Opportunities and Challenges to Build Behavioral Health Crisis Capacity in Rural America

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This column shares lessons learned from a 1-year pilot implementation of a crisis response program deploying crisis professionals to rural parts of Albany County, New York. The data (325 crisis interventions for 191 unique individuals, 57% of cases resolved on the scene) suggest that the program helps fill the crisis services gap in these communities. Police were present on 80% of cases. Educating police to build confidence in the program and providing clearer guidelines on the triage process for dispatchers may be important strategies to continue shifting crisis response duties from traditional first responders to crisis professionals.

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For decades, the United States has had insufficient and declining resources for the community-based behavioral health care services necessary to effectively respond to and prevent behavioral health crises (1, 2). The lack of community-based crisis response systems has led to increases in costly emergency department (ED) visits and to behavioral health crisis response roles primarily falling on first responders, such as law enforcement (LE) (3, 4). Establishment of the national 988 Suicide and Crisis Lifeline in July 2022 increased efforts to develop a dedicated crisis response system at the local level analogous to the 911 emergency response system (4, 5). However, building a system that can address the unique behavioral health needs of rural communities with a historical lack of accessibility, availability, and acceptability of appropriate care presents challenges (6). In this column, we describe the effort in Albany County, New York, to improve responses to behavioral health 911 calls by sending a team of social workers and emergency medical services (EMS) providers. Specifically, we highlight opportunities and challenges in implementing a crisis response program to address behavioral health needs in rural communities, as observed through our work as the program's external program evaluator.

PROGRAM DESCRIPTION

Setting

In June 2021, Albany County, New York, launched the Albany County Crisis Officials Responding and Diverting (ACCORD) program. Although the ultimate goal was to offer the program countywide, the 1-year pilot program implementation targeted the Helderberg Hilltowns: Berne, Knox, Rensselaerville, and Westerlo. Despite making up 40% of the county's area, the Hilltowns account for only 3.3% of the county's population; more than 95% of the residents are White (7). Historically, people in this rural part of the county have experienced difficulty accessing behavioral health crisis services, because most behavioral health resources are located nearly an hour away in the City of Albany. Before the ACCORD program was established, the Albany County Department of Mental Health (ACDMH) mobile crisis team (MCT) provided behavioral health crisis services to the Hilltowns and assisted LE when requested. However, the county's behavioral health resources and the ACDMH MCT's services were historically underused because of the Hilltowns' distance from the City of Albany.

HIGHLIGHTS

- Albany County, New York, launched a crisis response program in June 2021 in rural parts of the county.
- Evaluation of performance in year 1 suggests that the program filled important crisis response service gaps in rural communities with historically limited access to behavioral health services.
- The presence of police at most crisis interventions highlights an opportunity to enhance up-front buy-in from law enforcement that facilitates the transition of crisis response duties from traditional first responders to the new program's specialized crisis responders.

Although New York State Police are also stationed in and may patrol Rensselaerville, the Albany County Sheriff's Office (ACSO) is the primary LE agency for the Hilltowns. Under a mutual aid agreement, ACSO provides dispatch services for the state police for the Hilltowns. State police were made aware of the ACCORD program before its rollout. From May 2020 to May 2021, ACSO officers responded to 2,446 emergency calls to 911 from the Hilltowns; 478 (20%) involved an emotionally disturbed person, and 122 (5%) involved a suicidal person. In addition to these historical data and contexts, the observed widening of rural-urban disparities driven by the COVID-19 pandemic provided the county legislature with a strong rationale to initiate the program in this underresourced area.

ACDMH has over 35 years of experience with the MCT and over 15 years of experience collaborating with LE, such as by providing crisis intervention team training to county LE agencies, including ACSO. The ACDMH has also been part of Law Enforcement Assisted Diversion in the City of Albany (https://www.albanyny.gov/366/Law-Enforcement-Assisted-Diversion-LEAD) since 2016. ACSO is known for implementing innovative behavioral programs in its jail, such as offering incarcerated individuals medications for opioid use disorder and comprehensive reentry support by a community-based harm reduction provider. These factors provided a strong foundation for the successful launch of the ACCORD program.

Development

Recognizing the intersection of behavioral health and adverse interactions with LE, the county legislature tasked the ACSO and ACDMH with identifying an innovative and more effective approach to helping people experiencing behavioral health crises. The stakeholders decided to model the ACCORD program on Crisis Assistance Helping Out On The Streets from Eugene, Oregon (8), and similar models in which 911 calls involving behavioral health crises and drug overdose issues are diverted to a team of behavioral health professionals and EMS providers. The county initially invested $170,000 to fund two full-time ACCORD social workers (salary and fringe benefits).

