Albany County Crisis Officials Responding and Diverting (ACCORD)

Pilot Implementation Program
Implementation Evaluation Report

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SCHOOL OF PUBLIC HEALTH
UNIVERSITY AT ALBANY
State University of New York

SCHOOL OF SOCIAL WELFARE
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Glossary of Frequently Used Acronyms and Terms

ACCORD = Albany County Crisis Officials Responding and Diverting
ACSO = Albany County Sherriff's Office
ACDMH = Albany County Department of Mental Health
ADHD = Attention-deficit hyperactivity disorder
CIT = Crisis Intervention Training
EMS = Emergency Medical Services
Encounter = an interaction between ACCORD patients and team member
MCT = Mobile Crisis Team
PT = Patient
PTSD = Post Traumatic Stress Disorder
Response = Actual responses to each case by the ACCORD team during each encounter (e.g., services provided, actions taken by the team)
SPH = School of Public Health
SSW = School of Social Welfare

1. Executive Summary

The Albany County Crisis Officials Responding and Diverting (ACCORD) program is an interagency collaboration designed to improve outcomes for nonviolent 911 calls of individuals experiencing a behavioral health crisis using social workers and emergency medical services (EMS) workers instead of law enforcement whenever possible. This pilot program began on June 10th, 2021 and has focused on services in the Hilltowns area of Albany County. The Hilltowns area was selected as the pilot site for its historically limited access to behavioral health services due to its rurality.

University at Albany School of Public Health (SPH; lead Dr. Tomoko Udo) and School of Social Welfare (SSW; lead Dr. Carmen Morano) have been tasked to conduct a formative evaluation of the ACCORD pilot implementation. In particular, the evaluation focuses on the feasibility and acceptability of ACCORD, with a goal to derive concrete recommendations for expansion of the program to the rest of Albany County. The data sources included the dispatch records provided by the Albany County Sheriff's Office (ACSO), administrative data and fieldnotes provided by the Albany County Department of Mental Health (ACDMH) during the period June 2021-June 2022, and a series of in-depth semi-structured interviews with key informants involved in development and implementation of the ACCORD pilot program.

Specifically, this evaluation focused on the following aims:

1. To comprehensively describe the characteristics of calls diverted and responded to by the ACCORD team
2. To comprehensively describe services provided by the ACCORD team
3. To understand the extent to which the pilot ACCORD program was implemented in the way it was originally designed (i.e., program fidelity)
4. To describe successes and challenges associated with the ACCORD pilot implementation
5. To develop recommendations for a county-wide program expansion

In brief, the findings from this evaluation highlight the growth and adaptability of the ACCORD program, and its efficacy at connecting individuals in the community in need for social service support and effectively reducing their reliance on emergency services. The benefits of stationing ACCORD teams in each community were also supported.

<u>Highlights of the ACCORD Pilot Program Performance</u>

There were a total of 240 dispatch calls diverted to the ACCORD team, resulting in a total of 548 encounters with 210 unique individuals. The ACCORD team was able to resolve the crisis on the scene for 122 encounters. The majority of the dispatch calls were less serious as they fell under Alpha and Bravo priority categories; less than 10% of dispatch calls were priority levels of Charlie or higher. Most calls were categorized as EMS calls or calls requiring general medical attention. Approximately 57% of the ACCORD patients were females, and 93% were White. Sixty-two encounters out of 548 were associated with mental illnesses, with known mental illness diagnoses, including bipolar disorder, generalized anxiety disorder, or borderline

personality disorder. Attention deficit hyperactive disorder was also a commonly noted diagnosis.

Additional in-depth thematic analysis of 80 randomly sampled case notes from the ACDMH administrative database found:

1. Consistent provision of in-depth biopsychosocial assessment with patients in the field by the ACCORD team;
2. Increased comfortability of the ACCORD team in effectively handling crisis situations and diverting from hospitalization when possible as they built experiences as a team; and
3. Increased ability to handle behavioral health crises with less extreme interventions, such as implementing safety plans and teaching coping strategies, and consequently, reduction in involvement of law enforcement officers, particularly faster release of the scene.

Highlights of the Program Success and Challenges

We conducted a total of 18 semi-structured interviews in two phases with administrators involved in the planning and implementation of the ACCORD project, supervisors from ACDMH and ACSO who oversee the ACCORD response team and day-to-day operations, and ACCORD response team members. Phase 1 (August 2021-March 2022) included 10 semi-structured interviews, focusing on initial implementation of the program. Phase 2 (June-August, 2022) included eight semi-structured follow-up interviews, focusing on further reflection at one year after the ACCORD launch.

Major themes regarding initial program development and launch (Phase 1) included:

1. ACCORD's ability to provide services to an underserved community;
2. The benefits of the existing interagency collaboration between the ACSO and ACDOM in crisis intervention. This provided a strong foundation for the success of ACCORD; and
3. Possible areas of improvement, including more opportunities for collaborative training involving all staff on de-escalation and interdisciplinary teamwork *before the program's launch*, and ensuring of initial buy-in from community and pilot partners.

Major themes regarding the program growth and adaptability (Phase 2) included:

1. The successes over time being seen at the patient level in the form of connecting frequent utilizers to community services;
2. Increased confidence in working on an interagency team with greater understanding of roles and responsibilities; and
3. Experiencing increased buy-in from agencies and community partners.

Respectfully submitted,
Tomoko Udo & Carmen Morano

2. INTRODUCTION

2.1. Program Background

The systematic dismantling of the United States' behavioral health care network, exacerbated by a steady decline in funding since the 1970s, has been devastating for the nearly eight million Americans living with a severe mental illness (Fuller et al., 2015; The Blue Ridge Academic Health Group, 2020). Today, nearly half of this population goes without essential services and treatments, including medication (Fuller et al., 2015). The reduction of behavioral health support structures for people with psychiatric and/or substance use disorders has shifted the responsibility of assisting this population from trained professionals to the police and has criminalized mental illness in the process (The Blue Ridge Academic Health Group, 2020).

It is well documented that individuals with behavioral health challenges are much more likely than other people to have contact with law enforcement. An estimated one in 10 of all law enforcement calls are regarding an individual with severe mental illness (Fuller et al., 2015). These interactions occur with this population for three main reasons: violence conducted by these individuals (particularly when they are in crisis), high rates of personal victimization, and elevated levels of homelessness (Pollack & Humphreys, 2020).

To address these challenges, on December 2, 2020, Albany County announced the launch of the Albany County Crisis Officials Responding and Diverting (ACCORD) program. ACCORD is a team consisting of an emergency medical staff (EMS) or paramedic from the Albany County Sheriff's Office (ACSO) and a behavioral health professional (social worker) from the Albany County Department of Mental Health (ACDMH) who responds, whenever possible, to 911 calls that are deemed nonviolent and have behavioral health components.

