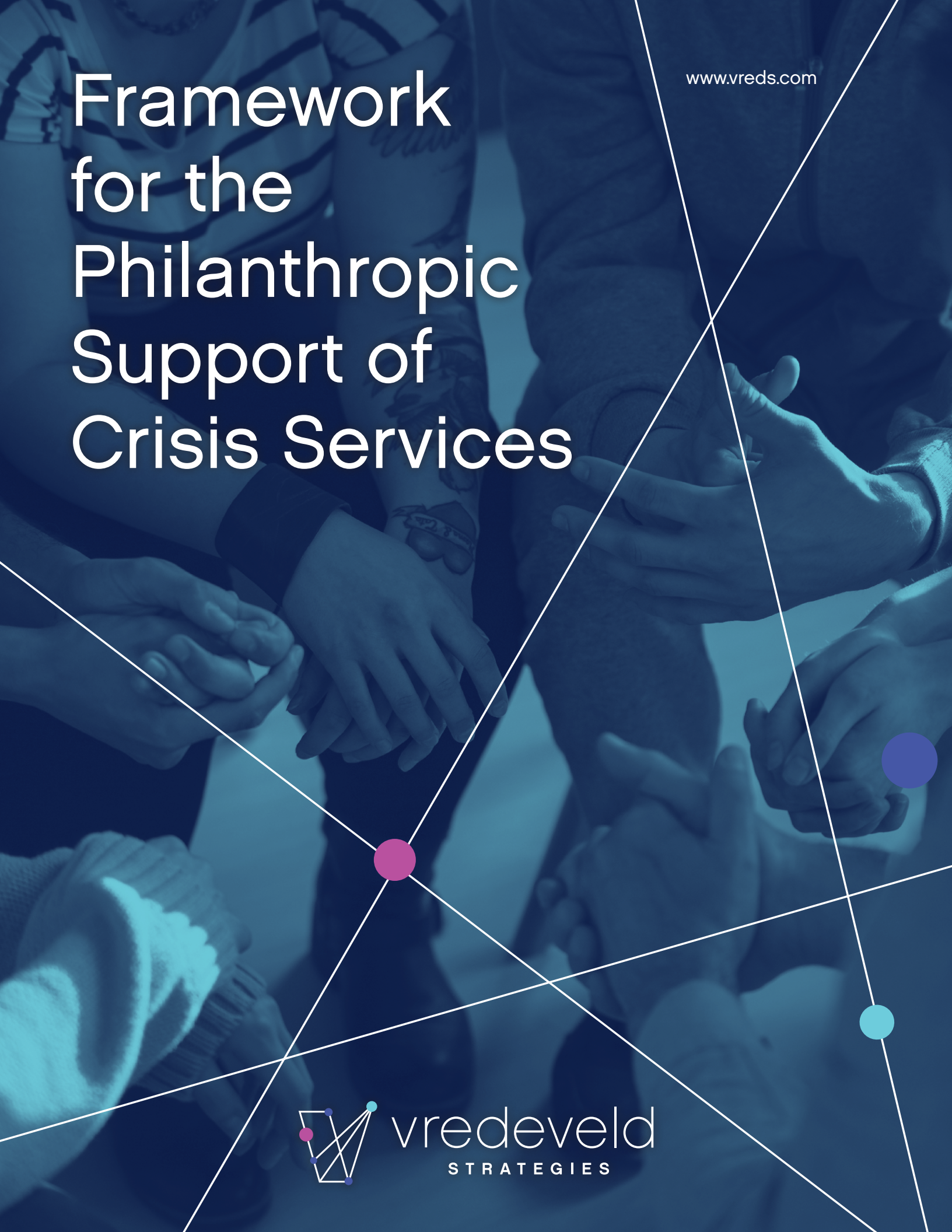

Framework for the Philanthropic Support of Crisis Services

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STRATEGIES

CONTENTS

EXECUTIVE SUMMARY

A growing number of philanthropists are exploring the impact of developing a universally available, community-based system of care for people experiencing mental health and substance use disorder (MH/SUD) crises and emergencies. Such a system would be built on principles of racial justice, health equity, digital health and advanced technologies, local control, and financial sustainability. One key outcome of this system is that jails, emergency rooms, and prisons are no longer the default response for people with MH/SUD conditions when they experience a crisis or emergency.

Building and sustaining such a system across every community and state in America will take many billions of dollars and far exceeds the direct reach of philanthropy. Nonetheless, philanthropy can employ strategic levers and catalytic opportunities to help create a bridge between our current fragmented MH/SUD response to the integrated, community-based system that has long been the vision of policy experts as well as affected individuals and their families.

This brief lays out strategic options for how philanthropy can help build that bridge. It explores the full range of issues involved, including philanthropy's unique role in stimulating private and public funding as well as innovative approaches that leverage both, such as social impact bonds. It also discusses how national philanthropy can best partner with local philanthropy and identifies the key roles for each.

Goal

If you fall on a sidewalk or have a heart attack, you receive medical transport and are taken to an emergency room. If you have a psychiatric illness, you deserve an evidence-based medical response specific to behavioral disorders. That is the goal—for emergency mental health services to be treated like a standard medical practice, just like any other medical emergency.

In in 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. SAMHSA sees 988 as a first step towards a transformed crisis care system in America. As of July 2022, "988 Suicide and Crisis Lifeline" centers are available as a behavioral health counterpart to 911. Their purpose is to offer care that aligns with 911 calls for physical emergencies. SAMHSA defines crisis care as having three components: someone to talk to, someone to come to the individual in need, and a safe place to receive care. Thus, just as ambulances come to an individual in a physical crisis and hospital emergency departments are available 24/7 for treatment, so too must behavioral health mobile crisis teams and behavioral health crisis "receiving and stabilization" centers be available 24/7 for behavioral health crises. The goal is vital "no-wrong-door" crisis services that deliver real-time access to people with behavioral health issues.

Challenges

As they are not reimbursed by commercial insurers, what MH/SUD crisis services do exist are currently kept afloat through Medicaid waivers or special grants in a handful of markets. Increased attention to the issue presents a window of opportunity for change. A first step is to recognize MH/SUD crisis and emergency response as a standard health care service. For this to happen, crisis care needs to be recognized as an evidence-based practice, integrated into the broader medical system beyond the ancillary public mental health system, and reimbursed at reasonable levels across all payers.