Given the historical data on service demand (with approximately 90% of nonviolent 911 calls occurring between 7:00 a.m. and 11:00 p.m.) and the availability of EMS providers and social workers, the program was offered Monday through Friday, with one social worker on duty for each day shift (7:45 a.m.–4:15 p.m.) and evening shift (3:45 p.m.–12:15 a.m.). However, coverage was not provided when ACCORD social workers were not available for reasons such as sick days, holidays, and vacation. For budgetary reasons, EMS providers were not hired specifically for the ACCORD program; instead, EMS providers working for ACSO could sign up for ACCORD shifts in addition to their regular EMS shifts. The sign-up took place each month, and shifts were assigned weekly. The ACCORD EMS providers received overtime compensation, which was covered by ACSO. Considering countywide expansion, the county legislature identified an academic partner and allocated an additional $30,000 to conduct an objective formative evaluation of ACCORD. Before the ACCORD program was launched, social workers and EMS providers received training based on existing MCT and crisis intervention team training protocols. The ACCORD team was stationed in the old 911 station in Voorheesville, a community adjacent to the Hilltowns, to reduce long dispatch response times from the City of Albany, an issue commonly reported in the county's rural communities (4, 5).

Operation

The ACCORD triaging process starts with a 911 dispatcher determining the reason(s) for and seriousness of a call. No clear triage decision-making tree was created for the ACCORD program's launch: if a call is from the Hilltowns, nonviolent, and seemingly connected to behavioral health (e.g., suicidal behaviors, an issue related to substance use), then the dispatcher triages the call to the ACCORD team. ACCORD social workers and EMS providers then travel to the scene in a dedicated unmarked vehicle provided by ACSO rather than in an ambulance.

After appraising the situation, the ACCORD team may provide immediate crisis counseling, give information about or facilitate referrals to community-based behavioral health and social services, or transport the patient to a psychiatric hospital or ED for further evaluation and care. If a situation is determined to be unsafe or escalates, the ACCORD team may request additional assistance from LE. If hospital transportation is required, per New York State law, an ambulance is called, or police transport the patient while the ACCORD team accompanies the ambulance or police. The ACCORD team calls ahead to alert the ED about the impending arrival in order to facilitate a smooth admission. Once at the ED, the ACCORD team takes over and stays with the patient so that the ambulance team or officers who transported the patient to the hospital can be released from the case. This process was particularly crucial during the COVID-19 pandemic, when the wait time for ED admission could take a few hours. Postintervention, an ACCORD social worker attempts to follow up with the patient, their family, or the hospital within 24 to 48 hours to ensure the patient had stabilized, consistent with existing MCT protocols.

To monitor the program's progress, the county formed an operations group with representatives from ACSO and ACDMH leadership, ACCORD social workers, and EMS supervisors. The group meets weekly or every 2 weeks to discuss program developments and strategies to overcome obstacles.

KEY FINDINGS

According to service records and case field notes, the ACCORD program provided 543 services (i.e., crisis responses plus follow-ups) between June 2021 and June 2022 to 191 unique individuals experiencing a behavioral health crisis.

Of these services, 325 (60%) were crisis interventions, and 52 individuals (27%) had multiple crisis interventions (mean±SD=3.6±4.4; range 2–33). The average time from ACCORD dispatch to crisis scene arrival was 20 minutes 54 seconds, considerably faster than MCT's response time from the City of Albany. The ACCORD team was most frequently dispatched for suicidal behaviors (25%, N=77 of 307 interventions) and for behavioral distress (26%, N=81 of 307), such as a posttraumatic stress disorder episode, severe depressive episode, or panic attack. A table showing statistics for additional ACCORD services is available in the online supplement to this column. Most patients (87%, N=166) had never used other ACDMH programs, confirming that ACCORD helped address the gap in use of behavioral health services in this underserved and underresourced community.

Most crisis intervention cases were successfully resolved on the scene (57%, N=184) when the ACCORD team provided a safety plan, service and treatment recommendations, linkage to services, a treatment plan that addressed the patient's immediate needs, or other services. Patients were transported to a hospital in 32% of cases (N=104), with 85% (N=88) resulting in involuntary admission. Four patients were arrested, and four patients were deceased when the ACCORD team arrived (three cardiac arrest cases and one completed suicide); in these situations, the ACCORD team provided support to the family and friends who were present. The ACCORD team also provided 218 follow-up services, mostly via telephone, such as check-ins with patients and their family members and status inquiries with hospitals, health care providers, and social service providers. Case management by the ACCORD team after the initial crisis intervention (e.g., ensuring linkage to referred services or care coordination with hospitals and other providers) was limited (12%, N=26 of 218 follow-up services) because the two ACCORD social workers did not have the capacity to complete these activities.

