

Transformation of Behavioral Health Emergency Response in MI

Problem: Behavioral Health Emergency Response (BHER) is often fragmented and ineffective in ensuring continuity of care across systems for individuals with mental health and/or substance use disorders. Law Enforcement are the primary first responders of BHER when calls come through the 911 system but spend precious time sitting in hospital emergency rooms waiting for services. Michigan Department of Health and Human Services (MDHHS) is committed to changing this through expansion of mental health mobile crisis units in each county, ten crisis stabilization units across the state, 988 Crisis Line and Crisis Hubs, however, there is little collaboration and coordination between our 134 county governed Public Safety Answering Points (PSAP/911) across the state and the behavioral health system. **Solution:** With support from the State 911 Council, MDHHS Crisis Services Section, CMH Board Association, and the Michigan Mental Health Diversion Council, the *Center for Behavioral Health and Justice at Wayne State University* is positioned to **develop a public/private partnership** between state/local municipalities and foundations (national, state, local), to enhance the collaboration/coordination necessary to ensure the crisis is matched to response type by acuity level and the risk of public safety.

Figure 1: BH Crisis Call Acuity Descriptions

BH Crisis Acuity	Someone to Call: No Wrong Door 911 Triage		Someone to Respond
	LOW Risk to Self/Others/ Public Safety	HIGH Risk to Self/Others/ Public Safety	
LOW BH Concern (BHC)	<i>Estimate 2% of 911 Calls (20% of identified BH calls)</i> Phone Response; connection with crisis line, 988, clinician (addressed in Goals 1 & 2)	<i>Estimate 5% of 911 calls</i> Law Enforcement response as usual. (Due to unlikely initial identification of BH due to high safety risk, this population of calls is not addressed in goals)	Phone Response can be clinicians embedded within 911 call centers or transfer to 988 or local Crisis Line. LE/EMS response as usual will be used in high-risk situations in which BH issues are not immediately apparent.
HIGH BH Emergency (BHE)	<i>Estimate 6% of 911 Calls (60% of identified BH calls)</i> Mobile Crisis, Crisis Hub; ART (Rural innovations using tablets; telepractice) (addressed in Goals 1 and 3)	<i>Estimate 2% of 911 Calls (20% of identified BH calls)</i> Co-Response /Crisis Intervention Team (CIT) (addressed in Goal 1)	CMH Mobile Crisis is two-person civilian response, accessible through MI Crisis Hubs ; functions as a pre-hospitalization assessment mechanism. Alternative Response Teams are civilian response teams typically dispatched by 911, but do not include law-enforcement in their response. Co-Response Teams are police/social work teams. Crisis Intervention Team police with specialized training in de-escalation and mental health needs.

**The CBHJ's estimates of all behavioral health 911 calls are depicted above in Figure 1 and accounts for 15% of all 911 calls across all risk and acuity levels suggested by research. Our project goals (articulated in Figure 3 below) target the 10% of 911 calls that we anticipate will be identifiable by 911 call takers.*

Plan. With the understanding that the PSAP and Community Mental Health are at the local level, CBHJ will facilitate development and pilot training with 911 dispatchers on the identification, coding and triaging of behavioral health issues in year one and assess these interventions in four to six sites that have alternative response options in place (Grand Rapids, Detroit, Ingham and Kalamazoo – hoping to recruit at least two rural sites from Livingston, Lenawee and Gratiot counties). Each year, we will add PSAPs while working with the State 911 Council to institutionalize training for all new dispatchers. Simultaneous to these changes in operation and practice, attention to state policy that encourages public/private partnerships in payer types (e.g., Medicaid and private insurers) will ensure long-term sustainability. **Ask.** To support local change efforts in technology and backfill training, we are asking for \$1 Million per year for three years. Depending on the size and complexity of the municipality, between \$100,000 and \$400,000 will be provided to the county to support training time and structural changes to their CAD systems to accept coding modifications and bridge to Behavioral Health Crisis Hubs for deployment of Mobile Crisis or immediate telephone support from 988 Crisis Line. CBHJ will utilize 80% of the funds for municipal/regional partners and 20% for support staff to facilitate and monitor change efforts. **Evaluation Efforts.** Outcomes include; accurate identification, coding and triage by 911 dispatch; a reduction in Law Enforcement's time spent responding to calls involving low to no risk to public safety; improved continuity of care with behavioral health treatment and services; and lower costs for municipalities. CBHJ has already collected pre-intervention dispatch data and final dispositions of calls in an effort to look at long-term implications and found that response by law enforcement only results in higher arrest rates and lower levels of treatment engagement.