June 2021

A Matter of Public Health and Safety: How States Can Support Local Crisis Systems

The COVID-19 pandemic has aggravated deep-rooted systemic problems related to inequitable access to necessary care and services to address—and prevent—mental health crises in communities. This is particularly true in Black, Indigenous, and People of Color (BIPOC) communities. Many people across the country need help now more than ever as they face worse behavioral health outcomes and a range of losses: employment and health care coverage sponsored by employers, housing not otherwise protected through the eviction moratorium, and even life.

Community members are calling for new, effective and equitable approaches to community health and safety that identify and address their specific needs. They need support to address critical inequities and strengthen their communities as state and county officials are facing severe budget cuts due to the pandemic.

Taking an intentional approach to creating and advancing local crisis care systems can help mitigate these situations, as building local crisis systems has proved to be successful and cost-effective. Local communities that have set up such systems have seen positive outcomes, including improved access to treatment, fewer days spent in jail, and cost avoidance and savings for criminal justice agencies and health care payers. Yet they continue to lack dedicated, adequate, and flexible funding to support this work. States play a critical role in funding, scaling, and sustaining crisis systems. Policymakers can take action to better meet specific local needs and help communities achieve more positive outcomes; maximize existing investments; and reduce a harmful overreliance on police officers, hospitals, and jails.

Actions State Policymakers Can Take to Fund and Sustain Local Crisis Systems

1. Increase direct state funding through general funds and grants whenever possible.

2. Leverage Medicaid—a jointly administered federal-state program—to recoup federal matching funds to improve access to crisis-related services across the continuum of care.

3. Form partnerships and help secure financial participation from non-public sectors.

4. Incorporate provisions related to crisis systems in state policies related to increasing access to behavioral health care and other supports.

5. Consider new financing models for public funds that are performance or value based.

Critical Role of States in Building Local Crisis Systems

Communities around the country are working across sectors and systems to build local crisis systems. They are navigating the complex process of moving from providing stand-alone crisis services to creating comprehensive systems with an integrated continuum of care and supports.

As they implement comprehensive crisis systems, community members are considering what public safety and public health mean to them, including what roles law enforcement, health care entities, social services, community leaders and members, individuals and their families, peers, and others should play. Many communities (including the jurisdictions featured below) are seeing efficiencies—and even cost savings—across systems (e.g., health, criminal justice, housing), as well as other improved outcomes for the people they serve (e.g., health, safety, well-being).

States are key partners in funding local crisis systems, and policymakers can take a range of actions to help communities finance and sustain efforts to build and scale these systems. (See Actions State Policymakers Can Take below.) Without critical state leadership and support, communities will struggle to form their own local or regional crisis systems, particularly in rural or under-resourced areas. They will also continue to encounter gaps that hamper their ability to fully realize potential impacts. Communities need flexible funding to build and advance their crisis systems in equitable and strategic ways and are looking to state leaders for help.

A state's budget should reflect the needs, priorities, and values of the people in that state (i.e., it is a "moral document"). Continuing to underfund local crisis systems will harm communities, compromise the impact of existing crisis service investments, and exacerbate entrenched challenges and inequities that many communities face. This ultimately leads to an inefficient, and often inequitable, use of resources that harms people—especially BIPOC—without improving outcomes.

Figure 1: A Comprehensive Crisis Strategy[1]

