office (referred to as a secondary transport agency (STA)). Funding has remained constant at $4 million for each of the program's three years of operation.

Requirements

To access to this grant, a participating sheriff department must meet several requirements aimed primarily toward accountability of grant recipients and protection of the individuals being transported. The requirements apply whether the sheriff directly transports persons in crisis or through a contracted STA. These requirements include:

- fingerprinting requirements for sheriffs,
- usage of the Tennessee Incident Based Reporting System,
- National Instant Criminal Background Check System compliance,
- compliance with the Death in Custody Reporting Act,
- mandatory reporting of child abuse and adult abuse,
- CODIS (Combined DNA Index System) and DNA requirements, and
- use of force training.[87]

Further, the grant requires agencies to use unmarked vehicles for transports, wear "class B" uniforms, submit quarterly and annual reports, commit to mental health awareness training for officers, ensure proper training for secondary transport agents, and enact a humane transport policy.[88] This policy must essentially ensure that the transportation of patients "does not criminalize, stigmatize, nor re-traumatize those in need of care while ensuring the safety and security of all involved in the transport process."[89] Jeremiah Morton, assistant director of the

Tennessee Department of Finance and Administration, indicated that grant compliance is not particularly burdensome for sheriffs' departments.[90]

After a sheriff's department meets these requirements, it can solicit the state government for funding based on its prior transports.[91]

Evolution of the Grant

During the program's first two years of operation, it was described as an "endowment model," whereby sheriff's departments received an advance payment of funds for the coming year and would return unspent funds to the state at the end of the fiscal year.[92] This model required sheriffs to track budgetary spending for transportation, and it raised issues such as when a department could use grant money to purchase a new vehicle that would be used for both mental health transportation and other daily uses.

Following feedback from sheriff's departments, the grant program was altered to an "appropriation model" that did not require detailed budget information, and unspent funds from one year are nominally retained by the sheriff departments. Under this appropriation model, any monitoring of this grant is also conducted under the standard comptroller audit rather than an independent audit.[93] Specifically, grantees are required to track a few key data points that can be used to verify their reported transportation numbers. These data points include agency transport ID, the county conducting the transportation, date of transportation, transportation starting point, and transportation end point. These data points will permit the comptroller of the treasury in Tennessee to verify reported transportation numbers against other records in case of an audit of any sheriff's department utilizing this grant. The effect of these changes has been to streamline the grant administrative process and minimize the burden on law enforcement officials.

In the first two years of the program, all funds awarded to sheriff departments were based on a variable rate directly related to the number of transports in the past year.[94] During this time, some smaller sheriff's departments were awarded only a few thousand dollars yet still had to take many steps to be in compliance with the grant's requirements. Consequently, many smaller localities chose to not apply for the grant.[95] However, beginning in the program's third year, FY 2022, Tennessee implemented a minimum amount of funding ($25,000) per sheriff's department that was guaranteed to every department that successfully completed their request and complied with the requirements.[96] The new minimum award was partly in response to smaller departments reporting that because they only performed a dozen or fewer transports per year, it was not worth the compliance efforts to receive a few thousand dollars.[97] Once the $25,000 minimum funding was implemented, the number of participating counties jumped from 33 departments to 44 departments (approximately 46% of all counties).[98]

The program has also seen a gradual shift away from sheriff's departments directly performing transport toward more departments paying for STAs.[99] In FY 2023, of the 44 participating departments, 11 used grant money to pay Amerimed, an STA, to conduct these transports, and several other departments used other independent STAs.[100]

Further, the grant has spurred cooperation between large sheriff departments such as Madison County (population 98,775) and surrounding, smaller departments such as Haywood (population 17,694), Crockett (population 13,979), and Hardeman (population 25,426) counties. Madison County serves as a pseudo-regional operational center and conducts transportation for its smaller neighbors, primarily from the smaller county medical evaluation centers to a medical treatment center in Madison County.[101] In return, Madison County receives the grant money that would otherwise be directed to these smaller counties. Madison County applies for this money and receives it directly, which saves smaller localities both the burden of transportation and the burden of administering this grant.

Lessons Learned

Stakeholders have found this grant program to be moderately successful in part because it has evolved to better suit the needs of those involved. Sheriff departments were initially skeptical of the low amount of funding provided to some departments and were worried about excessive oversight for relatively few dollars. However, the addition of the $25,000 funding floor has alleviated some of these concerns. Further, under the appropriation model, the administration of this program has been streamlined so that sheriff offices must only collect minimal data, such as the total number of transports, to receive funding in the following year.[102] Under this model, quarterly reporting is not required nor is a detailed budgetary report on the precise spending of the grant, but it is still subject to the standard comptroller audit as oversight.[103]

Mental health advocates are also pleased with the results of this program, as it emphasizes that individuals are being transported as "patients not prisoners." The requirement to develop a humane transportation policy is concrete evidence of this idea in practice.[104]

This program is noteworthy in that it took three years to develop a solution that seems to meet the needs of all parties. The key feature that allowed this program to satisfy all stakeholders was its administrative flexibility, which permitted it to evolve based on input from those involved.

Virginia

Introduction and Background

Virginia has a population of approximately 8,631,393, with much of its 42,775 square miles remaining rural and sparsely populated.[105] The population of Virginia has steadily grown over

the last century, primarily in the narrow corridor starting south of Washington, DC down through Arlington, Richmond, Newport News, Hampton, Norfolk, Virginia Beach, and Portsmouth.[106]

In this context of population growth that is spread across a relatively large area, Virginia, like many states, has historically relied on sheriffs to transport individuals experiencing mental health crises. After an individual has been evaluated at a mental health evaluation center and determined to meet the criteria to have a temporary detention order (TDO), sheriffs have been tasked with transporting these individuals from the evaluation center to a treatment facility. Evaluation centers only permit patients to stay for a few hours, but treatment facilities are designed around extended care. Consequently, transportation of patients to treatment facilities is critical for many individuals in mental health crises.

Between July 2020 and June 2021, Virginia conducted approximately 17,788 mental health transports.[107] During this time period, the average roundtrip mileage for these transports exceeded 120 miles in every region of the state and reached as high as 233 miles in some regions.[108]

Two features of Virginia combined to make this process particularly burdensome on sheriffs. First, Virginia has a "bed of last resort" law that mandates that a bed must be found for an individual who has been issued a TDO.[109] Second, Virginia's geographically large size means that often the closest available bed is hours away from an evaluation facility. This process ultimately meant that sheriffs across the state were putting individuals in the midst of mental health crises into the back of standard patrol cars and transporting them for multiple hours across the state to deliver them to an available bed.

Initial Implementation and Goals[110]

Numerous stakeholders, including sheriff's departments, magistrates, mental health community service boards, the Virginia Department of Behavioral Health & Developmental Services, the National Alliance on Mental Illness Virginia, and private hospitals agreed in 2018 that a new system for mental health transportation was needed in Virginia. Together, these stakeholders determined that an alternative transportation plan could satisfy the dual goals of providing better service to patients while also relieving law enforcement officers of transportation responsibilities. The stakeholders ultimately decided to have a third-party vendor provide transport of individuals in crisis when appropriate (i.e., the person was nonviolent). If the patient was not a suitable candidate, a sheriff's department would transport the patient.

This plan was initially piloted in 2018 through a small program in Whitfield, Virginia, through a contract with the company Steadfast. The central idea of this plan was that many individuals who need transportation from an evaluation facility to a bed could be served by nonemergency medical transport (NEMT) if the individual meets certain criteria, such as being nonviolent. This program determined that approximately 41% of individuals who need transportation could be serviced by an alternative transportation agent.

Following this successful pilot program, in October 2019, the State of Virginia signed a contract with G4S Solutions, a third-party NEMT, to roll out a similar program across the entire state. G4S was chosen as it had experience conducting similar transportation operations throughout North Carolina. The contract began in June 2020, and it is still ongoing. G4S was acquired by Allied Universal, but the relationship between the alternative transportation provider and the sheriff departments remains essentially unchanged.

Plan Details

This plan is best described as funding a series of eight interconnected operation centers staffed by NEMT agents (i.e., drivers) of Allied.[111] Allied provides agents who are capable of transporting nonviolent individuals in mental health crises after they have been evaluated at an appropriate evaluation facility.[112] This transportation is done in specialized vehicles provided by Allied and no restraints are used on the patients.[113]

Allied is held to several quantitative standards as well as multiple requirements for each of its alternative transport agents. Allied must have alternative transport agents on-call at all times of the day, every day of the year.[114] Also, upon being called to conduct a transport, an agent must arrive within two hours of receiving the call at least 90% of the time.[115] By contract, Allied is required to have its agents satisfy the following requirements:

- Background checks
- Drug screening
- Excellent driving record
- CPR certification
- First aid certification
- Knowledge of CPI and de-escalation techniques
- Mental health first aid training
- Understanding of the civil commitment laws
- Knowledge of human rights regulations
- Understanding of Health Insurance Portability and Accountability Act[116]

The Virginia Department of Behavioral Health and Developmental Services, the agency that administers this program, has also partnered with Allied to provide special training for transport agents to manage individuals with intellectual and developmental disabilities.[117]

At the program's inception, the legislature appropriated approximately $4.5 million annually for regular operations based on data gathered from the pilot program and extrapolated statewide as well as input from vendors.[118] However, this funding was roundly agreed to be insufficient to adequately staff the necessary positions and conduct the desired transports. During the 2022 legislative session, this program was appropriated additional funding for the following two years at $6,429,216 annually.[119]

Challenges and Adaptations

Virginia has faced multiple challenges throughout the implementation of its alternative transportation plan but has taken steps to remedy them. First, like many other medical transport companies, the provider, Allied, has faced staffing shortages for many of its transportation positions.[120] These shortages are compounded by the need for Allied to have staff ready to respond across the state 24 hours per day, 365 days per year. One possibility currently under consideration to resolve this issue is to change the total amount of time Allied must staff its locations from three, eight-hour shifts to two, eight-hour shifts.[121]

Further, this plan inherently requires a nongovernmental agent to take custody of an individual in a mental health crisis. This process was not codified into law at the program's initiation and had to be codified under Va. Code Ann. § 37.2-810. This statute authorizes sheriffs to transfer custody to alternative transport agents when a transportation order from a magistrate orders an alternative transport agent.[122] An accompanying provision was also codified that created a contingency for the situation in which an alternative transport agent is unable to continue with a transport. In this situation, the sheriff of the county where the alternative transport agent is located is mandated to complete the transport.[123]

An additional challenge in implementation has been the liability for the alternative transportation agents. Allied, as the sole alternative transportation company, was concerned with the liability its employees would face.[124] In response, Virginia amended Va. Code Ann. § 37.2-810(G) to give alternative transport agents immunity for "ordinary negligence or omissions" resulting from providing alternative transportation.[125]

Finally, the initial goal for the alternative transport agents to eventually conduct 50% of all transports has remained a distant hope. From July 2020 to June 2021, the highest monthly percentage of transportation by alternative transport agents was 15.84%, and the median utilization rate was approximately 10%.[126]

For the near future, there is no plan to discontinue this program, and low utilization remains the primary challenge to be solved. Two possible avenues are being considered. One option is to reorganize the program into regional systems rather than the current, statewide system.[127] The second option is to increase the amount of restraint that alternate transport agents can use, along with the kinds of patients they are permitted to transport.[128]

Lessons Learned

A thorough evaluation of the statutory implications this program would have prior to its adoption was clearly needed. Custody laws and liability laws are two major issues that must be addressed with a plan that uses third-party agents to transport individuals. Further, this program was not motivated by cost savings or designed to save money. Rather, this plan aimed to both relieve law enforcement officers of extra workload while simultaneously providing better care for patients. Until utilization rates substantially increase, these objectives will remain unmet.

