



Crisis to Care
COLLABORATIVE

2026 Progress Report

Erie County, New York
September 2026



Additional financial support was provided by the Peter & Elizabeth Tower Foundation and the Garman Family Foundation, which is administered by the Community Foundation for Greater Buffalo.

Contents

Contents..... 1

Executive Summary..... 2

Crisis to Care (CTC) Collaborative Background..... 6

Measurable Goals 10

 Objective 1: Improve the coding of 911 calls.....12

 Objective 2: Improve answering rates for crisis hotline calls.17

 Objective 3: Route at least 500 “Code 25” calls to nurse navigators.....21

 Objective 4: Improve and expand utilization of co-response programs.25

 Objective 5: Increase the rate at which mobile crisis teams complete assessments.33

 Objective 6: Increase the use of alternatives to CPEP.37

 Objective 7: Reduce repeat visits to CPEP.....42

 Objective 8: Ensure engagement in post-crisis treatment.45

 Objective 9: Support the workforce.48

 Objective 10: Support county-led initiatives and monitor progress.50

Conclusion..... 52

End Notes 53

Appendix 56

Executive Summary

OVERVIEW

The Erie County Crisis to Care (CTC) Collaborative is a public/private partnership that seeks to:

1. Ensure that people experiencing a behavioral health emergency receive accessible, effective behavioral health crisis stabilization services and follow-up care.
2. Reduce the likelihood that individuals in crisis are arrested or inappropriately taken to the Comprehensive Psychiatric Emergency Program (CPEP) at Erie County Medical Center (ECMC).

The CTC Collaborative is designing and implementing a plan that draws on the analysis of

extensive data, expertise of national consultants, and extensive consultation with people in Erie County who work on the front lines of public safety, emergency services, and behavioral health.

The CTC Collaborative organizes its work into three components: how calls to 911/988 involving a behavioral health emergency are processed (**CALL**); who is dispatched when an on-scene response is necessary (**RESPOND**); and, where someone who needs immediate care is transported (**GO**).

The CTC Collaborative is funded by the Patrick P. Lee Foundation. Additional support is provided by the Peter & Elizabeth Tower Foundation and the Garman Family Foundation, administered by the Community Foundation for Greater Buffalo.

MEASURABLE GOALS

	OBJECTIVE	2026 TARGET
Call	1. Improve the coding of 911 calls.	In Buffalo, Cheektowaga, and West Seneca PDs, code 13,000+ 911 emergency calls as behavioral health-related (up from 9,734 in 2025).
	2. Improve answering rates for crisis hotline calls.	Answer 85% of calls (up from 70% in 2025).
Respond	3. Route at least 500 “Code 25” calls to nurse navigators.	Route 500 Code 25 calls from Buffalo to nurse navigators (up from 0 in 2025).
	4. Improve and expand utilization of co-response programs.	Targets are department-specific — Buffalo, Cheektowaga, and West Seneca PDs are each working to increase behavioral health-related calls involving Behavioral Health Team officers and clinician co-responders.
	5. Increase the rate at which mobile crisis teams complete assessments.	Complete 65% of MCT community assessments (up from 49% in 2025).
Go	6. Increase the use of alternatives to CPEP.	Achieve 152 average monthly presentations (~5 per day) at the Intensive Crisis Stabilization Center (ICSC), (2025 data NA). Reduce ECMC CPEP visits to 8,987 (down from 9,963 in 2025).
	7. Reduce repeat visits to CPEP.	Reduce the number of visits by people with three or more visits in a year to 30% of annual CPEP visits (down from 35% in 2025).
	8. Ensure engagement in post-crisis treatment.	Partners continue to have conversations around multi-year targets.
Cross-Cutting	9. Support the workforce.	In partnership with University at Buffalo School of Social Work, regional strategies to support the workforce are being identified.
	10. Support county-led initiatives and monitor progress.	County leadership is working to identify multi-year targets.

PROJECT TIMELINE

- **December 2024** Top elected officials in Erie County write to the Lee Foundation seeking assistance to improve the response to people in crisis.
- **May 2025** The Leadership Committee, which includes the mayor of Buffalo, the CEO of the Erie County Medical Center, the county sheriff, the deputy county executive, the commissioner of Erie County Central Police Services, and the commissioner of the Erie County Department of Mental Health, in partnership with the executive director of the Lee Foundation, launches the Crisis to Care Collaborative.
- **August 2025** The CTC Collaborative begins convening listening sessions with advocacy groups and members of the community.
- **December 2025** The CTC Collaborative releases the *Status Report*, describing findings from an exhaustive analysis of 2024 data drawn from ten government agencies and health providers, and contributions from over 30 agencies participating in working groups.
- **September 2026** The CTC Collaborative publishes the *2026 Progress Report*, which provides ten objectives for improving crisis response across Erie County and based on what data showed in 2024, identifies targets that the CTC Collaborative expects to hit by end of 2026.

WHAT'S AHEAD

In early 2027, the CTC Collaborative's Leadership Committee and the Lee Foundation will evaluate progress towards the objectives and targets outlined in the *2026 Progress Report*. The findings will inform the development of a long-term strategic plan which will have clear milestones for the next 3–5 years. Realizing those goals has the potential to transform behavioral health emergency response in Erie County and to serve as a model for New York State and beyond.

Crisis to Care (CTC)

Collaborative Background

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 collaboration 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 (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 & Elizabeth Tower Foundation (Tower Foundation), the committee engaged nationally recognized experts to conduct an independent review of Erie County's behavioral health crisis response system.¹ 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 fielded²
- 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 Erie County Medical Center (ECMC), first responders, 911 call takers, officials representing the New York State Office of Mental Health (OMH), 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 small committee that included the deputy county executive of Erie

County, the mayor of Buffalo, the commissioner of Erie County Central Police Services (CPS), the commissioner of the Erie County Department of Mental Health (DMH), the Erie County sheriff, the chief executive officer of ECMC, and the executive director of the Lee Foundation. This Leadership Committee launched the CTC Collaborative, which has two 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 individuals in crisis are arrested or inappropriately taken to the Comprehensive Psychiatric Emergency Program (CPEP) at 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. Additional support is being provided by the Tower Foundation and the Garman Family Foundation administered by the Community Foundation for Greater Buffalo.

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.³ Among these efforts, the CTC Collaborative stands out for several reasons:

- 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.

- The 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 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.
- Three working groups—focused on the Call, Respond, and Go areas described above—undergird the CTC Collaborative’s work. Each working group includes representatives of crisis response and behavioral health service providers, ECMC, local law enforcement, emergency medical services (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.
- An Advocacy Working Group, which includes representatives of National Alliance on Mental Illness (NAMI) Buffalo and Western New York, Mental Health Advocates of WNY, community advocates, and several 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.

COMPREHENSIVE ANALYSIS

In December 2025, the CTC Collaborative released a *Status Report* describing the results of a first-of-its-kind analysis of how 911 emergency call centers, crisis hotline counselors, police, EMS, and health providers in Erie County respond to people experiencing a behavioral health-related emergency. Over 30 agencies independent government agencies and nonprofits (ten of which contributed data for quantitative analysis), along with community members and people with firsthand experience of behavioral health crises, were engaged in that report’s development. The report documented the county’s heavy reliance on police, EMS, and hospital-based crisis care. Findings highlighted shortcomings in

the existing system and presented opportunities to address these challenges.

CTC COLLABORATIVE PROJECT TIMELINE



Measurable Goals

MEASURABLE GOALS

Over the course of 2025 and into 2026, members of the CTC Collaborative identified objectives to be implemented over three years to improve crisis response across Erie County. For each of these objectives, this *2026 Progress Report* provides the following:

- Background: Each three-year objective begins with context, drawing on the findings from the *2025 Status Report*.
- Target: Using 2024 data as a baseline, this report identifies measurable improvements that could be achieved by the end of 2026. Based on trends that emerge over the course of the year, a revised set of targets will be set for 2028.
- Recent progress: The CTC Collaborative's partners have already made significant progress

toward many of the objectives. This subsection briefly summarizes those strides.

- Immediate priorities: Working group members have determined the next steps they will take in the remaining months of 2026 and into 2027. These steps should make it possible to realize the year-one targets and set the stage for additional progress in subsequent years.
- Additional considerations: This subsection provides key questions for further discussion related to each objective.

The first eight objectives are organized according to the Call-Respond-Go framework. Two additional objectives span this framework, which are described as “cross-cutting.”

CTC COLLABORATIVE THREE-YEAR OBJECTIVES

	OBJECTIVE
Call	1. Improve the coding of 911 calls.
	2. Improve answering rates for crisis hotline calls.
Respond	3. Route at least 500 “Code 25” calls to nurse navigators.
	4. Improve and expand utilization of co-response programs.
	5. Increase the rate at which mobile crisis teams complete assessments.
Go	6. Increase the use of alternatives to CPEP.
	7. Reduce repeat visits to CPEP.
	8. Ensure engagement in post-crisis treatment.
Cross-Cutting	9. Support the workforce.
	10. Support county-led initiatives and monitor progress.

Objective 1: Improve the coding of 911 calls.

2026 Target: Double the number of calls being coded as behavioral health-related.

BACKGROUND

- Three percent of 911 calls in Erie County—approximately 21,000 of the 710,000 calls received in 2024—were coded as behavioral health-related in the county’s Computer-Aided Dispatch (CAD) system.⁴ These calls encompass both police and medical emergencies. First responders in Erie County believe this figure significantly underrepresents the actual number of 911 calls that involve a person experiencing a behavioral health emergency.
- National experts have estimated that at least 15 percent of all 911 calls for police service involve a person who needs behavioral health services.^{5,6}
- Administration of the 911 system, which includes call taking and dispatch, is especially fragmented in Erie County. Erie County’s CPS employs the people who answer cellphone calls and text messages from the entire county, plus landline calls originating in the City of Buffalo. Most municipalities in Erie County maintain their own public safety answering points (PSAPs) that receive and dispatch all landline calls within

their jurisdiction. Most municipalities also have their own police departments, whose police chiefs report to their local elected officials, not the county.

- Once a call is placed to 911, there are three distinct opportunities for first responders to determine whether a person appears to be experiencing a behavioral health emergency and code the call as such: (1) when the call is first received, (2) when first responders are en route to the scene, and (3) after first responders arrive.
 - Calls first received: 911 call takers receive limited information when they are first interacting with the caller. In many situations that involve a behavioral health emergency, the caller is a third party reporting that someone else is experiencing the emergency.
 - En route to the scene: After a decision is made to dispatch a first responder and that first responder is en route to the scene, the call taker may receive additional information to relay to the first responder.
 - After arrival: After a first responder arrives on scene, a more complete understanding of the circumstances surrounding the call usually emerges. If the situation warrants a change to the dispatch code, a first responder can update the call dispatch code at close-out.
- In cases where the dispatch code involves “welfare check,” “domestic disturbance,” or another dispatch code unrelated to behavioral health, the first responder can use a disposition⁷ code to indicate an underlying mental health need.
- When 911 call takers determine that the call involves a behavioral health emergency, they can provide essential context to first responders, informing how they approach the scene. Understanding that the 911 call involves a behavioral health emergency also makes it possible to identify situations where an alternative to traditional emergency response might be appropriate (to the extent alternatives exist). Such alternatives include connecting the caller to someone who can assist them via phone, deploying mobile crisis teams, or dispatching co-responder teams that pair police with mental health clinicians.
- Monitoring whether and when calls to 911 are coded as behavioral health-related helps Erie County leaders and their community partners to assess improvements in coding accuracy, identify opportunities for additional training and system enhancements, and understand the demand for alternatives to traditional emergency response.