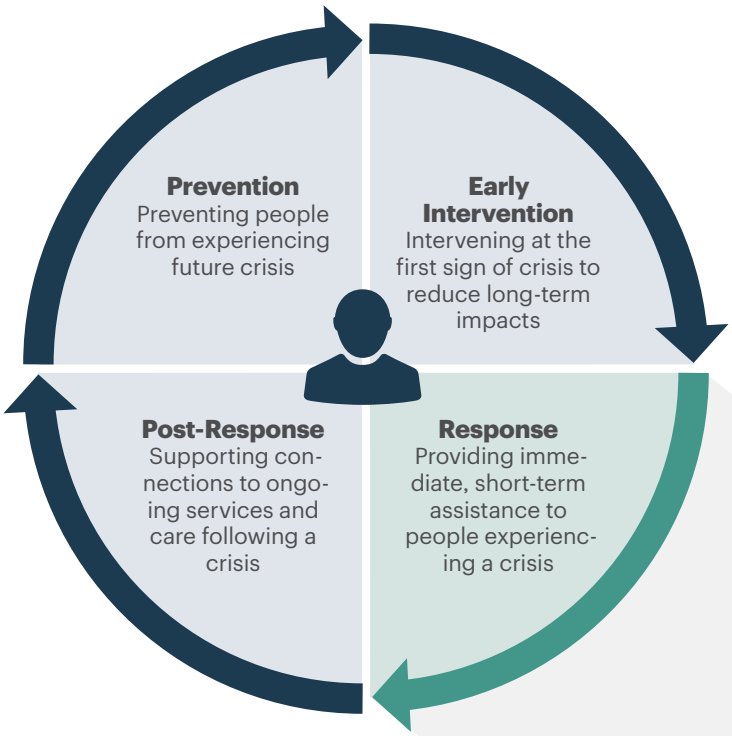
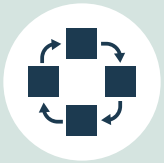


Figure 2: Essential Components of a Local Crisis Response System



Critical elements that must be incorporated throughout comprehensive crisis response systems:

- Person-centered and strengths-based
- Community response and peer supports
- Law enforcement collaboration
- Trauma-informed care and recovery

A high-tech 24/7 crisis call center that can connect people with services, provide on-the-spot telehealth support, and coordinate the crisis response network.

Reachable through:

- Dedicated crisis line (e.g., 988)
- Existing emergency line (e.g., 911) with dedicated response staff

Round-the-clock mobile crisis team responses that provide services to anyone, anywhere in the community.

May include community responders or co-responses with law enforcement.

Short-term crisis stabilization services that provide intensive treatment and supports in collaboration with emergency departments for people experiencing a behavioral health crisis.

This may include crisis stabilization units (CSUs), drop-off centers, or even in-home crisis stabilization.

Local Crisis Systems in Action

The two case examples that follow illustrate how local crisis systems achieve cost savings and positive outcomes for communities. The findings demonstrate outcomes of a particular crisis system component: crisis receiving and stabilizing services, specifically a crisis stabilization unit (CSU). CSUs give communities more options as they struggle to answer the common question posed about diversion: "divert to what?" Often, without this brick-and-mortar service, jurisdictions struggle to find options for diversion from arrest, jail, and court.

While the CSU impacts are examined independently in the following examples, it is important to note that these CSUs do not operate as discrete services within the highlighted jurisdictions but instead are part of a broader local crisis response. To create these systems, both jurisdictions in the following examples have engaged the wide range of stakeholders essential for success, including health care agencies and providers, health care payers, hospitals, social service agencies and providers, law enforcement agencies, school leadership, and others.[2] Through these strong collaboratives, both jurisdictions have conducted intentional strategic planning that has enabled them to transform a set of individual programs and services into a comprehensive system of crisis care. This intentionality and collaboration has led to multi-year plans, cross-payer collaboration, and the ability to collect and analyze integrated data to better understand their local behavioral health needs and the impact of the solutions implemented.[3] This approach has yielded positive outcomes in both jurisdictions for all critical stakeholders, including criminal justice agencies, health care payers, community members, and people living with mental health conditions. As illustrated below, these outcomes include improved access to treatment, fewer days spent in jail, and cost avoidance and savings for criminal justice agencies and health care payers.

Example 1: Bexar County, Texas

Focus: Impact of a crisis stabilization unit (CSU), a pre- and post-booking jail diversion strategy, on local criminal justice spending and health outcomes for people experiencing a mental health crisis

Bexar County offers CSUs and court-ordered treatment as options for people with serious mental health conditions to be diverted from jail. To understand the costs and effectiveness of these options in Bexar County, a cost-benefit analysis was conducted in 2008 by the Center for Health Care Services and RTI International. This analysis examined nearly 1,000 people across four cohorts: those offered pre- and post-booking jail diversion between 2003 and 2005 and two matched comparison groups.

Key Finding: When the county uses arrest, jail, and court processing to respond to a person experiencing a mental health crisis, taxpayer costs are significantly higher than when using a pre-booking CSU approach.