Establishing Evidence-Based Practice

Evidence-based practice typically emerges out of the private sector, but even then, there is often a long lag between the time a new practice is developed and the time it scales across the system. For instance, when new compounding agents are developed for joint replacements—one the best types of reimbursed practices—the lag can be as long as fifteen years. In the case of mental health, however, innovation has not historically come from the private sector. Due to long-standing failures to uphold U.S. legislation on mental health parity, which requires that insurers offer equal coverage limits for mental health benefits and medical benefits, innovation has instead come from some (but not all) Medicaid programs and grants. The good news is that there are currently significant federal financing incentives to use funding from Medicaid, the Department of Justice (DOJ), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to build out a comprehensive crisis system by developing new approaches and scaling what works.

Structural Issues

The public mental health care system has long been reimbursed by state and federal grants, supplemented (in some states) by Medicaid waivers. The main providers for the public behavioral system are Community Behavioral Providers, who for decades have been providing the bulk of behavioral services, including crisis services. These providers have pioneered several essential services like mobile crisis, call centers, and 23-hour stabilization centers. In states where Medicaid waivers are used, they also have expertise in blending these flexible approaches with grants. Yet such crisis services vary significantly in quality and capacity, and since they aren't reimbursed by commercial insurers or Medicare (or Medicaid in many states), they are not available to most of the U.S. population. Until now, the primary focus of the Federal Government has been to provide funding for crisis services delivered by Community Behavioral Health programs (including Certified Community Behavioral Health Clinics) via grants. The result is an underfunded set of crisis services and reliance on medical emergency rooms, ambulances, and jails for most citizens. To strengthen MH/SUD crisis and emergency services, it must be integrated into the broader medical system.

Reimbursement

Historically, many community-based providers have been reluctant to bill for crisis services due to several factors: lack of standardized billing codes across insurers, high administrative costs, and lack of familiarity on the part of the public mental health system with commercial billing practices. These problems are all rooted in the historic split between behavioral health systems and the general medical system. This split has in turn led to the propping up of community mental health system with grants and waivers, rather than standard billing. Unfortunately, this has perpetuated the problem: commercial billing is unnecessary for community mental health providers able to figure out local grant and waiver incentives, but this has limited and slowed the spread of community mental health and exacerbated the shortage of providers. For this reason, crisis services join a long line of evidence-based practices that are not regularly billed by community mental health providers or reimbursed by commercial insurers.

Addressing these challenges will require major efforts on several fronts, many of which fall out of the purview of philanthropy. There is, however, a key role for philanthropy to play.

HOW PHILANTHROPY CAN HELP

The role of philanthropy in creating an integrated, community-based MH/SUD system plays out across two broader ecosystems. The first is the health care ecosystem, including providers, insurers, and state and employer purchasers. The second is an ecosystem of potential funders already interested in developing better systems for MH/SUD

crisis and emergency response, including public funders, for-profit investors, and national and local philanthropists. Two smaller, related stakeholder groups also play an important role: the emerging field of for-profit technology entrepreneurs, who are striving to develop alternatives to the existing health delivery system, and policy entrepreneurs in the social services sector, who are striving to integrate public support for housing, food, and employment with health care payment systems.

While philanthropy could undertake countless activities to address these issues, this brief focuses on five strategic opportunities for transformational change. These opportunities are summarized below and explored in greater detail in the sections that follow.

1 Supporting Sustainable Reimbursement and Financing

How do you get more of a service in health care? By paying for it. Major health systems will be unlikely to adopt new practices until U.S. employers demand it and commercial insurers reimburse for it. One of philanthropy's opportunities is to advocate for better reimbursement from private payers for MH/SUD crisis and emergency services. There are also opportunities to leverage public systems beyond health care.

To make a case for sustainable financing and reimbursement, it will be necessary to demonstrate success in a real-world implementation project across multiple states. Maximum leverage can be achieved by combining private and public approaches with multi-state scaling to promote sustainable funding streams through adoption by all payers (commercial, Medicaid, and Medicare).

2 Demonstrating and Scaling Evidence-based Practice through Public Financing

One of philanthropy's most important roles is to directly fund some of these pilot projects to show what works. Philanthropy can also develop multi-state pilots by leveraging state and local government incentives. This includes investments in evaluation and technical support to fund strategic financing plans in collaboration with state and local governments. These investments fall into two broad categories, explored in more detail in the body of the report:

- Infrastructure and start-up funding:
    - Direct funding for focused demonstrations
    - Developing comprehensive financing plans to integrate federal, state, and local funding for longer or more comprehensive demonstrations
- Ongoing costs and sustainable financing:
    - Supporting states in comprehensive planning, financing, and applications for waivers and use of block grant funds
    - Funding state and local advocacy efforts

3 Using Social Impact Bonds to Fill Health System Gaps

One theory about the reason evidence-based practices have not spread further within the public sector is that the savings and benefits gained by better caring for these patients accrues largely to local jails, not the state-based health budget, even though the cost will be

largely borne on the health side. Such issues are known as "wrong pocket problems."

A potential solution to this tension is social impact bonds, which for more than a decade have achieved financial and social impacts on a range of social issues. Early examples include the social impact bonds to reduce recidivism in New York City and Massachusetts in 2012 and 2014, respectively. More recently, philanthropists have launched additional social impact bonds in both states as well as Ohio, North Carolina, and California to address early childhood education, homelessness, health, and other criminal justice efforts.

One of philanthropy's most important roles is to directly fund some of these pilot projects to show what works.

Several organizations have emerged as leaders in this area, including Social Finance, Third Sector, and Quantified Ventures. In recent years, some of these organizations have moved beyond the rigidity of early social impact bond models—though there are still several implementation issues that could pose challenges for applying the approach to MH/SUD crisis services. Nonetheless, social impact bonds represent a promising opportunity for philanthropy to develop in these areas.

4 National/Local Partnerships to Support Change in Local Communities

National philanthropists have not always been successful at investing in local communities. There are inherent tensions between national and local philanthropists, akin to the tensions between national and local governments, and these must be brought into balance for effective collaborations to succeed. Fortunately, there are also solutions that center on true, multi-dimensional partnerships—though it takes time and the right people to broker enduring relationships.