CONSIDERATIONS

The following consideration is based on the information collected for Part II of the report on policies of nine southeastern states regarding mental health transportation.

Review transportation programs from other states. Learn from other state programs to develop policy options for Georgia on ways to fund the transport of mentally ill persons in crisis. The report provides a scan of how other states in the southeastern United States address the transport of individuals with mental illness. A deeper analysis of the grant program in Tennessee may be helpful in developing policy options for Georgia as it complements our state's diverse population, service needs, and large number of counties.

CONCLUSION

Part II of this report scans mental health involuntary transportation policies of nine southeastern states. In six of the nine states, a law enforcement agency has primary responsibility for transporting individuals to a mental health evaluation center and if needed, a treatment center. Three states (North Carolina, Texas, and Virginia) also make provision for non-law enforcement transport under certain conditions. In most of the states studied, the local government or individual is responsible for paying the transportation costs. State's like South Carolina and Tennessee have guidelines or incentives to encourage officers doing transports to wear civilian clothes or class B uniforms and have crisis intervention training. Case studies on innovative programs in Tennessee and Virginia highlight two different approaches states have taken to try and address the cost and burden of transporting persons with mental illness who are in crisis.

Tennessee offers a grant program to fund sheriff departments that perform transports if certain rules and reporting requirements are met. A floor of $25,000 in funding per grant increased participation and some counties developed collaborative agreements to meet their transportation demands. Mental health advocates in Tennessee like that the program emphasizes that individuals are being transported as "patients not prisoners."

Virginia developed a strategy to relieve law enforcement officers of some of their transportation responsibilities and shift transports to nonemergency medical transport (NEMT). Virginia funded a contract with a transportation partner to develop a statewide network to drive non-violent patients from evaluation facilities to treatment facilities. The utilization of the NEMT service has been much lower than expected due to workforce challenges and concerns about driver liability and legal questions about custody as well as a limited ability to restrain patients during transport.

PART III: Bed Coordination with State-Funded ERETs in Georgia

Ensuring the appropriate number of inpatient beds are available at any given time for people experiencing a mental health crisis is the essence of bed coordination. However, achieving this goal is far more challenging than it first appears. Part III of this report briefly examines Georgia's process to efficiently match ERETs with available beds to patients waiting for one. This research focuses on bed coordination for state-funded inpatient treatment. The analysis finds that (1), the expanding demand for mental health services, combined with the current labor environment, has made the process more difficult; (2) coordination requires multiple stakeholders working together; and (3) improvements are possible over the long term with increased communication and data evaluation and the continued strategic expansion of ERET facilities.

This section first provides a brief overview of the bed coordination process in Georgia and then reflects on a few of the challenges in managing it. The final part of this review offers options to address or at least lessen these challenges over the long term. The information collected for this study came from interviews with mental health treatment coordination stakeholders[129] and documents and presentations from the Georgia Department of Behavioral Health and Developmental Disabilities as well as national and state mental health service organizations.

BACKGROUND

The Georgia Department of Behavioral Health and Development Disabilities (DBHDD) is the state's administrator for behavioral health service delivery and regulation. For managing mental health crisis services, a core component of DBHDD's continuum of care is the Georgia Crisis Access Line (GCAL),[130] which now also takes calls through the 9-8-8 hotline, which is

available 24/7. GCAL serves as a central point of access to care. An individual in crisis can call, text, or chat GCAL to receive support and outpatient referrals if needed. Callers may be referred to an outpatient treatment provider. However, if they need an immediate and more intensive level of care, a GCAL employee will coordinate with emergency services (e.g., 911) for active rescue or can send a mobile crisis unit to assist the individual with on-site crisis management. Only if these other responses cannot stabilize the individual are they transported to an ERET for inpatient treatment. Employees at GCAL triage each call to identify the most appropriate level of care for the caller.

In addition to being a crisis contact, GCAL manages the "bed registry," which lists all the available beds by state funded ERET. The registry allows GCAL staff to see which ERETs have available beds at any given time. The bed registry is updated regularly as ERETs must contact GCAL to receive authorization for services from DBHDD when they admit an individual for inpatient treatment. Consequently, GCAL knows when a bed has become occupied. A variety of stakeholders or "transporters" can call GCAL for information about bed availability. The GCAL system collects large volumes of information about crisis services, such as the number of crisis calls received, response times to answer calls, the use of mobile crisis units, calls regarding the bed registry, bed capacity, and bed occupancy rates.

The bed registry is integrated with the ERET "bed board." The bed board provides patient referral information to ERETs and hospitals. From the bed board, ERETs can see where patients who have been evaluated are waiting for inpatient ERET services such as at a particular hospital. Outside access to the bed board is limited to groups holding people in need of inpatient treatment, i.e., hospitals and jails. When an ERET that is located close to a patient has a bed opening, it will accept the waiting patient. GCAL has no authority to mandate ERETs to accept patients, but it does have data showing ERET capacity through the bed board.

This analysis focuses on DBHDD-managed and -funded ERET facilities, which include behavioral health crisis centers (BHCCs), crisis stabilization units (CSUs), and state hospitals (see Methodology in Part I for definitions of these facilities). DBHDD also funds a limited number of beds through contracts with private facilities. These DBHDD-funded ERETs focus on serving people who lack their own payer source. Individuals with private insurance that come to a BHCC will be transferred to a private behavioral health hospital for treatment. To increase diversion from inpatient services and thus better manage bed availability, DBHDD is converting CSUs to BHCCs as the latter also offer outpatient treatment services and brief intervention services (i.e., temporary observation) as state fiscal resources permit.

The ERETs must follow federal and state regulations for treating patients in addition to the protocols set forth by DBHDD. These protocols not only focus on patient safety but also manage

bed capacity. For example, BHCCs may limit the number of patients they accept who are waiting at an emergency department in order to ensure space is available for persons who walk into their facility. This is important because individuals waiting at a hospital or jail are safe, and a BHCC wants to avoid turning away a person who arrives at the facility due to limited capacity. CSUs do not have to leave beds unfilled as all their patients arrive as a result of a referral. Multiple days may be required to appropriately stabilize a patient before they can be discharged. For example, a patient who is suicidal may need to stay at an ERET for five to seven days before being discharged.

Bed Capacity

Table 36 shows bed capacity at state-funded ERETs by type as of October 5, 2022. At that time, Georgia had a total of 1,553 beds at state-funded ERETs, and 88.5% were operational. Beds may not be operational due to COVID-19 protocols or a lack of staffing, exacerbating challenges to meet inpatient treatment demand. Sixty percent of all beds were at state hospitals, which only serve adults. Less than 5% (4.8%) of all these beds are dedicated to children and adolescents. One reason more state-funded beds are dedicated to adults is that minors are more likely to have a payer source (i.e.., private insurance, PeachCare for Kids) than the adult population, and thus have more inpatient treatment options.

Table 36. Bed Capacity by State-Funded ERET Type

ERET Type	Total Beds	Operational Beds
State Hospital	933	849
BHCC/CSU - Adult	546	472
CSU – Child and Adolescent	74	54
Total	**1,553**	**1,375**

Statewide, ERETs not managed by DBHDD have 25% more total beds than those managed by DBHDD. These ERETs have a total of 2,150 beds, of which 1,633 are for adults and 517 are for child and adolescents.[131] DBHDD cannot track bed capacity for ERETs that are not state managed and has no role in prioritizing bed placement at these facilities.[132]

Transporters of persons in mental health crisis, particularly law enforcement, are important stakeholders for bed coordination. Sheriff departments have the legal responsibility for transporting persons who have been issued a 1013 Order, which is a legal order authorizing the transport of persons who appear to be mentally ill and require involuntary treatment. The order mandates sheriff departments to transport such persons to an emergency receiving facility, which includes ERETs and general hospitals. Because of this flexibility, sheriffs often transport

individuals under a 1013 Order to a hospital emergency department for two reasons. First, they may be located closer to the patient pick-up point than an ERET. Second, the deputies may be concerned that the patient has medical issues that should be examined before being dropped off at an ERET.

Sheriff departments are directly impacted by bed availability because they are responsible for ensuring people with 1013 Orders are taken to ERETs that have the capacity to accept additional patients. Yet, the deputies infrequently utilize the GCAL's bed registry. Some departments have developed relationships with their local ERET and will call that facility directly to learn if it has bed availability.

CHALLENGES

Effective bed coordination ensures timely access to inpatient behavioral health services while limiting wasted resources caused by unused beds. The foremost goal of all those in the behavioral health sphere is ensuring that persons who need emergency inpatient treatment can quickly receive it. The State of Georgia plays a pivotal role in this regard by serving as the provider of last resort for residents who lack their own payer source (i.e., lack private health insurance or Medicaid). Because public funds pay for these services, the state also has an obligation to judiciously spend those dollars. Therefore, an ongoing challenge for the state is balancing the cost of services and meeting service demand.

The availability of beds continuously varies by ERET across the state, depending upon the ebb and flow of the admission and discharge of patients. In other words, bed availability is constantly fluctuating. The challenge for DBHDD and all ERETs is not knowing exactly when and where beds will be needed, yet having them available when they are. The fluctuations in bed availability can cause challenges for transporters. According to interviewees, there have been instances when law enforcement has called GCAL and been told where an ERET had an available bed for a person in mental health crisis. By the time the peace officer arrived at that ERET, the bed was no longer available. Thus, the officer wasted substantial time driving the person to that ERET and still needed to find them a place to stay. The frequency of this situation could not be determined from the data collected for Part I of this study.

In rural areas, ERETs serve multiple counties because of relatively low population densities. As a consequence, some people in crisis need to travel long distances to reach an ERET. Additionally, in many rural counties, only one or two sheriff deputies may be working per shift. Therefore, sheriff departments want to ensure that any transports for inpatient treatment they perform are successful in that the ERET can accept the person in crisis. If that does not occur, the sheriff department has wasted resources.

The number of ERET operational beds may be low in an area where need is high, causing a temporary mismatch between supply and demand. Labor shortages and COVID-19 mitigation protocols limit the number of beds that can be filled at any given ERET. When reduced bed availability is coupled with unusually high or even growing demand, coordination difficulties will occur.