2026 TARGET: DOUBLE THE NUMBER OF CALLS BEING CODED AS BEHAVIORAL HEALTH-RELATED.

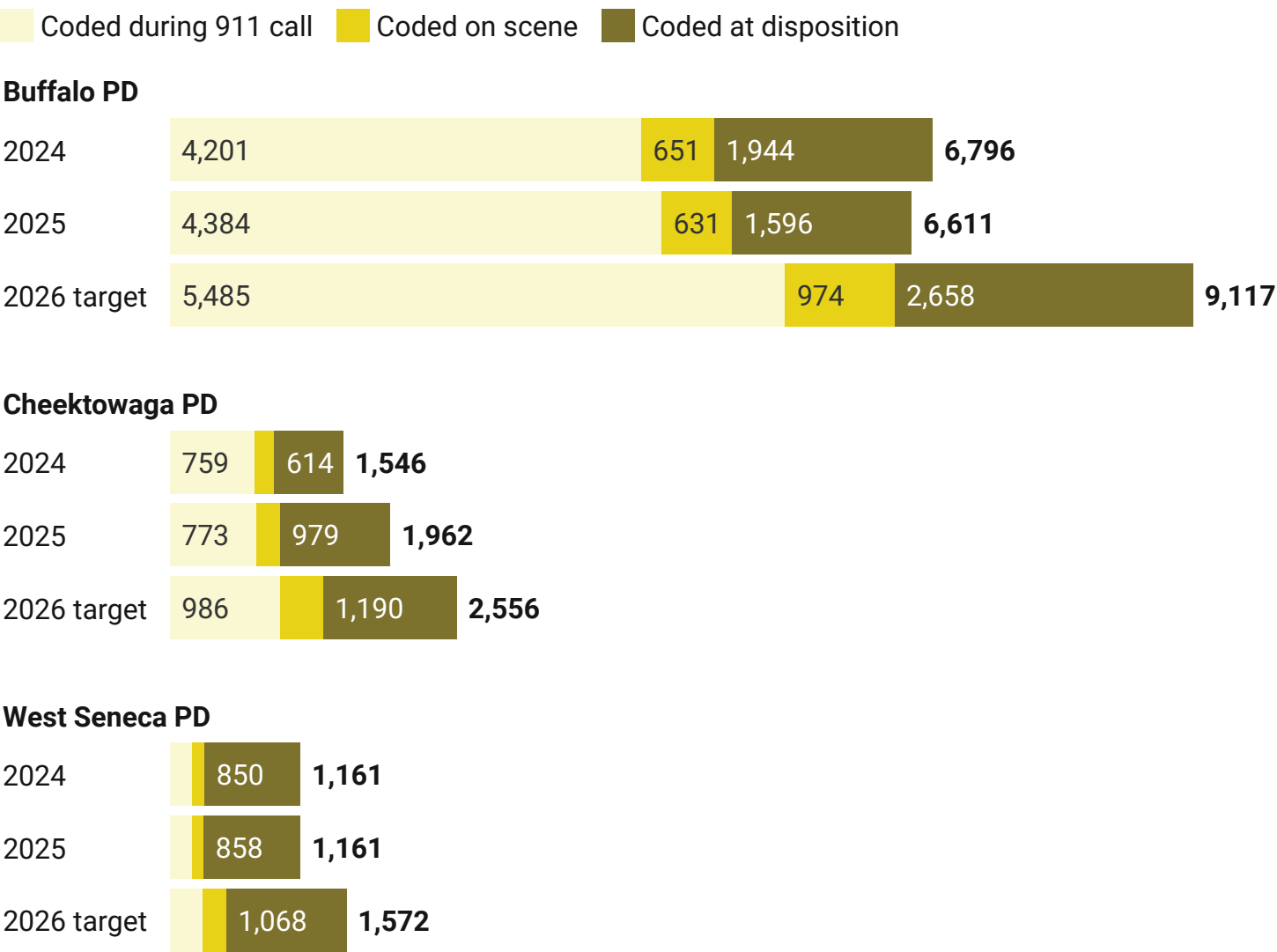
Several call codes that are currently used in Erie County’s dispatch field are clearly behavioral health-related. Police officers use some combination of call codes such as “mental health,” “suicide threat,” and “confused person” to flag dispatches related to behavioral health.⁸ They use codes such as “§ 9.41 MH (Mental Health) Evaluation” and “CIT (Crisis Intervention Team) Referred” to identify the call disposition.⁹ A

disposition code is entered at the end of an on-scene incident, during the call close-out process.

For this objective, the CTC Collaborative envisions 911 call takers and first responders more accurately identifying and coding calls as behavioral health-related at three specific points in the processing of an incident: initial dispatch, final dispatch, and in the call disposition field. Figure 1 presents the behavioral health-related codes at these points for 2024 and 2025, and sets targets for 2026.

FIGURE 1

When Are 911 Emergencies Coded as Behavioral Health-Related?



“Coded during 911 call” refers to the code assigned by the call taker at the start of the incident. “Coded on scene” refers to the code updated by responding officers based on what they find. “Coded at disposition” refers to the code documented when officers close out the call and record how it was ultimately resolved.

RECENT ACCOMPLISHMENTS

- Until recently, most municipalities in Erie County independently managed the dispatch of ambulance/EMS services. In 2025, Erie County CPS assumed responsibility for operating the Medical Emergency Radio System (MERS) countywide, ensuring one centralized, coordinated
- system for receiving and dispatching all medical emergency calls. As part of this transition, Erie County CPS acquired 21 staff from MERS and began cross-training call takers and dispatchers to perform both functions. The county also implemented standards developed by the

Association of Public-Safety Communications Officials (APCO) International, introducing structured scripts and decision-support tools that will promote greater consistency in call taking and dispatch operations.

- Erie County CPS has adopted a new CAD software platform that is scheduled to go live in 2027. The system will support secondary call codes, allowing incidents to be classified more accurately. For example, a welfare check could also be coded as involving a behavioral health

concern, providing a more complete picture of community needs and service demands.

- The Cheektowaga Police Department (CPD) reviewed its call coding procedures with Erie County CPS in early 2026. As a result, CPD added a new disposition code, “Mental Health Contributing,” to its list of available codes. The change is expected to increase the number of incidents being identified as having an underlying behavioral health factor.

ADDITIONAL CONSIDERATIONS

- Expansion: Several municipal and county agencies in Erie County, in addition to those already highlighted, are taking steps to improve the processing of 911 calls that involve behavioral health, including the Erie County Sheriff’s Office and the police departments serving Amherst, Lancaster, Town of Hamburg, and Town of Tonawanda. The CTC Collaborative will work more closely with these law enforcement agencies in the coming months.
- Enhancement: County leaders should assess the feasibility and potential benefits of embedding mental health clinicians within the Erie County CPS communications center. Integrating behavioral health professionals into the call-taking process could improve the identification of behavioral health-related emergencies at the earliest stages of response while strengthening coordination, data collection, dispatch decision-making, and system accountability.

IMMEDIATE PRIORITIES

- 1.a. Train Erie County CPS call takers and dispatchers: Erie County CPS will continue training call takers and dispatchers on the recently adopted APCO International standards and protocols.
- 1.b. Train police officers: The Erie County CPS Law Enforcement Training Academy is expanding its four-day Field Training Officer (FTO) program by adding a fifth day focused exclusively on behavioral health and mental health response. Because FTOs mentor newly hired officers during field training, this enhancement will help ensure that new officers are familiar with available community resources and are better equipped

to determine when it is appropriate to order an involuntary psychiatric evaluation under § 9.41 of the New York State Mental Hygiene Law.

In addition, New York State’s Municipal Police Training Academy has indicated that it plans to increase mental health training requirements for police recruits from 20 to 40 hours. Although Erie County already exceeds the current standard by providing 32 hours of mental health instruction, adoption of the new statewide standard will increase mental health training provided to police recruits in Erie County.

- 1.c. Modify existing CAD software: The new OnCall CAD platform, scheduled for

implementation in 2027, will allow multiple call codes to be associated with a single incident. Erie County CPS also plans to incorporate a behavioral health indicator into the call close-out process, enabling officers to document when an incident involved a person who appeared to need behavioral health services, regardless of the call code(s).

In the interim, before the new platform is fully operational, police departments may add new disposition codes to the existing CAD system to identify behavioral health involvement in calls, as the Cheektowaga Police Department recently did.

- 1.d. Continue participating in the state effort to explore licensure for telecommunicators: Erie County CPS continues to participate in a statewide initiative led by the New York State Office of Interoperable and Emergency Communications to evaluate the feasibility of telecommunicator licensure. Establishing a professional licensure framework would formally recognize the specialized skills and responsibilities required of emergency communications personnel.

CASE STUDY: TRAVIS COUNTY, TEXAS

Embedding Resources in 911 Call Centers

In Travis County, Texas,^{10,11} mental health clinicians have been embedded directly in the 911 call center since 2019. Under this model, call takers at the Austin Police Department and Travis County Sheriff's Office may hand off behavioral health calls that meet certain criteria (including a determination that there is no immediate safety threat) to an on-site clinician. The clinician conducts a crisis screening and needs assessment and may dispatch a mobile crisis outreach team when an in-person response is warranted. Since 2021, 911 call takers have asked whether the emergency is related to police, fire, medical, or mental health, becoming the first Public Safety Answering Point (PSAP) in the U.S. to offer this option explicitly.

The program currently operates 24/7, with a minimum of one clinician at all times and, during peak times, up to three clinicians. A peer-reviewed study of this program, spanning the first five years of implementation, found significant reductions in the probability of emergency psychiatric detention and in the probability of arrest when the embedded clinicians were involved in calls. Notably, the study found a 43.2% lower probability of peace officer¹² emergency detentions, and a 37.5% lower probability of arrest for calls handled by the embedded clinicians.

In a related effort to strengthen emergency response systems, Texas enacted legislation in 2019 formally recognizing emergency call takers and dispatchers as first responders, acknowledging their critical role in public safety and crisis intervention.

Objective 2: Improve answering rates for crisis hotline calls.

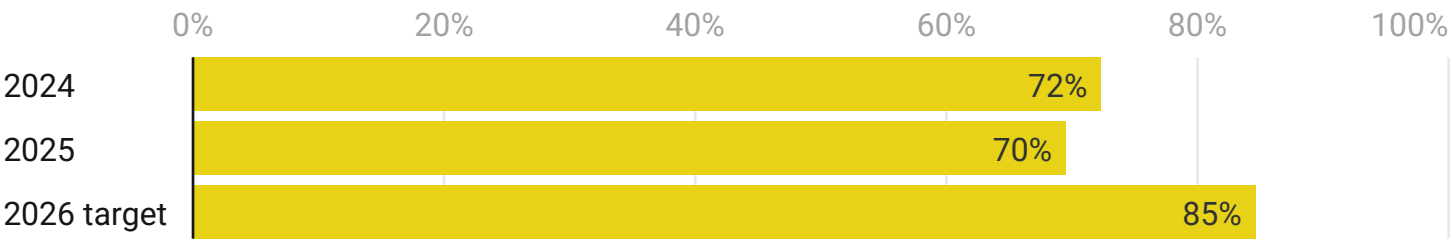
2026 Target: Raise the percentage of calls answered to 85 percent (from 70 percent).

BACKGROUND

- For more than 57 years, Crisis Services, a nonprofit organization headquartered in Buffalo providing behavioral health services in Western New York, has operated a crisis hotline serving residents of Erie County experiencing suicidal thoughts, mental health crises, and other behavioral health emergencies. The organization also serves as the local contact center for 988 Suicide and Crisis Lifeline calls originating within Erie County.
- A landmark study published in April 2026 documented a notable decrease in suicide deaths among youth and young adults following the launch of the 988 Lifeline in 2022. Specifically, the researchers estimated 11 percent fewer suicide deaths than were projected. States with higher 988 call volumes experienced greater decreases in suicides among people aged 15 to 23.¹³
- Additional research has provided empirical evidence of the effectiveness of the 988 Lifeline for individuals at high risk for suicide.¹⁴ The majority of people interviewed reported that the crisis call was effective, and that the intervention prevented them from taking immediate action.
- In 2024, Crisis Services received over 78,000 calls to 988 and the local crisis hotline number. Approximately 56,500 of those calls were answered by a crisis counseling specialist. Twenty-eight percent of the local hotline calls went unanswered by Crisis Services.¹⁵ Calls to the 988 line roll over to be answered by a back-up call center.
- Like many crisis call centers across the country, Crisis Services has faced ongoing workforce challenges, which were exacerbated by the COVID-19 pandemic.
- The growing volume of 988 calls, combined with increasing call complexity and longer calls, has placed additional demands on crisis counseling specialists and reduced the system's capacity to answer calls promptly.

FIGURE 2

Crisis Hotline / 988 Answer Rate



2026 TARGET: RAISE THE PERCENTAGE OF CALLS ANSWERED TO 85 PERCENT (FROM 70 PERCENT).

For the purposes of this objective, unanswered calls include those in which the caller disconnects before speaking with a crisis counseling specialist, declines to remain on hold, or is unable to access

an available line. Crisis Services will regularly share data with the CTC Collaborative to monitor progress toward this target.

RECENT ACCOMPLISHMENTS

- In July 2025, Crisis Services implemented a new telecommunications platform, Telesystem, which enables them to identify peak demand periods, better understand why calls go unanswered, and manage the flow of calls arriving from both the local crisis hotline and the 988 Lifeline network.
- Over the past year, Crisis Services expanded the use of structured follow-up practices beyond the requirements of the 988 Lifeline. Crisis counseling specialists now offer follow-up contacts to eligible callers across all hotline services, not just those reaching the organization through 988. These follow-up calls provide additional support to individuals experiencing ongoing distress and help reinforce connections to community resources.
- As part of a broader recruitment and retention strategy, Crisis Services increased compensation for crisis counseling specialists. These efforts have contributed to improved workforce stability. Notably, the hotline program experienced no voluntary staff resignations during 2025.