Philanthropy can best collaborate with local partners by championing and supporting local MH/SUD crisis programs through early investments in planning, start-ups, and demonstrations of effective implementation. The following roles and associated competencies are essential:

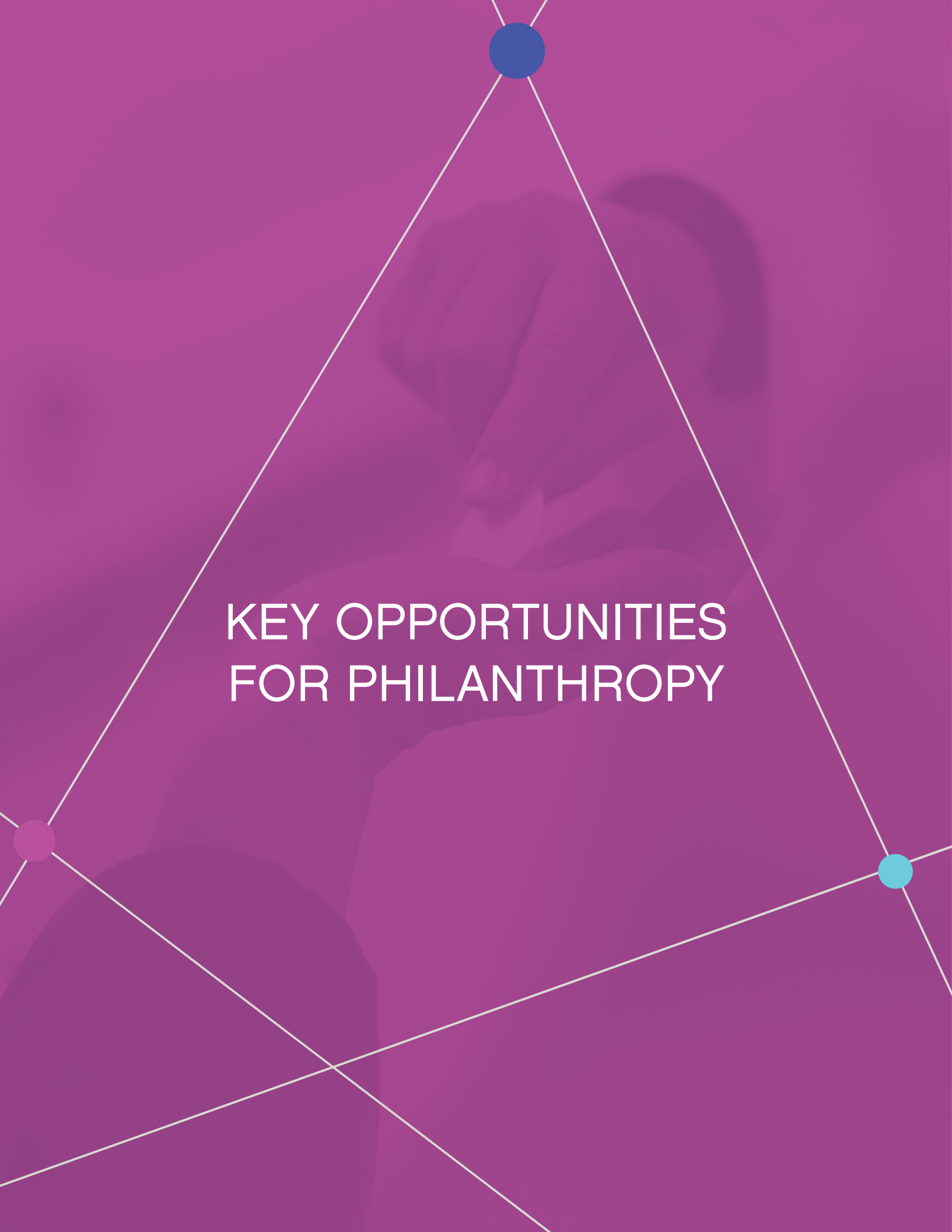
- **Trusted Broker:** Philanthropists can play a very important role in bringing people together around common interests.
- **Mobilizing Stakeholders:** Philanthropists can also contribute by mobilizing and convening the most important stakeholders in a local market.
- **Championing Change Agents:** Philanthropists can support individuals and teams who lead the charge to bring evidence-based programs to local communities, develop new programs, and manage implementation activities.
- **Evaluating:** Evaluations can be essential to legitimize a project and move it from the pilot stage to sustainable funding, and philanthropists are well-placed to support them.
- **Strategic Financing Plans:** Philanthropists can empower social entrepreneurs as well as local and state governments to develop comprehensive financing plans and waiver applications.

5 Promoting Place-Based Philanthropy through National/ Local Partnerships

Effective place-based philanthropy is the key to successful national/local partnerships to create system change. Place-based philanthropy is more of a mindset than a function of targeting certain zip codes. It is the mindset that philanthropy's purpose is to spend money for the benefit of specific communities under the guidance of local leaders, regardless of whether the communities are urban, rural, or regional.

CONCLUSION

Philanthropy has multiple avenues to create exponential financial and social impacts by helping develop a universally available, community-based system for behavioral health crisis and emergency services and integrating it with existing health care and reimbursement systems. National philanthropists can spur broader funding by leveraging a wide range of existing funding streams, including federal grants, state and local funding, private investment, employer-funded insurance, and local philanthropy. The current moment offers a critical opportunity to help usher in a brand-new standard of practice.



KEY OPPORTUNITIES FOR PHILANTHROPY

SUPPORTING SUSTAINABLE REIMBURSEMENT AND FINANCING

OPPORTUNITIES WITH PRIVATE PAYERS

National philanthropy can support transformation by investing in efforts to fold crisis services into the general medical system. This takes crisis care beyond the public mental health clinics that have long borne the burden. It requires promoting commercial reimbursement for these services. Three examples below highlight innovative ways to approach this very sticky challenge. It should be noted that crisis services follow in a long line of unreimbursed innovations in mental health, and approaches like those noted below will require sustained effort and significant financial commitment.[1]

Driving change through employer-based commercial insurance

Creating an integrated, community-based MH/SUD system would require integrating a new standard of practice in health delivery systems. However, health delivery systems across the United States are unlikely to be capable of instituting a new standard of practice, unless all payers (Medicaid, Medicare, and commercial insurers) sign on. However, since commercial insurers pay more for most services than Medicaid or Medicare, major health systems rarely adopt a practice until commercial insurance pays. Moreover, as most Americans covered by commercial insurance are enrolled in employer-based plans, the U.S. health care system is uniquely centered around employers.