As stated previously, ERETs not managed by DBHDD are not required to participate in GCAL's bed registry, although they are not prohibited from doing so. Without access to this information, DBHDD cannot fully understand where people in crisis are being served. Because BHCCs allows the public to walk into their facilities, some people in crisis with private health insurance come to their facilities. If, after, evaluation, these people are determined to need inpatient treatment, staff at the BHCC must coordinate with a private ERET to accept them. If all ERETs were included in the bed registry, this matching process would likely be improved.

The objective of co-responder units is for the counselor to de-escalate the person in crisis at the scene and then link the person to outpatient treatment services. If the person requires further evaluation at an ERET, they are encouraged to seek treatment voluntarily.[133] Ultimately, the goal of the co-responder units is to re-direct entry of persons in crisis from the criminal justice system, i.e., jails, to treatment. Any substantial increase of individuals in crisis seeking treatment will also magnify the need for inpatient services and effective bed coordination.

CONSIDERATIONS

Based on the research conducted, the following considerations are offered as means to improve overall bed coordination and collaboration between ERETs with transport stakeholders and other emergency receiving facilities.

1. **Create a working group**. Because of the challenges and resulting frustrations with bed coordination, DBHDD may want to regularly convene a group of stakeholders to evaluate how to address ongoing issues as a team. The goal of this working group would be to collectively develop solutions so that every member understands their responsibilities to improve the process. Possible discussion topics may include opportunities for improving GCAL technology and functionality and how GCAL may be able to partner and coordinate with the Georgia Coordinating Center (GCC).

2. **Increasing law enforcement's use of the bed registry**. With a potential increase in on-site issuance of 1013 Orders now possible under HB 1013, sheriff departments may no longer need to have the person in crisis first evaluated at an emergency department and can instead go directly to a BHCC or CSU. Therefore, law enforcement should be

encouraged to utilize the bed registry through GCAL to find open beds for their transports.

Currently, DBHDD regional offices provide presentations and engage with local law enforcement departments to inform peace officers about GCAL and the bed registry. DBHDD could enhance its communication and outreach efforts to local law enforcement and transport providers across the state to make them aware of GCAL's Bed Registry and Bed Board. Also, DBHDD may want to also explore working with the Peace Officer Standards and Training Council or the Georgia Public Safety Training Center to inform new officers about the bed registry. Information about the bed registry could be included in crisis intervention training as well.

3. **Encourage wider ERET participation in the bed registry**. Expanding ERET participation in the bed registry is one of DBHDD's long-term objectives. To create a comprehensive bed registry system, ERETs not managed by DBHDD would need to participate. The Governor's Office of Health Coordination and Strategy and DBHDD may be able to research and explore possible incentives for ERETs to actively participate in the registry.

4. **Research an option to reserve a bed for a 1013 transport**. Protocols could be established, in partnership with law enforcement associations, for peace officers to reserve a bed at an ERET when transporting a person long distance under a 1013 Order and after they have contacted GCAL for a recommendation. GCAL would issue the peace officer a recommendation, and then GCAL and DBHDD could potentially reserve a bed for an individual at that recommended facility for a limited amount of time. Research would be needed to determine the best way for such a system to work. This situation would need to be very limited because of the high demand for beds, such as for transports over 100 miles in one direction. Ultimately, a bed reservation process would need to be managed by GCAL.

5. **Utilize data for strategic planning**. DBHDD collects a tremendous amount of critical data about persons in mental health crisis and utilizes it for strategic decision making. Utilizing this data, the Department could perform periodic reviews of ERETs and compare the length of time individuals at emergency departments and jails wait to be transferred to an ERET for assistance. It may be useful to integrate this information with bed availability at ERETs.

CONCLUSION

Part III of the report summarizes research and considerations related to ERET bed coordination. Currently only state-funded beds are part of the GCAL bed coordination system. Priority for state-funded beds is given to persons in crisis without their own payer source. More coordination and communication between GCAL and its stakeholders may help address common challenges. If there were a central clearinghouse of all available ERET beds (public and private) it could make it easier on sheriffs and hospital staff looking for an available bed. Having the ability for law enforcement or an ambulance team to reserve a bed when traveling a long distance to admit a person into an ERET would help reduce frustration. Law enforcement would benefit from training and general awareness of how the ERET system works and how utilize the services at GCAL in responding and assisting a person having a mental health crisis.

Study Conclusion

This report fulfills the requirements for a study of the transport of persons experiencing a mental health crisis to and from ERET facilities under HB 1013. Ambulances, family and friends, and law enforcement are the three most common ways that persons experiencing a mental health crisis reach an ERET facility. At discharge, family and friends are the dominant form of transport, followed by agency-owned vehicles. The dataset included several descriptive variables that allowed for more nuanced analyses of the transportation data. Cost estimates for the different forms of transport showed that ambulances are the most expensive on a per-trip basis and that less expensive methods, such as NEMTs, may be viable alternatives in some situations.

The findings also showed that patients do not generally have to wait a long time to be admitted to an ERET and that those admitted to BHCCs/CSUs stay at the facility longer than those at hospitals. Data on miles driven for admission to an ERET show that the large majority (75%) of trips are less than 49 miles one way with almost half of the reported admissions being a trip of less than 15 miles in distance. Some of the longest trips are done by ambulance. Each case is unique but developing ways to shift transports from ambulances to lower cost options like NEMT or agency-owned vehicles would likely result in aggregate state savings.

The scope of this study was defined by HB 1013 to investigate how persons experiencing a mental health crisis are transported to and from ERETs. Therefore, transport data to emergency departments that are not licensed as ERETs were not collected. To fully understand the transport of people experiencing a mental health crisis, a study that includes all ERFs, not just ERETs, would present a more holistic picture of transportation for persons experiencing a mental health crisis. Expanding the research to include ERF's would be particularly beneficial to

sheriffs' departments that transport people in crisis to emergency departments. Ultimately, the goal of this larger study would be to present a more holistic picture of transportation for persons in mental health crisis.

Data from ERFs on admissions, discharge, and any co-occurring conditions would also provide helpful context to understanding the interplay between ERFs and ERETs in stabilizing and treating people experiencing a mental health crisis.

One caveat to the data collected by the ERETs for this study, though informative, is that a six-week sample has limitations. A study with a longer time horizon could provide more definitive answers regarding transportation to and from ERETs. Additionally, a custom data collection instrument was used to do this study because the data required was not being collected at intake or discharge and is not maintained in any administrative or billing systems.

Part II of the report scans transportation policies of nine southeastern states and Georgia regarding mental health transportation. Case studies on innovative programs in Tennessee and Virginia highlight two different approaches states have taken to try and address the cost and burden of transporting persons with mental illness who are in crisis. Tennessee offers a grant program to fund sheriffs performing transports with certain rules and reporting requirements. Virginia developed a strategy to shift transports of non-violent patients to nonemergency medical transport (NEMT) through a statewide contract with an NEMT provider.

Part III of the report summarizes research and considerations related to ERET bed coordination. Currently, only state-funded beds are part of the GCAL bed coordination system. Priority for state-funded beds is given to persons in crisis without insurance. More coordination and communication between GCAL and its stakeholders may help address common challenges. If there were a central clearinghouse of all available ERET beds (public and private) it could make it easier on sheriffs and hospital staff looking for an available bed. The data in Part I of the report indicate that about 14 percent of admission trips are over 100 miles. In these rare cases, having an assurance that a bed is available when the ambulance or sheriff arrives would reduce frustration. Law enforcement benefits from general awareness of how the ERET system works and how to utilize the services at GCAL in responding and assisting a person having a mental health crisis.

It is important to note that sheriffs often transport individuals under a 1013 Order to hospital emergency departments for two reasons. First, a hospital emergency department may be located closer to the patient pick-up point than an ERET. Second, the deputies may be

concerned that the patient has medical issues that should be examined before being dropped off at an ERET.

Sheriff departments are directly impacted by bed availability because they are responsible for ensuring people with 1013 Orders are taken to ERETs that have the capacity to accept additional patients. Yet, the deputies infrequently utilize GCAL's bed registry. Some departments have developed relationships with their local ERET and will call that facility directly to learn if it has bed availability.

This study provides state leaders insights into the transport of persons experiencing a mental health crisis to and from ERETs. The final assessment is that persons in crisis rely on a variety of methods to reach and leave ERETs. Ambulances, friends and family, law enforcement, and agency vehicles are the most common methods of transport to and from ERETs.

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- Participating ERETs
- Georgia Department of Behavioral Health and Developmental Disabilities
- Georgia Sheriff's Association

Appendix A

All ERETs in Georgia

Behavioral Health Crisis Centers and Crisis Stabilization Units	County
Advantage Behavioral Health Crisis Clinic	Clarke
Albany Area Community Service Board – Aspire Behavioral Health Crisis Center	Dougherty
Community Service Board of Middle Georgia – Quentin Price Crisis Stabilization Unit	Laurens
DeKalb Regional Crisis Center	DeKalb
Gateway Behavioral Health Crisis Center – Brunswick Crisis Stabilization Unit	Glynn
Gateway Behavioral Health Crisis Center – Savannah Crisis Stabilization Unit	Chatham
Gateway Behavioral Health Crisis Center – Lakeside Child & Adolescent Crisis Stabilization Unit	Chatham
Georgia Mountain Crisis Service Board – Avita Crisis Stabilization Unit	Hall
Georgia Pines Behavioral Health Crisis Center	Thomas
Highland Rivers Health Community Service Board – Cobb Crisis Stabilization Unit	Cobb
Highland Rivers Health Community Service Board – Floyd Crisis Stabilization Unit	Floyd
Highland Rivers Health Community Service Board – Polk Crisis Stabilization Unit	Polk
Highland Rivers Health Community Service Board – Whitfield Crisis Stabilization Unit	Whitfield
Legacy Behavioral Health Crisis Center	Lowndes
McIntosh Trail Community Service Board	Spalding
Middle Flint Community Service Board – Phoenix Pointe Crisis Stabilization Unit	Houston
Pathways Center Community Service Board – Adult Crisis Stabilization Unit	Coweta
Pathways Center Community Service Board – Child & Adolescent Unit	Coweta
Pineland Behavioral Health Crisis Center – John's Place Crisis Stabilization Unit	Bulloch
River Edge Behavioral Health – Adult Crisis Stabilization Unit	Bibb
River Edge Behavioral Health – Child & Adolescent Crisis Stabilization Unit	Bibb
Serenity Behavioral Health Systems, Richmond County	Richmond
The Bradley Center – St. Francis Emory Healthcare	Muscogee
Unison Behavioral Health – St. Illa Crisis Stabilization Unit	Ware
View Point Health – Charles L. Knight Adult Crisis Stabilization Unit	Gwinnett
View Point Health – Child & Adolescent Crisis Stabilization Unit	DeKalb
View Point Health – Child & Adolescent Autism Crisis Stabilization Unit	Rockdale