IMMEDIATE PRIORITIES

- 2.a. Increase the team of available crisis counseling specialists:
 - 2.a.1. Broaden the volunteer base: Crisis Services will relaunch its volunteer crisis counselor program in 2026 to supplement staffing levels and increase call-answering capacity. A new volunteer training cohort is scheduled for the fall of 2026.
 - 2.a.2. Recruit part-time workers: Crisis Services is increasing the number of temporary crisis counseling specialists, who provide flexible staffing support. Crisis

Services refers to these staff as per diem crisis counseling specialists. These part-time professionals help fill coverage gaps, support peak call periods, and ensure continuous 24/7 operations.

- 2.b. Improve data collection and reporting: Drawing on insights provided by the new Telesystem platform described above, Crisis Services will use these enhanced tools to monitor key performance indicators, including call answer rates, wait times, call duration, types of abandoned calls, and patterns associated with high-frequency callers. These data will support

ongoing quality improvement efforts and inform future operational decisions.

- 2.c. Improve the response to high-frequency callers: Crisis Services will develop strategies to better manage the volume of calls from high-frequency callers while maintaining appropriate clinical engagement. Potential approaches include call diversion and specialized intervention strategies that would allow crisis counseling specialists to remain available for other individuals in need of immediate assistance.

ADDITIONAL CONSIDERATIONS

- 911/988 interoperability: Improved interoperability can help ensure that individuals experiencing behavioral health crises are connected to the most appropriate level of care while reducing unnecessary involvement of law enforcement, EMS, and hospital emergency departments. Interoperability can take several forms, including dedicated transfer lines that facilitate communication between emergency call centers, shared dispatch protocols, and co-locating behavioral health professionals within emergency communications centers. In 2023, Erie County leaders pilot-tested transfer of calls between 911 and Crisis Services. Few calls met the criteria established for call transfer between 911 and Crisis Services. That reality, along with many other factors, limited the impact of the pilot, which was later discontinued. Recent investments within both the county's 911 communications system and the Crisis Services telecommunications platform create an opportunity to revisit this pilot.

CASE STUDY: ORANGE COUNTY, NEW YORK

Co-locating Services to Maximize Interoperability

Since 2019, Orange County, New York, has operated an Emergency Operations Center that houses the county's 911 PSAP, 311/988 Crisis Call Center, Mobile Response Team program, and peer support services within a single facility. Co-locating these services has proven instrumental in strengthening coordination across the behavioral health crisis continuum and facilitating effective 911/988 interoperability. Before implementing this model, county leaders convened law enforcement agencies, fire and EMS providers, and nonprofit crisis service partners to establish shared protocols and a common understanding of imminent risk. Once those agreements were in place, eligible

911 calls could be transferred directly to crisis counselors for assessment and intervention.

Depending on the nature of the call, crisis counselors may provide de-escalation support, connect callers to community resources, dispatch a Mobile Response Team, or engage peer support services. Likewise, callers who contact 311 or 988 and are determined to be at imminent risk can be transferred directly to 911 through an integrated CAD process. By bringing critical crisis response functions together under one roof, Orange County accelerated the development of cross-system protocols, strengthened relationships among partner agencies, and increased confidence in call diversion strategies. The model demonstrates how co-location can catalyze a more integrated and responsive crisis care system.¹⁶

Objective 3: Route at least 500 “Code 25” calls to nurse navigators.

2026 Target: Route 500 Code 25 calls from Buffalo to nurse navigators.

BACKGROUND

- In 2024, of the 10,000 behavioral health emergency calls to 911 originating in the City of Buffalo, approximately one-third (n=3,369) were medical emergencies handled by EMS. Medical calls that indicate a behavioral health emergency are labeled as “Code 25” (psychiatric) calls in Buffalo, and the dispatcher engages American Medical Response (AMR) to provide ambulance services. Of the Code 25 calls for which an ambulance was dispatched, approximately one-third (n=1,210) resulted in a hospital transport to ECMC’s Emergency Department, while the remaining two-thirds were resolved on scene, suggesting that at least some of these calls may warrant an alternative response.
 - Unnecessary ambulance dispatches limit the availability of EMS resources for higher-acuity emergencies. In addition, when an ambulance is dispatched but does not transport a patient to a hospital, providers often receive little or no reimbursement for the response.
 - Buffalo EMS uses the Medical Priority Dispatch System (MPDS) to triage calls by level of severity. The lowest severity Code 25 calls—classified as 25A00, 25A01, 25A02, and 25A03—generally involve non-life-threatening circumstances.
- These calls may be appropriate for an alternative response. In 2024, one-third of the Code 25 calls to 911 (in Buffalo) had one of these four low-acuity codes.
- AMR offers the 911 Nurse Navigation Program,¹⁷ a service developed by its parent company, Global Medical Response, to reduce unnecessary ambulance usage. Applying structured clinical screening protocols, emergency call takers identify callers whose needs may be safely addressed through consultation with a nurse navigator rather than through an ambulance dispatch. Nurse navigators assess the individual’s needs, provide clinical guidance, and connect callers to the most appropriate community-based services and supports.
 - By diverting eligible calls from traditional EMS dispatches, nurse navigation programs can reduce unnecessary ambulance dispatches, improve resource availability for higher-acuity emergencies, decrease reliance on hospital emergency departments, and connect individuals to more appropriate behavioral health services.

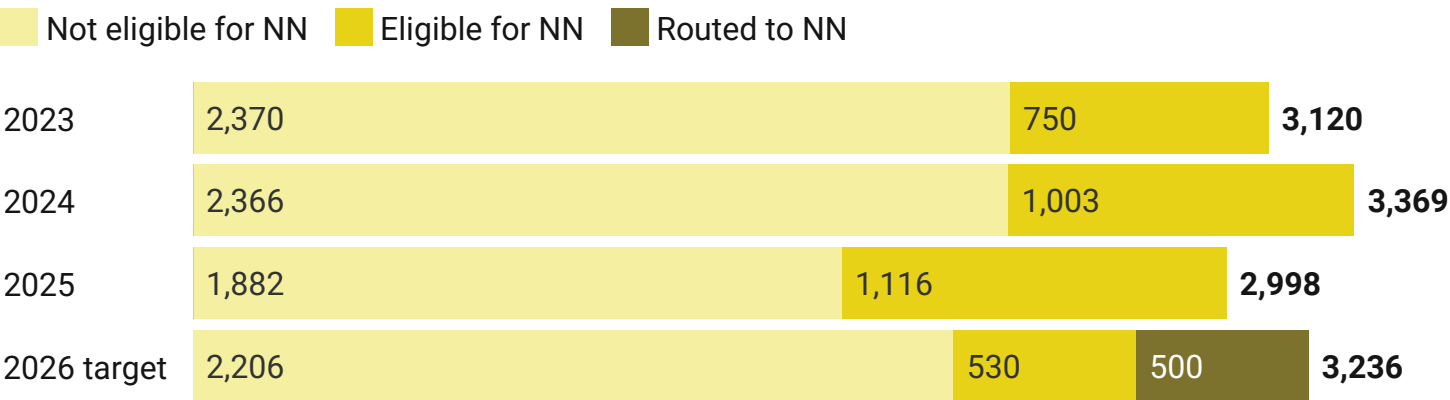
2026 TARGET: ROUTE 500 CODE 25 CALLS FROM BUFFALO TO NURSE NAVIGATORS.

This target focuses specifically on behavioral health-related emergency calls that meet established clinical criteria for nurse navigation. Progress

toward this goal will be monitored through ongoing collaboration among Buffalo EMS, AMR, and the CTC Collaborative.

FIGURE 3

Buffalo EMS Code 25/Psychiatric Calls Dispatched, 2023–2026



“NN” is shorthand for Nurse Navigators. Prior to 2026, there were no Code 25 calls routed to nurse navigators because the program was not yet operational.

RECENT ACCOMPLISHMENTS

- In coordination with the Buffalo Fire Department’s Emergency Medical Service, AMR launched the Nurse Navigation Program in Buffalo in December 2025 to provide an alternative response option for low-acuity EMS calls that may not require ambulance dispatch or hospital transport.
- The program focused initially on diverting Code 25 (psychiatric) and Code 26 (sick person) calls. To ensure eligible behavioral health-related calls are identified consistently and routed appropriately, AMR and its partners in the Buffalo Fire Department developed structured screening protocols and dispatch scripts and trained personnel on their use.
- Following successful implementation, the program was expanded to allow any MPDS-coded call to be routed to a nurse navigator when the call taker determines that diversion is clinically appropriate.
- The Nurse Navigation Program maintains an inventory of community-based resources available to callers. In 2026, BestSelf Behavioral Health opened the BestResponse Intensive Crisis Center in Buffalo, the first Intensive Crisis Stabilization Center (ICSC) to open in Western New York. The ICSC was added to the nurse navigators’ network of referral options, expanding the range of alternatives available to individuals experiencing behavioral health crises.

- Within the first few months of the Nurse Navigation Program's launch, nearly 100 Code

25 calls were successfully diverted to nurse navigators.

IMMEDIATE PRIORITIES

- 3.a. Improve data collection: AMR currently maintains a performance dashboard that tracks utilization and outcomes of the Nurse Navigation Program, and Buffalo EMS staff have access to these data. However, the dashboard does not differentiate the responses by call type, and the system does not currently allow for reporting on the number of Code 25 calls diverted to nurse navigators. Buffalo EMS currently provides quarterly data extracts to the CTC Collaborative that include information on ambulance dispatches, patient transports, and EMS utilization trends. Buffalo EMS will coordinate with the CTC Collaborative to incorporate nurse navigation metrics into the quarterly reporting framework that the CTC Collaborative is developing.
- 3.b. Coordinate with Crisis Services: Buffalo EMS will explore opportunities to develop formal protocols between the Nurse Navigation Program and Crisis Services. Such coordination could allow nurse navigators to engage mobile crisis teams in situations involving behavioral health emergencies that do not require ambulance dispatch but would benefit from an in-person response. As mobile crisis capacity expands, closer integration between these programs may further enhance the county's ability to provide the right response at the right time.
- 3.c. Enhance training and awareness: Buffalo EMS and AMR are working to strengthen awareness and utilization of available diversion resources through targeted training initiatives:

CASE STUDY: SANTA CLARA COUNTY, CALIFORNIA

Expanding the Impact of Nurse Navigator Programs

Several jurisdictions within Santa Clara County, California, piloted a Nurse Navigation Program for more than a year before expanding the model countywide.¹⁸ The program allows callers to connect to nurse navigators through two pathways: emergency dispatchers can transfer eligible callers during the initial 911 call, or first responders already on scene can refer individuals to the nurse navigation program when an incident is determined to be low acuity. Early pilot results demonstrated strong acceptance among patients who were offered

an alternative to a traditional EMS response. Building on that success, Santa Clara County expanded the program on January 1, 2026, enabling all participating 911 dispatch centers to refer eligible callers to nurse navigators. While community-based referrals by field responders remain limited to the original pilot jurisdictions, the countywide expansion for 911 calls demonstrates how nurse navigation programs can grow incrementally while maintaining clinical oversight and public confidence. The model highlights the potential for nurse navigation to reduce unnecessary ambulance utilization while still connecting individuals to appropriate levels of care.

- 3.c.1. Train EMS personnel: EMS staff should receive training on referral criteria, transportation protocols, and appropriate usage of the BestResponse Intensive Crisis Center as an alternative to emergency department transport when clinically appropriate.
- 3.c.2. Provide nurse navigators with ongoing education: Inform nurse navigators of available behavioral health crisis resources throughout Erie County, including mobile crisis services, crisis stabilization programs, and other community-based treatment alternatives.
- 3.c.3. Develop a public education campaign: Increase community-wide awareness and understanding of the Nurse Navigation Program.

ADDITIONAL CONSIDERATIONS

- Rural resources: In rural areas of Erie County, access to behavioral health professionals may be limited. The county could consider cross-training selected first responders, including sheriff's deputies and emergency medical technicians (EMTs), in behavioral health first aid, crisis intervention, and de-escalation techniques. This approach could strengthen the county's capacity to respond effectively to behavioral health crises in areas where embedded clinicians or specialized crisis response teams are not readily available.
- Expansion: As the Nurse Navigation Program matures, Erie County could consider expanding the model to support EMS operations countywide. Broader implementation could further reduce unnecessary ambulance dispatches, improve EMS system efficiency, and increase access to care by connecting residents with appropriate health and behavioral health resources through nurse-led triage and referral services.