- Nearly $1.4 million in local spending on arrest, court, and jail services was avoided when 384 people were diverted to the CSU before booking. As demonstrated in Figure 3, this cost avoidance occurred within the first six months following the crisis event.[4]

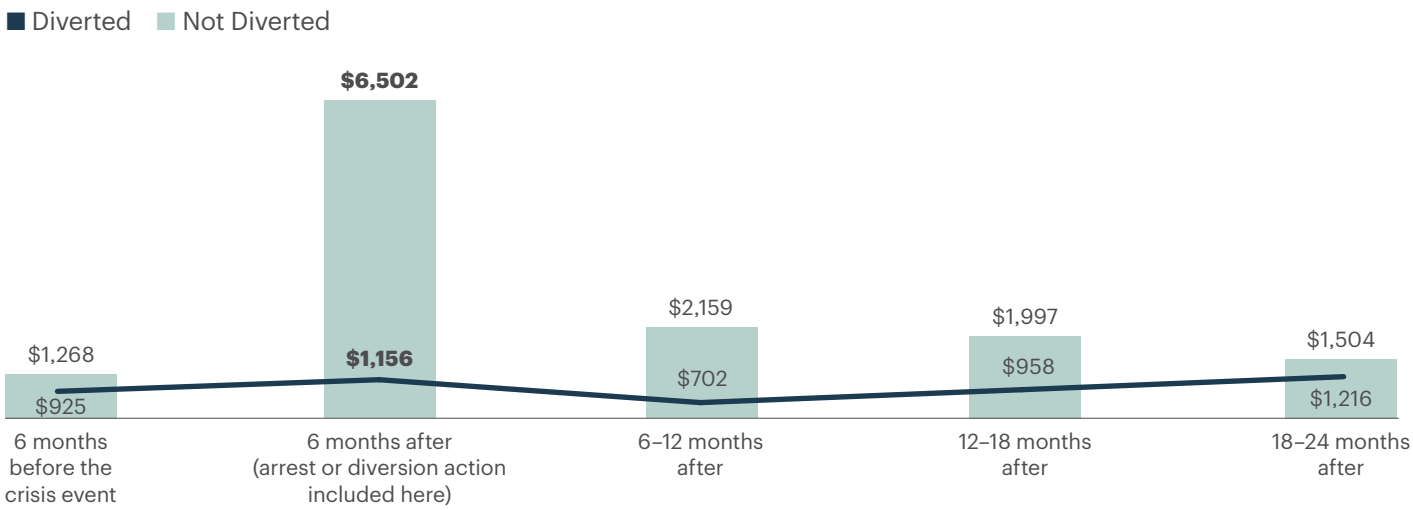
Key Finding: When people experience a crisis and are offered stabilization services instead of arrest, jail, and court services, they see better long-term mental health outcomes.

- The analysis found that when people were diverted either before or after jail booking, they were more likely to access mental health treatment, including counseling and medications, in the 12–24 months after the crisis event compared to people who were not diverted.[5]

Key Finding: When diversion options are offered—before or after booking—impacts system savings.

- While post-booking, court-ordered diversion ultimately saved criminal justice agencies $400,000, these savings were not realized until 18–24 months after the crisis event. This timing reflects the fact that it typically takes 12–18 months to complete court-ordered treatment services. As a result, associated criminal justice savings are smaller than the $1.4 million saved in pre-booking diversion, and these savings are also delayed.[6]
- Thus, pre-booking diversion saves more taxpayer money, specifically nearly $1 million more in criminal justice funds.[7] Further, pre-booking diversion connects people to the same treatment services as post-booking diversion options without the added 12–18 months of justice system involvement.

