crisis to care

COLLABORATIVE

# Status Report

## Erie County, New York
## December 2025


Additional financial support was provided by
the Peter and Elizabeth C. Tower Foundation.

# Contents

# Executive Summary

## Erie County's Crisis to Care (CTC) Collaborative is a first-of-its-kind initiative in New York State.

Improving the response to people experiencing a mental health- or substance use-related emergency is a priority for local and state government officials everywhere. Several features of the CTC Collaborative make it unique in New York State and of interest nationally.

| | |
|---|---|
| **Leadership** | Top city and county elected officials and health executives oversee the initiative. |
| **Key stakeholders** | Police, emergency medical services (EMS), 911, behavioral health providers, hospital officials, and community members make up three working groups: **CALLS** to 911, 988, and local crisis hotlines; options for on-scene **RESPONSE**; and destinations where people who need immediate care can **GO**. |
| **Community listening sessions** | Representatives from advocacy and peer agencies facilitate community listening sessions and small focus groups, ensuring that the process benefits from voices of lived experience. |
| **Philanthropic partnerships** | The Patrick P. Lee Foundation provides thought leadership and project management support. The foundation also helps ensure leaders' commitment to transparency, adherence to project deadlines, and engagement of community voices. |
| **Data** | More than 10 government agencies and nonprofit behavioral health providers contribute data, allowing for unprecedented quantitative analysis. |
| **National experts** | Consultants with expertise in data analysis and national best practices guide the initiative. |

## What are the CTC Collaborative's goals?

1 Ensure that people in Erie County experiencing a behavioral health emergency receive accessible, effective behavioral health crisis stabilization services and follow-up care.

2 Reduce the likelihood that people experiencing a behavioral health emergency are arrested or unnecessarily taken to the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center (ECMC).

## Why are the stakes so high?

| | |
|---|---|
| **People in crisis aren't getting help they need** | People referred from the emergency department for outpatient services at CPEP spend an average of 31 hours there. One out of three people receiving emergency services at CPEP returns there for emergency services at least two more times in the same year. |
| **Inefficient use of scarce resources** | Police report that they often must wait at least three hours before an individual they brought to CPEP can be seen by a psychiatrist. $23.3 million is spent on outpatient CPEP encounters annually — more when people are admitted for inpatient treatment. |

## A Three-Pronged Strategy to Reimagine Responses to Behavioral Health Emergencies

# New analysis of data from 2024 highlights shortcomings in the existing system and points to opportunities to address these challenges

## Call

### At least 21,000 Erie County calls to 911 are flagged as mental health-related.

**CHALLENGE**

Approximately 3 percent of calls to 911 are coded as mental health related. The actual number of mental health calls is likely much higher.

**OPPORTUNITY**

The county's overhaul of its Computer Aided Dispatch (CAD) system creates an opportunity to identify tens of thousands of additional mental health-related calls.

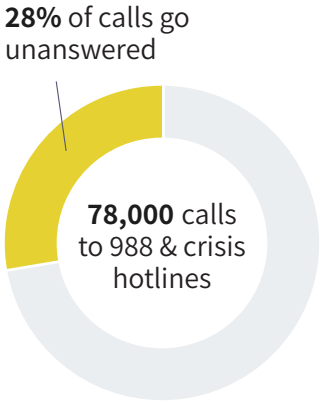

### A quarter of calls to crisis hotline numbers go unanswered.

**CHALLENGE**

Ideally, calls to crisis hotline centers are answered within 30 seconds. In Erie County, 28 percent of calls to the crisis hotline go unanswered, either because the caller hangs up or refuses to stay on hold while waiting for an available crisis call taker.

**OPPORTUNITY**

Improving call answer rates is a top priority for Crisis Services, which is engaging with local partners, the county, and the state to develop solutions.



# Respond

## Buffalo police and/or EMS are dispatched to a mental health emergency approximately 27 times a day.

**CHALLENGE**

Lights and sirens are a default response to 911 calls for mental health emergencies.

**OPPORTUNITY**

Co-response teams pair specially trained officers and mental health clinicians. They are demonstrating promise in the police departments in Buffalo, Cheektowaga, and West Seneca.

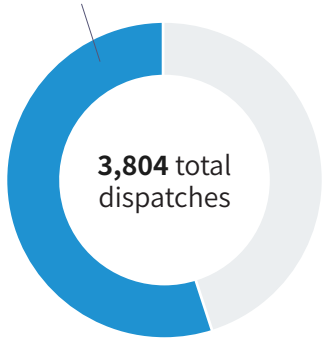
## 55% of the time, mobile crisis teams are unable to complete the visit.

**CHALLENGE**

In Erie County, mobile crisis teams are comprised of counselors and professionals at the Master's and Bachelor's level, respectively. The current staffing model allows urgent calls to be handled within an hour, but less urgent calls frequently involve wait times of several hours.

**OPPORTUNITY**

Mobile crisis teams have demonstrated effectiveness diverting people from the emergency department. Crisis Services is developing a plan to expand their mobile crisis teams.



# Go

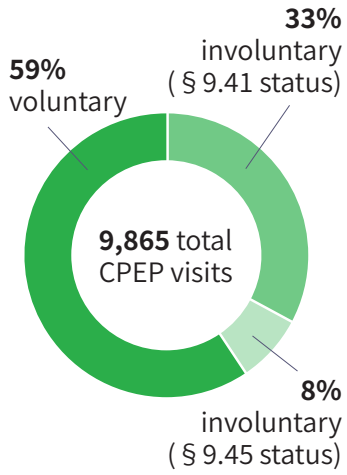
## An ambulance or police car arrives at the ECMC emergency department every three hours with a person from Buffalo reporting a mental health emergency.

**CHALLENGE**

ECMC's CPEP is currently first responders' only reliable option for someone who needs immediate care. This is true for calls to 911, 988, and local crisis hotlines.

**OPPORTUNITY**

A new intensive crisis stabilization center, available 24/7 to first responders and walk-ins, is scheduled to open in late 2025. It presents an alternative for individuals in crisis and can be effective in connecting people to community- based care.



# Introduction

## Origins of the Crisis to Care (CTC) Collaborative

The Crisis to Care Collaborative is a promising new initiative in Erie County, New York, focused on improving the response to people experiencing an emergency related to mental health or substance use ("behavioral health"). The CTC Collaborative builds on a rich history of partnership among Erie County's behavioral health and public safety leaders, who have held trainings and launched pilot programs to increase the likelihood that people in crisis are connected to effective community-based health services.

The origins of this initiative date back to fall 2023, when the Erie County Department of Mental Health established the Behavioral Health Crisis Continuum Committee. Membership included frontline behavioral health providers and representatives of the Patrick P. Lee Foundation and gradually expanded to involve additional stakeholders, such as law enforcement and 911 call takers. The committee initially used broad parameters to define its scope, examining not only what services are provided to a person in crisis, but also how to prevent such an emergency and how to support someone in the weeks and months after the crisis.

At the encouragement of the Lee Foundation, the committee agreed to refine its focus. With support from both the Lee Foundation and the Peter and Elizabeth C. Tower Foundation, the committee engaged nationally recognized experts to conduct an independent review of Erie County's behavioral health crisis response system.[1]

1 Please see the appendix for more information on the consultants engaged in this project.

The consultants' assessment zeroed in on the following operational segments of the behavioral health crisis continuum:

**CALL:** How emergency hotline calls (e.g., to 911, 988, or local hotline numbers) involving a mental health- or substance use-related crisis are fielded[2]

**RESPOND:** Who is dispatched when an on-scene response is necessary

**GO:** Where a first responder can bring someone experiencing a behavioral health crisis who needs immediate care

Between March and June 2024, the expert consultants met with approximately 50 people representing a broad cross section of perspectives, including crisis response services, behavioral health service providers, law enforcement executives, elected officials, clinicians and administrators working at ECMC, first responders, 911 call takers, officials representing the New York State Office of Mental Health, community-based advocates, and people who had received services when they were in crisis.

The consultants found that a number of important and promising initiatives had been launched to improve the response to people in crisis in Erie County, but the impact of these efforts to date had been very limited. They identified four sets of issues that prevented these initiatives from realizing their potential: workforce, data, funding, and governance.

In response to these findings, top city and county officials established a leadership committee that included the deputy county executive of Erie County, the mayor of Buffalo, the commissioner of Erie County Central Police Services, the commissioner of the Erie County Department of Mental Health, the sheriff of Erie County, the chief executive officer of ECMC, and the executive director of the Lee Foundation.

2 Crisis Services has operated a 24-hour crisis hotline number since 1968, which handled approximately 85 percent of answered calls in 2024. Calls to 988 represented 15 percent of calls answered by Crisis Services.

# The CTC Collaborative's Goals

**1** Ensure that people in Erie County experiencing a behavioral health emergency receive accessible, effective behavioral health crisis stabilization services and follow-up care.

**2** Reduce the likelihood that people experiencing a behavioral health emergency are arrested or unnecessarily taken to the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center (ECMC).

Following a written request from the Leadership Committee in December 2024, the Lee Foundation agreed to provide a range of support for this effort, including funding, project management and meeting facilitation, subject matter expertise, data analysis, and communications assistance.

At an event in May 2025, which was covered extensively by local media, the Leadership Committee announced the establishment of the CTC Collaborative and the launch of a rigorous quantitative and qualitative analysis of the crisis response system in Erie County. This report describes the results of that assessment. It includes an unprecedented analysis of quantitative data from 2024, maintained by more than 10 independent county and city government agencies and providers of behavioral health services, as well as dozens of virtual and in-person interviews and meetings among key stakeholders to discuss and understand trends emerging from the data analyzed.[3] The appendix contains a detailed explanation of the data used for the findings in this report.[4]

3 Where this analysis focuses on findings at the municipal level, it concentrates on three localities: Buffalo (the largest city in Erie County, at 278,349 people), Cheektowaga (a city of approximately 76,829 people that borders Buffalo), and West Seneca (a suburb of Buffalo with approximately 45,500 people).

4 Wherever possible, this report uses "behavioral health" to encompass mental health and substance use disorders. When the report references "mental health," it does so to ensure consistency with terminology used in the data systems that were analyzed.