CASE STUDY: WASHINGTON, D.C.

Reducing Ambulance Dispatches through Nurse-led Triage

As part of the Washington, D.C. "Right Care, Right Now" pilot program, certain low-acuity 911 callers were transferred to registered nurses for secondary clinical triage rather than automatically receiving an ambulance response. Nurses could provide self-care guidance, direct callers to appropriate community-based services, arrange alternative transportation, or return

the call to the standard 911 dispatch process if an ambulance was deemed necessary. A randomized controlled trial of this program found that the intervention reduced ambulance dispatches and emergency department utilization while maintaining patient access to appropriate care. The study found that the proportion of low-acuity calls resulting in an ambulance dispatch dropped significantly, from 97 percent to 56 percent.¹⁹ The program demonstrates how clinical triage can help preserve EMS resources for higher-acuity emergencies without compromising patient safety.

Objective 4: Improve and expand utilization of co-response programs.

2026 Targets are department-specific — Buffalo, Cheektowaga, and West Seneca PDs are each working to increase behavioral health-related calls involving Behavioral Health Team officers and clinician co-responders.

BACKGROUND

- In Erie County, some, but not all, law enforcement officers have received CIT training. Whether police responding to a person experiencing a behavioral health emergency have participated in CIT training varies from one call (and one police department) to the next.
- Several police departments in Erie County have implemented some form of a co-response program, which pairs specially trained police officers with mental health clinicians skilled in responding to people in crisis. In research conducted elsewhere, co-responder teams have been shown to reduce the use of force in behavioral health emergencies and increase the likelihood a person is connected to community-based care, as opposed to being brought to the hospital or arrested.²⁰
- The utilization of mental health clinicians varies from one municipality to the next, for police departments that have these programs. For example, in some jurisdictions—including Amherst, Cheektowaga, Lancaster, and Town of Hamburg—the municipality contracts with Endeavor Health Services, a nonprofit organization that provides behavioral health services. Other police departments, including West Seneca, directly employ (or contract with) individual clinicians supporting their departments. Some police departments rely primarily on federal or state grants to fund their programs, which can make sustaining and expanding programs challenging. Some other police departments receive recurring appropriations from the local city council.
- How and when the co-responder teams are deployed in response to a call for service also

differs across the county. Some police departments directly dispatch a co-responder team when calls are received through the CAD system. Other departments' co-responder teams monitor the dispatch board and can self-dispatch to behavioral health calls, responding alongside the directly dispatched patrol unit.

- The hours and availability of co-responder teams also vary by municipality. One police department offers 24/7 on-call coverage, while others operate only on weekdays from 8:00 a.m. to 6:00 p.m.
- Across the county, participating police departments report that existing co-responder teams are not staffed sufficiently to meet the level of demand for their services. In Buffalo, every day, approximately 18 calls to 911 are coded as behavioral health-related. Specially trained police officers assigned to BPD's co-responder Behavioral Health Team (BHT) responded to six or seven of these active calls per day in 2024, usually by self-dispatching after a regular patrol unit had been assigned to the call. Mental health clinicians accompanied the BHT officers on approximately one call per day. These clinicians spent most of their time conducting follow-up

activities. While case follow-up is an important component in connecting individuals to community services, it can reduce the clinicians' availability to provide the on-scene assessment and de-escalation for which these co-response programs were designed.

- In some instances, clinicians embedded in police departments report that some of the services they provide are billed to Medicaid. It is unclear to what extent reliance on Medicaid reimbursement incentivizes providers to focus embedded clinicians' time on follow-up visits instead of responding to people actively experiencing an emergency.

The following sections identify the unique targets, accomplishments, and immediate priorities for each of the police departments with co-responder programs participating in the CTC Collaborative, as well as for Endeavor Health Services, which has been the primary provider of embedded clinicians for police departments in Erie County. Because data collection and reporting capacity vary across police departments, the charts with 2026 targets are unique to each agency.

2026 TARGET (BUFFALO POLICE DEPARTMENT): REEXAMINE THE BHT/CO-RESPONSE PROGRAM

RECENT ACCOMPLISHMENTS

There have been several significant developments at the Buffalo Police Department that affect the department's Behavioral Health Team, including:

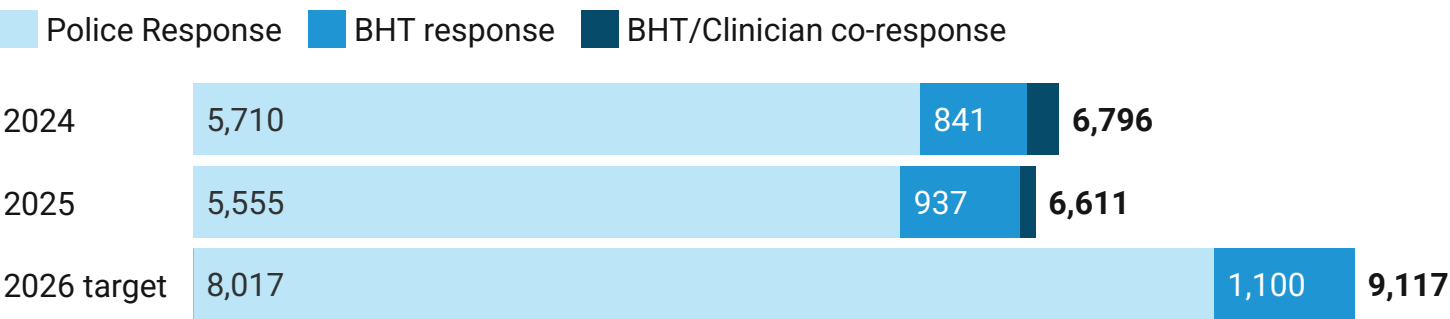
- A comprehensive review of policies and practices related to the department's BHT, which began in early 2026;
- Release of a request for proposals (RFP), through the Erie County Department of Mental Health, to select a community partner to provide

embedded mental health clinicians for the Behavioral Health Team; and,

- Implementation of the new Records Management System (RMS) software (Axon) in June 2026, which is expected to improve the identification, tracking, and reporting of behavioral health-related incidents.

FIGURE 4A

Buffalo PD—Response to Behavioral Health–Related Calls



The number of calls indicating a “BHT response” in 2024 is estimated based on historical trends. BPD does not have a projected “BHT/Clinician co-response” target for 2026 because the department is in the process of identifying a partner for embedded clinicians to begin in 2027.

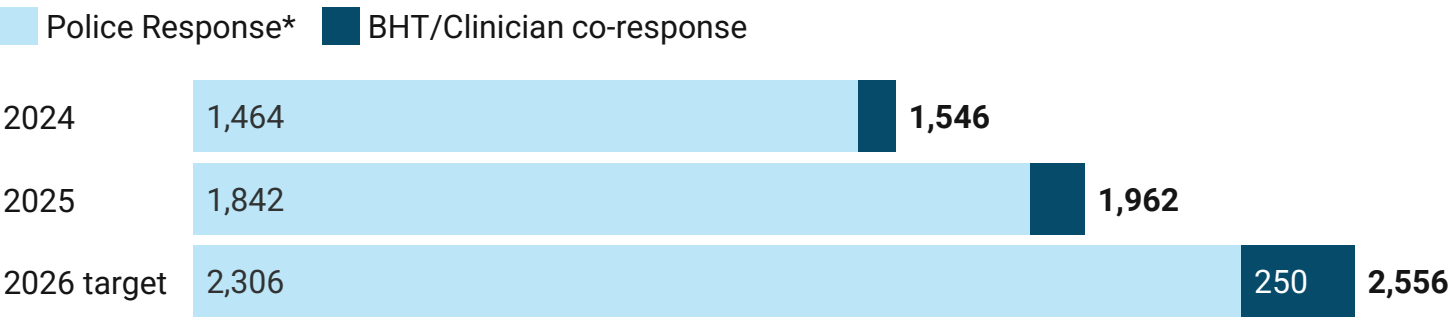
IMMEDIATE PRIORITIES

- 4.a.1. Select a behavioral health services provider: Applicants to the RFP mentioned above must commit to providing up to five licensed mental health professionals to work alongside BPD’s Behavioral Health Team and commit to ensuring the availability of at least two mental health clinicians when the BHT operates (Monday through Friday from 8:00 a.m. to 6:00 p.m.).
- 4.a.2. Increase active call engagement: The BHT is working with BPD’s dispatch personnel to facilitate direct assignment of BHT officers to behavioral health-related calls. BPD anticipates that a greater emphasis on using 911 to dispatch BHT officers directly, and a shift from using BHT officers primarily for follow-up visits, will at least double the number of active behavioral health calls handled by BHT officers in 2027.
- 4.a.3. Strengthen performance measurement: BPD will explore whether and how it can improve its collection and analysis of data to make the following possible:
 - Distinguish between transports conducted under Mental Hygiene Law § 9.41 and transports to the ICSC;
 - Identify whether BHT personnel were directly involved in § 9.41 and ICSC transport decisions; and
 - Incorporate additional performance measures into quarterly reporting as needed.

2026 TARGET (CHEEKTOWAGA POLICE DEPARTMENT): DOUBLE THE NUMBER OF CALLS INVOLVING BHT/CLINICIAN CO-RESPONSE

FIGURE 4B

Cheektowaga PD—Response to Behavioral Health–Related Calls



*In Cheektowaga, “Police Response” includes responses from both BHT and non-BHT officers. The department is beginning data collection efforts to identify which behavioral health-related calls involve a BHT officer.

RECENT ACCOMPLISHMENTS

- The Cheektowaga Police Department’s Behavioral Health Team increased its involvement in active calls accompanied by an embedded clinician by 46 percent from 2024 to 2025.
- The number of involuntary mental health transports initiated under Mental Hygiene Law § 9.41 has declined each year since reaching its peak in 2021. Based on current trends, the department is projected to record its lowest number of § 9.41 transports in recent years—an estimated 55 percent reduction from 2021 levels.

IMMEDIATE PRIORITIES

- 4.b.1. Expand team resources: The department will explore opportunities to:
 - Increase the number of officers assigned to the Behavioral Health Team;
 - Expand clinician availability through additional funding; and,
 - Evaluate the feasibility of adding a dedicated case manager to support follow-up activitiesthat do not require both an officer and clinician response.
- 4.b.2. Adopt best practices: The department applied for a grant through the Lee Foundation to acquire an unmarked vehicle for Behavioral Health Team operations. The vehicle will be used to respond to calls and transport individuals to the ICSC or CPEP when appropriate. This approach aligns with emerging best practices for reducing stigma and promoting

trauma-informed interactions during behavioral health emergencies.

4.b.3. Enhance data reporting:

Recommended measures to report include:

- The number of behavioral health-related calls involving a BHT officer, regardless of whether a clinician was present;

- The number of individuals transported to the ICSC; and,
- Comparisons showing whether transport decisions were initiated by BHT personnel or traditional patrol units.

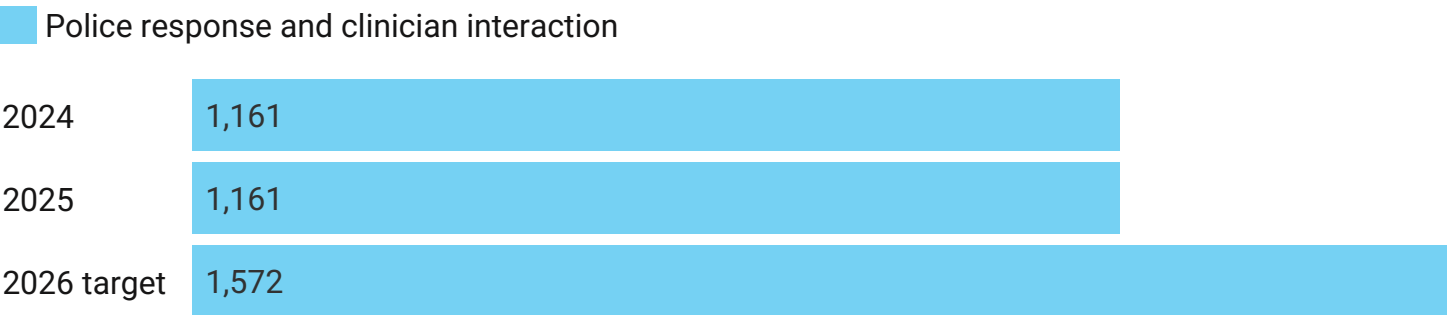
2026 TARGET (WEST SENECA POLICE DEPARTMENT): FORMALIZE CO-RESPONSE PROGRAM

The West Seneca Police Department directly employs a behavioral health clinician who can ride alongside officers during active calls or provide assistance by phone to officers in the field. The

which calls involved the embedded clinician as part of a co-response to an incident, but the department estimates that the clinician is engaged in nearly all behavioral health-related calls either during or

FIGURE 4C

West Seneca PD—Response to Behavioral Health-Related Calls



clinician also conducts follow-up activities. The department does not currently capture in the data

following the incident.