Figure 3. Comparison of Average Cost Per Person of Bexar County Pre-Booking Diversion Program and People Not Diverted, 2008



Example 2: Sebastian and Pulaski Counties, Arkansas

Focus: Impact of CSUs on health care and jail utilization for people with significant mental health needs and deep system involvement

As part of a statewide effort to provide alternatives to incarceration to people with serious and persistent mental illnesses, Arkansas implemented four regional CSUs beginning in 2018. To help inform the implementation of CSUs across the state, two counties, Sebastian and Pulaski, collected data from 2018 to 2019 on the characteristics and expenditures of the potential clients the CSUs would serve. The Arkansas Center for Health Improvement (ACHI) analyzed data on 921 and 1,464 people from the Sebastian and Pulaski county jails, respectively. The analysis described the jail involvement, health care utilization, diagnoses, and criminal justice and health costs for people with a history of three or more jail bookings during the year prior to the study. ACHI also analyzed data from Sebastian County on the impact of the CSU on people's health care utilization and jail involvement. Covering 2017–2019, this analysis was a pre- and post-assessment of 235 people who accessed the CSU and had health care coverage for 12 months.

Key Finding: People with a serious, persistent mental illness (SPMI) and deep system involvement—including at least two inpatient stays and three jail bookings—have higher treatment costs than their peers without SPMI.

- The median health care expenditures for people in Sebastian and Pulaski Counties who had SPMI and three or more bookings was $3,522—$2,808 more than for people who had three or more bookings but no SPMI.[8]

Key Finding: The CSU has a tangible impact on improving people's daily lives.

- Sebastian County observed a 12.5 percent reduction in the total number of days people experienced undesirable, disruptive events, such as jail stays or hospitalizations, in the six months after a CSU visit as compared to six months before a CSU visit.[9]
- Specifically, Sebastian County observed reductions in the total number of people booked into jail (5.3 percent), the total number of days people spent in jail (27.5 percent), the total number of bookings (12.2 percent), and the total number of inpatient hospital days (15.6 percent).[10]

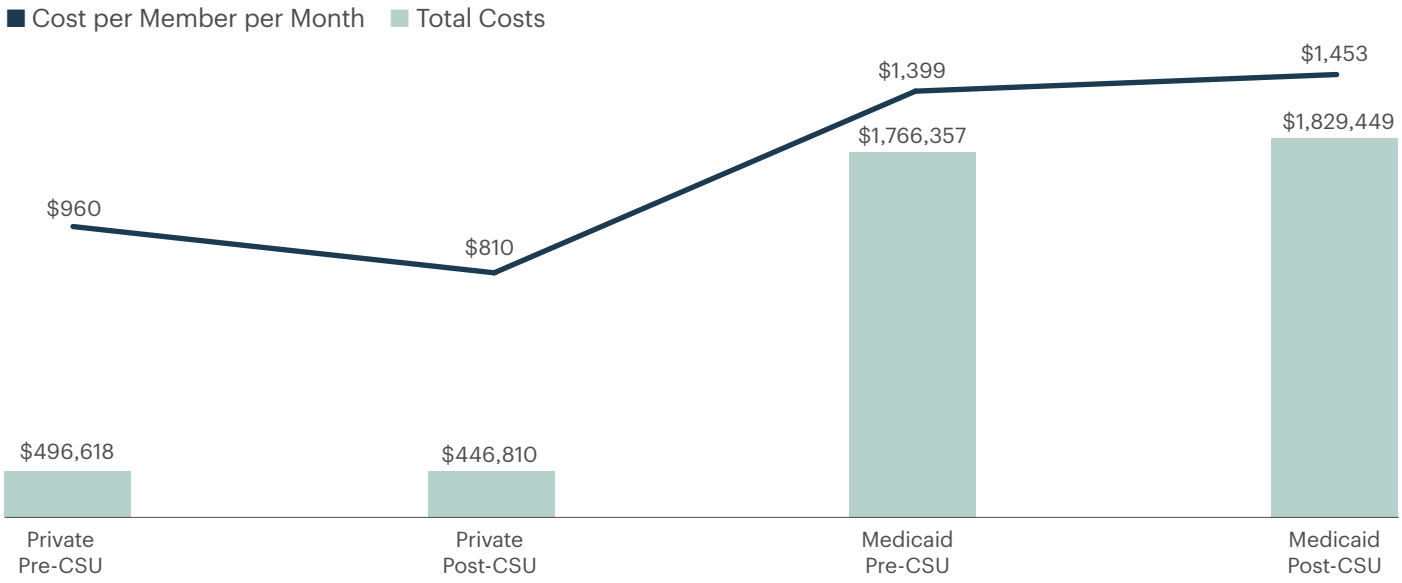
Key Finding: The CSU helps connect people to appropriate, continuous care.