ACDMH has more than 35 years of experience with the county's Mobile Crisis Teams (MCT) and more than 15 years of experience collaborating with law enforcement, including providing Crisis Intervention Team (CIT) training to the officers. These experiences provided a strong foundation for the successful launch of the ACCORD program in a timely manner once the ACCORD team members are identified and trained.

The ACCORD program is distinctively different from the MCT or CIT programs, as the ACCORD response includes a team consisting of staff from EMS and behavioral health professionals to the scene of crisis. The goal is to reduce the amount of time when law enforcement officers are involved (e.g., no involvement at all or releasing the scene sooner). In addition to reducing unnecessary law enforcement involvement in nonviolent behavioral health crises, the ACCORD team provides follow up and referral services with patients whenever appropriate and possible after the initial interaction. This illustrates an added component of ACCORD relative to the county MCT. With expansion, the ACCORD program would ensure that ACCORD team(s) are stationed in each municipality, which would help with reduction in response time to behavioral health crisis in each community.

2.2. Goals of the ACCORD Program

1. To reduce the number of adverse encounters with law enforcement and unnecessary arrests among individuals with behavioral health issues in Albany County defined by the number of cases where law enforcement was deployed, and the amount of the time that law enforcement stayed involved in the case after it is determined that the ACCORD team can appropriately and safely handle the case.

2. To reduce the risk of future mental health crises by providing linkage to appropriate care and services, and to encourage continued engagement with said care and services.

3. To ultimately reduce the costs associated with behavioral health crises in the community through the reduction of unnecessary hospitalizations and incarcerations among those experiencing a behavioral health crisis, as well as reducing the amount of time that officers spend on nonviolent situations.

2.3. ACCORD Implementation

The implementation of ACCORD began in the Hilltowns area of the county on June 10, 2021. The Hilltowns were selected as a result of the community's historically limited access to appropriate behavioral health services due to its rurality and geographical distance to the City of Albany. After observing that this access gap was further widened by the COVID-19 pandemic, the county legislators, ACSO, and ACDMH decided to first implement ACCORD in this underserved area. The ACCORD teams were stationed in Clarksville. This evaluation report, completed by a team of researchers from University at Albany School of Public Health (SPH) and School of Social Welfare (SSW) (PIs: Tomoko Udo, PhD and Carmen Morano, PhD), summarizes the performance of ACCORD pilot implementation, as well as lessons learned and recommendations for county-wide expansion.

3. ACCORD PROGRAM DESCRIPTION

This section briefly describes how the workflow of ACCORD was originally designed by the ACSO and ACDMH. A logic model developed by the UAlbany team (p. 22) also describes key program components, outputs, and expected outcomes.

3.1 Initial Dispatch Call

When a 911 call is received, a dispatcher at ACSO quickly gathers critical information about the situation using the International Academy EMD Protocol for Dispatching. The dispatcher elicits clues as to the reason for the call, the seriousness of the situation, and the best way for ASCO to respond using ACCORD team training protocols to determine if a call is appropriate for diversion to the ACCORD team; for the pilot implementation, the call also had to originate from the Hilltowns area.

Qualifying criteria include:

1. No sign of violence
2. A determination of nonviolent and an appeared connection to a behavioral health crisis (e.g., mental health issue, trauma and stress, suicidal ideation, or substance use-related emergency).

3.2. After ACCORD Team Arrival on the Scene

Upon arrival, the ACCORD team will appraise the situation to determine how the patient should be approached, employing de-escalation techniques, if necessary, to better understand the needs of the patient. The response options are diverse, including but not limited to, a) immediate crisis counseling; mental health first aid; b) referrals for community-based mental health and social services; and c) transportation to an institution for further evaluation and care. If a situation is determined to be unsafe upon arrival or escalated, the ACCORD team may request additional assistance from law enforcement.

3.3. Follow-up

When it is determined appropriate, a member of the ACCORD team attempts to contact the patients with a follow-up call within 24-48 hours after the intervention to ensure the patients have stabilized, utilized referred car and potentially reduce their future reliance on emergency services for assistance. Contact between the case manager and the patient, or their caregiver, may continue for up to six months. The goals of these interactions will be to: a) collaboratively establish a plan of action to manage the patient's behavioral health; b) to identify and connect with available community resources and supports; and c) to prepare the patient or caregiver to take over the responsibility of managing the plan and resources.

4. DATA SOURCE

For a comprehensive description of the characteristics of 911 calls and services provided by the ACCORD team, a data usage agreement with the ACSO and ACDMH was established to obtain access to 911 call records and ACCORD service records, including summary data sheet and fieldnotes, respectively. Then, a case-level ACCORD activity data was created by merging dispatch and ACCORD service records at the level of address and time stamps.[1] Patient demographic characteristics were also extracted from ACCORD fieldnotes.

In addition, to identify successes and challenges associated with the ACCORD pilot implementation, we conducted a total of 18 semi-structured interviews in two phases with administrators involved in the planning and implementation of the ACCORD project, supervisors

[1] The dispatcher calls were matched with ACCORD encounters on the service address provided by both the dispatcher data and the ACDMH data. There were 95 dispatch calls that we were unable to identify a corresponding encounter record in the ACDMH database. Of these 95 unmatched dispatch calls, we were able to identify that one call was cancelled prior to ACCORD dispatch, nine were cancelled in route, and six involved either a patient not being present or refusing service. This results in 79 dispatch calls with missing service encounter information from the ACDMH database.

from ACDMH and ACSO who oversee the ACCORD response team and day-to-day operations, and ACCORD response team members. Phase 1 (August 2021-March 2022) included 10 semi-structured interviews, focusing on initial implementation of the program. Phase 2 (June-August 2022) included eight semi-structured follow-up interviews, focusing on further reflection at one year after the ACCORD launch.

5. RESULTS

5.1. ACCORD Overall Program Activities between June 10th, 2021 and June 10th, 2022

The dispatcher database indicated that **240 calls were diverted** to the ACCORD team, and the ACDMH database indicated that the ACCORD team had **548 encounters with 210 unique individuals**.

Of the 240 ACCORD dispatch calls, 22 cases were not handled by the ACCORD team. These include 19 cases where the call was cancelled prior to an ACCORD dispatch and three cases where the call was cancelled en route. Thus, a total of **218 dispatch calls were responded to by the ACCORD team**. Of those, the ACCORD team **provided services to 202 dispatch calls,** while services were not provided to 16 calls due to the patient not being found or refusing assistance.

According to the dispatch records, the average time from the initial call being received to ACCORD being dispatched was **5 minutes 11 seconds**. The average time from the ACCORD dispatch to arrival at the scene was **20 minutes 54 seconds**. It should be noted that during the early implementation, the time to dispatch was influenced by dispatchers awaiting confirmation that the call is appropriate for the ACCORD team. It should also be noted that the travel time represents non-emergency travel (no lights or sirens) from the ACCORD 'home' base in Clarksville to the site of disturbance in the Hilltowns area. Yet, this represents a significant reduction in response time, compared with, for example, dispatching of county MCT from the City of Albany.