Improving the response to people experiencing a behavioral health crisis is a priority for local and state government officials across New York State, and in urban and rural counties throughout the U.S.[5]

# What Makes the CTC Collaborative Unique?

## Leadership

The CTC Collaborative is a bipartisan, intergovernmental effort, led by elected officials from both Erie County and the City of Buffalo, as well as the chief executive officer of ECMC, the largest publicly funded hospital in Western New York, which also operates one of the busiest psychiatric emergency programs in New York State.

## Interdisciplinary Groups Using Data

Three working groups — focused on the Call, Respond, and Go areas — undergird the CTC Collaborative's work. Each working group includes representatives of crisis response and behavioral health service providers, ECMC, local law enforcement, EMS, and 911 call takers. They review analyses produced for the CTC Collaborative and help shape findings and recommendations presented to the Leadership Committee. The organizations represented in these groups have a successful history of designing and implementing pilot programs that provide alternatives to the dispatch of a traditional "lights and sirens" response and options other than jail or the emergency department where people who need immediate care can be transported.

5 See, for example, National Association of Counties' *Shaping Crisis Response Spotlight Series*, The Council of State Governments Justice Center's *Stepping Up Initiative*, International Association of Chiefs of Police's *Responding to Persons Experiencing a Mental Health Crisis: Model Policy*, and Substance Abuse and Mental Health Services Administration's *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit.*

## Community Listening Sessions

An Advocacy Working Group, which includes representatives from advocacy and peer agencies, is advising the CTC Collaborative. This working group has facilitated community listening sessions and small focus groups to ensure the voices of people with firsthand experiences of behavioral health crises are reflected in the CTC Collaborative's efforts.

## Philanthropic Partnerships

The Patrick P. Lee Foundation serves as a key partner in the initiative, working collaboratively with leadership to provide a range of support. The foundation's staff ensures adherence to project timelines, facilitates access to data, and keeps the public informed through regular updates. In addition, the Lee Foundation contributes thought leadership, fostering community dialogue and promoting sector-wide collaboration across the behavioral health crisis response system.

## National Experts

National experts with backgrounds in behavioral health and public safety are informing the work of the initiative, conducting extensive analyses of behavioral health and public safety data from Erie County and drawing on experiences of other jurisdictions across the U.S.

# Behavioral Health Emergency Response System: Brief Orientation

## The behavioral health emergency response system is fragmented.

As is the case across New York State and in counties large and small throughout the U.S., no single government agency in Erie County is responsible for administering the system necessary to ensure an effective response to someone in crisis. In Erie County, responding effectively to 911, 988, and local crisis hotline calls that involve mental health and substance use emergencies requires the coordination of a complex web of city, county, and state/national government agencies, as well as community-based nonprofit organizations that provide behavioral health services. The geographic areas these entities cover do not mirror each other.

For example, Erie County's Central Police Services (CPS), a department overseen by the county executive, employs the people who answer cellphone calls, text messages, and landline calls (within the City of Buffalo) to 911. Most municipalities in Erie County have their own police departments and maintain their own public safety answering points (PSAPs) that receive and dispatch all landline calls within their jurisdiction. The police chiefs of these agencies report to their elected officials, not the county.

The Erie County Medical Director, serving both the Sheriff's Office and Department of Health, oversees county-operated EMS and Emergency Medical Dispatch (EMD) programs, but not those of the City of Buffalo or other surrounding communities. In addition, first responders and behavioral health service providers draw on distinct sources of revenue, are accountable to different regulatory bodies and independently elected officials, and maintain data in stand-alone silos. A number of large, well-established, independent nonprofit organizations serve people across Erie County and, in some instances, counties across

Western New York. They are accountable to the state, to managed care companies, and to the Erie County Department of Mental Health. Their revenues come from an array of sources, including Medicaid and private insurance.

## Analyzing 911 call data to measure trends in behavioral health emergency response is complicated.

To measure how calls to 911 involving a behavioral health emergency in Erie County were processed in 2024 — and how law enforcement responded to such emergencies — two sources of data are essential: the Computer Aided Dispatch (CAD) system and the Records Management System (RMS). This report reflects the results of a preliminary analysis of data and reports provided by law enforcement agencies and behavioral health service providers. Additional analyses are taking place involving CAD and RMS data, which will result in a more complete understanding of emergency response system operation and performance.

A number of factors make it extremely difficult to use these sources of information to pinpoint the number of calls to 911 that involved a mental health — or substance use-related emergency — and to determine what precisely happened in each of these calls. Despite these challenges, the analysis conducted for this report has made it possible to establish, for the first time, the frequency with which 911 calls were coded as mental health-related and to develop a clear picture of who was dispatched in such instances.

# Analyzing 911 Call Data: The Importance (and Limitations) of CAD and RMS Information Systems

CAD is the core system first responders (911 telecommunicators, police, fire, and EMS) use to manage emergency response in real time, making it possible for them to prioritize incidents, allocate resources, and relay critical details to officers to ensure their safety during active responses. Its primary value as a tool is to manage the flow of information and resources. Data entered into the CAD, often referred to as "911 data," can be used to measure how 911 call takers used limited information to categorize calls and how those categories corresponded to dispatch decisions.

The RMS serves as the official, comprehensive record of law enforcement and police activity. It includes information required for investigations, charging decisions, and compliance reporting. RMS provides the final call type code, all outcome information, detailed narratives, victim and suspect information, evidence documentation, and supplemental reports that investigators and prosecutors rely on to build and prosecute cases. It also ensures compliance with the National Incident-Based Reporting System (NIBRS), capturing multiple offenses, demographics, and coding required for accurate state and federal reporting. Beyond legal needs, RMS data supports crime analysis, resource allocation, and accountability, making it the backbone of the public safety, crisis, and criminal justice workflow. RMS data, in contrast with CAD data, makes it possible to provide a nuanced analysis of what happened when police appeared on scene and what actions were taken based on what they learned.

Erie County CPS owns and maintains the CAD software for the county. Data are entered by 911 call takers employed by Erie County CPS and dispatchers employed by individual municipalities. For action and outcome recording, individual police agencies enter information into the RMS in accordance with each agency's policies and style. Because these systems are owned and operated by several independent agencies, matching variables across these datasets can be challenging.

Complicating matters further, the CAD software Erie County CPS currently uses allows for only one code to be entered for each 911 call. So, if multiple observers call 911 and attempt to describe a single public disturbance, several different codes could

be entered based on the limited information received, such as “drunk and disorderly,” “mental health,” or “domestic,” but not all three. Depending on how a call taker interprets the limited information they receive in a very short period, a medical emergency that is behavioral health-related could be coded in the CAD system initially as a psychiatric emergency — or something altogether different.

FIGURE 1

## Analysis of Buffalo calls focused on call codes that make explicit reference to mental health[6]

Explicit reference to mental health

| Buffalo PD Call Type Codes Make Explicit Reference to MH | |
|---|---|
| MHC | Mental Health Call |
| SUIC | Suicide Call |
| SUICTH | Suicide Threat |
| HEALTH | Mental Health Follow-Up |
| CRSAST | Assist Crisis Services |

| Examples of Other Buffalo PD Call Type Codes Where Underlying MH Issues Might Be Present | |
|---|---|
| DOM | Domestic Violence |
| DRUNK | Drunk and Disorderly |
| OVERDO | Overdose |
| WELF | Welfare Check |

| One EMS Code Makes Explicit Reference to MH | | | |
|---|---|---|---|
| 01 Abdominal Pain | 10 Chest Pain | 19 Heart Problems | 28 Stroke |
| 02 Allergies | 11 Choking | 20 Heat/Cold Exposure | 29 Traffic Accident |
| 03 Animal Bites | 12 Seizures | 21 Hemorrhage | 30 Traumatic Injuries |
| 04 Assault | 13 Diabetic | 22 Inaccessible Incident | 31 Unconscious |
| 05 Back Pain | 14 Drowning | 23 Overdose | 32 Unknown Problem |
| 06 Breathing | 15 Electrocution | 24 Pregnancy | 33 Transfer |
| 07 Burns | 16 Eye Problems | 25 Psychiatric | 36 Pandemic |
| 08 CO Alarm | 17 Fall | 26 Sick Person | 99 Fire Standby |
| 09 Cardiac Arrest | 18 Headache | 27 Stabbing/Shooting | 99 Helicopter Assist |
| | | | 99 Police Assist |

6 911 calls requiring a medical response are transferred to the appropriate EMS dispatch operators. In Buffalo, a nationally approved Medical Priority Dispatch System (MPDS) protocol is followed to determine the appropriate level of response.

# Preliminary Findings

## Call

### A significant proportion of calls from Erie County to 988 and other behavioral health crisis hotlines go unanswered.

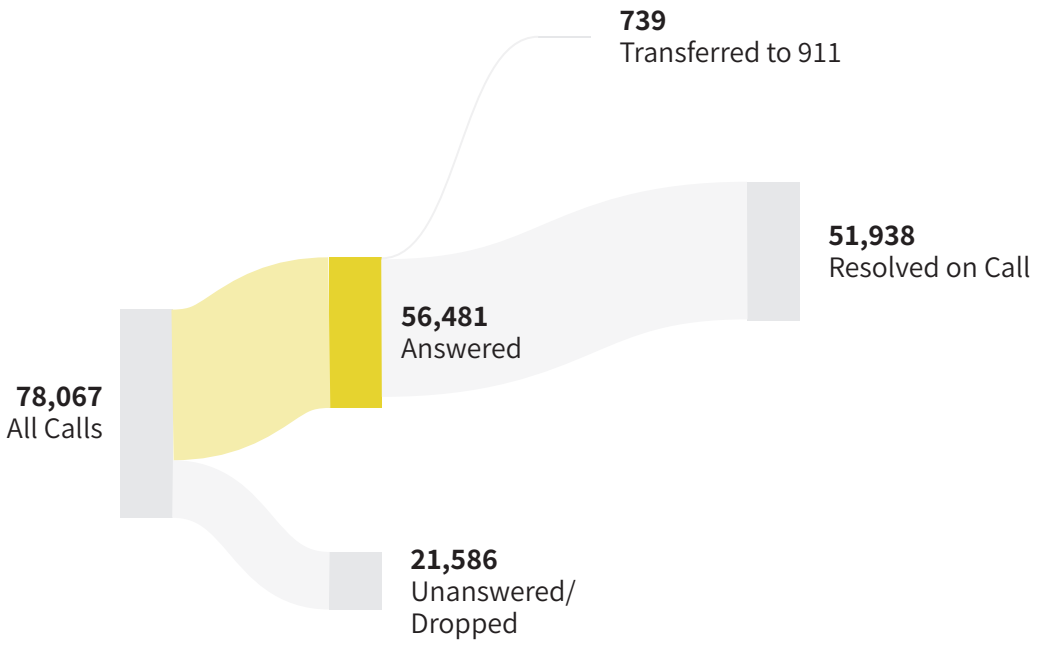
Crisis Services, an independent nonprofit crisis call center, has operated a hotline to serve people in Erie County experiencing a suicidal and/or mental health crisis for 57 years. Crisis Services also serves as a call center handling 988 calls originating in Erie County.