- In Sebastian County, there was an 11.4 percent increase in total prescription utilization and a 6 percent increase in the total number of people who incurred health care costs after a CSU visit, meaning more people were accessing treatment.[11]

Key Finding: The CSU produces cost savings for private health care payers, demonstrating the potential for additional, long-term health care savings.

- For people served by the CSU in Sebastian County, total costs for private health care payers decreased 10 percent, and the cost per member per month went down 15.7 percent. Medicaid costs increased no more than 4 percent in these categories.[12] This demonstrates that there were no large cost shifts to health care payers when people with SPMI were diverted to a CSU as an alternative to jail. Figure 4 illustrates the impacts of the CSU on private and Medicaid costs, both total costs and monthly cost per member.
- While Medicaid costs increased slightly, this could be because Medicaid patients often have greater needs and less access to care than non-Medicaid patients, which results in their receiving care in relatively expensive settings.

Figure 4. Insurance Cost Per Member Per Month and Total Cost for Pre-CSU and Post-CSU Period, Mar, 2018–Oct. 2019



Actions State Policymakers Can Take to Fund and Sustain Local Crisis Systems

As communities work to set up local crisis systems, they often face funding gaps, which force them to braid a range of inconsistent and restricted funding sources to support services. States can help address these gaps by providing consistent and flexible funding that can be used to support local crisis systems.

As policymakers at all levels navigate budget pressures and cuts, particularly in the short term due to the pandemic, they should assess current levels of support for local crisis systems and take action in any form to make new investments or at least safeguard existing ones. Armed with an understanding of the benefits of increased investment, state policymakers can take the following actions to help fund, scale, and sustain local crisis systems.

1. Increase direct state funding through general funds and grants whenever possible.

Assess current level of public funding that is available to support local crisis systems, for whom, and under what circumstances (see box on the following page).

Provide dedicated financial support for communities to build intentional partnerships to effectively and productively plan and implement the crisis system components.

- *Example:* Arkansas passed Justice Reinvestment legislation in 2017 (Act 423, the Criminal Justice Efficiency and Safety Act) that required and funded CSUs and crisis intervention team (CIT) training for law enforcement officers. Since enactment, $6.4 million in state funding has been allocated for CIT training and regional CSUs, and four CSUs serving 28 counties are now operational.
- *Example:* In Colorado, 2019 legislation (SB 8) authorized the development and implementation of five new co-responder programs throughout the state with an allocation of $1.4 million per year.

Review and streamline data collection and reporting requirements across state funding sources to alleviate the administrative burdens that communities must navigate as they blend multiple resources to make up for a lack of consistent funding.

Leverage federal grants, including set-asides under block grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), and leverage flexibility built into those awards and others administered by states, such as the U.S. Department of Justice's Byrne Jag awards.[13]

2. Leverage Medicaid—a jointly administered federal-state program—to recoup federal matching funds to improve access to crisis-related services across the continuum of care.[14]

Consider amending the state's Medicaid plan to increase coverage for allowable crisis-related services, such as peer services.[15] The 2021 American Rescue Plan (ARP) authorized an 85 percent enhanced federal match that will be available in 2022 for 3 years for states that cover "community-based mobile crisis intervention services" through their Medicaid programs (authorized until 2025).[16] The ARP Act also directs the U.S. Department of Health and Human Services (HHS) to disburse up to $15 million in planning grants to help states plan for and submit state plan amendments or applications to pursue waiver authorities (see next bullet) to expand coverage of these services.[17]

Pursue Section 1115 demonstration and other waiver authorities, including those that allow payment of mental health service delivery in inpatient settings known as "institutions of mental diseases" (IMDs).

Common Sources of Funding for Local Crisis Systems

It's helpful to first gain an understanding of a state's current funding landscape and to what extent it's directly funding local crisis systems or helping communities secure funding from other non-public sources. A recent Milbank Fund report provides an overview of how states have funded local crisis systems. Findings include:[18]

- **State government** grants and contracts provide an estimated 60 to 70 percent of all funding. Private sector contributions account for 15 to 30 percent.
- All states fund some portion of crisis systems through **Medicaid**, a program jointly administered at federal and state levels.
- Programs are funded by **(SAMHSA)** block grants (including a new provision for a required 5 percent crisis services set-aside starting in 2021) and other contracts.
- Crisis programs also receive federal support through the **Veterans Administration** and the **Health Resources and Services Administration**'s funding for community health centers.