5.2. Description of Dispatcher Calls

As shown in **Appendix B Supplemental Table 1**, 911 calls were categorized by priority level codes of Alpha, Bravo, Charlie, Delta, and Echo, with Alpha being considered the least serious or life-threatening, and Echo considered the most serious or life-threatening (Clawson & Dernocoeur, 2001). **The majority of the dispatch calls (*n* = 219, 91.3%) fell under Alpha and Bravo priority categories.** Thus, less than 10% of dispatch calls were at priority levels of Charlie or higher. For both Alpha and Bravo-level calls, **EMS, general medical assistance, and services for those who reported suicide attempts, all without transportation services**, were the top problems diverted to the ACCORD team.

5.3. Description of ACCORD Patients and Services

5.3.1. Description of the ACCORD patients

The ACDMH administrative data and fieldnotes were used for a detailed description of the patient characteristics. If an individual had multiple encounters with the ACCORD program, the record from the first encounter was used for the descriptive analyses. The data shared by the ACDMH indicated that the ACCORD team had a total of 548 encounters with 210 unique individuals between June 2021 and June 2022 (see **Appendix B Supplemental Table 2**). The average number of encounters with the ACCORD team was **4.65 ± 7.76 (range = 1-48)**; however, this should be interpreted cautiously as this average includes a limited number of locations requiring multiple responses. During this pilot year, calls originating from Voorheesville and Ravena accounted for 30% of the ACCORD responses.

The average age of patients was **44 years old, 56.6% were female, and 92.9% were identified as White** by the social workers. Over half of ACCORD patients (67.7%) were listed as being single, 24.7% were married, 4.7% were widowed, and 2.9% were divorced, respectively. While 17% of individuals were known to the ACDMH on their first encounter with the ACCORD team, **the majority of the ACCORD encounters were with those who had never utilized services offered by the ACDMH**. It was noted that 62 encounters were in response to individuals with a mental health diagnosis listed in the database. Among those with a diagnosed mental illness, 25.8% were diagnosed with bipolar disorder, followed by anxiety disorders (17.7%), and borderline personality disorder (14.5%). ADHD was also a frequently listed known diagnosis (11.3%).

5.3.2. Description of the ACCORD services

The ACDMH database included a total of 760 activity codes across 548 encounters. “Mobile field crisis regular” is a code that refers to any routine call where an ACCORD social worker is sent out to a patient along with EMS. “Mobile field crisis two” refers to the same kind of situation, except two ACCORD social workers are sent in these cases along with EMS. ACSO is a code referring to any cases where, law enforcement was present from ACSO when ACCORD arrived. “NY state police” indicate that law enforcement from NY state police was present, and “Other police agency” indicate that law enforcement from an agency other than ACSO and NY state police. Resolved on the scene refers to situations where no form of transportation was needed, and the situation was resolved at the location to which ACCORD was dispatched. “Transported to ‘xxx hospital’” refers to when an ACCORD team member transports a patient to a hospital, with xxx indicating the name of hospital. Lastly, “Hospital discharge” refers to any time the ACCORD team assisted with an ACCORD patient being discharged from the hospital or made a follow up call to the patients who were discharged from the hospital (ACCORD team member presence not required to be considered as an ACCORD service). **Table 1** summarizes the number of times that each service codes were indicated in the ACDMH database.

Table 1. Service Codes Recorded by ACCORD team

Types of services	*n*
Mobile field crisis regular	151
Albany county sheriff	214
Resolved on scene	122
AMC ED	83
Hospital discharge	52
NY state police	57
Other police agency	31
Mobile field crisis two	19

In addition to these on-the-scene services, the record also shows that 31 services were delivered over the phone. This included ACCORD team follow-up and making additional referrals.

At the encounter level, of 548 total encounters, **42.5% (*n* = 233) included service codes indicating a law enforcement officer was at the scene**. It is important to note that the data does not allow us at this time to know if officers were originally there at the beginning of the encounter or showed up after the fact. The service codes indicate a particular police agency presence but do not allow a for a distinction of when in the encounter, or for what capacity, they were present.

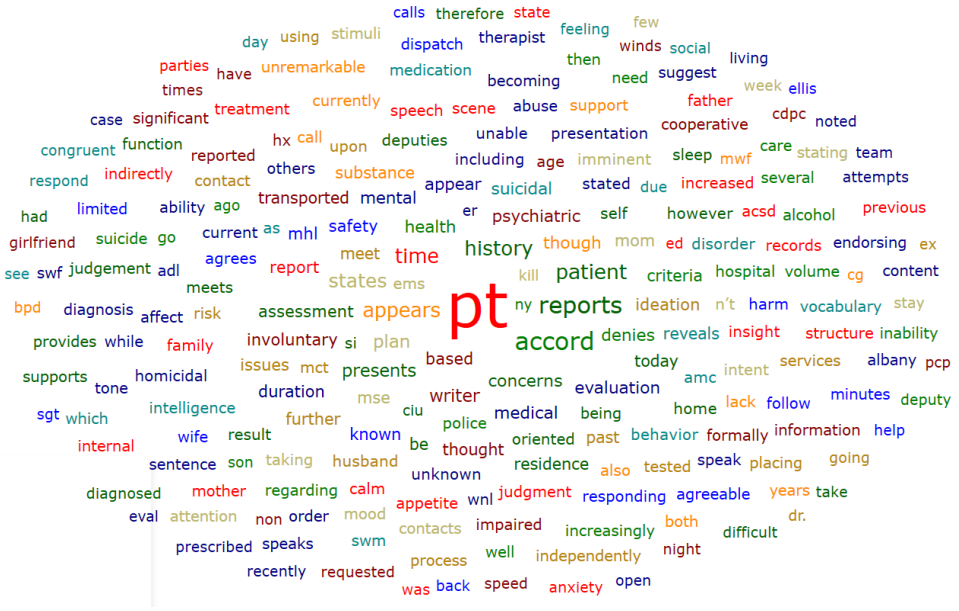
5.4. In-depth Understanding of ACCORD Program Operation

The evaluation included a thematic analysis on a random sample of ACDMH ACCORD staff fieldnotes to gain an in-depth understanding of program operations and patient interactions. The analysis was conducted on a random sample of 80 ACCORD fieldnotes retrieved from the ACDMH administrative database (i.e., Imaserve) during the pilot year. Fieldnotes were de-identified by one researcher and assigned to four independent coders who received 20 narratives each to conduct the thematic analysis.