RECENT ACCOMPLISHMENTS

- The department has maintained a full-time mental health clinician since 2021. In addition to providing support and consultation for behavioral health-related calls, the clinician supports West Seneca PD officers by overseeing wellness initiatives and providing mental health resources to department personnel.

IMMEDIATE PRIORITIES

- 4.c.1. Formalize a Behavioral Health Team with established policies and procedures: The West Seneca Police Department recently established a Behavioral Health Team which will consist of one lieutenant and six officers. Team members are being identified, and will receive specialized behavioral health training in addition to the CIT training already provided to all department personnel. Whenever possible, BHT officers will serve as the primary responders to behavioral health-related calls and will be supported by the department’s embedded clinician. The department will develop a policy manual that formalizes the co-response model and increases its sustainability, insulating it from changes in department personnel or leadership.
- 4.c.2. Expand the clinical team: The department will explore funding opportunities to add a part-time clinician. Additional clinical staffing would provide scheduling flexibility, enhance service continuity, and reduce the burden placed on the current clinician.
- 4.c.3. Standardize and enhance data reporting: Although the department can quantify the number of behavioral health-related incidents, the system does not yet have the capacity to link clinician participation to incidents. West Seneca PD estimates that their clinician is currently involved in all behavioral health-related incidents, either in person or by phone consultation. However, formally capturing this involvement in their data will enable the department to report on it. West Seneca PD will develop this reporting capability to strengthen program evaluation efforts and support future expansion of clinical services, including the addition of case management support.

ENDEAVOR HEALTH SERVICES: IMPROVE CONSISTENCY IN DATA REPORTING

Endeavor Health Services (EHS) is currently the only provider of embedded mental health clinicians contracting with police departments in Erie County. As more police departments adopt the co-response program, this could evolve, and additional behavioral health providers could contract with police departments to provide clinicians.

RECENT ACCOMPLISHMENTS

- Drawing on a grant from the U.S. Department of Justice, Endeavor Health Services developed a Behavioral Health Team Resource Guide in 2025. This guide provides law enforcement officers with contact information and referral resources organized across multiple service domains, including housing, food assistance, transportation, behavioral health treatment, substance use services, health care, financial assistance, employment support, education, and legal resources.
- EHS expanded its embedded clinician program by establishing partnerships with the Amherst and Lancaster Police Departments. The organization now provides embedded clinicians to participate in co-responder programs for five law enforcement agencies: Amherst Police Department, Cheektowaga Police Department, Lancaster Police Department, Niagara Frontier

Transportation Authority, and Town of Hamburg Police Department.

- Restoration Society, Inc., a peer-operated organization specializing in recovery-oriented mental

health services and life coaching, has joined EHS's network, expanding the range of supports available through the organization.

IMMEDIATE PRIORITIES

- 4.d.1. Support the use of embedded clinicians: EHS will explore supplemental funding opportunities to help offset the difference between the actual cost of embedding clinicians within police departments and the financial contributions currently provided by participating municipalities.
- 4.d.2. Enhance reporting capacity: The organization is interested in improving data collection systems used by embedded clinicians to better

track § 9.41 involuntary transports, voluntary hospital transports, and ICSC diversions and transports.

Implementation of these enhancements depends on modifications to the electronic medical record (EMR) platform administered by an external vendor. Other providers, including BestSelf Behavioral Health, have already requested similar changes to the platform.

ADDITIONAL CONSIDERATIONS

- Training enhancements: As noted previously, Erie County plans to extend its Field Training Officer (FTO) curriculum from four days to five days by adding a day dedicated to behavioral health and crisis response. Police chiefs across the county have expressed unanimous support for this enhancement. The expanded curriculum presents an opportunity to standardize decision-making related to Mental Hygiene Law § 9.41 transports while increasing awareness of alternatives such as the ICSC and other diversion options.
- Expansion: The CTC Collaborative continues to engage additional law enforcement agencies interested in implementing or strengthening alternative response strategies for behavioral health emergencies. Expanding participation will increase access to specialized crisis response services across Erie County and create additional opportunities for shared learning among departments.
- Long-term sustainability: A critical priority for the county is identifying stable, recurring funding sources for co-response programs. Sustainable funding would allow departments and provider organizations to plan strategically, invest in staffing and infrastructure, and reduce reliance on short-term grant opportunities.
- Multidisciplinary approach: Several jurisdictions across the country have adopted multidisciplinary response models that combine the expertise of law enforcement officers, behavioral health clinicians, and emergency medical personnel when responding to behavioral health crises. These approaches recognize that behavioral health emergencies often involve overlapping medical, behavioral, and public safety considerations. By ensuring that the appropriate mix of expertise is available during a response, multidisciplinary teams may improve outcomes while reducing unnecessary hospitalizations and criminal justice involvement.

CASE STUDY: ALBUQUERQUE, NEW MEXICO

Taking an Alternative Approach to Calls for Service

Since September 2021, the City of Albuquerque has operated the Albuquerque Community Safety (ACS) Department, a cabinet-level agency dedicated to responding to behavioral health crises and quality-of-life concerns that may not require a traditional police, fire, or EMS response.^{21, 22} ACS responders can be dispatched directly in response to 911 and 311 calls involving concerns such as welfare checks, homelessness, behavioral health crises, and other community needs. Because ACS is integrated into the emergency response system, ACS responders are seamlessly dispatched through the CAD system and can request additional public safety resources

whenever circumstances warrant a higher level of intervention. The system also allows police officers to request ACS support after a scene has been stabilized, enabling connections to services, transportation, shelter, or ongoing care. Triage specialists at ACS dispatch specific response teams based on the nature of the incident, including Behavioral Health Responders, Community Responders, Street Outreach Responders, and Mobile Crisis Team Clinicians. Mobile Crisis Team Clinicians respond with CIT-trained officers. To support workforce development, ACS has established a dedicated training academy for community responders. With an annual operating budget exceeding \$17 million, supplemented by more than \$5 million in grant funding, Albuquerque has developed a comprehensive alternative response system that bridges the gap between traditional public safety services and community behavioral health needs.

Objective 5: Increase the rate at which mobile crisis teams complete assessments.

2026 Target: Increase the share of completed assessments to 65 percent.

BACKGROUND

- Mobile crisis teams are civilian-led behavioral health responders that typically include some combination of clinicians, peer support specialists, and, in some models, emergency medical personnel. Mobile crisis teams provide rapid, on-site assessment, de-escalation, crisis intervention, and connection to ongoing care for people experiencing a mental health or substance use crisis. As an alternative to police response, these teams are designed to resolve crises in the least restrictive setting; reduce unnecessary arrests, emergency department visits, and psychiatric hospitalizations; and improve linkage to community-based treatment.
- Recent research suggests that well-implemented mobile crisis programs can safely manage many behavioral health crises, reduce hospitalizations, increase engagement with services, and reduce reliance on law enforcement for situations that are primarily health-related.^{23, 24}
- Crisis Services administers Erie County's Mobile Outreach Program. Crisis counseling specialists who work for the crisis hotline, which Crisis Services also administers, transfer calls to the Mobile Outreach Program when they determine the call meets certain criteria.
- Crisis Services' mobile crisis teams are highly effective in identifying individuals who require hospitalization. In 2025, approximately 67 percent of individuals transported to CPEP following a community assessment by a mobile crisis team were subsequently admitted for inpatient psychiatric treatment. By contrast, only 29 percent of individuals in Erie County brought to CPEP by police officers on an involuntary psychiatric evaluation order were subsequently admitted to inpatient treatment.
- In 2024, approximately 4,148 calls were transferred from the crisis hotline to the Mobile Outreach Program, and mobile crisis teams were deployed to the community 3,804 times. Crisis Services was unable to complete assessments in more than half of the cases in which a mobile crisis response was requested, often because of delays due to resource limitations or challenges locating individuals. This indicates significant unmet demand for mobile crisis services—a widespread challenge among behavioral health organizations across the U.S.
- Demand for mobile crisis services continues to grow. Since 2022, the number of cases opened by Crisis Services' Mobile Outreach Program has

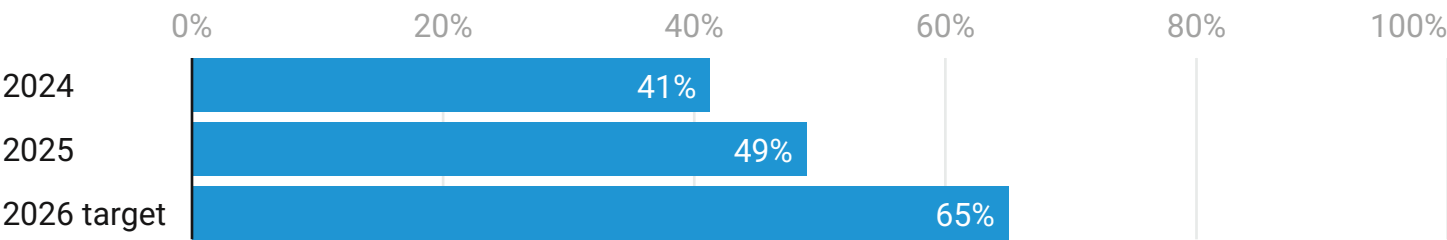
increased by 27 percent. Although the agency consistently responds within recommended timeframes for urgent cases, it faces increasing challenges meeting the New York State OMH standard of a three-hour response time for less urgent referrals. Staffing constraints are

compounded when Crisis Services requests law enforcement or EMS assistance to transport an individual under a Mental Hygiene Law § 9.45 involuntary evaluation order, sometimes waiting one to two hours for those resources to become available.

2026 TARGET: INCREASE THE SHARE OF COMPLETED ASSESSMENTS TO 65 PERCENT.

FIGURE 5

Mobile Crisis Teams’ Community Assessment Rate



RECENT ACCOMPLISHMENTS

- Crisis Services recently implemented a 30-hour workweek for full-time clinicians within the Mobile Outreach Program as part of a broader effort to reduce burnout and improve staff retention. The initiative is expected to be particularly beneficial in retaining master’s-level clinicians, who represent a critical component of the mobile crisis workforce.
- Staffing levels in the Mobile Outreach Program have begun to improve, with 16 new employees joining the mobile crisis team workforce since the beginning of 2026.
- After a period of transient staffing of the CIT Training Coordinator, the position has been filled by the same trainer for more than three years. Thus far in 2026, the program has conducted two 40-hour CIT trainings for law enforcement, both of which were filled to capacity, two CIT dispatcher trainings, and one CIT Advanced training for law enforcement. An additional one to two 40-hour CIT trainings and one to two CIT Advanced trainings are planned for the remainder of 2026.
- Crisis Services has partnered with the School of Social Work at the University at Buffalo to explore strategies for expanding the local crisis intervention workforce. Discussions have focused on increasing student exposure to crisis response practice and exploring micro-credentialing opportunities that could help prepare future professionals for careers in crisis services.

IMMEDIATE PRIORITIES

- 5.a. Increase the number of mobile crisis teams: Crisis Services entered 2025 with 10 mobile crisis teams. Its goal is to operate 16 fully staffed teams by the end of 2026. To that end, through grant funding provided by the Lee Foundation, the agency seeks to hire an additional 19 staff members to meet current demand and anticipated future growth in service utilization.
- 5.b. Review policies of the Mobile Outreach Program: Crisis Services will review and update policies, procedures, and programmatic practices associated with the Mobile Outreach Program. This periodic review serves as a quality assurance measure to ensure that services remain effective, responsive, and aligned with best practices.
- 5.c. Coordinate with other partners:
 - 5.c.1. Reestablish and strengthen partnerships with law enforcement agencies throughout Erie County: Crisis Services has served as the county's sole provider of Crisis Intervention Team (CIT) training since 2013.
 - 5.c.2. Develop protocols that facilitate the involvement of mobile crisis teams in behavioral health emergencies originating through the 911 system and initially routed to EMS: Buffalo EMS and its newly launched Nurse Navigation Program represent a promising partnership opportunity for Crisis Services. For incidents that do not require ambulance dispatch, nurse navigators could coordinate directly with Crisis Services to deploy mobile crisis teams for an in-person response. Preliminary discussions regarding this collaboration have already begun.
- 5.d. Develop approaches to billing that support financial sustainability:
 - 5.d.1. Explore additional reimbursement options to supplement cost of mobile crisis team services: Currently, Crisis Services bills for mobile crisis team services through ECMC as part of the CPEP mobile unit. However, reimbursement rates for community mental health assessments do not fully cover the cost of service delivery.
 - 5.d.2. Explore billing strategies to cover other program costs: Assess whether cases managed through the Mobile Outreach Program that are successfully resolved without requiring an in-person community assessment may qualify for reimbursement under existing crisis intervention funding streams.