As a result, employers have historically been the leaders in incentivizing new health care practice adoption. This is the premise of Path Forward for Mental Health and Substance Use Disorders, a partnership of worker, physician, and policy groups driving market-based improvements in access and care for mental health and substance use—specifically by leveraging the purchasing power of employers in the insurance industry. Path Forward is currently working to persuade employers and state governments to expand coverage for a range of services that benefit MH/SUD patients, including collaborative care, early detection of psychosis, universal screening of behavioral health conditions, and measurement-based tracking of symptoms. Expanding employer-based commercial insurance coverage for these services would greatly increase the ability of providers to detect illness earlier, when it is easier to treat and more likely to prevent the types of relapses that frequently land MH/SUD patients in jails.

Standardizing and scaling MH/SUD billing codes

A project by RI International and the National Association of State Mental Health Program Directors has identified billing codes for the three SAMHSA-defined elements of crisis.[2] The group plans to develop an insurer request package for providers, which would include a sample bill using the identified codes. They will coordinate nationally to identify which providers are willing to submit bills to commercial insurers, which Medicaid Managed Care Organizations (MCOs) are not reimbursing, and in which states these challenges are greatest, focusing on states where regulators are knowledgeable and proactive on parity enforcement. The group would then help these selected providers prepare their asks and track the responses. The goal of the project is to get bills for crisis services from community mental health clinics and certified community behavioral health clinics going to both self-insured and fully insured employers, so both the Department of

Labor (DOL) and state regulators would have to respond to denials. By billing Medicaid MCOs, they would also engage the Centers for Medicaid and Medicare services. The intent is both to assist community providers in accessing funding and to highlight the ways that crisis services currently are a prime example of failure to comply with the federal parity law.

Using technology to scale MH/SUD crisis services in major health systems

Many of the largest provider chains are making efforts to better care for the complex care patients who cycle in and out of jail. For instance, CommonSpirit Health is a large healthcare provider in 21 states, with non-profit hospitals that have a significant impact on their communities. Partially because of the Affordable Care Act's mandate to provide community benefit,[3] they provide grant money to support programs and services through community building. As anchor institutions, they look at things other than just providing grants or prevention programs, such as local hiring, local purchasing, and community investing. They even have an allocation from their investment portfolio towards community investing of approximately $400 million, where they make low-interest loans to non-profit organizations to address specific issues around housing, environment, expansion of clinics, workforce development, access to capital, and other issues. Since the inception of the program, they have provided close to $300 million in small loans.

While these types of grants are a very important part of the ecosystem, they are not as impactful as fully reimbursed practice changes that filter through an entire system. An effort by a group of 30 chief innovation officers seeks to create this targeted change. The work started during the COVID-19 pandemic to scale promising efforts to help hospitals deal with the pandemic. A recent example from mental health, developed at the University of Pennsylvania, pairs individuals with substance use disorders with peer specialists in the emergency room. The broader learning group shares information on best practices. At the local hospital level, clinical and tech teams redesign workflows and billing, then map the changes to apps they develop. Apps like these are ideal solutions because they contain intellectual property, can be commercialized, and lend themselves to system-wide scaling through integration with widely used health system software like Epic Systems. The group is exploring developing a for-profit company to commercialize some of the most promising apps. Their plan is to sell the apps to the large integrated health systems—groups like Nashville-based HCA Healthcare ($42.6 billion in annual revenue), Kaiser Permanente ($29.1 billion), Common Spirit Health ($28.3 billion), Ascension ($18 billion), and others.

While these types of grants are a very important part of the ecosystem, they are not as impactful as fully reimbursed practice changes that filter through an entire system.

Philanthropists could directly engage this community to identify scalable opportunities in health systems for crisis services. Instituting a key practice at any one of the integrated delivery systems noted above would be a game changer for the entire industry.

OPPORTUNITIES WITH PUBLIC PAYERS

Only the most progressive health systems—those responsible for both payment and provision of services, who accrue savings from keeping people healthy—truly have the incentive structure to fold social services into their offerings as a way of caring for the most complex patients. Developing value-based payment systems that will work in a greater range of fee-for-service payment settings is a big concern of national philanthropists, falling within the broader "Social Determinants of Health" (SDOH) movement. Recognizing

that interventions targeting high-cost, high-needs patients can best underscore the link between social service provision and health impacts, many SDOH leaders prioritize complex care patients, including those likely to be incarcerated. Their hope is that demonstrating gains for complex care patients may help scale efforts to reframe housing, food, transport, and a range of other social programs as health services. A handful of groups, funded through philanthropy or state grants, are actively engaged in local pilots and early-stage scale of these efforts, both in crisis response and broader health and social services for complex care patients who are typically incarcerated. Below is one such example.

Piloting new community-based models for complex care

The Camden Coalition is an alliance of hospitals, healthcare providers, social services organizations, and community representatives that collaborate to deliver better healthcare to the most vulnerable citizens of Camden, New Jersey, and the South Jersey region. The alliance engages diverse stakeholders in the development of culturally appropriate, community-driven initiatives. Major accomplishments include codifying a practice approach that is now trained across the country as well as pioneering and evaluating the practice of "healthcare hot-spotting" (as featured in a *New Yorker* article by Atul Gawande[4]). As one of New Jersey's four Regional Health Hubs, the organization acts in a bridging role between the New Jersey Medicaid Office, the state Department of Health, their region's Medicaid recipients, and the organizations and institutions that serve them.

Since most of the Camden Coalition's clients have mental health needs, and many have been involved or are currently involved with the criminal justice system, they recently developed a new demonstration program called Pledge to Connect (P2C). The program aims to increase connection to outpatient behavioral health services, to prevent and reduce individuals' involvement with the justice system, and to improve the patient experience during transitions of care (TOC) from emergency rooms. P2C seeks to establish a single TOC metric for behavioral health for all stakeholders; develop regional data infrastructure for tracking the metric; highlight barriers to high-quality outpatient behavioral health services in the alliance's region; and pilot new workflows to connect hospitals with behavioral health services for individuals that would otherwise remain hospitalized or end up in the local jail. As part of P2C, the Camden Coalition plans to conduct retrospective data analysis to identify potential upstream intervention points that could have prevented involvement of the justice system. They are also piloting new ways to involve support services with their Medical-Legal Partnership (MLP) with Rutgers Law School, which helps participants enrolled in their care management programs resolve the legal matters that affect their health and well-being.

Lessons learned from this work will be disseminated broadly through the Camden Coalition's networks—including their National Center for Complex Health and Social Needs, and their annual "Putting Care at the Center" conference with the hope of creating new best practice recommendations for the field.