5.4.1. Sample structure

The sample of narratives included a total of 37,197 words. To better understand the nature of the interactions between the patients and the ACCORD team, the structure of the narratives was analyzed. **Figure 1** illustrates the results of a Key word density analysis utilizing Atlas.ti software, to produce a word cloud. Pronouns and auxiliary language were removed.

Figure 1. Key Word Density Analysis



The most prevalent term found within the fieldnotes is "PT," which translates to patient. This word cloud illuminates **the ACCORD team's patient centered approach to program implementation and case documentation**. The word cloud also highlights **the multidimensional approach of the ACCORD team's assessment process** in the use of language to describe psychosocial factors such as a patient's environment, family, mental health diagnosis.

In addition to the word cloud, a phrase density analysis was completed, in which key phrases of frequently combined words were identified to highlight major themes that were found in the narratives. The most frequently noted phrases are presented in the **Table 2** below. With the exclusion of 'appears stated age' the remaining phrases suggest the presence of severe mental health (imminent safety concerns and suicidal ideation and the need for immediate response [i.e., criteria for involuntary evaluation]).

Table 2. Key Phrases

Key phrase	Number of times used
Criteria involuntary evaluation	73
Imminent safety concerns	45
Appears stated age	43
Suicidal homicidal ideation	36

5.4.2. Summary of major themes

The following summarizes the major themes that emerged from the case notes. The team

identified a particular alignment between the thematic analysis of the fieldnotes and the quantitative analysis conducted on the activity codes. This has provided a more comprehensive picture of the types of services the ACCORD team provided, as well as to identify the effective strategies used to de-escalate crisis situations.

a. Dispatched/Source of Referrals

All narratives reviewed included a mention of source of referral. The referrals ranged from a request from a patient or a family member for the ACCORD team to law enforcement requesting the team's presence. ACCORD team members frequently reported being requested or greeted by police, who are most often already on the scene when they arrive.

b. Presenting Situation and Biopsychosocial Assessments

Each call narrative analyzed included a brief description of the presenting situation and previous stressors relevant to the situation. The majority of the ACCORD responses occurred at the individual's home. However, community spaces, as well as the sheriff's office were also noted. Most narratives highlighted demographic information such as sex, race, and marital status, although, it was unclear whether the information was based on self-reports by the individual or observation by the ACCORD team. The narratives indicated the ACCORD team responded to situations where the individuals were experiencing intoxication, engaging in or experiencing thoughts of self-harm, and expressing suicidal ideation. The narratives also suggest the ACCORD team engaged in a variety or situations where the individual(s) were presenting with sometimes serious interpersonal conflicts. Additional barriers such as unstable housing and limited social supports were also noted. It is noteworthy that more recent narratives highlighted the expansion of call types that the ACCORD team are responding to, such as cardiac arrests and deaths, in which the team provides support to family or others involved at the scene. Some, but not all, narratives identified if the team was self-dispatched, dispatched by ACSO, or requested by law enforcement. The narratives also capture any medical diagnoses, medications, and other biomedical factors that the patient may be experiencing at the time of the interaction.

c. Interventions/Services Provided

The strategies the ACCORD teams took to assist patients were as varied as the patients themselves. When the patient was in a mental health crisis, it was critical that the ACCORD team de-escalate the situation, specifically the individuals prompting the need for ACCORD to enable the team to assess their physical, mental, and emotional wellbeing. ACCORD teams interviewed the individuals and their family and friends to gather critical information on the current situation, as well as to assess the patient's medical history and psychosocial stressors. The strategies included supportive, active listening techniques, positive affirmations, while maintaining a calm presence and tone. The narratives suggest the importance of understanding the individual's demeanor in order to make the individual feel comfortable and elicit as much information about their needs as possible. Some coping strategies suggested to the individuals noted in the narratives included:

- Taking a shower

- Getting outside and going for a walk
- Mindfulness
- Positive affirmations; and
- Establishing a word or phrase to say when a patient needs a break from an interaction.

In this sample of 80 records there were descriptions of rare cases where individuals had to be restrained or sedated by EMS in order to protect themselves and others because the ACCORD team could not pacify the individual. The narratives reported several follow-up phone calls made by ACCORD team members to individuals or their guardians to offer continued support and additional community-based resources and referrals.

d. Identified Patient Diagnoses

The case narratives included diagnosis for patients who have previously interacted with one or more of the services provided by the ACDMH, as well as patients that were able to self-report diagnoses. Diagnoses in this sample included:

- PTSD
- Anxiety and depression
- Schizophrenia.

Some patients denied any current or previous diagnosis while others appeared unable to answer questions about their history of any diagnosis.

e. Involvement in Other Systems

The ACCORD narratives frequently highlighted current or previous histories of involvement with other systems and services that were self-reported by the patients during ACCORD service encounters. These systems and services included, the Albany County MCT or the Northern Rivers MCT, psychiatric care in both inpatient and outpatient settings, as well as the criminal justice systems or child welfare systems.

5.5. Successes and Challenges of Pilot ACCORD Program Development and Implementation

5.5.1. Phase 1 interviews (from August 2021 to March 2022) – Reflection after initial program implementation

The first set of interviews were conducted between August 2021 and March 2022 with: (1) Administrators (n = 3) involved in the planning and implementation of the ACCORD project, (2) Supervisors (n = 2) including one from EMS and one from ACDMH who oversee the direct workers and day-to-day operations, and (3) the ACCORD response teams (n = 5) that included three EMS providers and two social workers. Interview questions, which consisted of between 20 and 26 open-ended questions, were designed to probe interviewees about their role and day-to-day experience with ACCORD, training they received, and any strengths and challenges of the program. The questions were tailored slightly to the interviewee's role (see Appendices C, D,

& E). The below presents a summary of key themes identified through content analysis of the interview transcripts.

a. Initial Observations on Success, Strengths, and Benefits of ACCORD

Theme 1: Scope of the Project

All interviewees identified ACCORD's flexibility and ability to connect patients with a variety of resources and services across the county as a major strength of the program. Interviewees defined ACCORD as being able to "*cover such a broad spectrum of problems"* and praised *"how willing we are to adapt to whatever the need is."* Another interviewee expressed how ACCORD teams are well equipped to assist in a variety of situations, stating "*I don't think that there is any type of inappropriate call for ACCORD...as long as we can offer some type of support... it doesn't have to be so black and white."* Most interviewees expressed feeling as though they are making a difference in an area that has been historically underserved.