In 2024, 78,067 Erie County calls were made to the local crisis hotline number or to 988. A significant percentage (28 percent) of Crisis Services hotline calls go unanswered (see Figure 2), either because the caller hangs up or refuses to stay on hold while waiting for an available crisis call taker.[7] Calls to the 988 line can roll over to other out-of-region centers. Crisis Services, like crisis centers across the country, has struggled with workforce challenges, which have been particularly acute since the COVID-19 pandemic.

7 Many calls to Crisis Services go unanswered because callers hang up before someone answered, or abandon calls after seconds. There are also situations in which a multi-stress or frequent caller makes numerous calls.

FIGURE 2

## Hotline Calls to Crisis Services for Erie County, 2024




Over the past few years, Crisis Services and Erie County CPS have attempted to increase 911-988/crisis hotline interoperability according to the SAMHSA guidelines.

As part of an effort that began in 2021 to facilitate the transfer of calls from 911 to a specialized hotline, officials from Crisis Services and Erie County CPS launched a pilot project in a few jurisdictions in which 911 call takers transferred calls meeting certain triage criteria. Representatives of Erie County CPS and Crisis Services agreed that the pilot did not meet its goals. The pilot operated only during select hours and days of the week, and the criteria that were used to determine whether a call would be transferred proved to be overly narrow. For these and other reasons, very few calls ultimately met these criteria and were able to be successfully transferred, and the pilot was discontinued.

This experience does not suggest that 911-988/crisis hotline interoperability is infeasible in Erie County. Similar challenges exist statewide: the Daniel's Law Task Force cited "partial integration or insufficient collaboration" as common barriers to coordination among 911, 988, and local crisis hotlines.[8] A deeper analysis of the pilot, combined with the lessons drawn from communities across the U.S. where interoperability has been successfully established, should make it possible to reboot this pilot and establish better conditions for success.

## There are missed opportunities to identify 911 calls that involve someone experiencing a behavioral health emergency.

Figure 3 describes how 911 calls to Erie County are processed. As the diagram reflects, all wireless calls to 911 are fielded initially by Erie County CPS and then routed to other call centers, also known as public safety answering points (PSAPs), that dispatch some combination of police, fire, or EMS. For calls placed from the City of Buffalo, call takers at Erie County CPS record the type of call in the CAD system and transfer the call to dispatchers employed by the City of Buffalo. The dispatchers coordinate responses from the Buffalo Police Department, Buffalo Fire Department, and/or ambulance services, which are provided by a private contractor.[9]

8 New York State Office of Mental Health, *Daniel's Law Task Force New York State Behavioral Health Crisis Response Report,* (Albany, NY: New York State Office of Mental Health, 2024).

9 In contrast, all 911 calls in Monroe County are answered by a single PSAP.

FIGURE 3

## Overview of Erie County 911 Call Centers

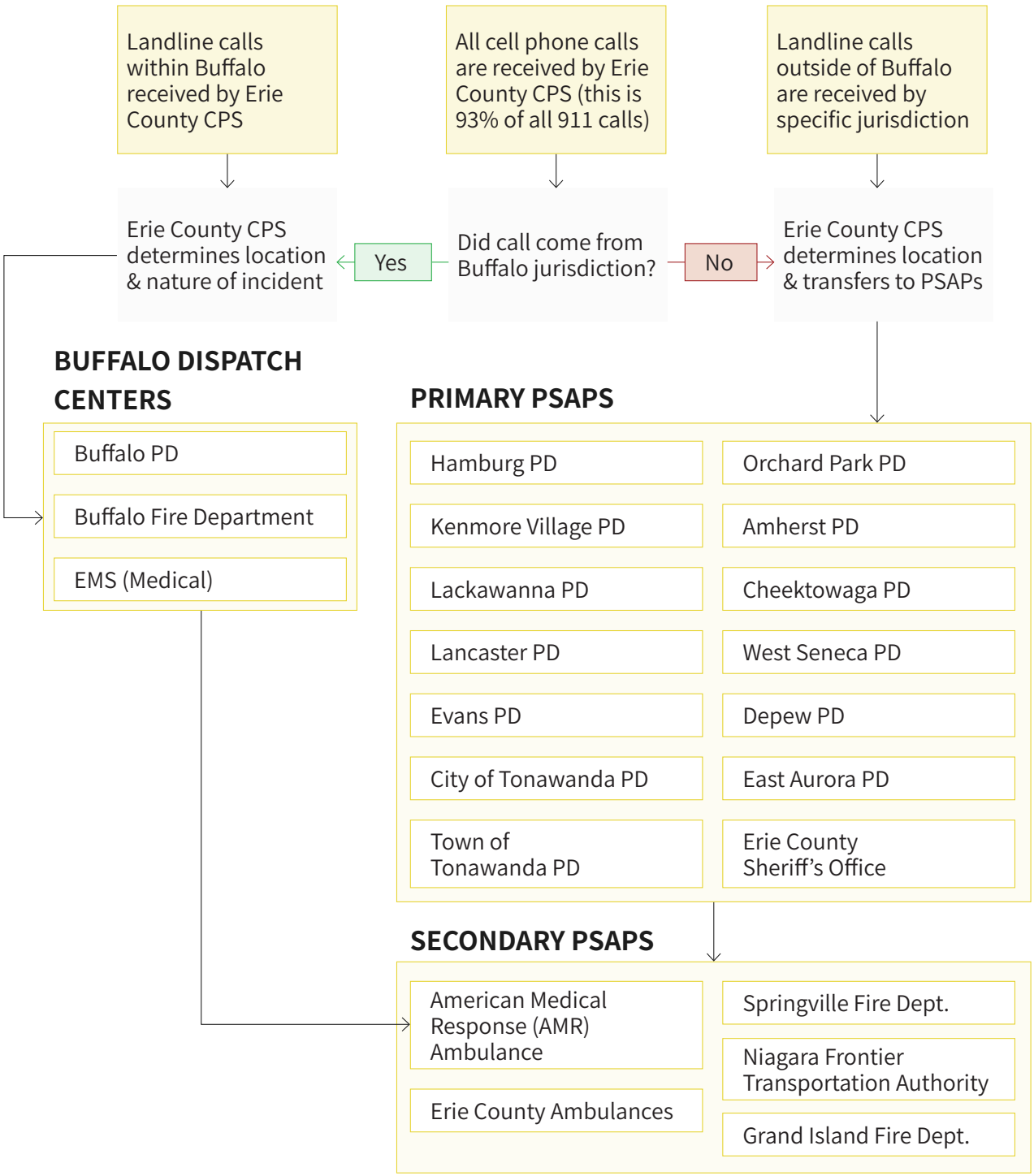
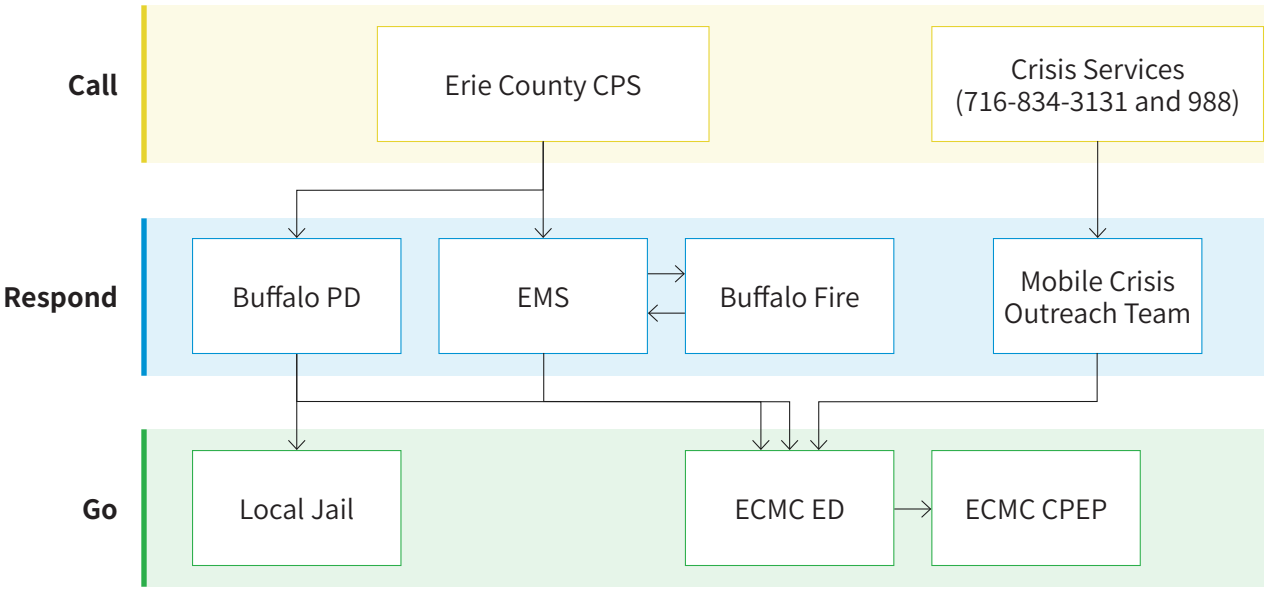


Figure 4 shows how a behavioral health-related 911 call from a Buffalo location could be dispatched and where first responders might take someone who needs immediate care. ECMC's Emergency Department (ED) is the primary destination used by first responders for behavioral health emergency calls that require more intensive services. However, a majority of calls for service with a primary behavioral health need are resolved on scene and do not require transport to the hospital.