BRINGING IT ALL TOGETHER

To make a case for sustainable financing and reimbursement with both private and public payers, these groups will need to demonstrate success for these practice changes in a real-world implementation project across multiple states. A few philanthropically and grant-funded initiatives are already focused on multi-state scaling. Some of these could possibly be persuaded to take on crisis services—such as the Path Forward partnership, which is working in major health systems across multiple states. Other existing efforts include:

- Efforts by the Providence St. Joseph Medical Center to develop system-wide initiatives

across multiple states on depression, suicide, and opioid use disorder, driven by CEO Rod Hoffman's special commitment to mental health.

- The National Institutes of Mental Health Research Network, though largely academic, also nurtures and invests in a range of quality improvement initiatives in mental health across research, practice, and policy groups, including across many Kaiser Permanente systems.[5]
- The Columbia Center for Practice Innovations, though largely academic and focused on New York, has locally scaled several innovative practices for serious mental illness, including Assertive Community Treatment, Coordinated Specialty Care, and Supported Employment. They are beginning to look at more national projects and could potentially be interested in crisis.

These existing and planned efforts, initiatives, and organizations showcase how meaningful support and engagement by philanthropy can drive change in MH/SUD care. Maximum leverage can be achieved by combining private and public financing approaches with multi-state scaling to promote sustainable funding streams through adoption by all payers (commercial, Medicaid, Medicare). Demonstrating the potential of more sustainable financing and reimbursement through a real-world implementation project could have transformative impacts on efforts to develop a universally available, community-based system of care for MH/SUD crises and emergencies.

DEMONSTRATING AND SCALING BEST PRACTICE THROUGH NEW PUBLIC FUNDS

Recent interest among criminal justice and mental health advocates—combined with emerging federal policies and expanded resources in response to COVID-19—provide a significant opportunity to pilot new programs, evaluate them, and build on a nascent national movement for change. Philanthropy can act as an early-stage investor to catalyze broader support by federal and state government, while amplifying the issue with policymakers, stakeholders, and the public.

Despite recent momentum, there are many challenges. While the private sector typically incentivizes health care innovation, mental health is less driven by market dynamics. Largely due to long-standing failures to uphold U.S. legislation on mental health parity, which requires insurers to offer equal coverage limits for mental health benefits and medical benefits, mental health delivery has largely been carved out of the medical system, while access to and insurance coverage for mental health services is broadly inadequate. As a result, it is the public sector rather than the private sector that drives most of the substantive program innovation in MH/SUD.

As with many entrenched social problems, it will be necessary to work across a range of complex systems, including justice, law enforcement, health, housing, and social services to solve these challenges. Authority for MH/SUD does not live in a single public entity or department, making accountability complex. Efforts will necessarily be hyper-local and responsive to the needs of diverse communities, including the lived experiences of those most affected. Financing is particularly challenging: free-rider problems necessitate holistic responses from state and local government, while the patchwork system of public and private financing that characterizes U.S. health care necessitates all payers to adopt changes before new practices are taken up at scale by providers.

To put philanthropy's role into perspective, it is helpful to consider the scale of funding needed to build a new system—including infrastructure capital for establishing call centers, mobile crisis teams, and crisis facilities and beds. Costs average in the tens of millions for localities and the hundreds of millions for states.[6] While some system components, like 24/7 facilities, will require investments that exceed the scope of philanthropy, more focused components, like mobile response units or some 911/988 integrations, can be supported by philanthropy in ways that support system transformation more broadly. Most components will require a strategy that leverages philanthropy against additional government and health system funding for start-up costs and demonstrations and sustainable funding streams like Medicaid and commercial insurance. Many states also have access to enhanced governmental funding—including funds from the American Rescue Plan Act (ARPA), the DOJ, and SAMHSA—which can be used to plan and build out their systems or aspects of them.

The scale of investment needed suggests that philanthropy can play two broad types of funding roles, summarized in the chart below. For several components, philanthropy may be a direct funder, particularly during the early stages of investment. Philanthropy can also work through government funding and private insurance to stimulate smarter programming. This could include helping

communities, state and local governments, and health systems leverage new dollars from ARPA, DOJ, and SAMHSA, or helping states access existing Medicaid waivers and SAMHSA block grants to sustain crisis systems. Finally, philanthropy can also advocate for sustainable funding through private insurance and Medicaid.

CATEGORY	STATE AND LOCAL FINANCING	ROLE OF PHILANTHROPY
Infrastructure and Start-up	• $350 billion in ARPA funds to state and local governments (must be spent by 2026, highly flexible funds) • $282 million in SAMHSA funds for 988 implementations • 85% match from Medicaid for new Mobile Crisis Systems, plus $15 million in planning grants • $35 million to start 988 call centers • Opioid settlement funds • Some state general funds • Local government funds (targeted)	• Provide direct funding for focused demonstrations • Use philanthropy to develop comprehensive financing plans to integrate federal, state, and local funds for longer or more comprehensive demonstrations
Ongoing Costs and Sustainable Financing	• Existing Medicaid benefits: crisis stabilization, case management, peer supports • Medicaid waivers (including 1915 and 1115) and federal administrative matches • $1.6 billion SAMHSA Mental Health Block Grant (double last year), including $75 million set aside for crisis services • $3.5 billion SAMHSA SUD Block Grant • State general funds • State telecom fees • Local government funds (ongoing) • Private insurance	• Support state in comprehensive planning, financing, and applications for waivers and use of block grant funds • State and local advocacy

While funding is critical, the diversity of local systems and sheer size of the systems involved compound the challenge of building and scaling these components. Consider 988, for example. By converting the national suicide prevention lifeline to a three-digit number, the US Congress and the Federal Communications Commission (FCC) have certainly made the number easier to remember. Yet only 150 of the country's 800 emergency call centers participate in 988 programs, and more than half of calls are routed through the remaining centers. Moreover, most call centers lack standards, processes, or trained operators for these calls. Unlike 911 lines, 988 programs also do not have legal authority to geocode calls; operators must instead guess at callers' locations using area codes, which, in the era of cell phones, is often a poor predictor of location. Similar issues persist across many of the components listed above, which must be built carefully with attention to data systems, workflow, and workforce issues.

Working at the state and local levels offers clear opportunities to develop and pilot innovative new models that could ultimately be scaled nationally.