Theme 2: Interagency Collaboration

Interviewees consistently stated the positive and longstanding relationship between ACDMH and ACSO as a foundational component that has contributed to the success of the program. One interviewee explained the partnership stating, *"We don't see this as being an either-or, we see it as a collaboration where we both have different expertise."* Interviewees pointed to the existing Mobile Crisis teams that are operated by ACDMH and used frequently by ACSO as assisting with interdisciplinary communication and collaboration.

b. Challenges and Possible Areas of Improvement upon Launching ACCORD

Theme 1: Program Implementation and Fidelity

Most interviewees mentioned police involvement and reported that police were consistently dispatched and at the scene before the ACCORD team arrived. Some interviewees shared concerns that police added an inherent escalating feature to the scene, *"Somebody maybe just needed some time to calm down."* Others stated that it depended more on the situation. Several members of the ACCORD teams reported feeling ready to have more independence when responding to appropriately diverted calls. It was noted that although the ACCORD team is not the first on the scene, the responding officers appear to be more aware and willing to withdraw from the immediate proximity of the scene upon arrival of the ACCORD team.

One interviewee stated, *"We are missing some opportunities to be the first responders and interact with people in crisis first."* When discussing the challenges related to gaining buy-in from dispatchers and building confidence in the program, one interviewee explained, "*I don't think it's the dispatchers themselves, I think it is their set up."* Another interviewee suggested *"follow the plans that have been put in place, to help, to actually request the teams that are needed,"* in reference to dispatching the ACCORD team first when appropriate. Given that one of the program goals (i.e., removing law enforcement from the scene of nonviolent behavioral health crises), this finding highlights a genuine concern for the safety of the ACCORD team by law enforcement, but also suggest an area for improvement in communication between the

ACCORD team and dispatchers. Collaborative training of the ACCORD team and dispatchers may also be warranted.

Theme 2: Training

Some interviewees from the ACDMH and ACSO reported feelings of anxiety and uncertainty after completing the existing training and going out in the field, *"I felt like a fish out of water,"* and *"I was really intimidated."* Others also indicated that the training did not cover enough on the information that they needed to know before being sent out, particularly about the tools to de-escalate situations involving a person experiencing a mental health crisis. Indeed, this theme of wanting more training, specifically de-escalation training, was reported by almost all interviewees (both social workers and EMS). The EMS interviewees also indicated a desire to receive more mental health training to increase their engagement with individuals. In addition, there was a suggestion for role-playing as a potentially effective de-escalation training tool, stating "*You know, learning and teaching on an EDGE method* (Explain, Demonstrate, Guide, Enable) *goes a long, long way."* The importance of conducting ride-a-longs with EMS, MCT, and the ACCORD teams as a training method prior to starting in the field was also mentioned by several interviewees.

It should be noted that there were inconsistencies when asked about the nature of the de-escalation training that was provided. Some reported that the training covered de-escalation while others did not. A consistent definition for de-escalation and what was included in the training does not seem evident based on interviewee responses. Given the previously noted lack of a clear established definition of de-escalation, however, this finding is not surprising.

Theme 3: Limited Community Resources

Interviewees identified a lack of resources in the community as a challenge the ACCORD team faces. Specifically, one interviewee reported that there *"is not as many community services to divert to.*" Others identified few options for patients outside of formal business hours, hospitals experiencing long wait times and being understaffed, and an overall lack of resources in the county, especially in rural areas. COVID-19 was repeatedly cited as one of the causes for hospital diversions and overcrowding. The insufficient mental health services available in the United States as a whole, as well as the stigma surrounding these services, were also raised by several interviewees as challenges they felt the program faced.

Theme 4: Adopting to the Changing Community Needs

When discussing the origins of the program and the potential impact ACCORD will have on the community, political change was identified in several interviews as being one of the kickstarting events that led to the development of the project. Interviewees mentioned the uprisings during the summer of 2020 surrounding Black Lives Matter and police reform, while others cited energy for police reform prior to this. Interviewees identified public pressure alongside changing political ideology as major motivators for the project to get off the ground. One interviewee explained, "*It felt like this was centered around a Defund the Police campaign because of*

everything going on during the pandemic... it's not about defunding police, we've actually educated law enforcement." There was a consensus that this program is not meant to replace law enforcement, but to work collaboratively with them, and to allow the police to focus on calls better suited to their training and expertise.

5.5.2. Phase 2 interviews (from June 2022 to August 2022) – Reflection after one year of program implementation

Phase 2 included a second round of interviews with (1) Administrators (n = 2), (2) a ACDMH Supervisor (n = 1), (3) ACCORD Response team members (n = 5). This phase also included an initial interview with (4) Dispatchers with experience dispatching the ACCORD team (n = 5). Interview questions, which consisted of between 7 and 10 open-ended questions, were designed to probe interviewees about any change in their role and day-to-day experience with ACCORD, any additional training they may have administered or received, and any strengths and challenges they see within the program as it moves towards expansion. The questions varied slightly depending on the interviewee's role to better capture their experience with the program (see Appendices F & G).

a. Growth and Development of the Program

Theme 1: Role and Model Establishment

Regardless of role, administrative, supervisee, or direct response team, many interviewees reported feeling "better settled" and more familiar with their role in the ACCORD Team. One interviewee stated, *"We're definitely getting more into a groove as far as working together,*" in reference to the collaboration between EMS and social work providers on the ACCORD Team. Interviewees reported still feeling that social workers were taking on most of the responsibilities of the ACCORD teams and appeared motivated to explore ways in which EMS providers could assist in evening this out. One stated "*I think my perception of the roles has changed, because I think when we first started, we were anticipating having the EMS provider be a lot more active on calls. I think you know we anticipated there being more opportunities for them to use their EMS experience. And we really haven't had that."* Furthermore, interviewees report that after having a better-established understanding of the ACCORD model, the program appears to be running smoother.

Theme 2: Increased Buy-in

Interviewees frequently described feeling that different agencies, particularly law enforcement agencies, appeared to be more open to and reliant on the ACCORD team for certain calls. One reported most ACCORD dispatch calls are coming from law enforcement officers in the field themselves. Another stated, *"So we are getting more calls and there is more buy in from law enforcement to see that were helpful on these calls, and you know to call us when they see something that they think we can assist with"*. This increased buy-in from LEO's appears to have a positive effect on the program's overall operation.

Theme 3: Growth

Interviewees highlighted growth and expansion of the program in a few major ways. Many reported ACCORD being dispatched to a wider breadth of calls and being able to provide support. One interviewee described assisting patients in the field with anything from referrals to New York Connects to providing grief and bereavement to family members at the scene of a death. Another aspect of growth highlighted by the interviewees is the approval and hiring of a third social worker to be a part of the ACCORD Team.

b. Suggestions and Recommendations for Expansion

Theme 1: Legitimizing the ACCORD Team

The interviewees shared some issues with the current ACCORD central location where they share space with other entities. Specifically, noise makes it difficult to conduct some of the ACCORD activities. They suggested a designated office/space for the ACCORD team. Additionally, designated EMS help to increase ACCORD's consistency was given as another potential area of improvement. One interviewee described frequent challenges regarding the amount of time required to train new EMS workers and stated, *"I would strongly recommend designated medical staff,"* to increase the efficiency and response of the ACCORD team. Another interviewee noted that the location of the pilot being in the Hilltowns, with limited mental health services may be contributing to more responsibility for social workers and less responsibility for EMS, whereas being in a more urban area may result in more for EMS providers to do and contribute to.