The ACCORD team was occasionally dispatched to respond to non–behavioral health calls, such as domestic incidents (17%, N=53 of 307 interventions) and patients needing medical attention (4%, N=13 of 307), because the ACCORD team's availability and location sometimes allowed for faster responses compared with EMS dispatch from the City of Albany. Furthermore, despite ACCORD's original goal of reducing LE presence, police officers from ACSO or other departments were on the scene with the ACCORD team for 80% of interventions (N=188 of 235 on-scene interventions). Although officers did not directly interact with patients most of the time (78%, N=147 of 188 cases), restraint was required for 22 patients (12%) who were endangering themselves or others. Initially, members of ACDMH, ACSO, and the county legislature were concerned about the response time of LE in this rural part of the county should the ACCORD team need assistance. They decided that a backup officer should be sent along with the ACCORD team while the team gained experience, but no plan to transition to call responses without LE backup was put in place. ACCORD team members also indicated that initially low levels of buy-in and trust from dispatchers and LE contributed to the low number of 911 calls triaged to the ACCORD team relative to the 600 calls received for behavioral health issues and suicidal persons the year prior, resulting in LE (rather than the ACCORD team) being dispatched for potentially ACCORD-appropriate calls.

LESSONS LEARNED: IMPLICATIONS FOR THE REST OF THE COUNTY AND BEYOND

ACCORD helped improve the crisis response capacity in historically underserved rural communities by sending trained professionals to crisis scenes with much faster response times than those of traditional EMS. Challenges with removing LE from behavioral health crisis responses stemmed partly from the initial lack of trust of LE in ACCORD and the rurality of the Hilltowns. However, development of trust of dispatchers and LE in the ACCORD team took longer than desired but has increased as the program has gained traction in the community. Indeed, semistructured interviews with ACCORD social workers and EMS providers highlighted that police officers quickly began to reduce their involvement at the scene as they became more familiar with the ACCORD team and confident in its ability to handle patients, suggesting that the ACCORD program has helped reduce officers' time on the scene. Thus, the ACCORD team members felt that more up-front education of LE about the program, along with collaborative preprogram launch training involving ACCORD team members, dispatchers, and police officers, would have helped build a stronger initial partnership and confidence in the ACCORD program and team. More clearly defined dispatcher guidelines identifying the call types that should be handled solely by ACCORD may also make 911 call triaging more efficient. In addition, active outreach and education for patients' families and for community members will make people aware that ACCORD team members—rather than police officers—may be requested as responders.

Members of ACDMH, ACSO, and the county legislature have appreciated the potential of the ACCORD program to reduce the costs associated with behavioral health crisis responses by decreasing the time LE officers and EMS providers spend responding to and managing such cases and by reducing the risk for future crises and subsequent hospitalizations. The county is extending the program to other jurisdictions, with $350,000 allocated by the New York State legislature for this expansion. However, the process has been slow, because the county needs to consider each community's unique service needs and resources and the ACCORD program's long-term financial sustainability, particularly in jurisdictions with their own LE and EMS agencies.

Critical evaluation of the ACCORD program's role in efforts to improve the county's crisis response system is also ongoing. For example, after the statewide implementation of the 988 crisis hotline in 2022, the ACDMH worked with the regional crisis contact center to ensure that the ACCORD program would be considered a resource for

Hilltowns residents. For example, when 988 counselors call 911 for emergency services, the counselors can request that the ACCORD team be dispatched for calls involving Hilltowns residents. The psychiatric hospital in the City of Albany may also request the ACCORD team to check on an individual if a request for support from a 988 counselor comes from the Hilltowns area. With the governor's commitment to enhancing behavioral health service capacity in New York State, supportive and intensive crisis stabilization centers will be established in Albany County, and the number of psychiatric hospital beds will increase. Through sequential intercept mapping exercises, the county is working to enhance collaborations between programs and community organizations that serve overlapping populations so that they can use the limited existing behavioral health resources more efficiently. This collaboration includes finding ways to add case management components to the ACCORD program, which would help to promote service engagement and reduce hospitalizations. A comprehensive, summative evaluation is also needed to understand the ACCORD program's impact on 911 crisis calls from the covered areas, postcrisis hospitalization rates, and the cost-benefit status of the program, all of which were beyond the scope of this formative evaluation study.

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