ADDITIONAL CONSIDERATIONS

- Coordination with the nurse navigator program: As discussed in Objective 3, increasing the availability of mobile crisis teams may create opportunities for greater integration with the Buffalo EMS Nurse Navigation Program. As team capacity expands, the county could consider authorizing nurse navigators to coordinate directly with mobile crisis teams when responding to behavioral health emergency calls that do not require ambulance transport.
- Use of GPS: Crisis Services could explore using GPS-enabled deployment software to improve the efficiency and coordination of mobile crisis team operations. Such technology can provide real-time information regarding team location, status, and availability, enabling dispatchers to assign resources more effectively. The

organization has identified Trek Medics Beacon, a cloud-based platform that offers GPS tracking, team coordination, and automated alert notifications through mobile devices.

CASE STUDY: PIMA COUNTY, ARIZONA

Pursuing Technological Improvements to Deploy Mobile Crisis Teams

Pima County, Arizona, has been widely recognized for its early adoption of innovative approaches to behavioral health crisis response. Since 2015, individuals calling 911 with behavioral health-related emergencies have had the option to be transferred to the Pima County Crisis Line and connected with a crisis counseling specialist. The county later expanded

these efforts by embedding mental health clinicians within its 911 PSAPs.

More recently, the Pima County Crisis Line implemented a GPS-enabled dispatch optimization system that provides real-time visibility into the location and status of mobile crisis teams operating in the field. A color-coded interface indicates whether teams are available, assigned, or en route to a call. By improving situational awareness and resource allocation, the technology has enhanced the efficiency and responsiveness of mobile crisis team deployment.²⁵

Objective 6: Increase the use of alternatives to CPEP.

2026 Targets: (A) Average 152 monthly presentations (approximately five daily) at the ICSC. (B) Reduce visits to CPEP, with particular emphasis on reducing presentations that do not result in extended observation or inpatient admission.

BACKGROUND

- People from across Western New York arriving at ECMC's emergency department because of a behavioral health-related emergency are referred to ECMC's CPEP, the only facility in the state west of Rochester that provides 24/7 psychiatric emergency services and accepts involuntary admissions.
- Between 2023 and 2025, the number of people who received services at CPEP increased by approximately 5 percent. Periods of high patient volume create operational challenges for ECMC, including extended wait times and increased staffing pressures. To address these demands, ECMC strives to maintain two physicians within CPEP for a substantial portion of operating hours and supplements physician coverage with psychiatric nurse practitioners and resident physicians.
- In 2024, ECMC's emergency department received approximately 10,000 people who reported a behavioral health-related emergency, which represents approximately one in seven emergency department visits. Approximately 75 percent of people arriving at the emergency department with a reported behavioral health emergency are brought by police or ambulance services.
- Many of these individuals could have been served effectively through community-based programs instead of the hospital. For example, of the 3,208 people who were brought to CPEP by law enforcement on involuntary status in 2024, less than one-third (29 percent) were subsequently admitted for inpatient treatment (n=916). In fact, just one-quarter of all people arriving at CPEP in 2024 were later admitted to ECMC for inpatient treatment (n=2,480).
- ECMC estimates that the total annual cost for outpatient CPEP encounters²⁶ 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. Most individuals receiving services through CPEP are insured through publicly funded programs, including Medicaid and Medicare.
- Law enforcement officers report that they often wait three to four hours (and sometimes longer) in the emergency department until a physician is available to evaluate someone who appears to need mental health services.

- To meet the demand for behavioral health services, New York State has prioritized the launching of intensive crisis stabilization centers (ICSCs) across the state. Several have already opened, most recently in Buffalo, where BestSelf Behavioral Health opened the BestResponse Intensive Crisis Center in January 2026.
- The ICSC creates a new community-based alternative to hospital emergency department care for individuals experiencing behavioral health crises. As the first ICSC in Western New York, the center serves both youth and adults, regardless of insurance status, who require stabilization and connections to ongoing care but do not necessarily require hospitalization.
- Modeled after nationally recognized crisis stabilization centers, the ICSC operates 24/7 and accepts both walk-ins and voluntary transports by first responders. Research suggests that crisis stabilization centers can reduce reliance on hospital emergency departments even when a substantial portion of clients self-refer for services.²⁷
- Over the first few months, intake at the new ICSC generally lasted approximately 15 to 20 minutes, allowing officers to return to service much more quickly than when taking someone to CPEP.

2026 TARGETS: (A) ACHIEVE AN AVERAGE OF 152 MONTHLY PRESENTATIONS (APPROXIMATELY FIVE PER DAY) AT THE ICSC. (B) REDUCE VISITS TO CPEP, WITH PARTICULAR EMPHASIS ON REDUCING PRESENTATIONS THAT DO NOT RESULT IN EXTENDED OBSERVATION OR INPATIENT ADMISSION.

FIGURE 6

ECMC CPEP Visits



RECENT ACCOMPLISHMENTS

- BestResponse has clearly defined inclusion and exclusion criteria for receiving treatment at the ICSC. People eligible for services include those experiencing a mental health crisis or substance-related emergency who are medically stable and voluntarily agree to receive services. Individuals requiring a higher level of medical care, including those experiencing significant medical instability, chest pain, seizure-related concerns, acute alcohol withdrawal, or other acute medical conditions, are referred to more appropriate treatment settings.
- Between January and March 2026, fewer than 3 percent of individuals presenting to the ICSC required transfer to CPEP for a higher level of care. These early results suggest that the center is appropriately serving individuals whose needs can be addressed in a community-based crisis stabilization setting.

- ECMC has reduced the amount of time individuals spend in CPEP, largely through expanded psychiatric staffing and more timely clinical evaluations. Because only physicians can authorize discharge from CPEP, increased psychiatric coverage has improved patient throughput. Approximately 55 percent of CPEP visits in 2025 were completed within 24 hours, compared with just under 47 percent in 2024. By comparison, the average total length of stay at the ICSC was under three hours during its first few months of operation in 2026.
- ECMC is currently implementing the EPIC electronic health record platform, which is expected to enhance reporting capabilities and support more robust data analysis in the future.
- BestResponse continuously engages with law enforcement and community partners to address questions regarding clinical eligibility, legal considerations, and risk management practices. The center offers tours and educational sessions to increase familiarity with the facility and its role within the crisis response continuum.

IMMEDIATE PRIORITIES

- 6.a. Invest in ongoing outreach and awareness: BestResponse will conduct targeted outreach to additional law enforcement agencies to increase awareness of the ICSC and ensure officers understand the eligibility criteria, referral process, and operational benefits of the center. Several law enforcement agencies—including those in Amherst, Buffalo, Cheektowaga, Town of Hamburg, and West Seneca—have already begun utilizing the ICSC as a crisis stabilization option. However, many municipalities across Erie County have not yet incorporated the center into their response practices.
- 6.b. Inform CPEP visitors about the ICSC: ECMC will revise its discharge paperwork to include information regarding the ICSC. Currently, people leaving CPEP receive information on ECMC's Help Center and other behavioral health providers at discharge. Increasing awareness of the ICSC may help reduce future reliance on emergency department-based psychiatric care.
- 6.c. Authorize ambulance transport to the ICSC: The ICSC will complete and submit the necessary regulatory approvals with the New York State Department of Health to permit direct ambulance transport to the facility. Once authorized, this change could expand access to community-based crisis stabilization services and further reduce reliance on hospital-based emergency care.
- 6.d. Improve ICSC data reporting: As noted in Objective 4, BestSelf Behavioral Health, which is the parent company of BestResponse, has submitted a request to its EMR vendor to expand data collection capabilities related to services delivered through the ICSC. Enhanced reporting functionality will improve the county's ability to evaluate outcomes, monitor utilization patterns, and assess the center's impact on the broader crisis response system.

ADDITIONAL CONSIDERATIONS

- Metrics for success: As utilization of the ICSC increases, Erie County should establish clear metrics for measuring successful diversion from CPEP. Key questions include whether increases in ICSC presentations correspond with reductions in CPEP visits and whether

those reductions occur among populations most appropriate for community-based stabilization services. ECMC and BestResponse should consider conducting a formal evaluation after the first year of operation to determine the extent to which the ICSC is reducing demand on hospital-based psychiatric emergency services.

- Raising awareness: More than half of individuals presenting to CPEP each year are estimated to arrive as walk-in clients rather than through law enforcement or EMS referrals. The county should consider implementing a targeted outreach and public education strategy to increase awareness of alternative crisis care options. Identifying the

most effective communication channels and messaging strategies could help redirect appropriate individuals to less restrictive and more timely options for behavioral health support, including the ICSC.

BESTRESPONSE’S ICSC INCLUSION AND EXCLUSION CRITERIA

Appropriate for ICSC (Inclusion Criteria):

- Behavioral health or substance use crisis; medically stable
- Suicidal ideation/distress without acute medical instability
- Opioid overdose reversed with naloxone, stable
- Voluntary acceptance of services
- Adults & youth (12+) in crisis
- Children under 12 years old with parent/legal guardian

Inappropriate for ICSC (Exclusion Criteria):

- Chest pain, stroke, seizure, head trauma
- Severe respiratory distress or unstable vitals
- Acute alcohol withdrawal (seizure risk)
- Actively violent or involuntary admission needed
- Patients requiring emergency department medical clearance or advanced medical care

The ICSC operates 24 hours a day, 7 days a week, 365 days a year.

CASE STUDY: GEORGIA

Streamlining Emergency Department Diversion

Georgia's behavioral health crisis system, administered by the Department of Behavioral Health and Developmental Disabilities, provides a statewide "no-wrong-door" continuum designed to reduce reliance on hospital emergency departments through integrated access points for crisis care. Central to this model are Behavioral Health Crisis Centers (BHCCs) and Crisis Stabilization Units (CSUs), which operate 24/7 as walk-in and referral-based alternatives to emergency departments for individuals experiencing psychiatric crises.²⁸ These facilities provide rapid assessment, short-term stabilization (ranging

from hours in BHCCs to several days in CSUs), and direct linkage to outpatient and community-based services. In many regions of the state, these facilities also accept transports by law enforcement and EMS. The system is explicitly structured to divert individuals from hospital-based emergency psychiatric care when inpatient admission is not clinically required, thereby reducing pressure on emergency departments and psychiatric inpatient units while improving access to timely stabilization services. Georgia continues to expand this infrastructure as part of a coordinated statewide crisis strategy that integrates mobile crisis response, the 988 crisis line, and crisis stabilization facilities into a unified behavioral health response system.

Objective 7: Reduce repeat visits to CPEP.

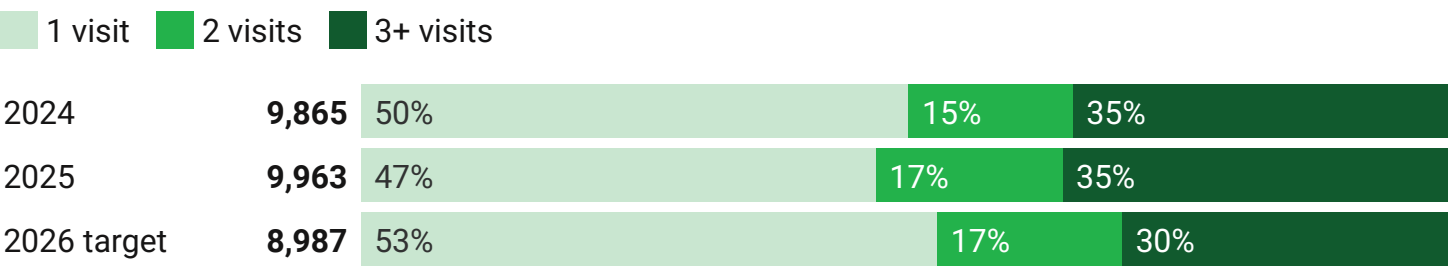
2026 Target: Reduce repeat CPEP visits by 5 percentage points

BACKGROUND

- The CTC Collaborative defines repeat visitors to CPEP as three or more visits to CPEP within a calendar year. In 2024, just 669 individuals were responsible for 3,405 unique visits, or more than one out of every three visits to CPEP. Eighty-five percent of visits by the high-frequency population were covered under Medicare or Medicaid.
- ECMC convenes regular interdisciplinary meetings with hospital staff and community providers to review individuals with high-frequency CPEP utilization, particularly those with three or more visits within a month. These discussions inform care coordination strategies and targeted interventions.
- Individuals with repeated behavioral health crises place substantial and recurring demand on the emergency system. This pattern of frequent CPEP utilization indicates persistent unmet behavioral health needs and gaps in continuity of care.
- ECMC data further show that while the number of unique individuals with high utilization decreased slightly in 2025 (n=649) compared to 2024 (n=669), the frequency of visits among this population increased, suggesting greater

FIGURE 7

How many CPEP visits come from repeat visitors?



intensity of reliance on services among a smaller cohort.