ERETs Hospital	County
Anchor Hospital	Clayton
Appling Healthcare System	Appling
Archbold Northside Center for Behavioral and Psychiatric Care	Thomas
Atrium Health Floyd	Floyd
Atrium Health Navicent	Bibb
Coastal Harbor Health System	Chatham
Dodge County Hospital	Dodge
Donalsonville Hospital	Seminole
Dorminy Medical Center Silver Lights Care Center	Ben Hill
Eastside Medical Center	Gwinnett
Emanuel Medical Center	Emanuel
East Central Regional Hospital	Richmond
Evans Memorial Hospital	Evans
Georgia Regional Hospital – Atlanta	DeKalb
Georgia Regional Hospital – Savannah	Chatham
Grady Memorial Hospital	Fulton
Greenleaf Center	Lowndes
Jeff Davis Hospital	Jeff Davis
Jefferson Hospital	Jefferson
Jenkins County Medical Center	Jenkins
Lakeview Behavioral Health	Gwinnett
Laurel Heights Hospital	DeKalb
Laurelwood Behavioral Health	Hall
Lighthouse Care Center of Augusta	Richmond
Memorial Health University Medical Center	Chatham
Peachford Hospital	DeKalb
Phoebe Putney Memorial Hospital	Dougherty
Ridgeview Institute - Monroe	Walton
Ridgeview Institute - Smyrna	Cobb
Riverwoods Behavioral Health	Clayton
St. Simons By-The-Sea	Glynn
SummitRidge Hospital	Gwinnett
Tanner Medical Center – Willowbrooke at Tanner	Carroll
ERETs Hospital (continued)	**County**

Turning Point Care Center	Colquitt
Upson Regional Medical Center	Upson
Wellstar Atlanta Medical Center	Fulton
Wellstar Cobb Hospital	Cobb
Wellstar Cobb Hospital – Behavioral Health Unit	Cobb
West Central Georgia Regional Hospital	Muscogee

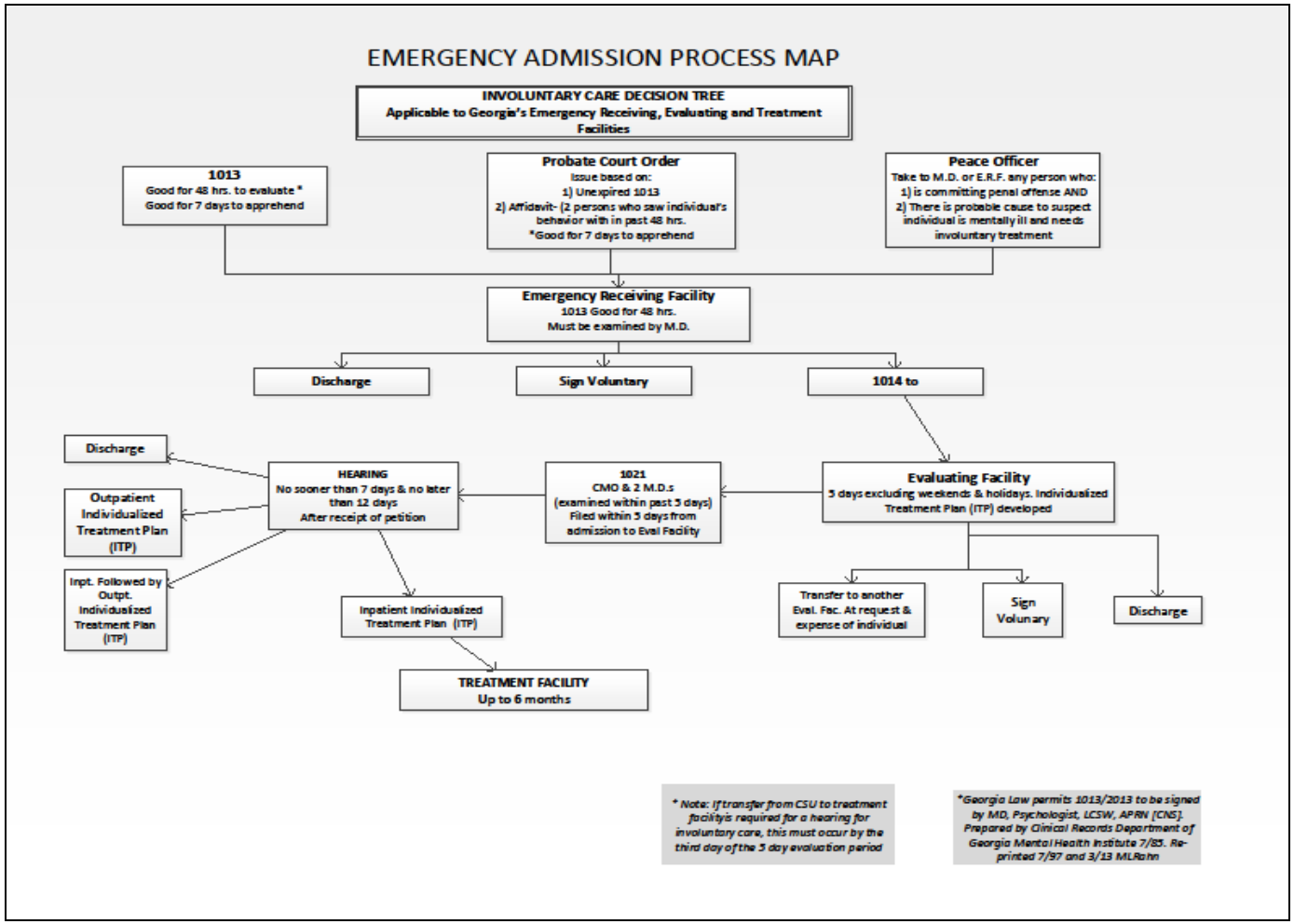
Appendix B

List of Participating ERETs

CSU	County
Advantage Behavioral Health Crisis Clinic[134]	Clarke
Albany Area Community Service Board – Aspire Behavioral Health Crisis Center[135]	Dougherty
Community Service Board of Middle Georgia – Quentin Price Crisis Stabilization Unit	Laurens
DeKalb Regional Crisis Center	DeKalb
Gateway Behavioral Health Crisis Center – Brunswick Crisis Stabilization Unit[136]	Glynn
Gateway Behavioral Health Crisis Center – Savannah Crisis Stabilization Unit[137]	Chatham
Gateway Behavioral Health Crisis Center – Lakeside Child & Adolescent Crisis Stabilization Unit[138]	Chatham
Georgia Mountain Crisis Service Board – Avita Crisis Stabilization Unit	Hall
Georgia Pines Behavioral Health Crisis Center	Thomas
Highland Rivers Health Community Service Board – Cobb Crisis Stabilization Unit	Cobb
Highland Rivers Health Community Service Board – Floyd Crisis Stabilization Unit	Floyd
Highland Rivers Health Community Service Board – Polk Crisis Stabilization Unit	Polk
Highland Rivers Health Community Service Board – Whitfield Crisis Stabilization Unit	Whitfield
Legacy Behavioral Health Crisis Center[139]	Lowndes
Middle Flint Community Service Board – Phoenix Pointe Crisis Stabilization Unit[140]	Houston
Pathways Center Community Service Board – Adult Crisis Stabilization Unit	Coweta
Pathways Center Community Service Board – Child & Adolescent Unit	Coweta
Pineland Behavioral Health Crisis Center – John's Place Crisis Stabilization Unit[141]	Bulloch
River Edge Behavioral Health – Adult Crisis Stabilization Unit	Bibb
River Edge Behavioral Health – Child & Adolescent Crisis Stabilization Unit	Bibb
Serenity Behavioral Health Systems, Richmond County	Richmond
The Bradley Center – St. Francis Emory Healthcare	Muscogee
Unison Behavioral Health – St. Illa Crisis Stabilization Unit	Ware
View Point Health – Charles L. Knight Adult Crisis Stabilization Unit[142]	Gwinnett
View Point Health – Child & Adolescent Crisis Stabilization Unit	DeKalb
View Point Health – Child & Adolescent Autism Crisis Stabilization Unit[143]	Rockdale

Hospital	County
Appling Healthcare System	Appling
Atrium Health Floyd[144]	Floyd
Coastal Harbor Health System[145]	Chatham
Dorminy Medical Center Silver Lights Care Center	Ben Hill
East Central Regional Hospital[146]	Richmond
Evans Memorial Hospital	Evans
Georgia Regional Hospital – Atlanta	DeKalb
Georgia Regional Hospital – Savannah	Chatham
Grady Memorial Hospital[147]	Fulton
Jeff Davis Hospital[148]	Jeff Davis
Jenkins County Medical Center[149]	Jenkins
Laurel Heights Hospital[150]	DeKalb
Laurelwood Behavioral Health	Hall
Lighthouse Care Center of Augusta – Children & Adolescent[151]	Richmond
Memorial Health University Medical Center[152]	Chatham
Phoebe Putney Memorial Hospital	Dougherty
St. Simons By-The-Sea	Glynn
SummitRidge Hospital[153]	Gwinnett
Wellstar Atlanta Medical Center[154]	Fulton
Wellstar Cobb Hospital	Cobb
Wellstar Cobb Hospital – Behavioral Health Unit[155]	Cobb
West Central Georgia Regional Hospital	Muscogee

Appendix C


EMERGENCY ADMISSION PROCESS MAP
INVOLUNTARY CARE DECISION TREE
Applicable to Georgia's Emergency Receiving, Evaluating and Treatment Facilities
1013
Good for 48 hrs. to evaluate *
Good for 7 days to apprehend
Probate Court Order
Issue based on:
1) Unexpired 1013
2) Affidavit- (2 persons who saw individual's behavior with in past 48 hrs.
*Good for 7 days to apprehend
Peace Officer
Take to M.D. or E.R.F. any person who:
1) is committing penal offense AND
2) There is probable cause to suspect individual is mentally ill and needs involuntary treatment
Emergency Receiving Facility
1013 Good for 48 hrs.
Must be examined by M.D.
Discharge
Sign Voluntary
1014 to
Discharge
Outpatient Individualized Treatment Plan (ITP)
Inpt. Followed by Outpt. Individualized Treatment Plan (ITP)
HEARING
No sooner than 7 days & no later than 12 days
After receipt of petition
1021
CMO & 2 M.D.s
(examined within past 5 days)
Filed within 5 days from admission to Eval Facility
Evaluating Facility
5 days excluding weekends & holidays. Individualized Treatment Plan (ITP) developed
Inpatient Individualized Treatment Plan (ITP)
TREATMENT FACILITY
Up to 6 months
Transfer to another Eval. Fac. At request & expense of individual
Sign Voluntary
Discharge
* Note: If transfer from CSU to treatment facility is required for a hearing for involuntary care, this must occur by the third day of the 5 day evaluation period
*Georgia Law permits 1013/2013 to be signed by MD, Psychologist, LCSW, APRN (CNS). Prepared by Clinical Records Department of Georgia Mental Health Institute 7/85. Re-printed 7/97 and 3/13 MLRahn