FIGURE 4

## Processing Emergency Behavioral Health Related Calls in Buffalo*




* There are many other behavioral health providers who treat people in crisis; this figure reflects only the most commonly used resources in Erie County.

## Approximately three percent of calls to 911 are coded as "mental health-related."

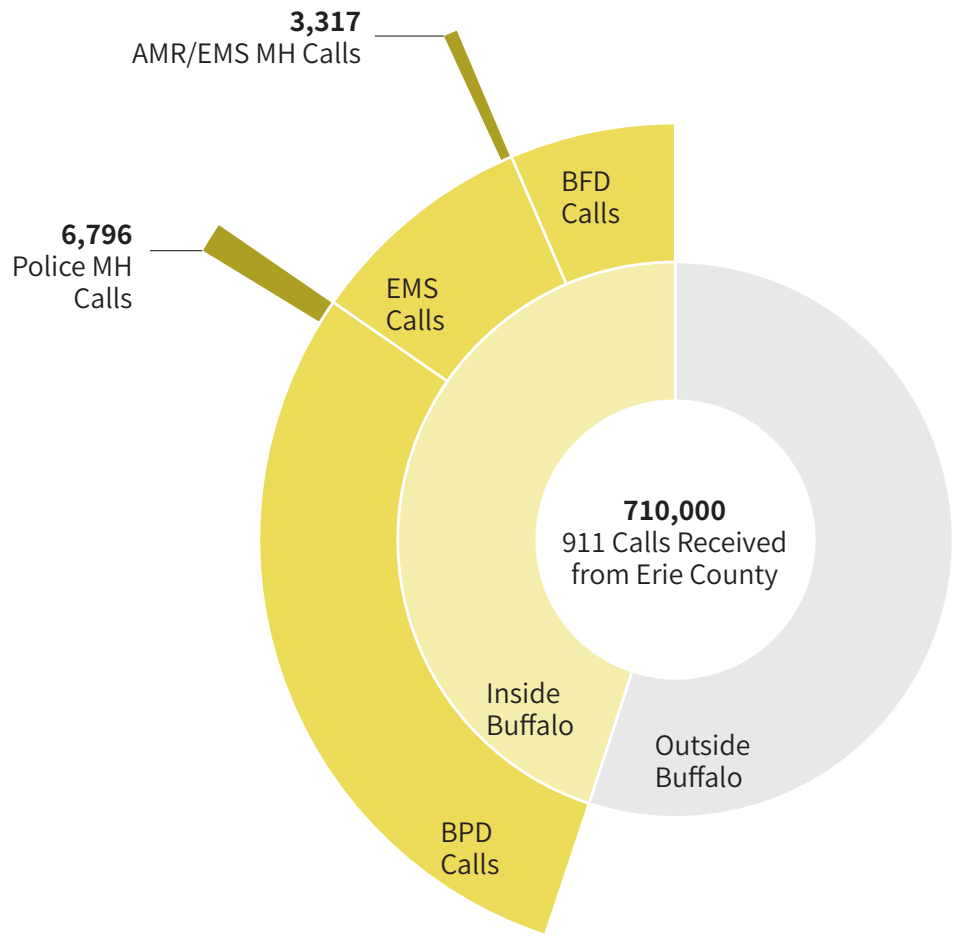
Erie County CPS received an estimated 710,000 calls to 911 in 2024, which includes calls for police, fire, or ambulance assistance. Based on an analysis of incident data from the three law enforcement agencies and from EMS, it is estimated that approximately 21,000 calls for police service and ambulance dispatches were coded as mental health emergencies.[10]

Of the estimated 203,500 calls to 911 for the City of Buffalo Police Department, 2.4 percent (n=4,850) were initially coded as mental health calls (defined as calls coded as "mental health call," "suicide," "suicide threat," or "Crisis Services assist"). An additional 1,946 calls had a disposition code indicating an underlying mental health need. So, the total number of calls identified as mental health-related comprised 3.3 percent (n=6,796) of all 911 calls, as shown in Figure 5.

10 Generally, estimated prevalence rates should be calculated based on total number of incidents, not total number of calls received, since more than one call to 911 can be made for a single incident. The migration to new CAD software should make these estimates more accurate in the future.

FIGURE 5

## Three percent of 911 Calls from Buffalo Coded as Mental Health-Related, 2024




Of the estimated 52,000 calls to 911 for the Cheektowaga Police Department, 3.0 percent (n=1,546) were coded as mental health calls. The department is currently in the process of determining additional call types that resulted in a mental health disposition code to more accurately estimate the call volume involving people reporting a behavioral health emergency.

Of the estimated 24,000 calls to 911 for the West Seneca Police Department, 1.6 percent (n=395) were coded as mental health calls. An additional 7 percent were coded as a "mental health exposure" calls (n=1,636) because dispatchers in the West Seneca Police Department identify other calls, such as welfare checks and domestic disturbances, as mental health-related.

There were approximately 3,300 calls for service coming from Buffalo and identified as psychiatric medical emergencies requiring an EMS response.

Based on call coding issues and their firsthand experience, Erie County CPS and local first responders believe mental health-related 911 calls are significantly underrepresented in current data. National estimates of police calls for service involving a behavioral health crisis are as high as 15 percent.[11, 12] Estimates are even higher from other major urban areas where improvements to the behavioral health emergency response system resulted in significant increases in calls coded as behavioral health-related. For example, a study in Galveston, Texas, found that 30 percent of police calls to 911 involved mental health needs.[13]

---

11 *Policing the Mentally Ill,* PowerDMS, December 22, 2020.

12 Another source estimates that, in some cities, 21 percent to 38 percent of 911 calls concern mental health, substance use, homelessness, or related issues. See Nicholas Turner, *We Need to Think Beyond Police in Mental Health Crises,* Vera Institute of Justice. July 20, 2020.

13 John Wayne Ferguson, *Galveston to Introduce Mental Health Response Unit,* The Galveston Daily News, June 2, 2022.

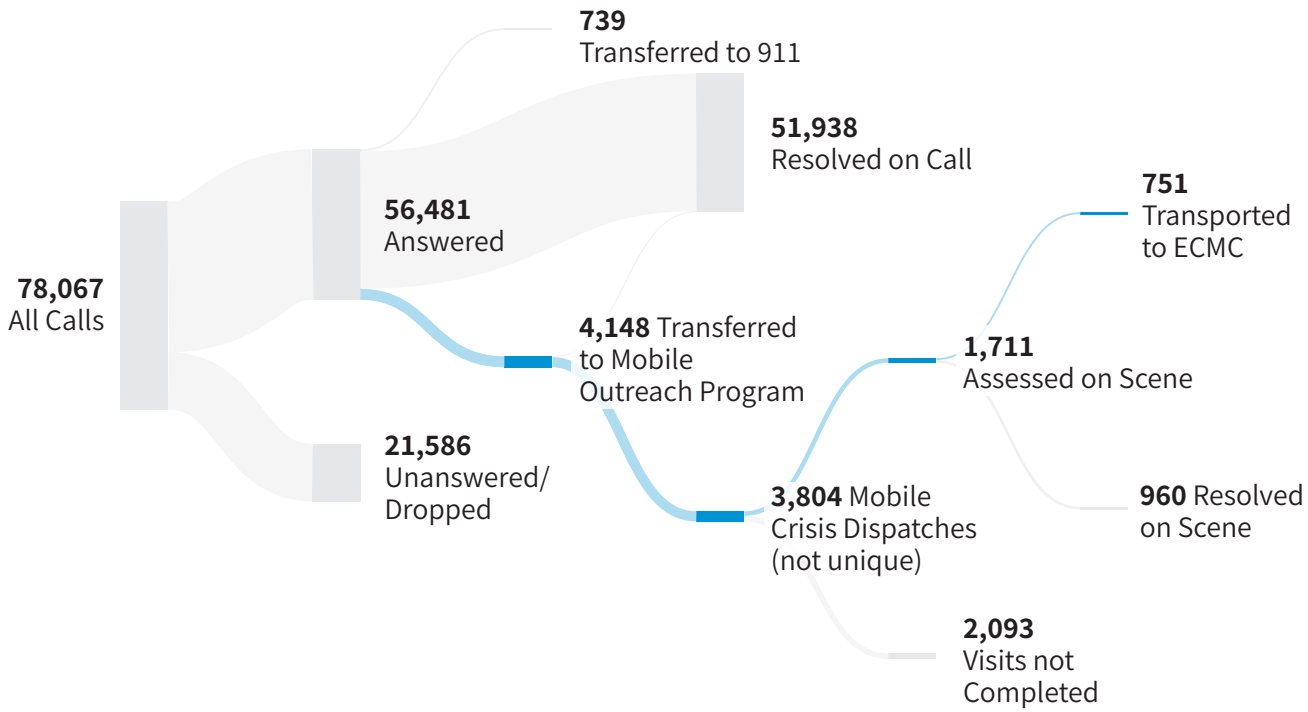
# Respond

## Mobile crisis teams demonstrate effectiveness in diverting people from the jail and emergency department.

Crisis Services operates a 24/7 Mobile Outreach Program serving Erie County, staffed by approximately 10 teams, each consisting of a master's-level licensed counselor and a bachelor's-level professional. These teams are dispatched based on the urgency of the call risk factors and if a team is readily available.

FIGURE 6

### Calls to Crisis Services Transferred to Mobile Outreach Program, 2024



A majority of calls that resulted in a completed visit — that is, one in which an assessment was conducted — led to successful stabilization of the crisis and connection to ongoing services. As a result, the Mobile Outreach Program at Crisis Services successfully diverted more than half of the individuals they served from both jail and ECMC's emergency department. Mobile crisis teams are also effective in determining when inpatient treatment is necessary. In contrast, the majority of individuals transported to ECMC under involuntary commitment by police, fire, or EMS are later found, upon psychiatric evaluation, not to require inpatient admission.

## Approximately half the time that mobile crisis teams are dispatched to the community, they are unable to complete an assessment of the person in crisis.

A majority of crisis calls fielded by the Mobile Outreach Program and deemed to be urgent are completed in an hour or less. However, many crisis calls not classified as urgent are not completed for hours or until the next day. The current staffing model is not adequate to meet demand for service. In over half of attempted visits, the individual in crisis cannot be located by the time the team arrives. Partly because of these delays, only 45 percent of calls needing a response result in a completed visit. These challenges are common among mobile crisis teams throughout the country.