Theme 2: Interagency and Interlevel Inclusion

Interviewees consistently reported a desire to be included in talks of expansion and growth with all agencies and individuals involved, including those who will implement the program. One interviewee suggested that "*Conversations with all parties involved before we go live*" would be beneficial, and another interviewee exclaimed, "*I would love to see more meetings that involve us to put our input in and just to have that perspective".* Interviewees warned of the missed opportunity by not including all parties, with one stating, *"I think it would be, again, a huge oversight, and really kind of unfortunate if we move forward, and the input from the people doing you know the work on the ground level isn't more kind of addressed and included in that*". This highlights an increased level of confidence and experiential knowledge wishing to be shared, as well as continued desire for interagency collaboration.

Theme 3: Ongoing Education

Interviewees that identified as social workers, EMS workers, and supervisors, endorsed the need for on-going and up to date training to ensure the efficacy and safety of the team. One team member supported the need for continued training but also acknowledged "But sometimes I think there's more emphasis into the fact that we need more training, training, training… when I do not think it's necessarily the training, I think it is the compatibility with escalated folks and how to respond to that," which may be contributing to the frequent mention of training.

6. SUMMARY OF FINDINGS

The findings from this evaluation strongly support the need for a program such as ACCORD in Albany County. The ACCORD team was able to resolve the problem on the scene in many cases and provided follow-up phone call services when needed. This suggests the great benefits of ACCORD as a program that can connect previously underserved communities with social services. In the long run, this may help reduce utilization of emergency rooms and medical services by individuals in or at risk for experiencing nonviolent behavioral health crisis.

This formative evaluation of the ACCORD pilot implementation has elicited a number of findings and lessons learned for expansion. Key members of the ACCORD team consistently expressed the need for more collaborative training and role definition before going live. Nonetheless, the program appears to be adapting and growing from experiential and on the job training. ACCORD workers reported that they have become more comfortable in their roles and confident in their abilities to respond to a crisis. Importantly, the program began to build more support particularly from law enforcement as the ACCORD team and law enforcement officers built more experience and subsequently confidence in the program. This appears to have translated into reduction in time spend by law enforcement on the scene of nonviolent behavioral and medical health crisis.

7. KEY RECOMMENDATIONS FOR PROGRAM EXPANSION

1. More Investment to Prepare the Team Before the Program Goes Live

The longstanding history of collaboration between law enforcement and ACDMH, as well as experiences with CIT training and the MCT, provided a strong foundation for the successful, smooth launch of the ACCORD. ACCORD team members also reported that they would have benefitted from more upfront time investment with planning and training *prior to launching the program,* as it has been difficult to find time to receive more appropriate training once the program was launched. This upfront time is likely to be even more important in communities were there has not been a long history of collaboration.

2. Involvement of Law Enforcement in the Training

The upfront investment should also include the time to build trust and partnership between ACCORD teams and law enforcement, including the dispatchers and officers on the ground. Understandably, there was an initial concern over the safety of the ACCORD team members. Our evaluation found that as law enforcement become more familiar with the ACCORD teams and their work, the responding officers grew more comfortable with keeping distance from the ACCORD team while they assess and respond to cases or removing their presence more quickly. Thus, in addition to embedding enough training time for the ACCORD team, including law enforcement in these training along with some guidance on how to assess readiness of the ACCORD team to work more independently may help ensure the fidelity of the program upon expansion.

3. Expand Breadth of Onboarding Trainings

In addition, the current reliance on CIT training provides a solid foundation upon which to build. ACCORD staff reported developing and refining their use of de-escalation practices in the field. While the CIT approach is one of the most implemented crisis intervention models in the country, it focuses on training law enforcement to de-escalate the scenes of behavioral health crises. The ACCORD program, on the other hand, aims to reduce the amount of police involvement in nonviolent behavioral health crises by dispatching emergency medical personnel and a social worker, which is a distinctively different approach that may benefit from additional de-escalation training.

De-escalation training attempts to reduce the use of violence and aggression during a crisis intervention with the hopes of avoiding restrictive interventions and promoting mutual respect and decision-making (Goodman, 2020). There is no consistent model on de-escalation used throughout the country, which may make finding pre-existing training difficult. However, clearly defining what de-escalation means to this program and how staff are meant to use the principles during calls should solidify the objectives and contents of the de-escalation training necessary for the ACCORD team.

4. Inclusion and Education of the Community at Large

Many of the interviewees highlighted limited education and community awareness about the ACCORD program as issues that might have contributed to general misconceptions about the program. For those communities that already have or plan to have multiple programs targeting overlapping populations (e.g., law enforcement assisted diversion [LEAD] or other deflection programs), clear definitions of the role of each program should be shared with the community. The expansion of the ACCORD model should include the voices of the community's residents. Continued education of residents and policymakers about the ACCORD project is also strongly recommended.

Additionally, including community members and residents in the implementation and expansion process is recommended for ACCORD moving forward. Not only does this increase awareness about the project but including the community in these aspects has been shown to have broader and positive impacts such as increased collaboration and program fidelity (Petiwala et al., 2021). See the Detroit Future City (2021) model for an example on including lived experience and community voice.

5. Improving Data Collection and Processing Efficiency

While the qualitative fieldnotes prepared by the ACCORD team social workers provides important complementary data to the dispatcher and ACDMH administrative data, the processing of the data can be time intensive, making it difficult to extract the helpful information for all encounters. With the expectation that the expansion will bring more data and the importance of the data from the fieldnotes to evaluate the fidelity of the program expansion and performance in multiple municipalities, we propose to develop a more efficient data collection and processing

system. This data should include time stamps and indicators of involvement of law enforcement to track the amount of time law enforcement spends on the ACCORD cases, which will be helpful for cost calculation in the future. Finally, the evaluation will move into the summative evaluation phase along with the county-wide program expansion. Clear definitions of outcomes, particularly around long-term service utilization and management of behavioral health issues among ACCORD patients, will be critical to further demonstrate the effectiveness of the ACCORD.

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Appendix A: Logic Model

Statement of the problem: Individuals with a mental health illness, including substance use disorder, are at higher risk for becoming a victim of adverse encounter with law enforcement or unnecessary interaction with the criminal justice system (CJS) as a result of mental health crisis.