Appendix D

Georgia Counties by Admission Transport Type

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Appling	0	0	0	0	0	0	0	1	0	0	0	0	11	0	18
Atkinson	0	0	5	0	1	0	0	1	0	0	0	0	2	0	4
Bacon	0	0	0	0	1	0	0	0	0	0	0	0	1	0	7
Baker	0	0	3	0	3	0	0	0	0	0	0	0	0	0	2
Baldwin	0	0	1	0	1	0	1	0	0	0	0	0	3	0	29
Banks	0	10	14	0	1	0	0	0	0	1	0	3	1	0	9
Barrow	0	0	2	0	2	1	4	0	0	0	0	2	1	0	17
Bartow	0	0	6	0	3	0	13	2	0	0	0	0	0	0	31
Ben Hill	0	0	8	0	8	0	0	1	0	0	0	0	2	0	7
Berrien	0	0	3	0	1	0	0	1	0	0	0	0	6	0	7
Bibb	0	0	0	0	0	0	2	12	0	1	0	1	6	0	125
Bleckley	0	16	73	0	14	0	0	1	0	0	0	0	0	0	2
Brantley	0	0	1	0	0	0	0	1	0	1	0	1	2	0	13
Brooks	0	0	0	0	8	0	0	0	0	0	0	0	0	0	1
Bryan	0	0	0	0	1	0	0	4	0	0	0	0	2	0	20
Bulloch	0	0	4	0	10	0	1	9	0	0	0	0	10	0	53
Burke	0	4	19	0	10	0	0	0	0	0	0	1	0	0	6
Butts	0	0	4	0	1	0	1	1	0	0	0	0	0	0	2
Calhoun	0	0	0	0	0	0	0	0	0	0	0	2	2	0	8
Camden	0	1	2	0	1	0	1	4	0	5	0	0	3	0	30
Candler	0	1	1	0	15	0	0	1	1	0	0	0	0	0	11

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Carroll	0	0	8	1	1	0	0	0	0	2	0	0	12	0	36
Catoosa	0	2	14	0	5	0	2	0	0	0	0	0	2	0	4
Charlton	0	0	0	0	0	0	0	3	0	0	0	0	0	0	5
Chatham	1	0	1	0	1	1	5	18	0	62	0	93	8	0	401
Chattahoochee	0	2	121	0	90	0	0	0	0	0	0	0	0	0	1
Chattooga	0	0	0	0	1	0	2	0	0	0	0	0	0	0	2
Cherokee	0	0	0	0	0	0	14	0	0	0	0	0	4	0	43
Clarke	11	0	21	0	4	1	9	0	1	5	7	23	5	0	103
Clay	0	0	28	0	13	0	0	1	0	0	0	0	0	0	3
Clayton	0	0	1	0	1	0	0	2	0	9	0	3	6	0	74
Clinch	0	0	48	0	6	0	0	1	0	0	0	0	1	0	3
Cobb	0	0	0	3	1	0	46	3	1	1	1	3	5	0	243
Coffee	0	38	121	0	21	0	0	1	1	2	0	0	8	0	22
Colquitt	0	0	3	0	7	0	0	2	0	2	0	1	10	0	32
Columbia	0	1	7	0	9	0	6	8	1	0	0	0	9	0	35
Cook	0	1	7	0	3	0	0	0	0	0	0	0	8	0	9
Coweta	0	0	0	16	1	0	0	4	0	3	0	2	11	0	109
Crawford	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	0	3	2	0	68	0	1	1	0	1	0	0	0	0	4
Dade	0	0	1	0	0	0	0	0	0	0	0	0	1	0	2
Dawson	0	0	0	0	1	0	0	0	0	2	0	1	3	0	12
Decatur	0	0	3	0	3	0	0	1	0	0	0	1	14	0	26
Dekalb	3	1	1	0	8	0	2	1	0	46	1	97	9	1	361
Dodge	0	2	178	0	21	0	0	1	0	2	0	0	3	0	11

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Dooly	0	0	3	0	2	0	0	0	0	1	0	0	0	0	5
Dougherty	0	0	4	0	0	0	1	1	3	26	0	38	10	0	284
Douglas	0	14	36	0	155	0	8	0	0	1	0	0	2	0	28
Early	0	0	14	0	3	0	0	0	0	2	0	0	1	0	7
Echols	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	0	0	1	0	3	0	0	8	0	4	0	1	3	0	42
Elbert	1	0	9	0	17	0	0	0	0	0	0	1	3	0	10
Emanuel	0	0	2	0	3	0	0	3	0	1	0	1	2	0	16
Evans	0	0	2	0	7	0	0	3	0	1	0	3	1	0	23
Fannin	0	0	7	0	8	0	3	0	0	0	0	0	1	0	7
Fayette	0	0	3	0	0	0	0	0	0	1	0	0	1	0	21
Floyd	0	0	6	2	13	1	25	0	1	1	0	1	27	0	87
Forsyth	0	3	25	0	1	0	9	1	0	0	0	1	0	0	28
Franklin	0	0	10	0	7	0	0	0	0	0	0	3	1	0	8
Fulton	1	0	4	0	0	3	11	3	0	201	6	41	5	0	1047
Gilmer	0	0	357	0	419	0	1	0	1	0	0	1	0	0	4
Glascock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	0	0	1	0	0	1	0	15	0	21	0	11	12	1	127
Gordon	0	2	12	0	52	0	2	0	0	0	0	0	3	0	10
Grady	0	0	3	0	2	0	0	0	0	1	0	0	4	0	13
Greene	0	0	2	0	6	0	1	0	0	0	0	0	0	0	6
Gwinnett	0	0	4	3	1	2	6	1	1	3	0	14	12	1	217
Habersham	0	2	67	0	105	0	4	0	0	1	0	2	2	0	20
Hall	5	0	8	0	3	0	96	0	3	15	0	82	3	3	316

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Hancock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	0	4	57	0	48	0	0	0	1	0	0	0	2	0	6
Harris	0	0	2	0	1	0	0	1	0	0	0	0	0	0	16
Hart	0	0	12	0	3	0	1	0	0	0	0	2	1	0	8
Heard	0	0	3	1	1	0	0	1	0	0	0	0	2	0	5
Henry	0	0	0	0	1	0	2	4	0	1	0	0	2	0	28
Houston	0	4	7	0	8	2	1	2	0	5	0	0	1	0	33
Irwin	0	3	8	0	11	0	0	1	0	0	0	0	2	0	5
Jackson	0	0	0	0	2	0	6	0	1	2	0	3	1	0	23
Jasper	0	2	3	0	5	0	0	0	0	0	0	0	1	0	3
Jeff Davis	0	0	2	0	0	0	0	0	0	5	0	0	9	0	32
Jefferson	0	3	5	0	10	0	0	1	0	0	0	0	7	0	9
Jenkins	0	0	1	0	0	1	0	0	0	2	0	0	1	0	8
Johnson	0	0	2	0	2	0	0	0	0	0	0	1	0	0	2
Jones	0	0	1	0	0	0	0	0	0	0	0	1	4	0	6
Lamar	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1
Laurens	0	0	0	0	0	0	1	9	4	1	0	3	5	0	48
Lee	0	4	13	0	8	0	0	3	0	2	0	1	1	0	24
Liberty	0	0	6	0	11	0	0	8	0	7	0	1	7	0	45
Lincoln	0	0	11	0	11	0	0	0	0	0	0	0	0	0	1
Long	0	0	0	0	1	0	0	0	0	0	0	1	0	0	4
Lowndes	0	0	2	0	1	7	0	6	0	1	0	6	37	3	114
Lumpkin	0	5	16	0	33	0	2	0	0	5	0	1	1	0	16

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Macon	0	0	5	0	2	0	0	0	0	0	0	0	0	0	2
Madison	0	2	0	0	0	0	0	0	1	0	0	1	0	0	3
Marion	0	0	1	0	0	0	0	1	0	0	0	0	0	0	7
McDuffie	0	0	5	0	1	0	2	0	0	0	0	0	3	0	7
McIntosh	0	0	2	0	0	0	0	0	0	0	0	0	3	0	8
Meriwether	0	0	1	0	4	0	0	0	0	0	0	1	2	0	11
Miller	0	0	0	0	8	0	0	0	0	0	0	0	1	0	2
Mitchell	0	0	0	0	1	0	0	0	0	1	0	0	6	0	12
Monroe	0	0	0	0	5	0	0	0	0	0	0	0	0	0	1
Montgomery	0	0	0	0	1	0	0	2	0	0	0	0	0	0	3
Morgan	0	0	1	0	0	0	0	0	0	0	0	0	2	0	6
Murray	0	0	2	0	2	0	0	0	0	0	0	0	1	0	3
Muscogee	0	0	1	0	1	9	4	3	6	0	0	31	19	0	319
Newton	0	172	16	0	59	0	2	0	0	0	0	0	1	0	12
Oconee	1	0	7	0	2	0	0	0	0	0	0	0	1	0	3
Oglethorpe	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2
Paulding	0	0	1	0	0	0	15	2	0	0	0	0	2	0	48
Peach	0	2	18	0	9	0	0	0	0	4	0	0	0	0	8
Pickens	0	0	3	0	1	0	2	0	0	0	0	0	0	0	3
Pierce	0	0	1	0	0	0	0	3	0	0	0	0	1	0	14
Pike	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Polk	0	0	0	2	10	1	6	0	1	2	0	0	6	0	27
Pulaski	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	0	0	1	0	8	0	1	0	0	0	0	0	6	0	9
Quitman	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Rabun	0	0	2	0	0	0	0	1	0	0	0	1	0	0	5
Randolph	0	0	2	0	1	0	0	1	0	0	0	0	3	0	7
Richmond	1	0	2	0	1	0	41	15	0	0	0	0	25	0	195
Rockdale	0	1	105	0	7	0	0	0	0	0	0	1	3	1	10
Schley	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Screven	0	0	3	0	0	0	0	1	0	0	0	0	0	0	4
Seminole	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3
Spalding	0	1	4	0	7	0	1	1	2	0	0	0	4	0	20
Stephens	0	1	6	0	1	0	4	0	0	1	0	0	4	0	17
Stewart	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	1	0	0	8	0	1	2	0	3	0	0	3	0	18
Talbot	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Taliaferro	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Tattnall	0	0	4	0	3	0	0	1	0	0	0	0	0	0	8
Taylor	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Telfair	0	0	4	0	0	0	0	1	0	1	0	0	0	0	6
Terrell	0	0	2	0	4	0	0	1	0	0	0	0	0	0	7
Thomas	0	5	5	0	27	10	0	2	0	0	0	0	34	0	83
Tift	0	0	22	0	12	0	2	3	0	0	0	0	10	0	49
Toombs	0	0	6	0	4	0	0	0	0	0	0	1	4	0	15
Towns	0	0	2	0	1	0	0	1	0	0	0	0	1	0	5
Treutlen	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Troup	0	1	1	0	18	0	0	2	0	3	0	0	12	0	37
Turner	0	0	0	0	0	0	0	1	0	1	0	0	5	0	7
Twiggs	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1