- According to ECMC officials, a growing percentage of people who present at CPEP three

or more times in a year because of a behavioral health emergency are experiencing housing instability, co-occurring substance use disorders, or both.

2026 TARGET: REDUCE REPEAT CPEP VISITS BY 5 PERCENTAGE POINTS.

RECENT ACCOMPLISHMENTS

- ECMC conducts biweekly multidisciplinary meetings focused on patients with high emergency department utilization to identify opportunities for improved care coordination and alternative service pathways. In addition, ECMC holds weekly case conferences to review adolescents with a history of repeated CPEP utilization, including both acute intervention planning and longer-term care coordination strategies.
- ECMC routinely notifies the Erie County Department of Mental Health of individuals with three or more CPEP visits within 30 days to support cross-provider coordination and linkage to community-based services.

IMMEDIATE PRIORITIES

- 7.a. Identify repeat visitors earlier: ECMC will develop a plan for flagging individuals who visit CPEP more than once within 30 days. Earlier identification of potential repeat visitors would enable more proactive intervention, enhanced discharge planning, and strengthened linkage to ongoing care and support.
- 7.b. Strengthen post-discharge engagement in treatment: ECMC will evaluate options to improve engagement in post-discharge behavioral health treatment for people visiting CPEP. Enhancing care transitions, including timely outpatient appointments and proactive outreach after discharge, is expected to reduce reliance on CPEP as the default crisis response setting.

ADDITIONAL CONSIDERATIONS

- Systemwide approach: A coordinated, systemwide approach is needed to improve accountability for continuity of care and reduce reliance on CPEP as a primary entry point for behavioral health treatment. Such an approach may include enhanced information-sharing across providers, standardized follow-up protocols for missed appointments, and more assertive outreach to individuals at high risk of disengagement. Strengthening engagement in ongoing behavioral health treatment is critical to reducing crisis recurrence and minimizing avoidable emergency department utilization. ECMC, BestResponse, and other providers should consider developing a systemwide accountability framework for post-crisis engagement in treatment.

- Involving Certified Community Behavioral Health Clinics (CCBHCs): Local CCBHCs could play a greater role in discharge planning for high-frequency populations. A mechanism to notify CCBHCs when individuals have recently presented at CPEP, for example, would enable more rapid outreach and care coordination.
- Post-crisis services: The New York State OMH is actively working with hospitals and community providers to improve post-hospitalization engagement. These approaches could

potentially be extended to CPEP discharges, particularly for individuals with repeated crisis presentations. Further exploration is warranted regarding how to better match individuals seen at CPEP with appropriate community-based services and reduce reliance on emergency care as the primary behavioral health access point.

CASE STUDY: OKLAHOMA

Adopting a Statewide Approach

Through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma has developed a comprehensive statewide behavioral health crisis system designed to reduce reliance on emergency departments and improve continuity of care across the crisis continuum.²⁹ The system integrates the 988 Lifeline with local community mental health centers and CCBHCs, enabling real-time appointment scheduling and linkage to ongoing care. ODMHSAS also coordinates mobile crisis response teams statewide and has supported cross-system communication

by distributing technology (including tablets) to first responders and providers to improve care coordination and information sharing. In addition, the state contracts for transportation services (via RideCARE) to ensure individuals can be transported directly to CSUs or Urgent Recovery Clinics (URCs), reducing reliance on hospital emergency departments for behavioral health crises. Oklahoma continues to expand CSU and URC capacity statewide, with facilities located in communities with populations of 20,000 or more. A 2025 evaluation of the system estimated that, once fully scaled, Oklahoma's integrated crisis continuum could result in up to 45,000 fewer emergency department visits annually, reflecting the impact of expanded alternatives to hospital-based crisis care.³⁰

Objective 8: Ensure engagement in post-crisis treatment.

2026 Target: Partners continue to have conversations around multi-year targets.

BACKGROUND

- Under 14 NYCRR Part 600.10, all ICSCs in New York State are required to facilitate connection to appropriate behavioral health services in the community following discharge.³¹
- Similarly, 14 NYCRR Part 590.8 establishes requirements for CPEPs to ensure that individuals discharged from emergency psychiatric care are linked to ongoing behavioral health treatment.³²
- While referrals are a required component of discharge planning, they do not guarantee engagement in care. Even when appointments are scheduled prior to discharge, individuals may not attend follow-up services. National data indicate that only approximately half of individuals discharged from inpatient psychiatric care complete a first outpatient follow-up visit within seven days, highlighting a persistent gap between referral and actual treatment engagement.³³

2026 TARGET: PARTNERS CONTINUE TO HAVE CONVERSATIONS AROUND MULTI-YEAR TARGETS.

RECENT ACCOMPLISHMENTS

- The Erie County Department of Mental Health has contracted with CCNY Inc. to develop an internal crisis care dashboard that integrates data from local behavioral health providers. Once fully operational and supported by appropriate HEALTHeLINK³⁴ access, this tool will enable more robust monitoring of post-crisis engagement.
- The BestResponse Intensive Crisis Center in Buffalo provides structured care coordination and facilitates direct linkage to providers within the BestSelf Health Home network under New York State's Medicaid Health Home program. In cases where individuals miss scheduled follow-up appointments, BestResponse conducts outreach to reschedule and re-engage individuals in care.³⁵

IMMEDIATE PRIORITIES

- 8.a. Strengthen post-crisis follow-up and outreach: ECMC and BestResponse will adopt or refine policies to ensure that individuals discharged from CPEP or the ICSC successfully engage in recommended follow-up care through proactive outreach and care coordination.
- 8.b. Enhance discharge planning: For individuals with repeated use of emergency behavioral

health services, ECMC and BestResponse will review the existing discharge planning process and identify strategies that will enhance the coordination protocols to support sustained engagement in community-based treatment. This may include stronger handoffs to providers, more structured follow-up expectations, and clearly defined accountability for ensuring continuity of care after discharge.

ADDITIONAL CONSIDERATIONS

- Measuring progress: Although both ECMC and the ICSC can document successful referrals to community-based services, additional strategies are needed to measure and improve actual treatment engagement, not just referral completion. This may include standardized tracking of appointment attendance, follow-up contact protocols, and escalation pathways for individuals who repeatedly disengage from care.
- Pilot programming: The Erie County Department of Mental Health should explore the feasibility of launching a pilot program that provides enhanced care coordination and incentivizes sustained engagement in outpatient behavioral health treatment.
- Augmenting post-discharge practices: The New York State OMH and the Erie County Department of Mental Health could collaborate on ways to strengthen post-discharge engagement practices related to the existing licensing oversight processes.

CASE STUDY: WHITE PLAINS HOSPITAL (WPH) CARES PROGRAM

Offering Multidisciplinary Telehealth Transitional Care

White Plains Hospital operates the WPH Contact After Emergency Department Discharge (CARES) program, a multidisciplinary post-discharge care coordination initiative designed to improve continuity of care following emergency department visits. The program comprises a team of nurse practitioners, physician assistants, registered nurses, social workers, and care navigators who provide structured follow-up after discharge. Rather than relying on a single post-discharge phone call, the program includes three integrated components: clinical outreach, access navigation, and clinical escalation. The care team contacts patients following discharge

to support appointment scheduling, medication access, and connection to community-based resources, while also addressing social determinants of health in collaboration with external partners such as social service agencies and pharmacies.³⁶

A 2025 evaluation³⁷ of the program found that WPH CARES efforts corresponded with reduced emergency department return visits at both 7 days and 30 days, demonstrating the effectiveness of structured, multidisciplinary transitional care in improving post-discharge engagement. The study also found that weekday contact attempts in the late afternoon and evening had the highest rates of successful patient contact, highlighting the importance of timing and persistence in post-discharge outreach.

Objective 9: Support the workforce.

2026 Target: In partnership with University at Buffalo School of Social Work, regional strategies to support the workforce are being identified.

BACKGROUND

- Nationally, there is a persistent shortage of behavioral health professionals, including crisis care staff, licensed mental health clinicians, psychologists, and psychiatrists. The COVID-19 pandemic intensified these shortages while simultaneously increasing demand for behavioral health services due to rising rates of anxiety, depression, and related conditions.
- Workforce shortages also extend to first responders. For many years, agencies have faced challenges in recruiting and retaining law enforcement officers and emergency communications center staff.

2026 TARGET: IN PARTNERSHIP WITH UNIVERSITY AT BUFFALO SCHOOL OF SOCIAL WORK, REGIONAL STRATEGIES TO SUPPORT THE WORKFORCE ARE BEING IDENTIFIED.

RECENT ACCOMPLISHMENTS

- As part of the CTC Collaborative, the University at Buffalo School of Social Work is working on a planning grant to strengthen the regional crisis care workforce pipeline. This includes developing a comprehensive curriculum for undergraduate and graduate students, as well as ongoing professional development opportunities for current practitioners. Financial support for this effort is being provided by the Garman Family Foundation.
- Several police departments in Erie County have implemented wellness initiatives to support their workforce, including emotional support animals and expanded wellness programming. Departments participating in co-response models report increased awareness of mental health concerns among personnel.
- The Lee Foundation also provided grant funding to the WNY Peer Helpline, which operates an anonymous peer hotline for law enforcement

and trains first responders in mental health supports.

IMMEDIATE PRIORITIES

- 9.a. Fund mental health support: Identify and pursue funding sources to support mental health programming for first responders and 911 emergency communications center staff.
- 9.b. Grow the crisis care workforce: Identify additional opportunities to support local police departments in expanding the use of embedded clinicians.

CASE STUDY: HIGHMARK BLUE CROSS BLUE SHIELD’S MENTAL WELL-BEING PROGRAM

Taking a Highly Integrated Approach to Care Coordination

Highmark Blue Cross Blue Shield, a health insurance company, has modernized its approach to behavioral health care delivery through its Mental Well-Being program, launched in January 2024. The program features personalized care pathways, dedicated care navigators, rapid access to providers, and comprehensive support options embedded within employee health plans. Serving eight counties in Western

New York, the health plan’s Mental Well-Being program employs licensed master’s-level clinicians who assist with care matching, referrals, and ongoing support. The Mental Well-Being program has also been integrated with Employee Assistance Programs (EAPs) to provide coaching, counseling, and care navigation services.³⁸

With expanded telehealth options, the program supports virtual therapy sessions and offers digital tools for ongoing wellness through both web-based and mobile platforms. The introduction of care navigators has created a more streamlined and integrated approach to mental health care coordination.

Objective 10: Support county-led initiatives and monitor progress.

2026 Target: County leadership is working to identify multi-year targets.

BACKGROUND

- Erie County has long worked to improve its behavioral health emergency response system through a range of initiatives. Historically, these efforts have often occurred within individual organizations or across limited partnerships focused on specific points (e.g., Call, Respond, Go) or discrete components of the crisis continuum. While these efforts have produced meaningful improvements, a fragmented approach is less effective in driving system-wide change.
- The CTC Collaborative represents a more integrated effort, bringing together stakeholders across the system and supported by local leadership, advocates, and community organizations.
- Multiple agencies and organizations across the county are investing in improvements to behavioral health emergency response systems. Without consistent analysis of data and trends, it will be difficult to determine whether these investments are producing intended outcomes.

2026 TARGET: COUNTY LEADERSHIP IS WORKING TO IDENTIFY MULTI-YEAR TARGETS.

RECENT ACCOMPLISHMENTS

- The Mental Health Crisis Response Triage Tool, originally developed by the Millennium Collaborative Care Delivery System Reform Incentive Payment (DSRIP) initiative, has been recently updated by a committee of community-based providers and advocates together with the Erie County Department of Mental Health, and re-released to community providers. It is designed to reduce unnecessary reliance on hospitalization and improve timely access to appropriate levels of care.
- As referenced in Objective 8, the Erie County Department of Mental Health has commissioned CCNY Inc. to develop an internal dashboard that will serve as a centralized platform for behavioral health data from local providers. This tool

has the potential to support a more coordinated regional response to individuals experiencing behavioral health crises.

- All data partners (See “Sources” for a full list of organizations providing data) have committed to regular data sharing with the CTC Collaborative

to inform quarterly progress reports for the Leadership Committee. Quarterly data submissions began in April 2026, and the first quarterly report was presented to the leadership committee in July 2026.

