carelon Behavioral Health

Crisis

# Crisis collaboratives

Optimizing the behavioral health system to increase access to care

# Executive summary

In the United States, behavioral health events afflicted more than 50 million Americans in 2020.[1] Additionally, more than half of all adults who experience a behavioral health problem do not receive treatment.[2] A fragmented behavioral health system has made it difficult to access care, particularly for vulnerable populations. Across the country, many experience barriers to care that include limited options, long wait times for appointments, cost of care, and discrimination.[3]

The immense volume of behavioral health needs, brought into alarming focus by the COVID pandemic, touched off a new sense of urgency to improve an overwhelmed behavioral health system that is largely unable to keep pace with demand.

## 988 is a harbinger of change

The new 988 Suicide and Crisis Lifeline is a significant first step in making the system more accessible to all by diverting crisis calls from 911. But it's only the entry point to a system beleaguered by fragmentation, provider shortages, inconsistent quality of care, and inadequate funding.

The advent of 988 marks an important opportunity for states, counties, and territories to establish the ideal crisis system by joining together disparate entities to align resources, form collaborative relationships, and unify the approach to care. These public/private partnerships are better equipped to identify gaps in service, find creative ways to fill those gaps, and leverage collective resources to increase access to care.

## Successful public/private partnerships lead to innovations in crisis care

Long before 988 was introduced, Carelon Behavioral Health worked with several states to implement stakeholder-driven crisis collaboratives. These innovations have led to important public/private partnerships that form the backbone of successful behavioral health crisis systems.

Our experience in Washington state stands out as a great example of Carelon Behavioral Health's work in the crisis space. This partnership focused on prevention, led to county-specific crisis protocols, and established dedicated crisis teams for specific populations. This paper explores roadblocks to crisis care in the United States and examines how to remove barriers to care while improving outcomes through stakeholder-driven community collaboratives.

# A fragmented system of care leaves too many behind

Even before the onset of the COVID pandemic, the frequency of behavioral health events was increasing. In 2020, the National Alliance on Mental Illness (NAMI) reported that 21% of Americans experienced a behavioral health event – approximately 53 million people.[4] This is more than 30 times the number of heart attacks and strokes combined that occur in the U.S. each year.[5,6] Put another way, eight times more people experience a behavioral health event annually than suffer a common bone fracture.[7]

The enormous demand for services far outpaces availability, leading to a system that is overwhelmed and people who are left without treatment. This is especially true for communities that have historically been excluded or unreached by the emergency system.

- Among Black Americans, suicide ranked as the leading cause of death in the 15-24 age group in 2019.[8]
- Only 1 in 3 Black Americans who need behavioral health care receives services.[9]
- About 35% of Latino/a adults with mental illness receive treatment annually. (The national average is 46%.)[10]
- In 2022, only 40% of LGBTQIA+ youth who wanted behavioral health care received it.[11]
- More than 60% of Americans in rural communities live in areas with a mental health provider shortage.[12]

On July 16, 2022, the nation took a significant first step towards increasing access to care and simplifying the coordination of treatment with the launch of the 988 Suicide and Crisis Lifeline. By dialing, texting, or chatting with 988, anyone in distress can connect directly with behavioral health professionals from over 200 crisis centers across the country.[13]

The advent of 988 is foundational to improving access to behavioral health care in this country, especially for vulnerable populations. However, it is only the starting point toward unifying a fragmented system that varies drastically from place to place.

Data from the National Academy for State Health Policy indicates that only about half the states had either enacted or introduced new 988 legislation.[14] Clearly, there is great disparity in readiness across the country when it comes to optimizing behavioral health infrastructure to handle 988 calls and, more importantly, an adequate service delivery system capable of responding with robust treatment options should the call itself not be sufficient to meet the individual's needs.

Now is the time for states to decide how best to ensure their behavioral health infrastructure can handle demand and meet the widely varying behavioral health needs of their people.

# A disconnect decades in the making

The overwhelming need for behavioral health treatment is a problem that is years in the making, although it received greater attention during the COVID pandemic. While the U.S. has developed effective protocols for handling medical emergencies through the 911 dispatch system, the same cannot be said for behavioral health emergencies.

Before the advent of the 988 Suicide and Crisis Lifeline, individuals experiencing a mental health crisis had to rely on the system for medical emergencies – 911 and hospital emergency rooms. As a result, law enforcement often served as first responders for behavioral health events, a duty they are ill-equipped to handle and that prevents them from responding effectively to other community needs.