County of Origin	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Union	0	1	2	0	1	0	3	0	0	2	0	0	3	0	12
Upson	0	0	4	0	0	0	0	0	0	0	0	1	1	0	6
Walker	0	0	7	0	0	0	0	0	0	0	0	0	1	0	8
Walton	1	0	6	0	3	0	5	0	0	0	0	1	2	0	18
Ware	0	7	3	0	16	0	0	3	1	4	0	1	36	2	73
Warren	0	0	0	0	1	0	0	0	0	0	0	0	4	0	5
Washington	0	0	2	0	0	0	2	0	0	0	0	0	7	0	11
Wayne	0	0	5	0	3	0	0	1	0	0	0	0	1	1	11
Webster	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Wheeler	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
White	1	0	2	0	7	0	1	0	0	4	0	2	1	0	18
Whitfield	1	0	6	0	1	0	3	0	12	0	0	0	12	0	34
Wilcox	0	0	7	0	0	0	0	0	0	0	0	0	0	0	7
Wilkes	1	0	2	0	0	0	0	0	0	0	0	0	0	0	3
Wilkinson	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Worth	0	1	2	0	2	0	0	1	0	3	0	1	1	0	11
Blank	1	0	443	0	297	5	1	3	1	37	11	12	0	0	812
Out of State	0	0	1	0	4	0	2	1	0	0	0	0	0	0	8
Total	**28**	**323**	**2,174**	**28**	**1,859**	**45**	**389**	**213**	**45**	**522**	**26**	**508**	**585**	**13**	**6,759**

Georgia Counties by Discharge Transport Type

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Appling	0	2	1	0	12	0	0	1	0	0	1	0	5	1	23
Atkinson	0	0	0	0	4	0	0	0	0	0	0	0	1	0	5
Bacon	0	2	1	0	1	0	0	0	0	0	0	0	1	0	5
Baker	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2
Baldwin	0	2	1	0	13	0	5	3	0	0	0	0	0	7	31
Banks	0	0	0	0	4	0	0	0	1	0	0	0	0	0	5
Barrow	0	2	0	0	11	0	0	2	0	0	0	0	0	0	15
Bartow	0	7	0	0	12	0	0	3	0	0	0	0	0	0	22
Ben Hill	0	0	1	0	5	0	0	4	0	0	0	0	2	2	15
Berrien	1	1	0	0	7	0	0	0	0	0	0	0	0	0	8
Bibb	0	34	10	0	53	0	0	3	2	0	1	1	2	15	121
Bleckley	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Brantley	0	0	0	0	9	0	0	0	0	1	0	0	3	1	14
Brooks	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2
Bryan	0	0	1	0	3	0	0	0	0	0	0	0	0	0	4
Bulloch	0	1	2	0	31	3	0	3	1	0	0	0	4	4	49
Burke	0	1	0	0	7	0	0	0	1	0	0	1	0	0	10
Butts	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Calhoun	0	0	0	0	1	0	0	1	1	0	0	1	0	0	4
Camden	0	2	2	0	14	0	0	0	0	1	1	0	1	3	24
Candler	0	0	1	0	7	0	0	8	0	0	0	1	0	0	17
Carroll	0	2	0	0	16	0	0	0	0	0	0	0	0	3	21
Catoosa	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Charlton	0	0	1	0	3	0	1	1	0	0	0	0	0	0	6

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Chatham	0	20	74	0	110	1	0	8	3	1	6	2	5	17	247
Chattahoochee	0	2	0	0	2	0	0	0	0	0	0	1	0	0	5
Chattooga	0	2	0	0	4	0	0	0	1	0	0	0	0	0	7
Cherokee	0	10	0	0	13	0	0	3	0	0	0	0	0	0	26
Clarke	2	33	9	0	27	0	0	2	1	0	5	4	2	1	86
Clay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	46	2	23	0	12	0	0	5	2	0	1	0	8	1	100
Clinch	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Cobb	12	29	20	0	72	2	0	17	3	0	5	1	9	21	191
Coffee	0	1	0	0	3	0	0	0	1	0	0	0	2	0	7
Colquitt	0	2	1	0	11	0	0	3	0	0	2	0	1	0	20
Columbia	0	0	0	0	25	0	1	0	0	0	0	1	1	3	31
Cook	0	0	1	0	4	0	0	0	0	0	0	0	0	0	5
Coweta	0	5	0	0	61	0	0	0	0	0	0	0	1	9	76
Crawford	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Crisp	0	3	0	0	3	0	0	0	1	0	0	0	0	1	8
Dade	0	2	0	0	1	0	0	0	0	0	0	0	0	0	3
Dawson	0	0	0	0	4	0	0	0	0	0	0	0	2	0	6
Decatur	0	1	1	0	8	0	0	0	0	0	4	1	3	0	18
Dekalb	134	13	40	0	63	0	0	2	10	0	23	0	11	5	301
Dodge	0	1	1	0	7	0	0	1	1	0	0	0	0	5	16
Dooly	0	0	2	0	0	0	0	4	0	0	0	0	0	0	6
Dougherty	0	1	3	0	33	32	0	2	4	3	0	28	6	2	114
Douglas	3	6	0	0	11	0	0	0	2	0	0	0	0	1	23
Early	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	**Total**
Echols	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	0	0	1	0	15	0	0	1	0	0	0	0	0	1	18
Elbert	0	3	0	0	2	0	1	0	0	0	0	0	0	0	6
Emanuel	0	2	0	0	7	0	0	5	2	0	2	0	0	1	19
Evans	0	0	0	0	3	0	0	0	0	0	0	0	0	1	4
Fannin	0	2	0	0	0	0	0	0	1	0	0	0	0	0	3
Fayette	1	0	0	0	8	0	0	0	0	0	0	0	0	2	11
Floyd	0	20	99	0	28	0	6	13	0	0	0	0	61	1	228
Forsyth	0	2	0	0	13	0	0	3	0	0	0	0	0	1	19
Franklin	0	0	0	0	4	0	0	0	0	0	0	2	0	1	7
Fulton	878	36	3	0	62	0	3	18	6	0	19	0	4	12	1041
Gilmer	0	1	0	0	2	0	0	0	0	0	0	0	0	0	3
Glascock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	0	7	24	0	30	94	0	8	0	0	0	2	3	3	171
Gordon	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Grady	0	2	0	0	7	0	0	0	0	0	0	0	0	0	9
Greene	0	0	0	0	3	0	0	0	1	0	0	0	0	0	4
Gwinnett	22	23	26	0	74	0	0	40	9	1	3	3	5	4	210
Habersham	0	1	0	0	12	0	0	0	1	0	0	0	0	1	15
Hall	5	23	4	0	55	0	0	80	9	0	2	0	2	4	184
Hancock	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Haralson	0	0	1	0	3	0	0	0	1	0	0	0	0	0	5
Harris	0	0	0	0	3	0	0	0	1	0	0	1	0	0	5
Hart	0	1	0	0	5	0	0	0	0	0	0	0	0	0	6
Heard	0	0	0	0	2	0	0	0	1	0	0	0	0	0	3

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Henry	3	0	0	0	20	0	0	0	0	0	0	0	0	0	23
Houston	0	2	1	0	21	1	0	0	0	0	0	0	0	1	26
Irwin	0	2	1	0	4	0	0	1	0	0	0	0	0	0	8
Jackson	1	0	0	0	8	0	0	0	1	0	0	0	0	1	11
Jasper	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Jeff Davis	0	2	1	0	8	3	0	1	0	0	0	7	0	2	24
Jefferson	2	2	1	0	4	0	0	0	0	0	0	1	1	2	13
Jenkins	0	1	0	0	4	3	0	3	0	0	0	0	0	0	11
Johnson	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
Jones	0	0	0	0	1	0	0	0	0	0	0	0	3	0	4
Lamar	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Lanier	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Laurens	0	3	4	0	19	0	0	5	2	0	0	3	0	4	40
Lee	0	2	0	0	9	0	0	0	2	0	0	0	0	0	13
Liberty	0	0	0	0	10	0	0	0	0	0	0	2	0	2	14
Lincoln	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
Long	0	0	1	0	2	0	0	0	0	0	0	0	0	0	3
Lowndes	0	27	7	0	25	1	0	11	2	0	0	0	2	1	76
Lumpkin	0	4	0	0	3	0	0	0	0	0	0	0	0	0	7
Macon	0	0	0	0	3	0	0	4	0	0	0	0	1	0	8
Madison	0	0	0	0	4	0	0	1	0	0	0	2	0	1	8
Marion	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
McDuffie	0	0	0	0	6	0	0	2	0	0	0	0	0	1	9
McIntosh	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Meriwether	0	0	0	1	17	0	0	0	0	0	0	0	0	1	19

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Miller	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Mitchell	0	1	0	0	10	0	0	0	0	0	0	0	0	0	11
Monroe	2	1	0	0	2	0	0	2	0	0	0	0	0	0	7
Montgomery	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
Morgan	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Murray	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Muscogee	5	48	11	0	135	13	0	1	20	0	0	28	1	2	264
Newton	0	5	0	0	12	0	0	2	0	0	0	0	0	1	20
Oconee	0	0	0	0	3	0	0	0	0	0	0	0	1	0	4
Oglethorpe	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
Paulding	0	8	0	0	22	0	0	0	0	0	0	0	1	1	32
Peach	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Pickens	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	0	2	0	0	4	0	0	0	0	0	0	0	0	1	7
Pike	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Polk	1	8	1	0	11	11	0	13	1	0	0	0	38	0	84
Pulaski	0	1	0	0	0	0	0	0	0	0	1	0	0	0	2
Putnam	0	2	0	0	2	0	0	0	0	0	0	0	2	0	6
Quitman	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Rabun	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Randolph	0	2	0	0	1	0	0	0	0	0	0	0	0	0	3
Richmond	1	11	12	0	97	0	3	5	8	2	1	0	3	16	159
Rockdale	1	0	0	0	6	0	0	0	1	0	0	0	1	0	9
Schley	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Screven	0	0	0	0	1	0	0	1	0	1	0	0	0	0	3

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Seminole	0	0	0	0	1	0	0	1	0	0	0	0	1	0	3
Spalding	0	0	0	0	13	0	0	0	1	0	0	0	2	1	17
Stephens	0	5	0	0	4	0	0	0	0	0	0	0	0	0	9
Stewart	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	3	0	0	7	0	1	1	0	0	0	1	1	0	14
Talbot	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Taliaferro	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	0	0	0	0	1	0	0	0	0	0	0	0	0	1	2
Taylor	0	0	0	0	2	0	0	0	0	0	0	1	0	0	3
Telfair	0	0	1	0	3	0	0	0	0	0	0	0	0	0	4
Terrell	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	1	40	1	0	21	11	0	2	2	0	0	0	5	1	84
Tift	0	1	3	0	20	0	0	1	0	0	0	0	1	0	26
Toombs	0	0	1	0	8	0	0	2	0	0	0	2	1	1	15
Towns	0	0	0	0	4	0	0	0	0	0	0	0	0	0	4
Treutlen	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Troup	0	2	0	0	19	0	0	1	0	0	0	0	0	7	29
Turner	0	0	0	0	2	0	0	1	0	0	0	0	0	2	5
Twiggs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	1	0	0	5	0	0	0	0	0	0	0	1	0	7
Upson	0	0	1	0	3	0	0	0	0	0	0	0	0	0	4
Walker	0	2	0	0	5	0	0	0	1	0	0	0	0	0	8
Walton	0	2	11	0	12	0	2	19	0	0	0	0	7	0	53
Ware	1	18	9	0	34	10	0	0	0	0	0	0	10	0	82
Warren	0	1	0	0	5	0	1	0	0	0	0	0	0	0	7