Inputs	Activities	Outputs	Short-term	Mid-term	Long-term
Populations Clients Dispatchers Officers EMT's Social Worker (MRT's) Intake Worker [Receiving Facility] Evaluators	**Organizational plan** • Dispatcher and officer training • Hire additional social workers • Train EMT and social workers • Develop workflow • Develop training and operational manuals • Develop data collection tools • Increase awareness of the program among the serving area(s) • Stakeholder meetings	• # of training provided to dispatcher, officers, and MRT • Contents of the training • # of calls received by dispatcher ○ Source of the call ○ The nature of the call ○ Time of the call • Time to arrive at the scene • Type of call from the dispatcher received by MRT • Description of the course of action taken by MRT • Descriptions of the clients • # of risk assessment and the results of assessment • Duration of the interaction • # and types of services provided by MRT • # of follow-up assessment/contacts made/reasons for unable to follow-up	• ↓ mental health crisis call handled by the police • ↑ linkage to proper mental health care • ↑ sustained engagement with mental health treatment among the MRT clients • ↓ repeated crisis calls	• ↓ hospitalization and ER utilization among the clients • ↑ Physical, psychological, and social function among the clients • ↓ # of mental health crisis calls	• ↓ fatal encounters with law enforcement involved an individual with a mental illness • ↓ in # of interaction with the CJS individuals with a mental illness • ↑ sense of safety among community members • ↓ cost associated with mental health crisis in the community
Institutions Funder Sherriff Commissioner of MH Inpatient UALBANY	**Service utilization** • Dispatcher determine the eligibility of the call • Dispatcher transfer the call to MRT • Dispatcher stays engaged with the caller while MRT is being dispatched? • MRT arrives at the scene • MRT assess the case, intervene, and determine the course of action • Family support • A follow up call by MRT				

Assumptions

- Persons with a mental illness are at increased risk for arrest/incarceration, often multiple times, or adverse encounter with law enforcement because: 1) Their mental health illness is often not addressed until a crisis happens; 2) Law enforcement is often the first party to respond to the crisis; 3) Officers are not trained to intervene mental health crisis; 4) There is no continuous care plan after crisis to prevent future crisis.

Assumptions

- Using a mental health crisis as an opportunity to help a person with a mental health illness linked to a proper mental health care will improve mental, physical, and social functioning and ultimately reduce risk for adverse interaction with law enforcement
- This will also help reduce cost associated with mental health crisis in the community.

Appendix B: Supplemental Tables

Table 1. Breakdown of Reason for Call and Call Disposition.

Call disposition (*N* = 240)	Description of problems	%
Alpha (*n* = 100)		
EAT: Assist – No transport (*n* = 49)		
	Falls	10.2
	Suicide attempt	36.7
	EMS	53.1
ECC: Call cancelled (*n* = 1)	EMS	100.0
ECER: Cancelled en route (*n* = 10)	Suicide attempt	50.0
	EMS	50.0
ECH: Checked (*n* = 2)	EMS	100.0
ECO: Completed routine service (*n* = 14)		
	Suicide attempt	50.0
	Sick person	7.1
	EMS	42.9
ENP: No patient found (*n* = 5)	Suicide attempt	40.0
	EMS	60.0
ERMA: Refused medical aid (*n* = 2)	Traumatic injury	50.0
	EMS	50.0
ETH: Transport to hospital (*n* = 11)	Suicide attempt	54.5
	EMS	45.5
ETOT: Other agency (*n* = 6)	Suicide attempt	50.0
	EMS	50.0
Bravo (*n* = 119)		
EAT: Assist – No transport (*n* = 44)		
	21 Voorheesville Avenue[1]	2.3
	Overdose	2.3
	Suicide attempt	4.5
	Medic radio call	15.9
	EMS	4.5
	MED[2]	70.5
ECC: Call cancelled (*n* = 2)		
	Medic radio call	50.0

	MED	50.0
ECER: Cancelled en route (*n* = 9)		
	Medic radio call	77.8
	MED	22.2
ECH: Checked (*n* = 1)		
	MED	100.0
ECO: Completed routine service (*n* = 19)		
	Suicide attempt	10.5
	Medic radio call	31.6
	MED	57.9
ENP: No patient found (*n* = 4)		
	EMS	25.0
	Medic radio call	50.0
	MED	25.0
ERMA: Refused medical aid (*n* = 3)		
	Overdose	33.3
	MED	66.7
ETH: Transport to hospital (*n* = 25)		
	Fall	4.0
	Overdose	4.0
	Suicide attempt	8.0
	EMS	16.0
	Medic radio call	12.0
	MED	56.0
ETOT: Other agency (*n* = 10)		
	EMS	20.0
	Medic radio call	30.0
	MED	50.0
EUF: Unfounded (*n* = 2)		
	Medic radio call	50.0
	MED	50.0
Charlie (*n* = 8)		
ETH: Transport to hospital (*n* = 8)		
	Allergic reaction	12.5
	Breathing problems	12.5
	Overdose	12.5
	Sick person	25.0
	Unconscious	37.5
Delta (*n* = 7)		
EAT: Assist – No transport (*n* = 3)		
	Cardiac arrest	33.3
	Suicide attempt	66.7
ERMA: Refused medical aid (*n* = 2)		
	Breathing problems	50.0

	Overdose	50.0
ETH: Transport to hospital (*n* = 2)		
	Chest pain	50.0
	Suicide attempt	50.0
Echo (*n* = 4)		
EAT: Assist- No transport (*n* = 1)		
	Cardiac arrest	100.0
ETH: Transport to hospital (*n* = 1)		
	Cardiac arrest	100.0
ETOT: Other agency (*n* = 1)		
	Cardiac arrest	100.0
FIRE (*n* = 2)		
ESIG2: Signal 20 (*n* = 2)		
	Odor leak	50.0
	Auto accident	50.0

Notes. [1] This address is the location of the ACCORD station center and is used when a patient walks into the station for assistance. [2] This call disposition refers to ACCORD calls requiring general medical assistance.

Table 2. Characteristics of ACCORD patients

Variables	
Mean age (SD)[1]	44 (23.5)
Female (%)[2]	56.6
Race/ethnicity (%)[1,2]	
White	92.9
Black	5.9
Marital status (%)[1]	
Single	67.7
Married	24.7
Widowed	4.7
Divorced	2.9
City where service was provided (%)[3]	
Voorheesville	19.3
Ravena	10.7
Clarksville	9.9
Preston Hollow	7.3
Selkirk	6.6
Westerlo	6.0
Albany	4.3
Coyman's Hollow	4.3
Medusa	3.9
Other	27.7
Patients already known to ACDMH (%)[1]	17.0
Diagnosis known at the time of interaction (%)	
Bipolar disorder	25.8
Anxiety disorder	17.7
Borderline personality disorder	14.5
Attention deficient hyperactivity disorder	11.3
Depression	4.8
Disruptive mood dysregulation disorder	3.2
Adjustment disorder	1.6
Unspecified illness	21.0
Mean number of interactions with ACCORD (SD)	4.65 (7.76)
Min-Max	1-48
Median (Q1, Q3)	2

Notes. [1] Demographic information was measured for the first encounter patients had with ACCORD; [2] Race/ethnicity was assigned by the ACCORD team members, not self-identified by the patients; [3]Cities that appeared less than 20 times in the dataset were combined into another category (Almont, Berne, Bethlehem, Cairo, Cobleskill, Delmar, East Berne, Feura Bush, Freehold, Glenmont, Green Island, Greenville, Knox, Latham, New Scotland, Rensselaerville, Schenectady, Slingerlands, Stillwater, Troy, Watervliet, and Worcester).