## The need for a dedicated behavioral health crisis line

When police officers are called to respond to a situation that would be better handled by a behavioral health professional, the consequences can be devastating (if not lethal) for people who need mental health care. This includes inappropriate hospitalization, detainment, incarceration, and even death.

A recent analysis of eight cities found that up to 38% of all 911 calls were related to "mental health, substance use, homelessness, and other quality of life concerns." With more than two million sufferers of mental health issues jailed every year, fatal results are not the only concern for vulnerable groups seeking care.[15]

A historical lack of prioritization of behavioral health and a fragmented approach to care delivery has created a dynamic in which law enforcement has become the first (and often, only) responders. Additionally, many states and counties operate crisis systems that were originally built around involuntary commitment processes. While their systems may be operating as designed, they are often inappropriately conflated as crisis services. In such an environment, the results produce predictably poor and often tragic outcomes.

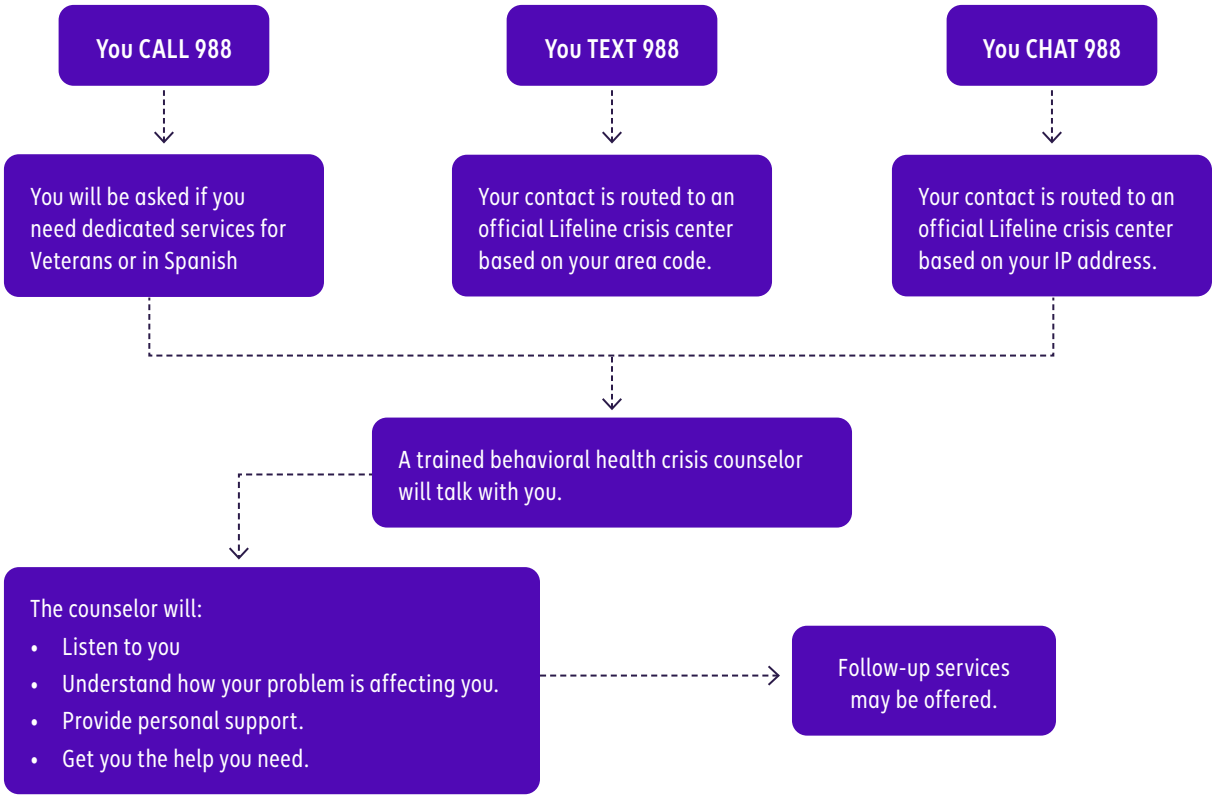
## A path forward sparked by 988

While the 988 Suicide and Crisis Lifeline stands to change this dynamic, every state and county in the nation will play a role in making sure that local callers receive the care they need. Especially in locations where behavioral health infrastructure is limited, effective coordination among behavioral health professionals, peers with lived expertise, patient advocates, and payers will be critical to removing obstacles to care.