County Destination	Blank	Agency-Owned Vehicle	Am-bu-lance	Co-Responder Unit	Family/ Friend	Internal Facility Transfer	NEMT	NEMT-Simple	Other-institution Owned Vehicle	Police	Public Trans.	Self-Transport	Sheriff	Taxi/ Ride-share	Total
Washington	0	2	0	0	1	0	0	2	0	0	0	0	1	0	6
Wayne	0	0	1	0	2	0	0	4	0	0	0	1	0	0	8
Webster	0	0	0	0	1	0	0	0	0	1	0	0	0	0	2
Wheeler	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2
White	0	2	0	0	5	0	0	2	0	0	0	0	0	0	9
Whitfield	0	14	2	0	10	0	0	1	0	0	0	0	9	0	36
Wilcox	0	0	3	0	2	0	0	7	0	0	0	0	0	0	12
Wilkes	0	0	0	0	2	0	0	0	0	0	0	0	0	1	3
Wilkinson	0	1	0	0	0	0	1	0	0	0	0	0	0	0	2
Worth	0	0	0	0	4	0	0	0	0	1	0	1	0	0	6
Blank	681	4	7	0	83	21	1	0	3	1	1	1	0	1	804
Out of State	0	8	0	0	14	0	1	0	0	0	1	2	0	3	29
Total	**1,803**	**554**	**434**	**1**	**1,826**	**206**	**28**	**345**	**112**	**13**	**79**	**102**	**240**	**191**	**5,934**

Appendix E

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Instructions for Completing Patient Intake (admission) and Discharge Forms

Who do I collect data for?
Data collection is ONLY for patients who are in need of *emergency mental health assistance*. Do NOT collect information for patients who only need assistance for substance abuse (e.g., 2013 order). If both mental health and substance abuse are involved, collect data for that patient. Collect the intake data for all emergency mental health patients, regardless of whether they end up staying overnight in your facility or not.

Patient Intake Form - Instructions

Question 1
Please write down the month and date the patient is being admitted to your facility.

Question 2
Please circle the type of transport used to bring the patient to your facility. If the patient arrived by a type of transport not listed, please write it down next to "Other." Below are the definitions for the different types of transportation.

Transport Definitions
Sheriff: Transported by personnel from a county sheriff's office
Police: Transported by personnel from either a city or county police department
Co-Responder Unit: Transported by personnel whose organization(s) have a law enforcement and mental health professional partnership
Private Ambulance: Transported by a private ambulance company
City/County Ambulance: Transported by an ambulance owned by a city or county EMT or Fire Department
Non-Emergency Medical Transport: Transported by a vehicle that is considered a medical vehicle but is NOT an ambulance
Family/Friend: Transported by a family member or friend in their personal vehicle
Taxi/Rideshare: Transported by taxi or rideshare service such as UBER or LYFT even if accompanied by another person (e.g., family member)
Public Transportation: Transported by public transportation even if accompanied by another person (e.g., family member)
Agency-Owned Vehicle: Transported by a vehicle owned by YOUR facility
Other Institution-Owned Vehicle: Transported by vehicle owned by a residential institution (e.g., group home) or other ERET that does not fit within the other categories
Walked to Facility: Patient walked to the facility and did not use any other form of transportation
Internal Department Transfer: Patient was discharged from one department and is being moved to another department within your facility (e.g., from ER to a psychiatric unit for an overnight stay)

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Question 3
Please circle the timeframe that represents the best estimate for the length of time the transport (e.g., sheriff deputy, ambulance EMT) accompanied the patient PRIOR to being seen by a medical professional. If the patient arrived by personal vehicle, taxi/rideshare, or public transportation, leave blank.

Question 4
Please circle the county where the patient transport began (i.e., trip origination). If the county is not listed on the data intake form, please write the county next to the "Other" option.

Question 5
Please circle Yes or No for whether the patient is being admitted under a 1013 order.

Question 6
Please circle Yes or No for whether the patient is under a Georgia Probate Court guardianship order. If the patient refuses to answer this question, circle No.

Question 7
Please circle whether the patient is an adult or a minor.

Patient Discharge Form - Instructions

Question 1
Please write down the month and date the patient is being discharged to your facility.

Question 2
Please circle the type of transport that the patient is using to leave your facility. If the patient leaves by a type of transportation not listed, please write it down next to "Other." Definitions for types of transportation are the same as given on the Patient Intake form.

Question 3
Please circle the county where the patient will be placed (i.e., trip destination). If the county is not listed on the data discharge form, please write the county next to the "Other" option.

Question 4
Please circle the timeframe that represents the best estimate for the length of time the patient stayed at your facility from admission to discharge.

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Question 5
Please circle Yes or No for whether the patient was under a 1013 order while at your facility.

Question 6
Please circle Yes or No for whether the patient is being transferred to a state psychiatric hospital (e.g., DBHDD Georgia Regional Hospital – Atlanta).

Question 7
Please circle whether the patient is an adult (18 years or older) or a minor.

If you have any questions regarding completing either the intake or discharge form, please contact Dr. Paula Sanford at sanfordp@uga.edu.

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ERET Name

Intake Form – Mental Health Patients Only

1. What date was the intake? (Month/Day)

   Month: _____ Day: _____

2. How was the mental health patient transported to your facility? (Circle transport)

Sheriff	**Police**	**Co-responder**
Private Ambulance	**City/County Ambulance**	**Non-emergency Medical**
Family/Friend	**Taxi/Rideshare**	**Public Transportation**
Agency-Owned Vehicle	**Walk-In**	**Other_____**

3. How long did the transport driver stay at your facility? (Exclude friends/family, circle time)

   Less than 15 min. **15 min. < 1hr.** **1 hr. < 2 hrs.** **Over 2 hrs.**

4. In what county did the trip originate? (Circle county)

Bibb	**Baldwin**	**Crawford**	**Houston**
Monroe	**Peach**	**Jones**	**Twiggs**

   Other: _____

5. Is the intake due to a 1013 order? (Circle one)

   YES **NO**

6. Is the patient under a guardianship order by a Georgia Probate Court? (Circle one)

   YES **NO**

7. Is the patient an adult (18+) or a minor? (Circle one)

   Adult **Minor**

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ERET Name

Discharge Form – Mental Health Patients Only

1. What was the date of the discharge? (Month/Day)

   Month: _____ Day: _____

2. How will the discharged patient leave your facility? (Circle form of transport)

Private Ambulance	**City/County Ambulance**	**Non-emergency Medical**
Family or Friend	**Taxi/Ride Share**	**Public Transportation**
Agency-Owned Vehicle	**Sheriff**	
Other Institution-Owned Vehicle	**Other: _____**	

3. To what county is the patient being transported? (Circle county)

Bibb	**Baldwin**	**Crawford**	**Houston**
Monroe	**Peach**	**Jones**	**Twiggs**

Other: _____

4. How long did the patient stay at your facility from admission to discharge? (Circle one)

0 < 3 hrs.	**3 < 6 hrs.**	**6 < 12 hrs.**
12 < 24 hrs.	**24 < 48 hrs.**	**Over 48 hrs.**

5. Did the patient being discharged have a 1013 order? (Circle one)

   YES **NO**

6. Is the patient being transferred to a state (DBHDD) psychiatric hospital? (Circle one)

   YES **NO**

7. Is the patient an adult (18+) or a minor? (Circle one)

   Adult **Minor**

Endnotes

[1] See HB 1013, as passed, lines 1347 to 1353.
[2] This study excludes substance-abuse-only emergency transports to emergency receiving, evaluation, and treatment facilities.
[3] Trenkner, Tina. September 29, 2011. "Georgia Overhauls Its Mental Health System." *Governing Magazine*. www.governing.com/archive/following-patient-reentry-orders-georgia.html; Ibid.
[4] *United States of America v. State of Georgia, et al*. Civil Action No. 1:10-CV-249-CAP;
[5] These ongoing mental health services are unrelated to the topic of this report and thus are omitted.
[6] Persons in other institutional settings, such as nursing homes, may experience mental health crises and require care at an ERET.
[7] Part 1 of Article 3 of Chapter 3, and Part 1 of Article 3 of Chapter 7 of Title 37 of the Official Code of Georgia Annotated
[8] Shelly Daniels. 2022, July. Georgia Sheriffs' Association.
[9] Alabama, Arkansas, Florida, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia.
[10] The meetings were held on July 21, August 2, August 3, and August 4, 2022. Each meeting lasted approximately two hours.
[11] The Health Insurance Portability and Accountability of 1996 established a "privacy rule" that ensure people's health information is properly protected. Summary of the HIPAA Privacy Rule, HHS.gov
[12] The research team excluded BHCCs and community service boards that do not provide inpatient services.
[13] If a variable was not answered only a handful of times during the six-week data collection period, the data are still considered complete.
[14] Eleven counties are included in the Atlanta metropolitan region: Clayton, Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and Rockdale.
[15] For one admission and one discharge data point, "medical flight" was provided. This form of transport is considered an anomaly and is excluded from the cost analysis.
[16] The cost is based on a Department of Human Services (DHS) contracted vehicle, which is similar in type to this general category. The cost for the DHS contracted vehicle comes from Dr. Perry McMillion, Department of Behavioral Health and Developmental Disabilities, interim director of the Office of Facilities and Support Services.
[17] Phone Interview with Pete Quinones, president/CEO, MetroAtlanta Ambulance Service, October 19, 2022.
[18] Email correspondence with Dr. Perry McMillion, Department of Behavioral Health and Developmental Disabilities, interim director of the Office of Facilities and Support Services.
[19] Phone interview with Chad Jones, vice president of business development, View Point Health, October 14, 2022.
[20] Phone Interview with Pete Quinones, president/CEO, MetroAtlanta Ambulance Service, October 19, 2022.
[21] Email correspondence with Dena Adams-McNeish, chief development officer, Southeastrans.