Appendix C: Phase 1 Key Developers Interview Questions

Day to Day Experience and Planning

1. Describe your role in the planning and implementation process of the ACCORD project.
2. How did you/ your organization initially get involved in the project?
3. Could you explain why the county decided to model this after the CAHOOTS program?
    a. How is the CAHOOTS/ACCORD model different from how your organization handled mental health crisis calls before?
4. How do you define de-escalation?
    b. What specific de-escalation techniques are the ACCORD teams trained to use?
5. By what process was the vision and mission of ACCORD developed? Were there challenges? If so, please explain.
6. Has your organization had any prior experiences that made you believe that you are ready to start the ACCORD program?
7. Were there any specific challenges your organization or the ACCORD planning team had to overcome during the program planning process?

Interdisciplinary Strengths & Challenges

1. What strengths have you noticed in working on the program with several interdisciplinary agencies?
2. What challenges have you noticed in working with several interdisciplinary agencies?
    a. If any exist, how have you resolved the challenges?
3. In your view, is this an equal partnership or does the primary responsibility of planning and implementing the program lie in one organization?
    a. If unequal:
        i. How have you managed this?
        ii. Do you have any recommendations as to how this could be avoided in the future?
4. What previous training (if any) have you received on working with interdisciplinary teams?

Program Launch

Now that it's been several weeks after the ACCORD launched, could you tell me the following?

1. What have been the top three biggest challenges to program operation so far?
2. Has your team had to make any adjustments to the original program operation plan due to these challenges?
    a. If YES, could you give me some examples?
3. Looking back, are there any resources you wish you had access to during the planning phase of the project?
4. Have you recognized any unintended positive and negative consequences of the program implementation to your organization or community at this point?

Appendix D: Phase 1 Middle Management Interview Questions

Day to Day Experience and Training

1. In your own words, please describe your role with the ACCORD team.
    a. How did you initially get involved in the project?
    b. Have you seen your role evolve since the ACCORD project first started in June? If so, please explain.
    c. What is the chain of command in your department?
    d. What does supervision of your staff look like?
2. How were the trainings for the ACCORD program designed?
    a. What are the main topics you cover in the trainings?
    b. How do you define de-escalation?
        i. What specific de-escalation techniques are the ACCORD teams trained to use?
    c. If you notice staff members need more training in a certain subject, what is the process to create or find more training?
3. Describe any training or orientation you received prior to starting this role.
    a. Anything specific to de-escalation techniques?
    d. How about interdisciplinary teams as part of your role?

Strengths & Challenges

1. What are the major challenges that this program faces?
    a. Do you think the challenges will be temporary or long-lasting?
    b. How have these challenges been addressed?
    c. What about challenges related to your personal experience?
2. What do you feel are the main strengths of the program?
3. Have you recognized any unintended positive and negative consequences of the program implementation to your organization or community at this point?
4. Albany County plans to expand the program to other municipalities. After experiencing the program for a few months, are there any specific recommendations you may have to other communities interested in adapting the program?
    a. Any additional training or resources you wish you had?

Appendix E: Phase 1 ACCORD Team Interview Questions

Day to Day Experience and Training

1. In your own words, please describe the day-to-day experience of being on the ACCORD team and how your role differs from other members of the team (EMS vs. MSW).
    a. Have you seen your role evolve since the ACCORD project first started in June? If so, please explain.
    b. How are 911 diversions communicated to the ACCORD team?
        i. Are the dispatchers' case descriptions clear and detailed enough to prepare you to arrive on the scene?
        ii. Do you feel like the cases diverted to the ACCORD team have been appropriate?
2. What training have you received to become part of the ACCORD team that you felt differed from your training as an EMS or social worker?
    a. Anything specific to de-escalation techniques?
    b. How about interdisciplinary teams as part of your role?

De-Escalation & Follow-Up Procedures

1. Have there been any cases so far that have required you and your partner to de-escalate the situation?
    a. What kind of techniques or strategies did you use?
    b. Did the required training sufficiently prepare you to de-escalate?
    c. Do you find yourself improving on a case-by-case basis?
2. Does a law enforcement officer's presence on a scene change the patient's escalation levels or willingness to cooperate?
    a. Have you had to request law enforcement backup for any of your calls so far?
    b. If yes:
        i. Could you describe what happened?
        ii. What other types of scenarios may lead you to call for police backup?
        iii. Do you feel the process to request backup is sufficient?
3. How does the ACCORD team make sure that any underlying condition(s) or circumstances that might have led to the crisis are addressed (ex. Direct referral to mental health specialists, linkage to social services, follow-up calls, etc.)?
    a. What information (community resources, expectations for the ACCORD follow-up process, etc.) is provided to patients during the initial encounter with the ACCORD team?

Strengths and Challenges

1. What are the major challenges that this program faces?
    a. Do you think the challenges will be temporary or long-lasting?
    b. How have these challenges been addressed?
    c. What about challenges related to your personal experience?
2. What do you feel are the main strengths of the program?

3. Albany County plans to expand the program to other municipalities. After experiencing the program for a few months, are there any specific recommendations you may have to other communities interested in adapting the program?
    a. Any additional training or resources you wish you had?

Appendix F: Phase 2 Key Developers and Managers Interview Questions

Program Evolution

1. Please describe how your agency's role has evolved since the initial start of the pilot.
2. Has the ACCORD mission and values changed since its initial inception? If so, please describe how?
3. Please describe any additional training you may have provided to the ACCORD team, since its launch.
    a. Describe what prompted training implementation.
    b. How did you go about finding and choosing these specific training courses?
    c. Describe, if any, feedback you may have received from your team about this training.

Program Expansion

1. Please describe how you and your agency are approaching the expansion of this project.
    a. What strengths do you foresee of expansion, what challenges?
2. Please describe how you and your department feel about resources you need to sustain and expand the program.

Appendix G: Phase 2 ACCORD Team Interview Questions

1. Please describe a typical ACCORD dispatch process?
    a. Please describe how the program has changed or evolved since its initial launch last June.
2. Can you tell us about your perception of roles and responsibilities on the Accord team?
    a. Have these changed since the program's initial launch?
3. Please describe some examples of cases where de-escalation was needed and what kind of techniques did you use?
    a. Please describe any additional training you may have received beyond the initial training.

Program Expansion

1. Albany County is expanding the program to other municipalities. Based on your knowledge about success and challenges with implementing ACCORD what are the key lessons learned that you can share with us?