It should be noted that several states have successfully developed innovative approaches that could be scaled elsewhere. The state of Georgia, for instance, has established a statewide database that provides real-time information about the availability of psychiatric beds, which significantly enhances the work of crisis call responders. Likewise, to improve outcomes for emergency room patients who attempted suicide, the state of New Jersey is developing a reimbursement model and billing code to cover safety planning and follow-up care. There are many other examples.[7]

As philanthropy seeks to support progress on these complex issues, working at the state and local levels offers clear opportunities to develop and pilot innovative new models that could ultimately be scaled nationally. While the scale of the challenge is immense, philanthropy's unique role makes it well-positioned to leverage existing momentum and funding streams in order to unlock new progress and change.

SOCIAL IMPACT BONDS

The broader challenge of financing MH/SUD crisis services in the United States comprises a more specific challenge: nearly one third of people in jails have a mental illness, and too many receive their first mental health diagnosis while incarcerated. While health and social systems could provide mental health services far more efficiently and effectively, jails are bearing a significant share of the costs for this population's mental health treatment. Meanwhile, jails would benefit from improved crisis services as fewer people would be incarcerated with mental illness, but health and social systems lack the means of recouping their outlays for crisis services—and thus have few financial incentives to improve them.

Social impact bonds are an innovative financing mechanism that can help overcome such "wrong pockets problems." In the simplest terms, social impact bonds involve a funder providing a loan to a social entrepreneur or government agency to develop a new service that can achieve public cost savings as well as desired social impacts. The loan is repaid using the savings generated by the service, with the funder's financial return tied to predetermined success metrics associated with the desired social change. The hypothesis is that spreading risks between funders, implementation partners, and payers can relieve the burden placed on implementers and make success more achievable.

Social impact bonds have been used for more than a decade for preventative programs known to have financial as well as social impacts. The first social impact bond in the United States was a 2012 program to reduce youth recidivism at the Rikers Island jail complex in New York City, funded with a $9.6 million loan from Goldman Sachs that was partially guaranteed with a $7.2 million grant from Bloomberg Philanthropies.[8] Loan repayment was based on the projected cost-savings that New York City would realize if recidivism decreased. If the recidivism rate dropped by 20 percent, for example, the city would save as much as $20 million in incarceration costs even after repaying the loan with a return; if the intervention wasn't successful, the city would pay nothing.

While the program ended after three years (when Goldman Sachs pulled funding after an unsatisfactory progress report[9]), many other similarly structured social impact bonds have had more success. The Massachusetts Juvenile Justice Pay for Success (PFS) Initiative, for example, was launched in 2014 with support from the Arnold Foundation, the Kresge Foundation, and others. The seven-year project aimed to reduce recidivism and increase employment rates among young men aged 17-24 who are on probation, at risk of reoffending, or leaving the juvenile justice system. The state of Massachusetts made an investment of more than $28 million in this project.[10]

Social impact bonds are being used to address a range of other social problems, including early childhood education, homelessness, health, and criminal justice. Other significant examples include:

- A PFS program by the Massachusetts Housing and Shelter Alliance (MHSA) to reduce chronic homelessness by purchasing housing units.[11]
- ResultsOHIO, a broad initiative launched by the Ohio Treasurer to enable policymakers and innovators to pursue PFS projects tackling any social or public health challenge that has identifiable, measurable outcomes.[12]
- The South Carolina Nurse-Family Partnership, a PFS initiative focused on improving health outcomes for mothers and children living in poverty, supported by Duke Endowment and other funders.[13]

- Impact Security, a results-based financing structure to fund a coding-focused workforce development program inside San Quentin prison, developed by nonprofit The Last Mile and financial advisory NPX. The program achieved 113% of its impact target.[14]

In a sense, each social impact bond project is its own social experiment and must be built from the ground up.[15] Each initiative must draw up its own contract with service providers and with the project evaluators who track the outcomes. The mechanism has led to both excitement and controversy, including conversations in Congress about the complicated structure of program contracts between governments, investors, and the various private operators involved. Detractors highlight efforts that failed to meet their targets, including the very first social impact bond in the UK.[16]

Despite this, several organizations specialize in designing social impact bonds, including Social Finance, Third Sector, and Quantified Ventures. A landscaping by Social Finance, a nonprofit, noted that by 2016 an estimated 60 social impact bonds had launched in 15 countries, 22 of which had reported performance data, of which 21 had achieved positive social outcomes. Of these, 12 had made outcome payments and four had fully repaid investors. The authors emphasized that not every project will deliver a positive impact.

As these organizations learn more about how the social impact model works in practice, some have moved away from the rigidity and theoretical purity of early efforts. For instance, increasing experimentation has moved beyond the view that every single stakeholder for a given social issue must be brought to the table when designing a social impact bond program. Early models also insisted on randomized controlled trials (RCTs) to evaluate performance, but more recently, stakeholders have been willing to work with evidence and evaluation approaches that are less rigorous but faster and more cost-effective.

Quantified Ventures focuses as a consultant and lender to community benefit organizations (CBOs), offering coaching and assistance with structuring direct contracts with Medicaid MCOs like AmeriHealth, Humana Milena, and Centene. While early social impact bond models insisted on a single metric as the condition of "success" that unlocked payment, Quantified Ventures has explored working with multiple success metrics. They have also moved away from the early view that all systems (social services, jails, health care) must be brought to the table, focusing instead on the health care system's specific savings—which are entirely generated through early intervention, when mental illness is easier (and less expensive) to treat. They believe this focused approach puts less burden on the model, increasing the chances of successful implementation.

In addition, Quantified Ventures has recently developed an innovative loan product that allows CBOs to choose from three products: a small loan of $500,000; a larger loan, in which Quantified Ventures acts as subordinate lender to a larger vendor (such as Goldman Sachs); and a guaranteed loan with performance risk. In this last instance, the CBO is expected to repay the loan, but they still have a small portion set aside if they are unable to achieve their targets.

Broken markets have long been the barriers to greater progress in problems that require collaboration across many related systems. With such a complex, multi-dimensional challenge as MH/SUD crisis and emergency care—requiring efforts across health, housing, and social services systems—innovative financing mechanisms could help address a range of market failures and misaligned incentives. While there are many implementation issues to work out, social impact bonds offer a promising approach to the MH/SUD challenge, and philanthropy is well-placed to convene the relevant experts, financiers, and other stakeholders to explore their potential further.