## Calls to 911 coded as mental health-related typically result in a "lights and sirens" response.

Virtually all the emergency calls to 911 coded as mental health-related result in the dispatch of some combination of police and/or ambulance (EMS).[14] In Buffalo, American Medical Response (AMR) provides ambulance services. The medical dispatch priority level of the call indicates whether a fire truck and two EMS personnel from the Buffalo Fire Department will also be dispatched to provide additional medical support and manpower. It is not unusual for all three first responders — police, fire, and ambulance — to be present when there is a behavioral health emergency.

Two-thirds of calls coded as mental health-related go to the police. A call to 911 that is routed to police departments and coded as mental health-related typically results in a patrol unit being dispatched to the scene. While Crisis Intervention Team (CIT) training is widely available to police departments in Erie County, it is not guaranteed that every response to a behavioral health emergency call will involve someone trained to respond to these situations.

14 In Erie County, municipalities have contracted with private companies such as AMR to provide EMS ambulance responses to the community. Other private companies also operate in the area. For the purposes of this report, any mention of "EMS" refers to "AMR."

FIGURE 7

## Breakdown of Calls Coded as Mental Health-Related Where Buffalo, Cheektowaga, and West Seneca Police Are Dispatched

The codes each city uses that are mental health-related varies from one jurisdiction to the next. Also noteworthy is how much more frequently West Seneca PD uses their MH codes (8.5 percent), at a rate that is more than double the practice in either Buffalo (3.3 percent) or Cheektowaga (3.0 percent).

● = 10 calls

BUFFALO PD

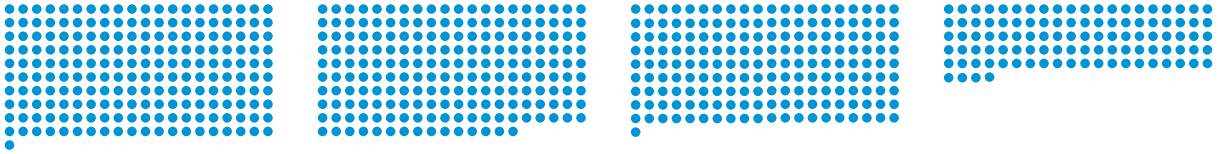
**6,796** total MH-related calls

**2,007** Suicide & Suicide Threats

**1,946** Other Call Types

**1,807** Mental Health Calls

**1,036** Crisis Services Assist



CHEEKTOWAGA PD

**1,546** total MH-related calls

**1,292** Mental Health Calls

**254** Other Mental Health Calls

WEST SENECA PD

**2,031** total MH-related calls

**1,099** Welfare Checks

**537** Domestic Disturbances

**395** Mental Health Calls

## Behavioral health co-response teams offer an alternative to traditional police-only response.

Several police departments in Erie County have established co-responder behavioral health teams (BHTs). These BHTs pair CIT-trained police officers with mental health clinicians.[15] The primary goal of these teams is to resolve crises safely while reducing criminal justice involvement and connecting community members to appropriate care.

Interviews conducted with the Buffalo, Cheektowaga, and West Seneca police departments, each of which operates a co-responder program, found that their policies and operating procedures differed. For example, some departments directly dispatch officers and clinicians to low-risk scenes. In Buffalo, however, the team is rarely dispatched directly. Instead, the Buffalo BHT monitors the dispatch board and can self-dispatch to behavioral health calls, responding alongside the directly dispatched patrol unit.

Table 1 describes how these three co-response teams compare. The sidebar illustrates the variety of co-response models in use across the country.

15 The consultants recommend that BHT mental health clinicians receive formal public safety training on situational awareness and safety protocols.

TABLE 1

## Comparison of Co-Response Models in Erie County

| Area | Buffalo PD | Cheektowaga PD | West Seneca PD |
|---|---|---|---|
| **Model** | Embedded clinician ride along (unmarked car) | Embedded clinician ride along (marked car) | Embedded clinician ride along (marked car) |
| **Referral** | Second responder (self-dispatch to calls) | First responder (direct dispatch) | First responder (direct dispatch) |
| **Hours** | Mon–Fri, 8am to 6pm | Mon–Fri, flex schedule | 24/7, on-call |
| **Police BHT Staff** | 8 officers, 2 lieutenants, 1 captain | 9 officers, 2 detectives, 2 sergeants, 1 lieutenant | Any officer can ride along with clinician* |
| **Clinicians** | 3 (contracted via Endeavor Health Services) | 1 (contracted via Endeavor Health Services) | 1 (employed directly) |
| **Can respond if weapons are present?** | No | No | Yes |
| **Can respond if drugs are present?** | No | No | Yes |

* West Seneca operates a co-response model for calls involving behavioral health crises, but the program does not yet include specialized training for officers beyond CIT training.

## Co-Response Model Variations

Across the U.S. and within states (and even counties), the design and operation of police/mental health co-response teams vary significantly from one jurisdiction to the next. Co-response approaches date back to the 1990's in Los Angeles, California, where one of the first such models, the System-wide Mental Assessment Response Team (SMART) pilot was launched, pairing a specially trained police officer with a mental health clinician.[16] Since then, cities and counties across the country have adapted and expanded the co-response concept.

**THE "SPRINGFIELD MODEL" SPRINGFIELD, MO[17]:** Launched in 2012, the Virtual-Mobile Crisis Intervention (V-MCI) program is a partnership between the Springfield Police Department and Burrell Behavioral Health. The program equips officers with iPads that allow them to connect in real time with behavioral health specialists for on-scene clinical assessments. In addition to virtual consultation, Burrell clinicians provide follow-up case management to support continuity of care for individuals encountered during crisis calls.

**BLENDED APPROACH: CO-RESPONSE + CIVILIAN FOLLOW-UP, ALBUQUERQUE, NM[18]:** The Albuquerque Police Department pairs CIT-trained officers with licensed mental health clinicians to staff traditional mobile crisis response units. After the immediate crisis is addressed, civilian crisis specialists from the Crisis Outreach and Support Team (COAST) engage in follow-up visits, providing outreach, referrals, and post-crisis support to promote longer-term stability.

**MULTI-DISCIPLINARY RESPONSE TEAM (MDRT), DALLAS, TX[19]:** In 2018, Dallas launched the Rapid Integrated Group Healthcare Team (RIGHT) Care program, a multi-disciplinary model that deploys a specially trained officer, a licensed mental health professional, and a paramedic to individuals experiencing a behavioral health emergency. This integrated team structure allows for on-scene medical evaluation, mental health assessment, and law enforcement support, enabling a more holistic and clinically informed response to behavioral health crises.

---

16 Amy C. Watson, Michael T. Compton, and Leah G. Pope, *Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models,* New York: Vera Institute of Justice, 2019.

17 Policy Research Institute, Inc. and National League of Cities, *Responding to Individuals in Behavioral Health Crisis Via Co-responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers,* January 2020.

18 Ibid.

19 Meadows Mental Health Policy Institute, *Multi-Disciplinary Response Teams: Transforming Emergency Mental Health Response in Texas,* Dallas, Texas, May 2021.

## Some aspects of the co-response models are showing a promising impact.

In 2023, Endeavor Health Services reported that 85 percent of people transported to CPEP at the direction of the Buffalo BHT were admitted to the hospital for inpatient care. By comparison, less than one-third of people brought on an involuntary status to CPEP by regular patrol officers were admitted to the hospital. The high rate of admission following the BHT clinician's recommendation demonstrates effective on-scene triage, ensuring the most appropriate population is transported for hospital admission, while others remain in the community for direct care linkages.

The West Seneca Police Department analyzed the impact of its co-responder program by comparing behavioral health call responses over the past four years — with an embedded clinician — to the preceding four-year period without one. The analysis found that transports to ECMC declined more than 30 percent for people on involuntary status.

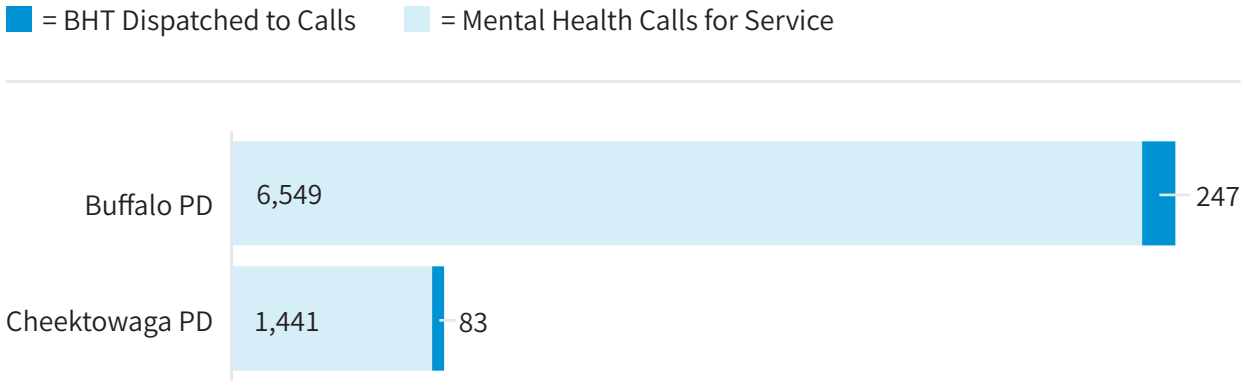
## BHTs in Buffalo and Cheektowaga respond to only a small fraction of behavioral health-related calls.

Data indicate that the Buffalo Police Department receives an average of 18 behavioral health-related calls for service each day. The BHT in Buffalo self-dispatches to one of those calls per day, but only on weekdays, as the BHT does not have staff for weekend coverage. Typically, there are two BHTs available for calls, providing coverage for the city's five districts. When BHTs respond on-scene, they are usually dispatched in addition to, not in lieu of, traditional police response.

The Cheektowaga Police Department receives an average of four mental health-related calls per day. Because there is only one BHT unit available at a time, and the team operates on a limited call eligibility policy, the BHT responds to just one out of every 18 mental health-related calls for service – in other words, a few calls per week.