IMMEDIATE PRIORITIES

- 10.a. Behavioral health treatment engagement: Support CCNY’s development of the behavioral health services dashboard. Phase One dashboard partners include BestSelf Behavioral Health, Crisis Services, Endeavor Health Services, and Recovery Options Made Easy (ROME). Phase Two may expand to include ECMC data integration.
- 10.b. Support training on the Mental Health Crisis Response Triage Tool: Explore funding opportunities to train local behavioral health providers on the updated triage tool.
- 10.c. Monitor progress through quarterly reporting:
 - 10.c.1. Share data regularly: Data partners will continue quarterly data sharing to support ongoing monitoring of trends.
 - 10.c.2. Automate quarterly reporting: Explore opportunities to automate portions of the quarterly reporting process by developing scripts or other tools to extract de-identified data into standardized, shareable formats. This would improve efficiency and reduce the time required to produce each quarterly report.

ADDITIONAL CONSIDERATIONS

- Cross-training: In areas of the county under the jurisdiction of the Erie County Sheriff’s Office, consider cross-training first responders (deputies and EMTs) in behavioral health first aid and de-escalation techniques to strengthen response capacity in regions without embedded clinical staff.
- Dashboard expansion: Assess the feasibility of expanding the behavioral health provider dashboard to include first responder data, such as 911 CAD records and trends from Behavioral Health Teams and other co-responder programs. Alternatively, consider developing an integrated dashboard that tracks behavioral health emergency responses from initial 911 call through dispatch, response, and final disposition.
- Triage tool integration: Explore integrating the Mental Health Crisis Response Triage Tool into provider software systems to better capture assessment data and evaluate how effectively the tool is being used.
- Release of performance metrics: While internal performance metrics are typically available to agency leadership, they are not always shared publicly. Increased transparency through regular reporting can enhance public awareness of challenges and progress, while also building broader community support for ongoing initiatives.

Conclusion

CONCLUSION

The objectives described in this *2026 Progress Report* are rooted in an unprecedented quantitative and qualitative analysis of public safety, emergency medical services, and behavioral health data in Erie County. In addition, leaders of key agencies and service providers had countless discussions about how calls to 911 and 988 are processed, who is dispatched when on-scene response is necessary, and where people who need immediate care are taken. These objectives also benefit extensively from the input of community-based advocates and people who have experienced a behavioral health-related emergency.

This report reflects that those efforts have paid dividends. Public safety and behavioral health officials across Erie County have taken significant steps to implement each objective, and they have committed to an extensive list of additional action items. Using 2024 data as a baseline, the CTC

Collaborative set measurable targets to hit by the end of 2026.

The Leadership Committee that oversees the CTC Collaborative is committed to reviewing quarterly reports, which the Lee Foundation will help generate, to track progress going forward. The CTC Collaborative will use those quarterly reports to inform the development of a long-term strategic plan with clear three- to five-year milestones. Realizing those goals could transform behavioral health emergency response in Erie County and establish a model for communities across New York State and beyond.

End Notes

1. Please see the appendix for more information on the consultants engaged in this project.
2. Crisis Services has operated a 24-hour crisis hotline number since 1968. Of the calls answered by Crisis Services in 2024, approximately 85 percent were placed to the local hotline number. Calls to 988 represented 15 percent of calls answered by Crisis Services.
3. See, for example, National Association of Counties' Shaping Crisis Response Spotlight Series and Promoting Health and Safety through a Behavioral Health Continuum of Care, 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.
4. Many of the 2024 data findings cited in this report were originally published in the CTC Collaborative's Status Report (December 2025).
5. Policing the Mentally Ill, PowerDMS, December 22, 2020.
6. Another source estimates that, in some cities, between 21 percent and 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, April 6, 2022.
7. A 911 dispatch code classifies an incoming emergency and dictates how help is sent at the start of an incident, while a 911 disposition code records the final outcome or result when an incident is closed by the first responder.
8. Calls involving a person experiencing a behavioral health crisis could be coded as "welfare

- check,” “domestic,” or “drunk and disorderly.” The target for this objective includes those dispatch call types only if the call disposition field indicates the call had a behavioral health component.
9. A “ § 9.41 MH Evaluation” refers to situations in which the police determine an individual requires psychiatric evaluation at the local CPEP. Calls disposed with a “CIT Referred” code indicate cases in which the officers on scene refer an individual to the Behavioral Health Team for follow-up activity.
 10. The Council of State Governments Justice Center, “Integral Care’s Expanded Mobile Crisis Outreach Team – Austin, TX,” updated January 3, 2025.
 11. G. S. Torres, et al., Embedding Behavioral Health Professionals in 911 Call Centers: Approaches to Alternative Response Workforce (Cambridge, MA: Harvard Kennedy School Government Performance Lab, 2024).
 12. T. A. Olmstead, et al., “The Impact of Embedding Behavioral Health Professionals in a 911 Call Center,” *Psychiatric Services* 77, no. 7 (2026): 604-609, doi:10.1176/appi.ps.20250322
 13. “Peace officers” in this context refer to police officers, sheriff’s deputies, and state troopers, and other law enforcement officials, all of whom have the legal authority to transport an individual to an emergency department for a psychiatric evaluation.
 14. V. R. Patel, M. Liu, A. B. Jena, “Suicide Mortality Among Adolescents and Young Adults After Launch of a Suicide and Crisis Lifeline,” *JAMA* 335, no. 19 (2026): 1721–1723, doi:10.1001/jama.2026.5157.
 15. M. S. Gould, et al., “National Suicide Prevention Lifeline (Now 988 Suicide and Crisis Lifeline): Evaluation of Crisis Call Outcomes for Suicidal Callers,” *Suicide and Life-Threatening Behavior* 55, no. 3 (2025): e70020, doi: 10.1111/sltb.70020.
 16. Many calls to Crisis Services go unanswered because callers hang up before reaching a crisis counseling specialist, decline to remain on hold, or are unable to access the system because of line congestion associated with high-frequency callers.
 17. S. Brooks Holliday, et al., *The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation, and Community Response* (Santa Monica, CA: RAND, 2024).
 18. Global Medical Response, “911 Nurse Navigation Program,” accessed August 30, 2026.
 19. County of Santa Clara Health System, “Innovative, Resource-Saving 911 Nurse Navigator Program Expands Countywide,” January 8, 2026.
 20. Kevin H. Wilson, et al., “A Randomized Controlled Trial Evaluating the Effects of Nurse-Led Triage of 911 Calls” *Nature Human Behaviour* 8, no. 7 (May 24, 2024): 1276-84, <https://doi.org/10.1038/s41562-024-01889-6>.
 21. 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, NY: Vera Institute of Justice, 2019).
 22. City of Albuquerque, Albuquerque Community Safety, “What is Community Safety?,” accessed August 31, 2026.
 23. The Council of State Governments Justice Center, “Albuquerque Community Safety Department – Albuquerque, NM,” updated April 4, 2025.
 24. R. L. Peters, et al., “Mobile Crisis Effectiveness: A Systematic Review and Associated Functions

- and Forms Framework,” BMC Health Services Research 26, no. 1 (2026): 60, <https://doi.org/10.1186/s12913-025-13806-2>.
25. University of Cincinnati, Center for Police Research and Policy, Assessing the Impact of Mobile Crisis Teams: A Review of Research (Cincinnati, OH: University of Cincinnati, 2021).
 26. National Association of Counties, Shaping Crisis Response: Spotlighting Pima County, Arizona (Washington, D.C.: National Association of Counties, 2023).
 27. In this context, “outpatient encounters” refer to emergency department visits that do not result in an admission to the hospital.
 28. A. Burns, et al., “Availability of Behavioral Health Crisis Care and Associated Changes in Emergency Department Utilization,” Health Services Research 60, no. 2 (2025): e14368. doi:10.1111/1475-6773.14368.
 29. Georgia Department of Behavioral Health and Developmental Disabilities, “The Crisis System of Georgia,” accessed August 31, 2026.
 30. Oklahoma Department of Mental Health and Substance Abuse Services, “Comprehensive Crisis Response,” accessed August 31, 2026.
 31. Healthy Minds Policy Initiative, Bringing Oklahoma’s Diversion Services to Scale (Tulsa, OK: Healthy Minds Policy Initiative, 2025).
 32. New York State Office of Mental Health, NYCRR Title 14, Part 600 Crisis Stabilization Centers (2022), https://omh.ny.gov/omhweb/policy_and_regulations/proposed/omh600revised.pdf.
 33. New York State Office of Mental Health, NYCRR Title 14, Part 590 Operation of Comprehensive Psychiatric Emergency Programs (2024), https://omh.ny.gov/omhweb/policy_and_regulations/adoption/
 34. National Committee for Quality Assurance, HEDIS Measure Library and Historical Data (Follow-up After Hospitalization for Mental Illness [FUH] measure, 1999-2024 trend data). Accessed September 28, 2026, from <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-hospitalization-for-mental-illness-fuh/>.
 35. HEALTHeLINK is part of the Statewide Health Information Network for New York (SHIN-NY), which allows health care providers efficient access to patient data. HEALTHeLINK serves providers in Western New York.
 36. A Health Home is a group of health care and service providers that facilitate comprehensive care plans, which can include treatment providers, medication assistance, and help with housing and social services. See https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ for more information.
 37. “Patient Information,” White Plains Hospital, accessed September 1, 2026.
 38. M. B. Light, et al., “Contact After Emergency Department Discharge by a Telehealth Transition of Care Program Is Associated with Reduced Emergency Department Revisit Rate,” Cureus 17, no. 12 (2025): e100433. doi:10.7759/cureus.100433.
 39. “Highmark EAP + Mental Well-being Solutions,” Highmark, accessed September 1, 2026.

Appendix

CONTRIBUTORS TO THE CTC COLLABORATIVE

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

- American Medical Response, Inc.
- Amherst Police Department
- 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
- Garman Family Foundation administered by the Community Foundation for Greater Buffalo
- Hilbert College
- Horizon Health Corporations
- Jericho Road Community Health Center
- Lancaster Police Department
- 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 Tower Foundation
- Recovery Options Made Easy
- Restoration Society, Inc.
- Spectrum Health and Human Services
- Town of Hamburg Police Department
- Town of Tonawanda Police Department
- University at Buffalo – SUNY
- Value Network IPA, LLC
- Villa Maria College
- West Seneca Police Department

Each of these organizations has contributed to the overall understanding of behavioral health emergency response in Erie County, and continues participating in working group meetings, listening sessions, and other events that further the work of the CTC Collaborative.

SOURCES

The project team would like to thank the many organizations that contribute data to this initiative on an ongoing basis.

- American Medical Response, Inc.: AMR data for emergency calls from within the City of Buffalo are provided for regular monitoring of EMS trends.
- BestSelf Behavioral Health: provides data on the number of people presenting at the BestResponse Intensive Crisis Center in Buffalo each quarter.
- Buffalo Fire Department: The Buffalo Fire Department provides quarterly data extracts of case-level/raw AMR ambulance dispatch data for psychiatric calls. This information includes the Emergency Medical Dispatch level of response, outcomes, and the hospital to which someone was transported.
- Buffalo Police Department: The Buffalo Police Department provides quarterly reports that present the total number of mental health-related calls aggregated by call types and call dispositions, and now includes the number of calls in which Behavioral Health Team officers responded.
- Cheektowaga Police Department: The Cheektowaga Police Department provides a quarterly spreadsheet of aggregated numbers showing the volume of calls identified by the department as mental health-related.
- Crisis Services: Crisis Services provides a tracking spreadsheet on a quarterly basis that includes tabs for the hotline calls and for the mobile crisis team's community assessments.
- Endeavor Health Services: Endeavor Health Services shares a spreadsheet quarterly which contains de-identified data relating to the number of unique cases in which an embedded clinician was engaged in a call for service and/or follow-up visit.
- Erie County Central Police Services: Erie County CPS currently provides CAD and RMS data on a quarterly basis identifying the behavioral health emergency calls for each of the CTC Collaborative's police departments (Buffalo, Cheektowaga, Town of Lancaster, and West Seneca) and for the Erie County Sheriff's Office.
- Erie County Medical Center: ECMC provides eight de-identified case-level/raw data files for this initiative on a quarterly basis, 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 include an aggregate spreadsheet of the total number of people who

were seen at CPEP in a given year, placed in extended observation beds, and admitted to inpatient treatment.

- West Seneca Police Department: The West Seneca Police Department provides a quarterly spreadsheet of aggregated numbers showing the volume of calls identified as behavioral health-related.

CONSULTANTS

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 more than 16 years working in the field of criminal justice policy analysis, and in recent years has focused her research 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.



Crisis to Care
COLLABORATIVE

crisistocare.org