The authors of this brief found that states and communities have also leveraged other funding not specified above, including sources administered by the Department of Justice, such as the Edward Byrne Memorial Justice Assistance Grant Program, or through specific grant programs, such as the Bureau of Justice Assistance's Justice and Mental Health Collaboration Program. At the time of publication, states are looking to navigate new opportunities to support communities—many described above—authorized in March 2021 under ARP that will continue to roll out over the course of the next eight years, including additional funding for community mental health centers, rural health care, and the Indian Health Service.

Recoup federal match for allowable administrative costs for crisis call centers, including technologies to link them to mobile crisis.[19]

Consider other demonstration opportunities, including the Certified Community Behavioral Health Clinic (CCBHC) demonstration that requires the availability of 24-hour crisis care, among other related services.[20]

Consider what role managed care can play in local crisis systems and what provisions can be included as part of future state contracts. For example, the Centers for Medicare and Medicaid Services (CMS) has issued regulations that allow for plans to cover services provided to members during short-term stays in IMDs.[21] Most recently, CMS issued guidance on managed care's role in value-based care opportunities under Medicaid (see action 5 below).[22]

3. Form partnerships and help secure financial participation from non-public sectors.

Directly broker or help communities form partnerships with private sector entities that have a stake in crisis-related services work and their own funding sources (e.g., private hospitals, health plans). For example, states can help communities engage private insurance companies from the outset, as they have a financial stake and their participation can offset Medicaid reimbursement rates, which are often lower than private health insurance payers.

Engage private philanthropic organizations—particularly those whose missions align with seeding innovation—to help local communities secure an initial investment to stand up crisis services and programs. The state can demonstrate its stake in the issue by providing funding to sustain and even scale up these services and programs if certain outcomes are met.

- *Example:* Utah passed two bills in 2019 (HB 32 and HB 35) to establish crisis centers, mobile outreach teams in rural areas, and additional state treatment beds. In doing so, the state built upon $150 million pledged by the Huntsman Foundation for public mental health.[23]

4. Incorporate provisions related to crisis systems in state policies related to increasing access to behavioral health care and other supports.

Include specific references to crisis systems and services as part of efforts to enforce "parity" across all health insurers and plans, ideally leading to universally accepted and used coding for crisis system services.[24] Parity refers to ensuring that limitations placed on mental health services by insurers are no more restrictive than those placed on physical health services.

- *Example:* Minnesota passed legislation (SF 1458) allocating $8 million to create a statewide crisis line, expand mobile crisis services, fund crisis beds, and develop state standards. The provision also requires private health plans to cover mental health crisis services under the emergency services category.[25]

Develop a strategy for statewide implementation of the national 988 suicide prevention hotline pursuant to the National Suicide Hotline Designation Act of 2020. The act required the Federal Communications Commission to pass rules requiring all telephone service providers to direct calls placed to "988" to the existing National Suicide Prevention Lifeline by July 2022.[26] The strategy should include a plan for (1) creating and sustaining the necessary infrastructure (e.g., passing legislation to levy telecommunications fees, common for 911 services, as authorized by the Federal Communications Commission) and (2) coordinating or integrating with existing hotlines, including 911.

- *Examples:* Colorado passed legislation (SB 154) to create the state's 988 Crisis Hotline Center and to initiate statewide implementation. The legislation includes provisions to impose a 988 "surcharge" that will then be reinvested in direct and indirect costs associated with the state's 988 Crisis Hotline Center.[27]

5. Consider new financing models for public funds that are performance or value based.

Tie funding to specific incentives and benchmarks.[28]

Explore different reinvestment-oriented or performance-based models to finance social services, such as private-public investment models like Pay for Success.

Other Ways States Can Support Local Crisis Systems

While not an exhaustive list, there are other, non-financial ways states can support communities to build and sustain comprehensive local crisis systems, including:

Establish oversight and accountability structures for crisis systems at the state level and provide direction and support to establish similar structures at local levels.