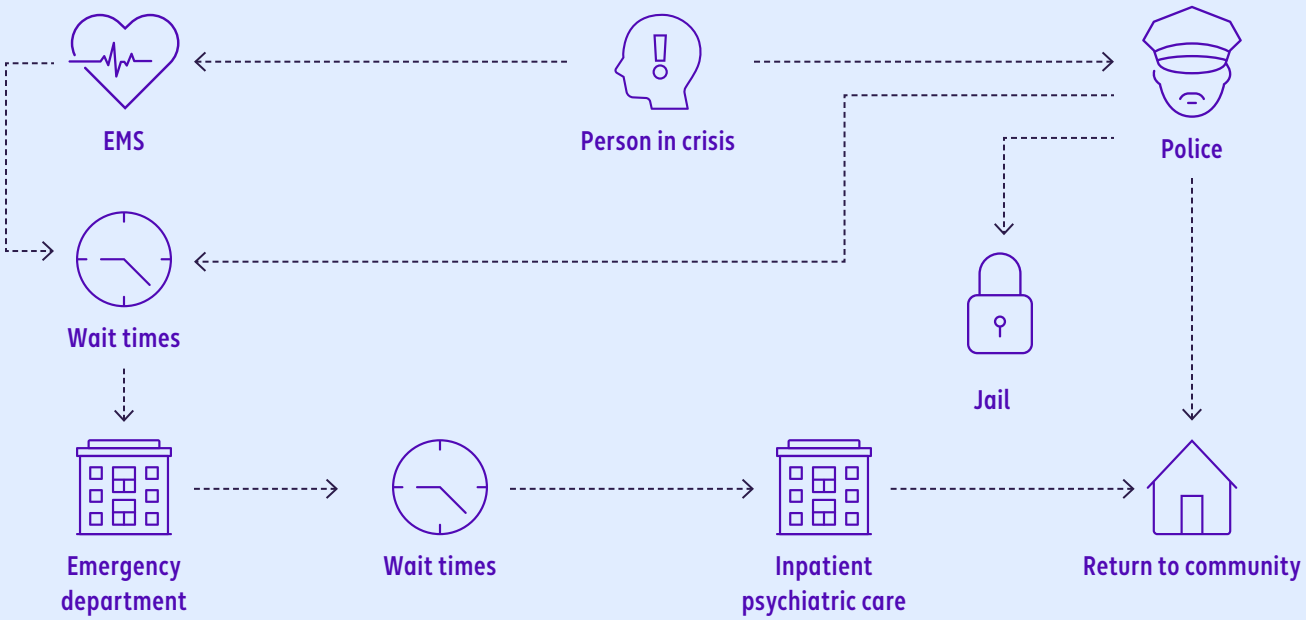
Without a coordinated crisis system, it's difficult to know if a behavioral health facility is full, for example, or how to arrange transportation in rural areas that do not have ready access to behavioral health resources.

Connecting local, lifesaving resources is vital to improving treatment quality and access to care for all.

## What happens when I contact 988?




## What happens when I contact 911 with a mental health crisis?



## Filling gaps in care to create a safety net for behavioral health emergencies

Fortunately, states can build and optimize crisis infrastructure by forming public/private partnerships that unify the providers, resources, and funding already in place. By connecting all stakeholders, states lay the foundation for a unified crisis system that leverages collective resources to fill service gaps and to generate improved behavioral health outcomes.

Coordinating local resources benefits everyone involved in the crisis response system. Executed effectively, this approach results in a continuum of care that enhances treatment pathways and provides multiple interventions to meet the needs of every individual. While a large number of 988 calls, texts, and chats can be resolved over the phone or online, mobile crisis teams, walk-in crisis centers, and behavioral health treatment facilities can come together to form a more complete system of care.

Ultimately, the ideal crisis system offers a safe resolution early in the crisis response, while effectively intervening in the least restrictive manner possible so that individuals remain in their communities. An effective crisis system reduces unnecessary trips to the emergency department, reduces law enforcement involvement, reduces the likelihood of incarceration or even death during a behavioral health event, and, most importantly, saves lives. This is, of course, the ideal – getting there can be challenging.