FIGURE 8

**ENGAGEMENT OF CO-RESPONDER TEAMS IN BUFFALO PD AND CHEEKTOWAGA PD AT DISPATCH**




## BHTs in Buffalo and Cheektowaga are primarily used for follow-up visits.

The BHTs in Buffalo and Cheektowaga provide up to three follow-up visits for each individual who has experienced a behavioral health emergency. These follow-up visits occur not only for cases to which the BHT responded initially, but also for the behavioral health-related dispatches that regular patrol officers flagged as needing support, including people who were transported to CPEP on an involuntary status.

Data indicate that Buffalo's BHT engaged in at least 2,000 follow-up visits in 2024, and Cheektowaga's BHT engaged in at least 500 follow-up visits. Follow-up visits play an important role in ensuring engagement in treatment; however, the current model limits the availability of the BHTs to respond to active emergency scenes, where their skills in de-escalation, assessment, and support are most needed.

# Go

## When police or EMS respond to a call coded as mental health-related, and immediate care is required, they almost always transport the person to ECMC.

ECMC is the only hospital in Erie County that operates 24/7 and can provide immediate psychiatric evaluation and treatment for individuals experiencing an acute behavioral health crisis through CPEP. While people can go to CPEP voluntarily for acute crises, the state's Mental Hygiene Law requires that people transported involuntarily to a hospital for psychiatric evaluation and treatment must be taken to a CPEP.

### Mental Hygiene Law

New York State's Mental Hygiene Law defines a comprehensive legal framework for providing mental health services to people in the state. Some sections of the law specify circumstances under which an order for emergency assessment, care, and treatment for individuals in mental health crisis can be required.

**§ 9.41** – Allows a police officer/peace officer to transport (involuntarily) an individual who is believed to be at risk of harm to themselves or others to a CPEP.

**§ 9.45** – Allows a director of community services or the director's designee to transport (involuntarily) an individual to a CPEP based on direct assessment or reports of risk of harm to self or others.

ECMC's ED received approximately 10,000 people in 2024 who were reporting a behavioral health-related emergency, which represents one out of every seven emergency department visits.[20] These individuals were referred to CPEP for further evaluation.[21] This volume of visits makes ECMC one of the busiest CPEPs in New York State.

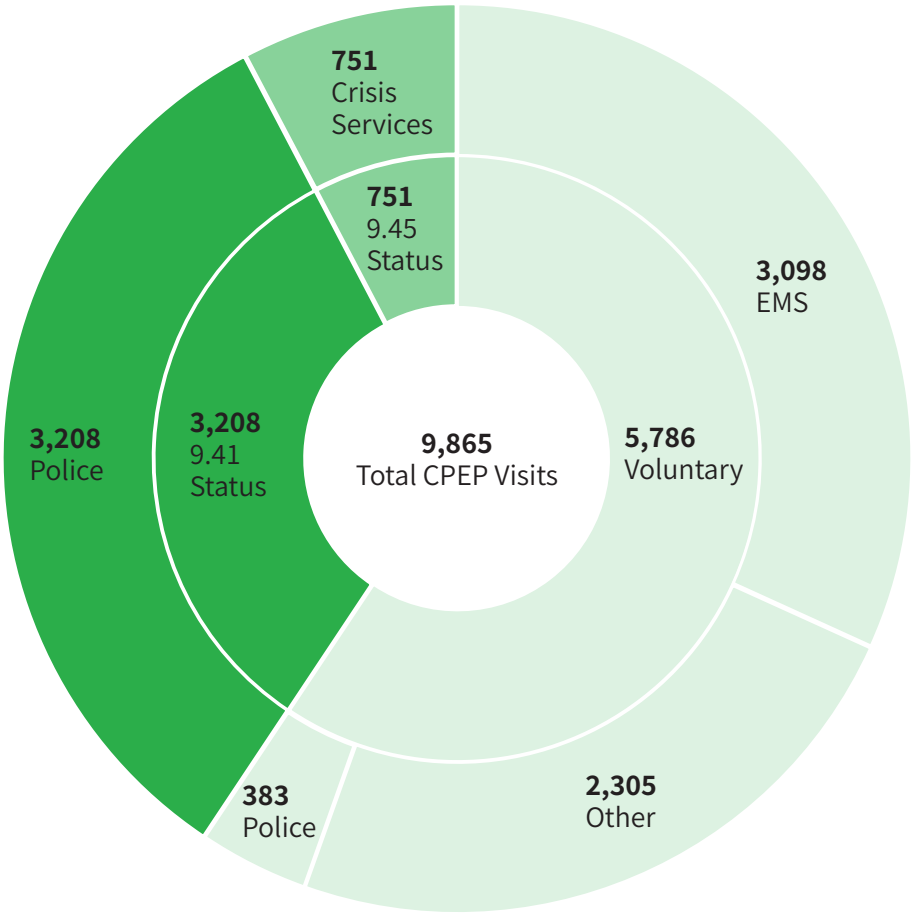
One-quarter of people arriving at CPEP in 2024 were later admitted to ECMC for inpatient treatment (n=2,480), suggesting that many visitors could have been served through alternative community-based programs rather than the hospital.

20 This figure does not include the substantial number of people who come to the emergency department and do not describe their health situation as behavioral health-related. Physicians at ECMC's ED report that it is very common to determine that a behavioral health need is driving requests for health services (e.g., when a person complaining of chest pains is suffering a panic attack).

21 Whether an individual with a behavioral health emergency walks in to ECMC or is brought by a first responder, that individual must first undergo a health screening at the ECMC ED before receiving a referral to CPEP for evaluation.

FIGURE 9

## ECMC Visits by Status & Mode of Transportation, 2024



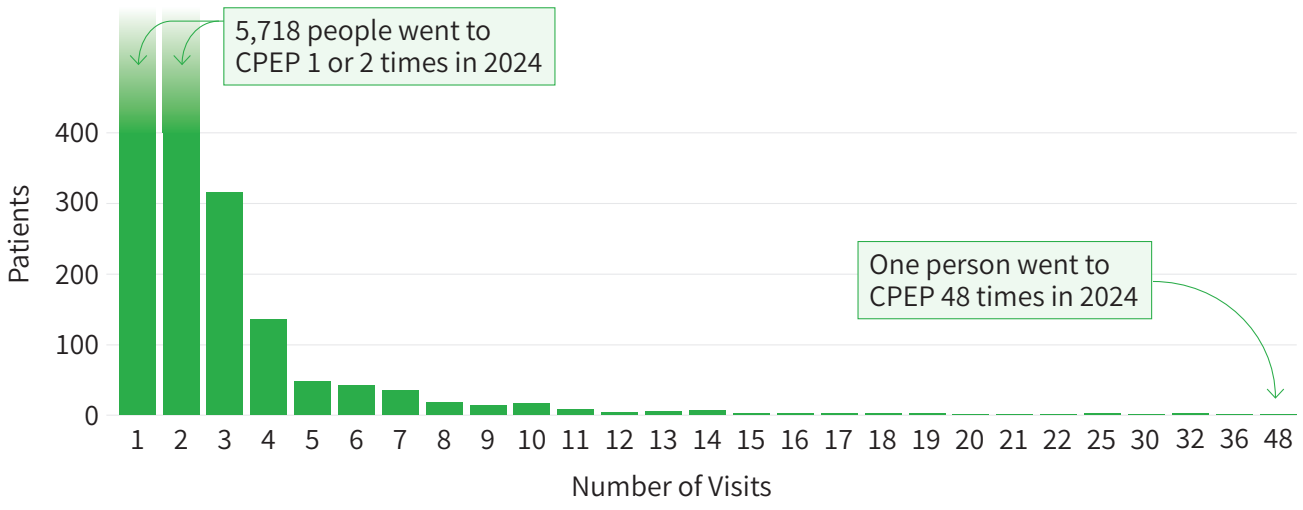

One-third of people arriving at CPEP were brought by law enforcement on an involuntary status (n=3,208). Approximately 29 percent of people brought on an involuntary status were subsequently admitted for inpatient treatment (n=916) at ECMC, also suggesting that many people transported on an involuntary status could have benefited from an alternative service. For the three police departments that provided data as part of this initiative, the analysis found that between 12 and 16 percent of all behavioral health-related calls for service resulted in an individual being transported to ECMC's CPEP on an involuntary status.

## One-third of CPEP visits in 2024 involved people with three or more CPEP evaluations within the past 12 months.

In 2024, 669 individuals were responsible for more than one out of three (n=3,405) visits to CPEP, as illustrated in Figure 10. This analysis found that these high-frequency patients often needed three or more visits in the same calendar year.

FIGURE 10

### CPEP Visitors in 2024




Eighty-five percent of visits by this high-frequency population were covered under a Medicare or Medicaid insurance program.

## Relying on ECMC to care for people experiencing a behavioral health emergency has significant costs.

ECMC estimates that the total annual cost for outpatient CPEP encounters is $23.3 million, with each CPEP encounter costing three times as much as a regular emergency department visit: $3,154

compared to $1,035. Sixty percent of visits to CPEP involve people covered under a Medicaid insurance plan. After preliminary intake, wait times at CPEP for psychiatric assessments frequently exceed three to four hours, exacerbating an already difficult experience for patients. During this period, police officers are required to remain with the individual, contributing to extended law enforcement engagement and reduced patrol availability.

## It was not possible to calculate through this analysis the percentage of 911 calls that resulted in an arrest of a person with a behavioral health need.

Almost none of the 10,000 calls to 911 coded as mental health-related in 2024 resulted in an arrest. As indicated earlier, if these individuals needed immediate care, they were transported to ECMC. Since only calls coded as mental health-related — not all 911 calls involving a behavioral health emergency — were analyzed, the overall arrest rate for behavioral health-related emergencies could not be determined.