[22] The cost is based on a Department of Human Services (DHS) contracted vehicle, which is similar in type to this general category. The cost for the DHS contracted vehicle comes from Dr. Perry McMillion, Department of Behavioral Health and Developmental Disabilities, interim director of the Office of Facilities and Support Services.
[23] 2021 Georgia Department of Community Affairs Wage and Salary Survey – Public Safety, Patrol Officers. Salary is an average of high and low reported salaries. Salary data also include average salaries of patrol officers from an email survey by the Georgia Chiefs of Police Association (August 2022). Includes jurisdictions within Clayton, Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and Rockdale counties. Benefits are measured as a percentage of salaries, with data coming from an email survey by the Georgia Chiefs of Police Association and the Georgia Local Government Personnel Association (October 2022).
[24] Email correspondence with Scott Freeman, chief of police, City of Rockdale, Georgia.
[25] Salary data: 2021 Georgia Department of Community Affairs Wage and Salary Survey – Deputy Sheriff. Salary is an average of high and low reported salaries. Counties within the Atlanta metropolitan area are Clayton, Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and Rockdale counties.
[26] Bibb, Camden, Chatham, Clarke, Clayton, Cobb, Columbus, DeKalb, Dougherty, Douglas, Fayette, Floyd, Forsyth, Fulton, Glynn, Gwinnett, Hall, Houston, Liberty, Lowndes, Pierce, Richmond, Rockdale, Toombs, Troup, and Wayne counties.
[27] Wellstar Cobb Hospital's behavioral health unit also submitted data that are presented separately.
[28] Mental Health America. 2021, October 19. *2022: The State of Mental Health in America*. Retrieved from www.mhanational.org/research-reports/2022-state-mental-health-america-report)
[29] The nine counties not identified in the sample were Crawford, Echols, Glascock, Hancock, Lamar, Pike, Pulaski, Quitman, and Stewart.
[30] These facilities provided the patients' counties of residence instead of trip origin; therefore, their county data had to be removed.
[31] Excludes admissions without a location identified for trip origination.
[32] For 60 admissions, the status of adult versus minor is unknown.
[33] August 29 through October 9, 2022

[35] The transportation data were also evaluated based on whether the county of trip origination was within the Atlanta metropolitan area. The general findings were the same as with the distinction of the ERET facility being located within the Atlanta area. This similarity is likely because people in crisis are transported to ERET closest to where they are first picked up for transport. Hence, people who begin their transport in a county in the Atlanta area will be transported to an ERET also within the Atlanta area.
[36] There are a total of 758 missing cases for these two tables
[37] There are a total of 88 missing cases for these two tables.
[38] Data are missing for 507 cases.
[39] The 46 reported trips by police exceeding 50 miles were likely the result of a reporting error.
[40] Coastal Harbor Care System, Grady Memorial Hospital, Laurel Heights Hospital, Lighthouse Care Center of Augusta, SummerRidge Hospital, and Wellstar Cobb Hospital-ED.

[41] Includes two units for Wellstar Cobb Hospital: the emergency department and a behavioral health inpatient unit.
[42] Data are missing for three cases.
[43] US Census Bureau. 2021 Census Estimate. Retrieved from www.census.gov.
[44] Data are missing for 803 cases. Neither Wellstar Atlanta Emergency Department nor Wellstar Cobb Emergency Department collected data on where patients were discharged, substantially reducing the number of cases to report. Patients transported out of state at discharge are counted as outside the Atlanta metropolitan area.
[45] Cases recorded as: Alabama (9), Florida (2), North Carolina (1), out-of-state (7), South Carolina (8), and Tennessee (3)
[46] Excludes transport out-of-state
[47] Data are missing for 240 cases. The "No" category includes 168 patients from the state's four psychiatric hospitals.
[48] US Census 2021 population estimates.
[49] There are a total of 88 missing cases for these two tables.
[50] Gateway Chatham C&A, Laurel Heights, Lighthouse Care Center, Pathways C&A, River Edge C&A, ViewPoint DeKalb
[51] Atrium Health (Floyd) Medical Center, Evans Memorial Hospital, Grady Memorial Hospital, Memorial Health University Medical Center, Phoebe Putney Memorial Hospital, Wellstar Atlanta Hospital, Wellstar Cobb Hospital
[52] Due to their similarity in staffing and vehicle type, the cost estimation formula for these two transport methods is the same.
[53] Ala. Code § 22-52-91.
[54] Ala. Code § 22-52-93.
[55] Ark. Code Ann. § 20-47-210.
[56] See www.arkleg.state.ar.us/Calendars/Attachment?committee=490&agenda=3237&file=Handout+2+Rpt+Trans+non+emerg+behavioral+hlth+patients+.pdf
[57] Ibid.
[58] Fla. Stat. Ann. § 394.462.
[59] Ibid.
[60] Miss. Code. Ann. § 41-21-67.
[61] Miss. Code. Ann. § 41-19-43.
[62] Miss. Code. Ann. § 41-21-73.
[63] N.C. Gen. Stat. Ann. § 122C-251.
[64] Session Law 2018-5 Section 11H.4(a).
[65] S.C. Code Ann. § 44-17-440.
[66] South Carolina General Assembly 123rd Session, 2019-2020.
[67] Tex. Health & Safety Code Ann. § 574.045.
[68] Tex. Health & Safety Code Ann. § 571.018.
[69] Video interview with Jeremiah Morton on October 27, 2022.
[70] Video Interview with Gail Paysour on October 20, 2022
[71] See www.census.gov/quickfacts/fact/table/TN/PST040221#PST040221
[72] See www.tn.gov/content/dam/tn/tdot/documents/Demographic_022316.pdf

[73] Tenn. Code Ann. § 33-6-406
[74] See ballotpedia.org/2019_Tennessee_legislative_session
[75] Tenn. Code Ann. § 33-6-901.
[76] Ibid.
[77] Ibid.
[78] Tenn. Code Ann. § 33-6-406.
[79] Ibid.
[80] Video interview with Jeremiah Morton, October 27, 2022.
[81] Ibid.
[82] See www.tn.gov/finance/office-of-criminal-justice-programs/ocjp/ocjp-grants-manual/redirect-fund-source-chapters/fund-source-chapters/mental-health-transport.html
[83] Video interview with Jeremiah Morton, October 27, 2022.
[84] Found at https://www.tn.gov/finance/office-of-criminal-justice-programs/ocjp/ocjp-grants-manual/redirect-fund-source-chapters/fund-source-chapters/mental-health-transport.html
[85] Tenn. Code Ann. § 33-6-406.
[86] Video interview with Jeremiah Morton, October 27, 2022.
[87] Tenn. Code Ann. § 33-6-406.
[88] See www.tn.gov/finance/office-of-criminal-justice-programs/ocjp/ocjp-grants-manual/redirect-fund-source-chapters/fund-source-chapters/mental-health-transport.html
[89] Ibid.
[90] Video interview with Jeremiah Morton, October 27, 2022.
[91] See https://www.tn.gov/content/dam/tn/finance/ocjp/FY23%20MHT%20Solicitation%20Grant.pdf
[92] Ibid.
[93] Ibid.
[94] Video interview with Jeremiah Morton, October 27, 2022.
[95] Ibid.
[96] See www.tn.gov/content/dam/tn/finance/ocjp/FY23%20MHT%20Solicitation%20Grant.pdf
[97] Video interview with Jeremiah Morton, October 27, 2022.
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] Ibid.
[102] Ibid.
[103] Video interview with Jeremiah Morton, October 27, 2022.
[104] Ibid.
[105] See www.britannica.com/place/Virginia-state
[106] Ibid.
[107] See rga.lis.virginia.gov/Published/2021/RD630/PDF
[108] Ibid.
[109] Video Interview with Gail Paysour, October 20, 2022.
[110] Information for this section comes from a video interview with Gail Paysour, October 20, 2022.

[111] See namivirginia.org/wp-content/uploads/sites/127/2021/03/Alternative-Transportation-Press-Release-20210318-Alternative-Transportation-3.18.21.pdf
[112] Video Interview with Gail Paysour, October 20, 2022.
[113] Ibid.
[114] Ibid.
[115] Ibid.
[116] See rga.lis.virginia.gov/Published/2021/RD630/PDF
[117] Ibid.
[118] Video Interview with Gail Paysour, October 20, 2022.
[119] 2022 Special Session I Virginia Acts of Assembly.
[120] Video Interview with Gail Paysour, October 20, 2022.
[121] Ibid.
[122] Va. Code Ann. § 37.2-810(B).
[123] Virginia amended Va. Code Ann. § 37.2-810(C).
[124] Video Interview with Gail Paysour, October 20, 2022.
[125] Va. Code Ann. § 37.2-810(G).
[126] *Alternative Transportation Program Annual Report – November 8, 2021*.
[127] Video Interview with Gail Paysour, October 20, 2022.
[128] Ibid.
[129] Video interview with Dawn Peel, DBHDD; Melissa Sperbeck, DBHDD; and Ashley Fielding, DBHDD, November 3, 2022; email correspondence, October 17, 2022 from Josh Mackey, Capital City Public Affairs; phone interview with Chad Jones, ViewPoint Health, October 4, 2022; phone interview with Ryan Luke, Georgia Coordinating Center, September 12, 2022; phone interview with Butch Ayers, Georgia Association of Chiefs of Police, September 7, 2022; video interview with Terry Norris and Brent Loeffler, Georgia Sheriffs' Association, August 24, 2022.
[130] GCAL serves people with mental health, substance use, and intellectual developmental disabilities including Autism Spectrum Disorder. However these latter services are not the subject of this report.
[131] Email correspondence from Melissa Sperbeck, DBHDD, and Gus Youmans, Governor's Office of Health Strategy and Coordination, October 19, 2022.
[132] Private ERETs must comply with the EMTALA rule for patient admissions.
[133] If the person in crisis cannot be settled, a 1013 Order can still be issued.
[134] Advantage Behavioral Health collected data for a total of seven weeks.
[135] Albany Area CSB – Aspire BHCC collected only intake data for four weeks from July 29, 2022, to August 31, 2022.
[136] Gateway BHCC – Brunswick collected five weeks of data.
[137] Gateway BHCC – Savannah collected three weeks of data.
[138] Gateway BHCC – Lakeside C&A CSU collected five weeks of data.
[139] Legacy BHCC collected four weeks of data.
[140] Middle Flint CSB – Phoenix Pointe collected four weeks of data.
[141] Pineland BHCC collected three weeks of data.
[142] View Point Health – Charles L. Knight Adult CSU collected five weeks of data.

[143] View Point Health – C&A Autism CSU was closed for the first four weeks of data collection and collected two weeks of discharge data when the facility reopened.
[144] Atrium Health Floyd only provided discharge data.
[145] Coastal Harbor Health System is composed of Coastal Behavioral Health for Adults and Coastal Harbor Treatment Center for Adolescents.
[146] The state hospitals started data collection a week after the original start date of the study.
[147] Grady collected six weeks of data from June 26, 2022, to August 7, 2022, and did not collect the transportation method for discharge.
[148] Jeff Davis Hospital collected data for both its behavioral health unit and emergency department.
[149] Jenkins County Medical Center collected data for a total of eight weeks.
[150] Laurel Heights Hospital is a pediatric hospital, so it only provided adolescent data.
[151] The Adult Unit at Lighthouse Care Center of Augusta was closed during the six weeks of data collection.
[152] Memorial Health University Medical Center provided pediatric and adult data.
[153] SummitRidge collected all six weeks of intake data, but only three weeks of discharge data.
[154] Wellstar Atlanta Medical Center data did not include 1013 Order admissions, how long transport stayed, or accurate county origination data. Wellstar Atlanta Medical Center closed on November 1, 2022.
[155] Wellstar Cobb Hospital provided two data sets: one for all patients defined as having a mental health consult and one for the behavioral health unit. The all-patient data did not include 1013 Order admissions, how long transport stayed, or accurate county origination data.