Establishing the ideal crisis system is expensive and many communities have limited resources. States spend an average of 2.4% of their budgets on behavioral health, or $225 billion in 2019. This figure rose 52% in the previous decade (compared to a 7% rise in the U.S. population).[16] [17] [18] While spending on behavioral health has increased, funded resources often remain siloed. Providers, payers, members of the behavioral health community, and the community at large often do not have an effective way to communicate, collaborate, or provide enough care for their communities.

What is needed is a convener in a leadership role with the ability to corral siloed and disparate groups to form community collaboratives capable of creating systemic change. The National Council for Mental Wellbeing advocates for this approach, stating that within the ideal crisis system "there is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems, and service recipients."[19] The convener model has been used successfully around the country and brings united approach to crisis care.[20]

## The convener: coordinating disparate, and often competing, interests

The great need for behavioral health services and the inconsistency in resources and provider availability necessitates smart system design and efficient coordination. But is it possible for competing hands to fully function in the best interest of patients and providers? Mental well-being, substance use, and physical health have been historically treated separately and continued to drift further apart until recently.[21] Because health-related care is handled idiosyncratically from one state to the next, from one county to the next, and from one insurance plan to the next, coordination has historically been challenging.

Successful attempts to transform the behavioral health service delivery system in a given region must unify all stakeholders including public health, behavioral health, social services, housing, education, criminal justice, and child and family services. While the challenges are formidable, a thoughtfully administered and well-executed public/private partnership utilizing a convener can lead to organized community collaboratives that join together disconnected, and sometimes competing, interests.

# Reimagining the crisis response system through a collaborative lens

While several states already have valuable crisis infrastructure in place for behavioral health, others need help. In many areas, a great deal of what is currently available amounts to some combination of emergency department services, first responder involvement, and civil commitment processes – all of which are expensive as measured by both the human and financial costs. Disjointed systems and siloed information further complicate things by acting as barriers to accessing appropriate services.

When behavioral health crisis systems are reimagined through a collaborative lens however, the treatment landscape changes to allow for the sharing of information, greater accountability, dedicated resources, braided funding, and a comprehensive continuum of care that is stakeholder-driven. Importantly, these systems have the potential to bring about greater equity as they make it easier for historically marginalized groups to access care.

## Leading by example in Washington state

When Carelon Behavioral Health became the Behavioral Health ASO in Washington state in 2016, the concept of stakeholder-driven crisis collaboratives was introduced. Up to that point in time, these regions experienced many of the same problems addressing the behavioral health needs of its residents as the rest of the country. And like many other areas, parts of their system did function as designed. For example, the involuntary commitment process worked well to identify and triage individuals who were at risk of harming themselves or others. However, this intervention is appropriate for only a small percentage of the overall behavioral health needs of the state.

With no single entity overseeing the behavioral health crisis system, the region suffered from a lack of accountability and coordination. Instead, each of the separate players operated largely independently. This led to confusion for individuals and their loved ones, poor customer service, and inefficiency.

Overuse of the involuntary commitment process led to providers frequently receiving patients who could have been better served in lower levels of care had they been made available. Increased utilization created an inaccurate demand for expanded inpatient bed capacity to handle the growing need, as individuals who legitimately needed those beds couldn't get them due to inappropriate placements.

Adding to the system's inefficiency was the fact that the larger continuum of care throughout the region lacked important treatment options such as prevention, early intervention, post-crisis services, and population specific services. As a result, vulnerable groups such as children, BIPOC, and those living in rural areas were routinely treated at hospital emergency departments, a costly practice that risked iatrogenic harm and was therefore not generally successful or sustainable.

## Turning the ship around – designing a new system

Designing and implementing a new service delivery system is a delicate balance of carefully planned actions and real-time course corrections. To make the transition as smoothly as possible, the first step in redesigning regional crisis systems for Washington state was to get input from all stakeholders.

Carelon Behavioral Health held extensive interviews with county governments, care providers, community groups, individuals with lived expertise, and advocacy organizations. The goal was to fully understand the existing system, its strengths and weaknesses, pain points, and what the groups thought they needed to fulfill their shared vision for an improved behavioral health crisis system.