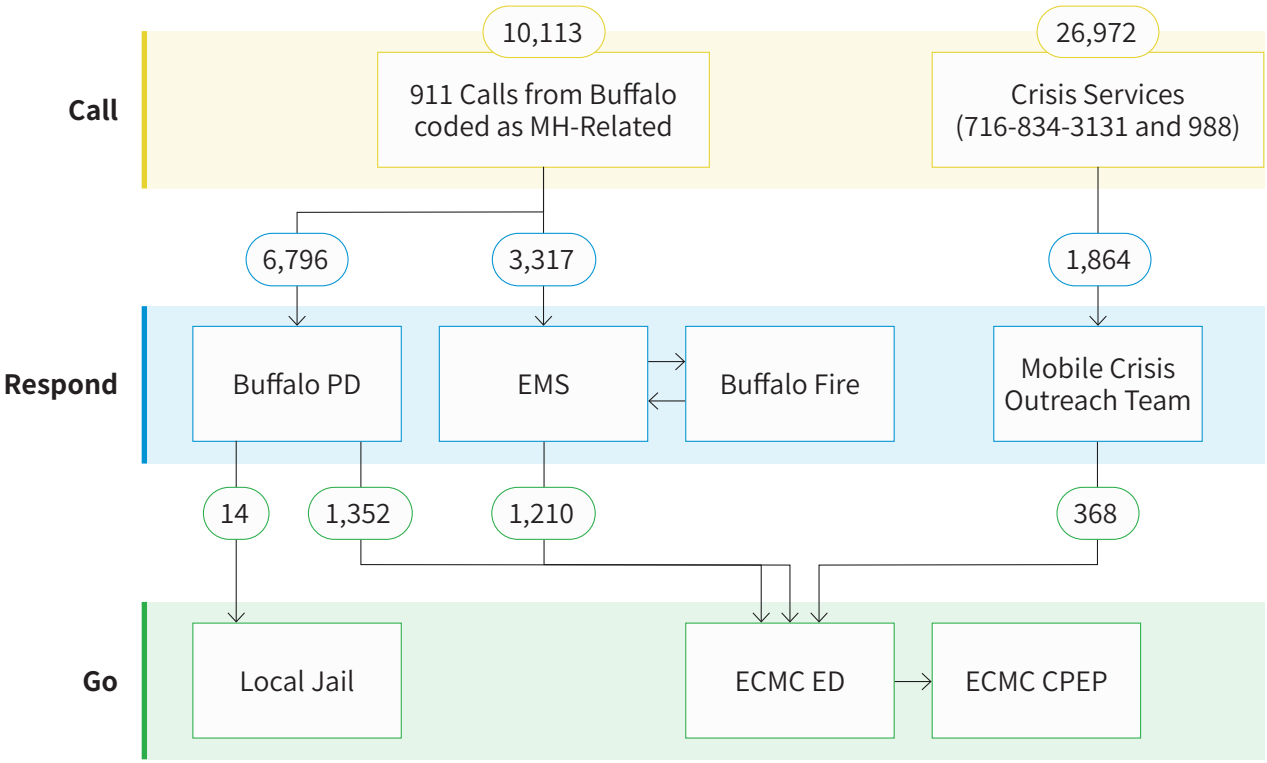
What is known is that approximately 2,800 people (54 percent) admitted into the Erie County Holding Center (ECHC) or the Erie County Correctional Facility (ECCF) in 2024 were referred to the forensic mental health team for assessment. Nearly one-quarter of people admitted to ECHC (n=1,251) were diagnosed with an Axis I (mental health or substance use) disorder. No data were available regarding the behavioral health needs of people who were arrested, ticketed, and released pursuant to New York State's bail reform laws.

# Overview of Behavioral Health-Related Calls from Buffalo

Figure 11 illustrates the estimated number of calls from Buffalo that are placed to emergency hotlines and are identified as mental health-related. The figure  describes who is dispatched to such emergencies and where people who need immediate care are transported. A more thorough assessment of the volume of behavioral health calls in Erie County will be undertaken using CAD and RMS data, which is expected to provide a more accurate picture of the volume of behavioral health-related calls and the nature of related responses.

FIGURE 11

## Overview of emergency calls from Buffalo coded as Behavioral Health Related, 2024




## Additional analysis is needed to understand engagement in treatment prior to and following a behavioral health emergency.

While the CTC Collaborative focuses on behavioral health crisis response, evidence suggests that improvements in ongoing community care can reduce the number of instances where crises develop. An estimated 80 percent of individuals in crisis seen by the co-responder teams or Crisis Services have been engaged in community care. However, data on their care prior to the crisis — including missed appointments and medication adherence — have not been received or analyzed, so it is unclear whether they had adequate follow-up care before their crisis.

# Opportunities to Improve Crisis Response in Erie County

A number of recently launched or planned initiatives create opportunities to improve the behavioral health emergency response system in Erie County. Examples include the following:

**INTENSIVE CRISIS STABILIZATION CENTER:** In 2025, BestSelf Behavioral Health will open the BestResponse Intensive Crisis Stabilization Center (ICSC) in Buffalo. The ICSC is designed as a community-based alternative to the emergency department, providing immediate access to mental health and substance use crisis services for youth and adults, regardless of insurance status. It will be the first facility of its kind in Western New York and one of several that have already opened throughout New York State. Modeled after nationally recognized crisis stabilization centers, the ICSC will operate 24/7 and will accept both walk-ins and first responder voluntary transports, offering a streamlined drop-off process measured in minutes — not hours.

**988:** Since the National Suicide Hotline Designation Act was signed into law in 2020, state and local officials in New York have been building the infrastructure to support calls, chats, and text messages available under 988. All 62 counties in the state had successfully implemented 24/7 in-state coverage by 2023. In Erie County, Crisis Services has operated the 24-hour crisis hotline since 1968 and the mobile outreach program for 40 years, and is also responsible for taking 988 calls. However, some challenges involving workforce limitations and subsequent response times have influenced the number of crisis hotline calls being answered.

**MOBILE CRISIS TEAMS:** Crisis Services operates the county's mobile outreach program. In 2024, mobile crisis teams conducted over 3,800

visits to the community to respond to someone in crisis, sometimes attempting to visit the same person more than once before face-to-face contact was made. Assessments were conducted for over 1,700 people. The limited staffing model — coupled with long wait times for police, ambulance, and repetitive attempts to find a client — affected the mobile outreach program, resulting in varying intervals between an initial call for help and the team arriving on-scene to assess the client. The CTC Collaborative is working with Crisis Services to address its staffing needs for the mobile outreach program.

**CAD SOFTWARE:** Erie County CPS is engaged in a major overhaul of its CAD software. In adopting new software, Erie County CPS is exploring how to make it easier to flag calls that are mental health-related, how to train telecommunicators in using these features, and how to streamline transfers of calls between Erie County CPS telecommunicators and dispatchers employed by municipalities across the county.

**CO-RESPONDER TEAMS:** Police executives in Buffalo, Cheektowaga, and West Seneca report that their police departments are short-staffed and are open to considering how to expand and/or redeploy co-responder teams so they can make better use of limited policing resources.

**ECMC HELP CENTER:** Responding to the overuse of CPEP for care that does not require hospitalization, ECMC created the Help Center at the hospital that can provide counseling and support for people needing this level of care. Although the program has demonstrated benefit for patients and served over 1,200 people in 2024, there remains additional potential for reducing CPEP overuse through increased awareness, targeted communication about program purpose and services, and the accessibility of the Outpatient Behavioral Health building on the ECMC campus.

**NURSE NAVIGATION:** Erie County has approved the implementation of a nurse navigation program[22] with GMR, which intends to reduce the number of EMS calls involving non-emergency or low acuity medical

22 The Nurse Navigation Program was developed by Global Medical Response. In Erie County, American Medical Response would be operating the nurse navigation system.

needs where an ambulance is dispatched. In a nurse navigation program, a 911 dispatcher asks a series of questions to determine whether the call is life-threatening and requires a traditional EMS response, or if it can be routed to a nurse navigator to coordinate an appropriate response. It is estimated that up to 30 percent of 911 calls involving medical needs are non-life-threatening, and reducing the number of ambulatory dispatches for those cases would free up these resources for more serious medical cases. In utilizing this program for specific call types, detailed questions can guide a more appropriate response and intentionally direct patients to more appropriate care.

**DATA COLLECTION:** This report required the collection and analysis of data maintained by 10 independent government agencies and nonprofit health organizations — an effort that required extensive time, resources, and political commitment. Never in Erie County (or New York State) has there been such an undertaking. Now, the foundation exists to generate periodic reports that can be used by city and county leaders to measure progress and troubleshoot problems.

**MENTAL HEALTH CRISIS RESPONSE TRIAGE TOOL:** Together with the Erie County Department of Mental Health, a committee of community-based providers and advocates helped to refresh the mental health triage tool launched by the Millenium Collaborative Care Delivery System Reform Incentive Payment (DSRIP) initiative. This tool was created for behavioral health providers, mental health clinicians, and first responders to use as a guide to assess what level of response/care is needed when someone is seeking, or appears to need, immediate behavioral health services. The tool is now available and has the potential to reduce excessive and unnecessary reliance on expensive and intrusive settings and facilitate timely access to the right level of care.

# Conclusion

The findings in this report detail the default response to a behavioral health emergency in Erie County, New York. A call is placed to 911, police and ambulance services are engaged for on-site assistance, and ECMC is the primary destination for immediate care. Improvements to the current system could result in better health outcomes for individuals and optimize the use of the county's limited resources. While several pilot projects have been launched to address these challenges, their impact to date remains very limited.

This situation is common in counties across the country. What sets Erie County apart is the strength of its leadership and support in this area, bolstered by significant philanthropic investment. The combination of existing pilots and emerging efforts presents a unique opportunity to advance meaningful systemwide improvements in the behavioral health emergency response system.

# Appendix

## Contributors to the Project

**The Crisis to Care Collaborative would like to thank the following agencies and organizations for their contributions:**

American Medical Response, Inc. • BestSelf Behavioral Health • BryLin Hospital • Cheektowaga Police Department • City of Buffalo Behavioral Health Team • City of Buffalo Fire Department • City of Buffalo Police Department • Crisis Services • Endeavor Health Services • Erie County Central Police Services • Erie County Department of Mental Health • Erie County Medical Center • Erie County Sheriff's Office • Hilbert College • Horizon Health Corporations • Jericho Road Community Health Center • Mental Health Advocates of WNY • Mental Health Peer Connection, part of the WNY Independent Living Family of Agencies • National Alliance on Mental Illness (NAMI) Buffalo & Western New York • New York State Office of Mental Health • Partnership for the Public Good • Patrick P. Lee Foundation • Peter & Elizabeth C. Tower Foundation • Recovery Options Made Easy • Restoration Society, Inc. • Spectrum Health and Human Services • University at Buffalo, Division of Forensic Psychology • Value Network IPA, LLC • Villa Maria College • West Seneca Police Department

Numerous meetings, working groups, and listening sessions were convened over the course of 2024 and 2025 involving county officials, county and local law enforcement, behavioral health and medical treatment providers, community advocates, peer specialists, people with lived experiences, and state agency officials. Each of these organizations contributed to the overall understanding of behavioral health emergency response in Erie County.