SUPPORTING CHANGE IN LOCAL COMMUNITIES

In thinking through how to move from the current state to the envisioned state, it is helpful to break down the process of developing a new program in a local community. The field of implementation science provides multiple frameworks for understanding how change occurs as well as its key drivers and stages of implementation, including: community readiness studies, planning and assessment, start-up funding, demonstration projects, evaluation, and the ideal end stage of full sustainability. Philanthropy can be helpful in identifying and supporting change agents to shepherd new programs through the early stages (e.g., community readiness, planning, start-up, and demonstrations), including leveraging federal and state resources to fund larger efforts. Philanthropy can also play a role in reaching stakeholders, mobilizing additional funders, and serving as a trusted broker.

National philanthropists have not always been successful at investing in local communities. There is an inherent tension between national and local philanthropists, and these must be brought into balance before effective collaboration can be achieved. This takes time and the right people to broker enduring relationships between stakeholders.

Philanthropy can best collaborate with local partners by championing and supporting local MH/SUD crisis programs through early investments in planning, start-ups, and demonstrations of effective implementation in local communities. Leveraging state and local incentive funding can support these efforts. National or local philanthropists can both play a role in local implementation, but it is critical that all stakeholders practice place-based philanthropy. Beyond local implementation, national philanthropist can be particularly helpful in scaling multi-state projects, including by developing evaluations and other applied knowledge that contribute to the evidence base. National philanthropists can also help by building a national will for change and for sustainable financing—including through convening, communications, and projects that engage and directly advocate with private insurers and employers.

The following roles and associated competencies are essential for national, regional, and local philanthropy to contribute to the MH/SUD change agenda:

1. **Trusted Broker:**
   Philanthropy can play a very important role in bringing people together around a change agenda. They are well-positioned to inject capital and influence at critical inflection points; philanthropists typically have more freedom to champion change efforts in ways that are not feasible for organizations with entrenched funding streams or inertia tied to legacy systems. They play an important role, for instance, in bringing private capital together around common interests, identifying and championing change agents who can achieve the intended goals, engaging blue-chip partners for specialized technical services such as government financing and evaluations, and legitimizing the broader change effort. *Activities in these areas will likely be funded by regional and local philanthropy.*

2. **Mobilizing Stakeholders:**
   Philanthropists and the nonprofits they fund can also contribute by mobilizing and convening stakeholders. Much has been written about the concept of "nothing about us without us,"

and research supports engaging stakeholders early to enhance program adoption and success. Because crisis response in particular spans so many diverse system—each with their own cultures, data, and processes—such an approach facilitates and is critical for success. Efforts to mobilize and convene stakeholders should directly engage Black, Indigenous, and People of Color (BIPOC) communities, as well as individuals with mental illnesses and substance use disorders, all of whom have directly experienced the flawed response of current systems. Local agents can also mobilize and convene stakeholders; state officials or local entities may wish to play this role. Regardless of whether philanthropy leads the process, however, it can also provide critical funding that is not beholden to the regulatory and political constraints of state and local government. *Activities in these areas will likely be funded by regional and local philanthropy.*

3 Championing Change Agents:

Philanthropists can support individuals and teams who can lead the charge to bring evidence-based programs to local communities, develop new programs, and manage implementation activities—including workforce development, training, coaching, evaluation, administrative supports (including data collection and analysis), and system integration. Change agents may take on multiple programming areas related to crisis or a single targeted area. While they may not need to be locally based, they will need to be able to gain the confidence of local entities, and it is typically useful for at least part of the change agent team to be local. They must be capable of developing strong working relationships with organizations, implementing to fidelity with the established evidence base, and managing the data, technology, workflow, and workforce challenges associated with implementing new programs. *Activities in these areas will likely be funded by regional and local philanthropy.*

4 Evaluation:

Evaluations can be essential to legitimize a project and move it from the pilot stage to sustainable funding. For large and complex interventions, however, developing a multi-state, white-shoe evaluation program can require significant capital. National philanthropy can play an important role in this area. Strong evaluations of program effectiveness can yield significant financial returns due to the part they play in integrating a program into a sustainable financing stream. High-quality, rigorous evaluations are typically developed by elite institutions, who also develop published articles and reports to broadly share the results of these evaluations. *Activities in these areas will likely be funded by national philanthropy.*

5 Strategic Financing Plans:

Philanthropists with the relevant background can play a helpful role assisting local and state governments to develop comprehensive financing plans and waiver applications. As noted, the scale of investment needed for MH/SUD crisis and emergency response is very large and driving change in this area will necessitate combining funds from federal programs, state and local budgets, and national and local philanthropy. Developing strategic financing plans will likely involve philanthropic expertise as well as a group with deep background in assisting state and local governments with developing comprehensive financing plans and waiver applications (e.g., a major consulting firm), which will be capital intensive. *Activities in these areas will likely be funded by national philanthropy.*

CHANGE PROGRAM EXAMPLES

The chart below provides examples of the types of change programs that may be pursued and highlights the roles that philanthropy can play. Local philanthropy can fund several of these components directly, such as community readiness studies, planning grants, and start-up funding for highly focused projects. In other cases, national philanthropy may have the resources and subject matter expertise for the development of plans to leverage resources from state and local government. For any change program, national philanthropy can partner with local and regional funders to help shift priorities toward more evidence-based and sustainable reforms. With well-designed strategies for MH/SUD change and a productive approach to collaboration, national and local philanthropy can join forces to achieve outsized impact on the ground.

	DIRECT PHILANTHROPIC FUNDING (NATIONAL AND LOCAL)	EXAMPLES
Call systems	• Planning grants • Start-ups and focused demonstrations • Evaluation of effectiveness • Comprehensive financing plans	• 988/911 integrations • 911 embedded mental health clinicians • Building 988/911 workforce competencies more broadly
Mobile response	• Planning grants • Start-ups and focused demonstrations • Evaluation of effectiveness • Comprehensive financing plans	• Multi-disciplinary response teams • Behavioral health-led responses • Crisis intervention training for police, clinicians, and paramedics • Incorporation of peer-based responses
Crisis stabilization	• Planning grants • Evaluation of effectiveness • Comprehensive financing plans	• Same-day walk-in clinic and prescriber services clinics • 24-7 community hospital and crisis bed capacity • Crisis detox and medical care for SUD
Breaking the cycle	• Planning grants • Evaluation of effectiveness • Comprehensive financing plans	• Housing referral and resources • Addressing social determinants more broadly • Initiatives focused on poverty and racial justice

PROMOTING PLACE-BASED PHILANTHROPY THROUGH NATIONAL/LOCAL PARTNERSHIPS

Place-based philanthropy is more of a mindset than a function of targeting certain zip codes. It is the mindset that philanthropy's purpose is to spend money for the benefit of specific communities under the guidance of local leaders, regardless of whether the communities are urban, rural, or regional.