After the initial information gathering phase, Carelon Behavioral Health's crisis leaders helped develop a plan for system redesign and initiated the launch of community collaboratives. The collaboratives, led by the Carelon Behavioral Health team, organized and assembled the system components identified in the overall plan. A significant effort was made to communicate and coordinate with managed care organizations under a Medicaid payer structure. Many of the providers had never worked under the managed care umbrella before, and it was essential both partners understood each other's needs.

## Rebooting the system

With a carefully crafted implementation plan in place, Carelon Behavioral Health's ASO regions moved to improve their behavioral health infrastructure in some important ways by:

- Reorienting the crisis system framework to focus on prevention, early intervention, and integration post crisis
- Launching region and county specific crisis collaboratives to solve problems
- Developing and publishing crisis dashboards to be reviewed in monthly crisis collaborative meetings and publicly posted
- Increasing transparency and improving decision-making through information sharing
- Establishing the crisis line as the front door to the behavioral health system (freeing up time for crisis teams to respond in the community)
- Clearly separating the processes and services of crisis intervention and involuntary commitment
- Filling service gaps to shift the focus from involuntary detention
- Incorporating real-world experience (rather than, for example, academic principles) into service delivery and decision-making
- Creating and staffing dedicated youth and adult mobile crisis teams, crisis stabilization centers, and co-responders
- Publishing mobile crisis best practices for both youth and adult crisis teams
- Making crisis prevention and response a shared responsibility across all service providers
- Publishing crisis protocols specific to each county clearly outlining roles and responsibilities

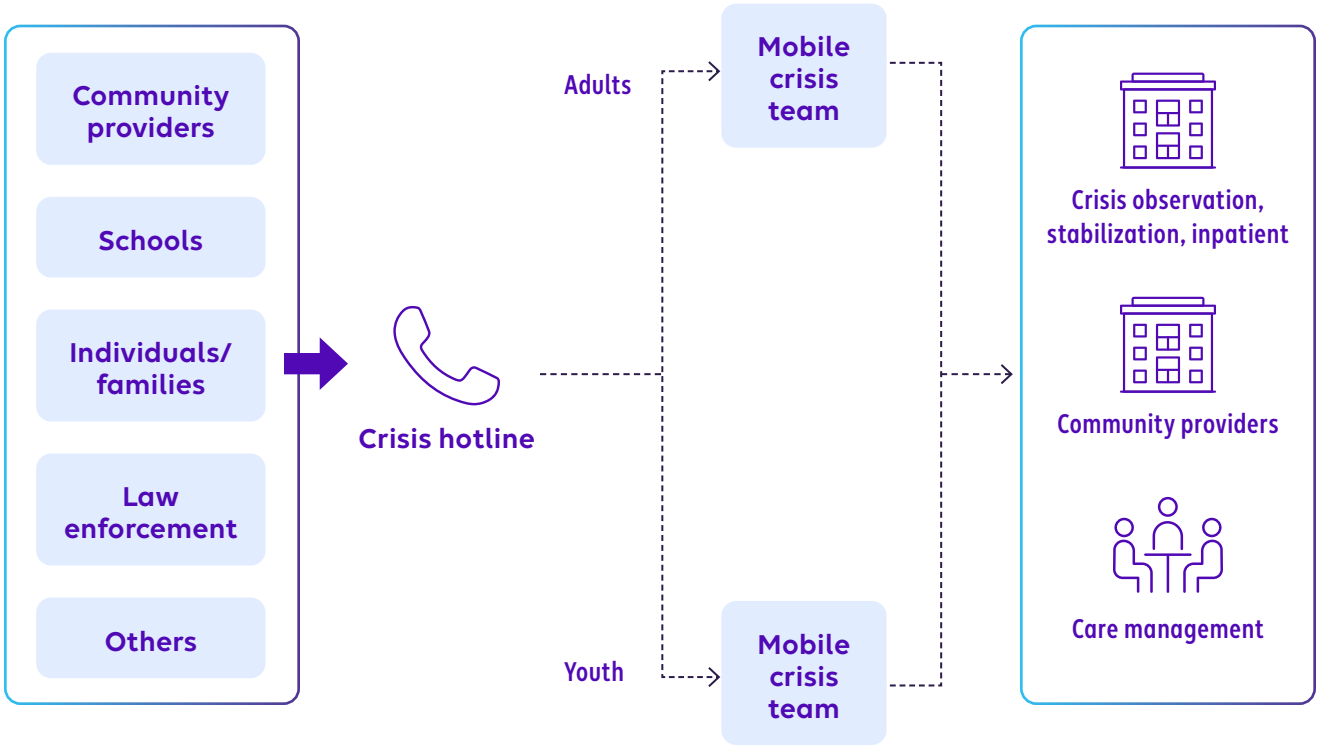
## Early results

With Carelon Behavioral Health in the convener role, Washington's community collaboratives showed early progress through increased interest and higher engagement among all stakeholders.