# Data Sources Used for This Report

The project team thanks the many organizations that contributed data to this initiative.

**AMERICAN MEDICAL RESPONSE, INC.** AMR data for emergency calls from within the City of Buffalo were analyzed for this report.

**BUFFALO FIRE DEPARTMENT.** BFD provided two years of case-level/raw AMR ambulance dispatch data for psychiatric calls. This information included the Emergency Medical Dispatch level of response, outcomes, and the hospital to which someone was transported.

**BUFFALO POLICE DEPARTMENT.** BPD provided four quarterly reports that presented the total number of mental health-related calls aggregated by call types and call dispositions from 2024. The reports also break down information by day of the week, hour of the day, and police district, which could allow a high-level analysis of districts with the highest volume of mental health-related calls.

**CHEEKTOWAGA POLICE DEPARTMENT.** CPD provided a spreadsheet of aggregated numbers showing the volume of calls identified by the department as mental health-related. The department also provided three years of case-level data on transports to CPEP of people on involuntary status.

**CRISIS SERVICES.** Crisis Services provided a tracking spreadsheet of hotline call volumes and mobile crisis unit dispatches for 2022–2024. Over the course of the project, they shared data updates covering the most recent trends.

**ENDEAVOR HEALTH SERVICES.** Endeavor Health Services shared a tracking spreadsheet containing data on the number of unique cases in which an embedded clinician was engaged in a call for service and follow-up visit. The data included services provided in Buffalo, Cheektowaga, Hamburg, and Niagara Frontier Transportation Authority.

**ERIE COUNTY CENTRAL POLICE SERVICES.** Erie County CPS worked with the project team early on to provide data on mental health-related calls that might have been eligible for the pilot effort on interoperability between 911 and the local crisis hotline. Erie County CPS also provided estimates on the total number of 911 calls received each year.

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH.** The Division of Forensic Mental Health Services shared an annual report that detailed the number of people admitted to custody in 2024 who were referred for a mental health assessment and the number who received treatment while in custody. The report also provided the proportion of people with serious mental illness incarcerated in the county jail.

**ERIE COUNTY MEDICAL CENTER.** ECMC provided several de-identified case-level/raw data files for this analysis, allowing the project team to identify the number of people seen at CPEP on a § 9.41 or § 9.45 status, the type of arrival and type of discharge, the proportion of high-frequency visitors out of all CPEP visits, and various insurance details. The reports included an aggregate spreadsheet of the total number of people in 2024 who were seen at CPEP, placed in extended observation beds, and admitted to inpatient treatment.

**ERIE COUNTY SHERIFF'S OFFICE.** The project team spoke with individuals from ECSO to put the jail population with mental illness into the context of larger admission trends. ECSO communicated the total number of admissions in 2024, as well as a breakdown by felony and misdemeanor cases, gender, and other details.

**RECOVERY OPTIONS MADE EASY.** ROME provided an aggregated report of 2024 crisis residence bed utilization.

**WEST SENECA POLICE DEPARTMENT.** WSPD provided outcomes data for the pre- and post-period of the co-responder program to demonstrate the impact of having an embedded clinician in the department.

Nearly all the data compiled for this report involved aggregated metrics, and the quality of the data was mixed. For the case-level data, a lack

of standardized data formats and definitions can lead to inconsistency in the content, complicating trend analysis. In many cases, the data were incomplete, or placeholder values were entered where null values should have been. Aggregated data offer less insight into the nature of interactions at various points across the behavioral health emergency response continuum. Some of the data points were gathered during meetings and interviews, as formal reports either have not yet been developed or do not provide sufficient details of the crisis response activity.

Publicly available reports on the number and type of 911 calls are not readily available. Data received for this effort were insufficient to distinguish between the number of calls to 911 and the number of incidents being reported. The project team is undertaking an analysis of CAD and RMS data, which will provide a greater understanding of these trends.

Data findings from police departments in Buffalo, Cheektowaga, and West Seneca are included in this report both because of the willingness of these departments to participate in the CTC Collaborative and their use of behavioral health co-responder teams as one of the tools available to respond to behavioral health crises. Trends from other municipalities would be useful to collect in future reporting.

The project team was able to quantify the people calling 911 or calling Crisis Services to access services during a behavioral health crisis. They were not able to determine how many of those people were received behavioral health treatment prior to the crisis taking place. Nor were they able to determine how many people engaged in treatment after release from ECMC or after being seen by clinicians from Crisis Services or from a BHT. A primary goal of the CTC Collaborative is to establish a system that tracks engagement and continuity of care for people receiving behavioral health services.

# Consultants / Report Authors

**DR. MICHAEL HOGAN** has a career spanning many decades working in the mental health system for state governments. He served as the New York State commissioner of mental health, overseeing 23 accredited psychiatric hospitals and managing a $5 billion public mental health system. Prior to that role, he served as the state commissioner of mental health in Ohio and Connecticut. Dr. Hogan chaired the President's New Freedom Commission on Mental Health (2002–2003) and was appointed as the first behavioral health representative on the board of The Joint Commission (2007) and as a member of the National Action Alliance for Suicide Prevention (2010). He served on the National Institute of Mental Health's National Advisory Mental Health Council (1994–1998 and 2014–2018), as president of the National Association of State Mental Health Program Directors (2003–2005), and as board president of the National Association of State Mental Health Program Directors Research Institute (1989–2000).

**MICHAEL THOMPSON** has spent more than 30 years leading and advising nonprofit, government, and philanthropic organizations. He served in senior leadership positions at The Pew Charitable Trusts, and he was the founding director of The Council of State Governments Justice Center. Over the course of his career, he has authored dozens of reports and testified many times before the U.S. Congress and state legislatures about strategies to increase access to behavioral health services for people with mental health and substance use disorders who are in contact with the justice system.

**ANGELA GUNTER** has spent 15 years working in the field of criminal justice policy analysis and, in recent years, has focused her efforts on people in the criminal justice system with behavioral health needs. She has worked with counties to document the flow of people with mental illness through arrest and pretrial processing, with large community supervision agencies to assess the impact of specialized mental health caseloads, and with the state systems to explore the prevalence of people in the justice system with a documented history of domestic

violence involvement. She also has experience with state agencies focused on victims and victim services.

**B.J. WAGNER** has worked with the Meadows Mental Health Policy Institute since 2015 and currently serves as the Executive Vice President for Health and Public Safety. With a unique background in law enforcement, criminal justice, and mental health policy, she focuses on the intersection of behavioral health and justice systems with a specific focus on emergency response models. Among her many contributions to the field, she was the primary architect of the first Multidisciplinary Response Team (MRT) in Texas, a model now being adopted in multiple sites across the state and the country. She also worked with the Texas legislature to launch the Texas Blue Chip program, which is the state's first peer network specifically focused on ending suicide among law enforcement personnel. She has developed curricula for disciplines across the criminal justice system on mental health awareness, symptom recognition, and verbal de-escalation techniques.

# Letter from Leadership Committee

December 12, 2024
Jane Mogavero, Executive Director
Patrick P. Lee Foundation
5166 Main Street, Suite 303
Williamsville, NY 14221

Dear Ms. Mogavero:

We are writing to request assistance from the Patrick P. Lee Foundation with the development of a plan to improve the response to people experiencing a behavioral health emergency in Erie County.

Every day, multiple times a day, calls from Buffalo and surrounding communities are placed to 911 involving someone who needs immediate assistance because of a mental health or substance use related crisis. We have worked hard to improve how those calls are processed, who is dispatched when an on-scene response is necessary, and where someone is brought when immediate care is needed. Although these efforts have resulted in important innovations and improvements, local law enforcement continue to respond regularly to behavioral health emergencies and many first responders report that their only option when someone needs immediate care is to bring them to ECMC's Comprehensive Psychiatric Emergency Program (CPEP). Additional improvements are necessary to increase the likelihood people in crisis are connected to the appropriate level of care that helps them recover. Such improvements would also help the city and county save money and make better use of scarce public safety resources.

We recognize addressing this situation requires extensive collaboration among multiple stakeholders representing municipal, county, and

state government, as well as people working in public safety and behavioral health. Support from the Patrick P. Lee Foundation could help us convene such stakeholders, collect and analyze data to better understand the current situation, and engage national experts who could determine where opportunities exist to improve existing policies. In making this request we are committed to the following:

1. Ensuring various data is made available to expert consultants including information regarding calls to 911 and other hotlines; the use of alternative responses, such as mobile crisis; and the use of jail, CPEP, and other options available to police and other first responders dispatched to a scene involving a person experiencing a behavioral health emergency.
2. Meeting and working together to review findings and recommendations from expert consultants.
3. Sharing with the public the initiative, conclusions, and next steps resulting from this process.

We appreciate your consideration of this request.

Sincerely,

Lisa M. Chimera

Lisa Chimera
Deputy County Executive
Erie County
95 Franklin St #1600
Buffalo, NY 14202

John C. Garcia

John C. Garcia
Sheriff
Erie County Sheriff's Office
10 Delaware Avenue
Buffalo, NY 14202

Thomas J Quatroche Jr.

Thomas J. Quatroche, Jr., PhD
President and CEO
ECMC
462 Grider Street
Buffalo, NY 14215

Mark O'Brien

Mark O'Brien, LCSW-R
Commissioner of Mental Health
Erie County
95 Franklin St. Rm 1237
Buffalo, NY 14202

Brian G. Ross

Brian Ross
Commissioner
Erie County Central Police Services
45 Elm Street
Buffalo, NY 14203

christopher p. scanlon

Christopher P. Scanlon
Mayor
City of Buffalo
65 Niagara Square
Buffalo, NY 14202

Design, Layout, and Data Visualization: Juan Thompson

crisis to care
COLLABORATIVE

CrisisToCare.org