Place-based philanthropy has a long history, starting with 19th century approaches by philanthropists like Andrew Carnegie and George Peabody. As federal funding has diminished over time, many philanthropists see a growing need to build and strengthen community infrastructure at the local level.

CATEGORY	NATIONAL	LOCAL
Characteristics	• Conceptual/theoretical • Focused • Emphasize rigor and evidence-based design • Thematic (e.g., health, education, social services) • Deep subject matter expertise • Top down	• Flexible/adaptive • Holistic • Emphasize locally developed projects • Polymathic, multidisciplinary focus on stabilizing, improving, and growing the community • Deep relationships in a community • Shared power
Roots	• 1960s Civil Rights Movement	• George Peabody and Andrew Carnegie's "Gospel of Wealth" in 1889
Perception of other	• Local philanthropists are "territorial and undisciplined"	• National philanthropists are "rigid and authoritarian"
Opportunity	• Better understand the motivations of local funders and the importance of local connectedness, ownership, alignment with community, flexibility, and realistic time horizons	• Important source of funding that is not beholden to political pressures (particularly where government funding is diminished) and that can be used to embrace projects with high risk/high reward potential

In practice, this has led to the growth of new and relatively smaller regional and local philanthropies. More than 90 percent of all U.S. foundations have assets of $10 million or less and 71 percent were established in the last 15 years.[22] Many of these small foundations are devoting resources to their local or regional communities.

National philanthropists can practice "place-based philanthropy," too, though their approach is typically different than local funders. The chart on page 21 highlights the key differences across four central categories, drawing on analysis by researchers at the University of Houston, Oklahoma State University, and Michigan State University.

National/local partnerships are not without their challenges. There is a great deal of persistent tension between the two approaches, akin to the conflict played out between national and local governments. Too often these tensions erupt into resource-based power struggles, and in some cases, irreconcilable differences have led local foundations to exit collaborations that include non-local funders. National funders often seek to resolve or avoid these tensions with their financial resources; many offer matching challenges to incentivize participation by local funders, and in many cases, their deep funding pockets can smooth over the differences in approach.

The crux of the issue, however, is ensuring mutual respect between stakeholders. Past approaches by national funders, for example, often constrained local actors' autonomy. Looking ahead, national funders should seriously consider new approaches, including more physical presence of program officers at the local level, longer lengths of engagement, and greater delegation of decision-making authority to local stakeholders.[23] Regional philanthropy can also act as trusted brokers between national and local philanthropy—as well as with a range of other stakeholders, including state and local government, local health systems, local police departments, and people with lived experience.

One example of successful national/local partnership is the LA Partnership for Early Childhood Investment.[24] The initiative is a public-private collaboration of the country's largest national and local foundations, the LA Chamber of Commerce, nonprofit and child-advocacy organization First 5 LA, and key government agencies. Funders who participate include the Hilton Foundation, the Ahmanson Foundation, the Annenberg Foundation, and local place-based foundations like the California Community Foundation, the Blue Shield of California Foundation, and the Ralph M. Parsons Foundation. Embracing a theory of change centered on investments in quality early childhood development (often called the Heckman Equation), the partnership is making significant investments in LA County, particularly in low-income communities, and rigorously measuring its impact. Since 2012, the collaborative has leveraged nearly $10 million to support early childhood development for the region's most vulnerable infants and toddlers.

Regional philanthropy can also act as trusted brokers between national and local philanthropy...

Another well-regarded effort is the Robert Wood Johnson Foundation's (RWJF's) Local Funding Partnerships (LFP) program,[25] which channeled more than $260 million (including contributions from local partners) into more than 300 community projects across the country from 1987 to 2015. The lessons learned, captured in a report[26] published on the RWJF website, include: the importance of delegating significant control to local stakeholders; flexibility in funding what local organizations chose to pursue; and investment in site visits and workshops to help build the capacity of local organizations. For much of its lifecycle, the program operated and strategized independently from the RWJF's other program areas. As national-local collaborations became more of a norm across

the organization, however, the LFP program was integrated into a more directive strategy, and it was shut down in 2015 amid the sense that a separate program was no longer needed. Nonetheless, LFP remains a positive example of how successful national-local collaborations can emerge, evolve, and grow.

Effective place-based philanthropy is the key to successful national/local partnerships to create system change. While less concrete than many of the details presented in this brief, it is one of the most important recommendations. Regardless of philanthropy's strategy and tactics for MH/SUD, and no matter where its programs are targeted, fully embracing and consciously practicing place-based philanthropy is a critical ingredient for long-term sustainable change.

CONCLUSION

Developing a universally available, community-based system of care for people experiencing MH/SUD crises and emergencies will require major levels of funding and significant short-and long-term efforts on many fronts. While it cannot succeed alone, philanthropy has multiple avenues to create exponential financial and social impacts in this issue area. In particular, there are promising opportunities to help develop crisis services, support their integration with existing health care systems and reimbursement streams, demonstrate and scale evidence-based practice, explore innovative financing tools like social impact bonds, and leverage new technologies. National philanthropists also have many paths to spur broader funding, including leveraging federal resources as well as state and local funding, private investment, employer-funded insurance, and local philanthropy. To be successful, national and local philanthropies should work together and promote place-based philanthropy to support meaningful and sustainable change in local communities. By employing strategic levers and harnessing catalytic opportunities, philanthropy can help build a bridge from our current fragmented MH/SUD response to a future system that is better for all stakeholders, especially individual patients and their families.

ABOUT THE AUTHOR

Anna Bobb is an independent philanthropic and strategic advisor based in the nation's capital. She helps individuals and organizations use their capital to catalyze meaningful, real-world changes by building the relationships and insight necessary to drive research into practice. She brings more than two decades of experience building high-profile, high-impact coalitions as well as creating and identifying key opportunities for philanthropists. Her perspective is shaped by her time at one of the nation's leading academic medical centers, where she helped departments incorporate new practices and approaches, improve the experience of people served, and increase revenue. This work extends to a range of commercialization projects with leading scientists, health services researchers, FDA policy experts, and philanthropists. Her latest focus is on medical education and the health workforce. Anna earned her Masters in Public Health from Johns Hopkins University.

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