- *Example:* In 2020, Mississippi legislation (SB 2610) created a "Coordinator of Mental Health Accessibility" position, and the Department of Finance and Administration was charged with assessing the adequacy of the state's services.[29]

Determine how crisis systems are currently functioning in the state and what their impact is in terms of costs and outcomes.

- *Example:* Through a public-private partnership, Connecticut conducts quarterly and annual performance reports and has evaluated the impact of the state's youth mobile crisis intervention on youth and families. These reports capture the data needed to understand what is working and also create the opportunity to reflect and set new goals for the year ahead. For example, for 2021, Connecticut set 14 goals across 4 areas: quality improvement, standardized training, enhancing the intervention, and supporting implementation of new components.[30]

Provide support for infrastructure and capacity to help communities collect, analyze, and share data and other information across sectors for making decisions and tracking progress.

- **Help communities gather and use the data** needed to make the case for local crisis systems and engage new partners (e.g., hospital systems, health care payers, law enforcement). Additionally, having data capacity can facilitate care coordination, regular reporting, and ongoing progress tracking to make course corrections and support sustainability over time.
- **Provide suggested performance and outcome metrics** encompassing health, criminal justice, housing, and others (e.g., referral type, demographics, economic indicators, insurance status, time to response, clinical outcomes, follow-up indicators, and cross-system involvement).
- **Offer sample materials** and templates (e.g., memoranda of understanding, data use agreements, model forms).

Other ways that states can help include refining statutory and administrative policies with adoption support to facilitate crisis response;[31] providing education and outreach to build community awareness and training on how to help people access crisis services; and providing direct assistance and guidance to communities.

Endnotes

1. Adapted from The Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, (Rockville, MD: U.S. Department of Health and Human Services, 2020) and Crisis Now, "Four Core Elements for Transforming Crisis Services," the National Association of State Mental Health Program Directors, accessed April 1, 2021, https://crisisnow.com/.

2. Methodist Healthcare Ministries of South Texas, Inc. and Meadows Mental Health Policy Institute, *Bexar County Mental Health Systems Assessment* (San Antonio: Methodist Healthcare Ministries of South Texas, Inc. and Meadows Mental Health Policy Institute, 2016).

3. Kayla Theriault et al., *Mobile Crisis Intervention Services Performance Improvement Center Annual Report FY2020* (Farmington, CT: Child Health and Development Institute of Connecticut, Inc., 2020).

4. Alexander Cowell et al., *A Cost Analysis of the Bexar County, Texas, Jail Diversion Program. Report 2: An Analysis of Cost-Shifting between the Treatment and Criminal Justice Systems* (Research Triangle Park, NC: RTI International, 2008).

5. Ibid.

6. Ibid.

7. Ibid.

8. Arkansas Center for Health Improvement (ACHI), *Healthcare Utilization, Diagnoses, and Expenditure Profile Of Sebastian and Pulaski County Jail Detainees*, (Little Rock, AR: ACHI, 2019).

9. Arkansas Center for Health Improvement (ACHI), *Healthcare Utilization, Diagnoses, and Expenditure Profile Of Sebastian and Pulaski County Jail Detainees*, (Little Rock, AR: ACHI, 2020).

10. Ibid.

11. Ibid.

12. Ibid.

13. The 2021 American Rescue Plan (ARP) authorized increases to both SAMHSA's block grants for community mental health services and for prevention and treatment of substance use disorders. See Sections 2701 and 2702, H.R. 1319, 117th Congress (2021).

14. Note that while Medicaid serves as a foundation for financing— especially for services—it is not a panacea and states should be mindful of the "strings" that are attached (e.g., federal- and state-level program requirements, such as policies on allowable uses, reporting, rate structures). Other funding streams allow for flexibility needed to be a responsive system.