Notably, in the regions where the collaboratives were working, hospitals saw decreased inpatient admissions and a reduction in families seeking services from emergency departments. The community collaboratives attribute the decreased utilization to widely publicized system enhancements, which were carefully promoted so that families were aware of new treatment options.

As the new system design intended, mobile crisis teams quickly became more frequently utilized, which meant more behavioral health concerns were solved in the field. This reduced the default response to seek care from hospitals and resulted in fewer law enforcement interactions in the majority of crisis response calls. At the same time, streamlining access to the crisis system through a unified number allowed mobile crisis teams to handle fewer redundant phone interventions. This created more time to respond to in-person requests. As Carelon Behavioral Health continued to optimize the system, these early successes were sustained and added additional momentum to the initiative.

**Crisis services workflow**




## Proving the concept with data

Over the course of the system redesign, data continued to support the concept that increased investment and engagement in behavioral health through high-touch collaboration benefits not only individuals seeking care but also the broader community as a whole. Some of the factors that demonstrated proof of concept included:

**2x**
Call transfers from 911 to the crisis line doubled in 12 months

**80%**
of events were resolved on the first call, with 24/7 phone access to crisis clinicians

**2 hours**
Mobile crisis teams consistently responded within two hours or less resulting in:

**>80%**
of events completed in person

**>90%**
of events included support from family and/or individuals with lived expertise

**>90%**
of events diverted from "traditional" (hospital and law enforcement) responders

**>70%**
of patients received follow-up attention within seven days

**<5%**
of patients experienced recidivism

## What we've learned about crisis system development

**When all stakeholders collaborate, everyone wins.** One of the greatest benefits of community collaboratives is that they create space for the many disparate interests and stakeholders involved in the behavioral health system. When collaboratives regularly meet and function as a team, any sign of trouble or system flaws can be caught quicker and resolved thoughtfully. In this way, the system continues to evolve and improve along with the needs of its people.

**Geography makes a difference.** The size and composition of a region is as important as population demographics. Because service demands differ from place to place, active engagement with the local community is imperative to develop the appropriate continuum of care that meets the community's needs.

**People come first.** The ideal behavioral health crisis system must be designed with the people it serves at the forefront of all decision making. The perspective of the person in crisis (and their loved ones) must take center stage. System barriers, limitations, or what is convenient for stakeholders and service providers must not be allowed to take precedence over the needs of individuals who need care.

**Keep an eye on the data.** Building a robust system for data collection and patient tracking is essential. Key performance indicators can drive process refinements, the development of best practices, positive public opinion, and stakeholder support.

**Include all stakeholders.** In a crisis continuum, stakeholders extend beyond the people who need care and providers who serve them. For example, law enforcement and emergency departments should be considered part of the collaborative even though the goal is to reduce the inappropriate utilization of their services. A behavioral health crisis do not occur in a vacuum. There are many instances where such groups are inextricably linked to the individual in need. Their input and alignment is indispensable to the success of the collaborative.

## Community collaboratives are the way forward

Carelon Behavioral Health manages the behavioral health crisis system in eight Washington counties, a region spanning some 18,500 square miles, most of which is rural. Such a vast area naturally encompasses widely varying opinions and beliefs about the behavioral health needs of the community, so the most important piece of system redesign is to listen.

Community collaboratives create a forum to forge better relationships with people who need care, the general public, payers, and providers. Building transparency and accountability into the system allows for greater equity, better data, better decision making, and better outcomes overall.

The results in Washington state are encouraging and can be replicated in large and small communities around the nation. States, counties, and territories can unite and mobilize the resources they have to build the ideal crisis system, increase access to life-saving care, and improve behavioral health outcomes for all.

## Is your state moving forward with behavioral health crisis care?

Carelon Behavioral Health can help address the crisis system in your region by providing guidance on evidence-based systems that form a continuum of behavioral health care.

# Endnotes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