15. Centers for Medicare and Medicaid Services, Dear State Medicaid Director letter on Peer Supports- SMD #07-011 (Washington, DC: The U.S. Department of Health and Human Services, 2007)

16. H.R. 1319, 117th Congress (2021), Sec. 1947 (c).

17. H.R. 1319, 117th Congress (2021), Sec. 1947 (e). A state can submit different types of waivers to CMS to request their approval for the state to be exempt from certain provisions of federal Medicaid laws and regulations. IMDs are typically psychiatric hospitals or other residential treatment facilities that have more than 16 beds. Medicaid prohibits coverage of care in IMDs—a policy known as the "inmate exclusion." This policy can impact local crisis systems, as the lack of federal payment under Medicaid for services in IMDs leads to a lack of inpatient psychiatric beds, which often results in people who need residential care being released from emergency departments. For more information on the 1115 waiver opportunity to increase coverage of services for people with SMI in IMDs, see: Centers for Medicare and Medicaid Services, *State Medicaid Director Letter on Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance-SMD #18-011* (Washington, DC: The U.S. Department of Health and Human Services, 2007).

18. Stuart Yael Gordon, *Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention* (New York: Milbank Memorial Fund, 2020). Findings are based on 2014 data from the following report: *Substance Abuse and Mental Health Services Administration, Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (Washington, DC: The U.S. Department of Health and Human Services, 2014), https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848.

19. Ibid.

20. CCBHCs under the demonstration are required to provide "crisis-related mental health services, including 24-hour mobile crisis response, emergency crisis intervention services, and crisis stabilization." A 2018 report to Congress found that just over half (51 percent) of the 66 CCBHCs across 7 states reportedly added crisis behavioral health systems. See: Office of the Assistant Secretary for Planning and Evaluation and Office of Disability, Aging, and Long-Term Care Policy, *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018* (Washington, DC: The U.S. Department of Health and Human Services, 2019). ARP authorized $420 million for communities to receive grants through SAMHSA to expand CCBHCs. H.R. 1319, 117th Congress (2021), Sec. 2713.

21. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Federal Register 27497 (final rule May 6, 2016).

22. Centers for Medicare and Medicaid Services, *Dear State Medicaid Director letter on Value-Based Care Opportunities in Medicaid- SMD #20-04* (Washington, DC: The U.S. Department of Health and Human Services, 2020).

23. H.B. 32, 63rd Gen. Assemb., Reg. Sess. (Utah, 2020); H.B. 35, 63rd Gen. Assemb., Reg. Sess. (Utah, 2020); Katie McKellar, "Utah Bill Seeking $21 Million to Build New Mental Health 'Crisis Centers' Advances, Deseret News, February 14, 2020, accessed March 1, 2021, https://www.deseret.com/utah/2020/2/14/21137047/mental-health-crisis-suicide-prevention-legislation.

24. For more information, see: "Mental Health Benefits: State Laws Mandating or Regulating," The National Conference of State Legislatures, accessed March 1, 2021, https://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx.

25. S.F. 1458, 89th Gen. Assemb., Reg. Sess. (Minn. 2015).

26. "New National Suicide Hotline," The National Conference of State Legislatures, accessed April 1, 2021, https://www.ncsl.org/blog/2020/11/09/new-national-suicide-hotline.aspx. "Implementation of the National Suicide Hotline Improvement Act of 2018," 85, Federal Register 57767 (16 September 2020, 57767–57783).

27. S.B. 154, 72nd Gen. Assemb., Reg. Sess. (Col. 2021).

28. For more information ona performance-based, public-private financing model, Pay For Success, and how it has been applied to criminal justice contexts: see Dave McClure et al., *Pay for Success and the Crisis Intervention Team Model*, (Washington, DC: Urban Institute, 2017) and Rayanne Hawkins et al., Using Pay for Success in Criminal Justice Projects, (Washington, DC: Urban Institute, 2017).

29. S.B. 2610, Reg Sess. (Miss. 2020).

30. Kayla Theriault et al., *Mobile Crisis Intervention Services Performance Improvement Center Annual Report FY2020*.

31. For example, clarifying law enforcement's authority to issue citations and working with leadership to support local adoption; authorizing transport to non-emergency settings, including CSUs; and aligning with administrative policies and reimbursement structures. See the following report for more information and state examples: Lars Trautman and Johnathan Haggerty, *Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response* (Washington, DC: R Street, 2019).

Justice Center
THE COUNCIL OF STATE GOVERNMENTS

This project was supported by Grant No. 2019-MO-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.