THINK **BIGGER** DO **GOOD**
POLICY SERIES

Building the Behavioral Health Crisis Response Workforce

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Dear Reader,

Now is the time to address the growing behavioral health needs across our country by advancing public policies that transform how mental health and substance use disorder services are delivered—and by modernizing outdated funding systems that stand in the way of progress.

This paper is part of *Think Bigger Do Good*, a series launched in 2017 through the leadership and support of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the topics have evolved over time, our mission remains constant: to shape a forward-thinking policy agenda that improves health outcomes for all.

In collaboration with national behavioral health experts—including our editors, Howard Goldman and Constance Gartner—we have identified several critical topics for this series of papers. Each paper defines the problem and offers clear, actionable solutions for policymakers, practitioners, and advocates alike.

We invite you to join us in championing stronger behavioral health policies. Please share this paper with your colleagues, community partners, policymakers at all levels, advocacy organizations, and voters. To explore the full *Think Bigger Do Good* series, visit **www.thinkbiggerdogood.org**.

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Building the Behavioral Health Crisis Response Workforce

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1 Introduction

Efforts are under way at the federal, state, and local levels to expand behavioral health crisis services and reduce the role of law enforcement in crisis response. These initiatives are unfolding along two parallel pathways: one focused on scaling up traditional mobile crisis teams that are embedded within behavioral health systems and accessed via 988 or agency crisis hotlines, and the other focused on developing civilian teams that are housed in governmental or community agencies and are dispatched in response to 911 calls. These pathways reflect overlapping approaches to ensuring that people experiencing a behavioral health crisis receive the most appropriate and least restrictive support possible.

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The success of these efforts depends on a workforce with the capacity and skills to take on this role. However, behavioral health clinicians may not have received crisis response training in their academic programs. Furthermore, they may not be interested in work that requires overnight and weekend shifts (1) or feel safe responding in community-based crisis settings without law enforcement (2). Behavioral health workforce shortages further compound this issue. Ensuring a skilled workforce to staff these teams requires structuring community behavioral health crisis response as a distinct profession with its own values, competencies, and skills; training standards; credentialing processes; and sustainable funding mechanisms. In this article, we provide an overview of the issue, propose a strategy to build a sustainable crisis response workforce, and offer policy recommendations.

2 Overreliance on Law Enforcement for Crisis Response

Reliance on law enforcement to respond to mental health crises can result in a variety of negative consequences. Research indicates that people with mental illness are at elevated risk for experiencing police use of force and related injury (3). People displaying signs of mental illness are overrepresented among those killed in interactions with police, and among those killed, individuals with mental illness are more likely to be killed in their homes (4). The intersection of race and mental illness is particularly deadly for specific populations. Black people are more than twice as likely to be killed by police compared with White people, and Black people with mental illness are more than four times as likely to be killed by police compared with Black people without mental illness (4).

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People with mental illness and their family members report that police involvement in mental health crisis response is stigmatizing and traumatic.

Reliance on law enforcement for crisis response can result in missed chances to support people without resorting to the use of hospitals or jails. It can lead to unnecessary emergency department transport as well as arrest and entanglement in the criminal legal system (5). People with mental illness and their family members report that police involvement in mental health crisis response is stigmatizing and traumatic (6–8). They report feeling extremely vulnerable and fear being hurt, killed, or arrested (7, 8). Furthermore, a growing body of research suggests that police contact itself can have negative mental health effects and increase the risk for psychotic experiences, suicidal ideation, and suicide attempts, particularly for members of the BIPOC (Black, Indigenous, and people of color) and LGBTQ communities (9, 10).

Reliance on police for crisis response may also violate federal laws. During the Biden Administration, the Civil Rights Division of the U.S. Department of Justice identified the reliance on police officers as sole responders to people experiencing behavioral health crises as a potential violation of the Americans With Disabilities Act (ADA) (11). In guidance co-issued with the U.S. Department of Health and Human Services, the Division made clear that mobile crisis teams should respond in "circumstances when a call involves a person with a behavioral health disability and there is no need for a law enforcement response" (11). The guidance also defined behavioral health crisis response as a parity issue, meaning that behavioral health emergencies should receive the same level of care as general medical emergencies.

3 Efforts to Shift Responsibility for Crisis Response

Recently, significant federal, state, and local initiatives have focused on building crisis response systems and on shifting responsibility for crisis response away from law enforcement. At the federal level, this effort has included the National Suicide Hotline Designation Act of 2020 (12), which was signed into law with bipartisan support during the first Trump Administration to create the 988 Suicide and Crisis Lifeline that launched in July 2022, as well as the option for states to assess a 988 telecommunications surcharge to support crisis services. The American Rescue Plan Act of 2021 (ARPA) (13) and the 2022 Bipartisan Safer Communities Act (14) provided increased funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) mental health block grant program. In addition, the Consolidated Appropriations Act (2021) created a requirement for states to allocate at least 5% of their mental health block grants to crisis services; that requirement was made permanent in 2023. ARPA also introduced financial incentives to expand crisis services by creating a temporary, enhanced 85% Medicaid match for mobile crisis services meeting specific criteria. Furthermore, the Bipartisan Safer Communities Act authorized expansion of Section 223 of the certified community behavioral health clinic (CCBHC) Medicaid demonstration. CCBHCs are required to provide or contract for mobile crisis response teams and other crisis services.

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Although the current administration has outlined more punitive strategies for addressing the behavioral health needs of people who are unhoused (15) and SAMHSA has indicated it will emphasize strong partnerships between law enforcement and crisis care systems (16), the federal actions of prior administrations have set the stage for state and local efforts to create new pathways to expand mobile crisis response. As of June 2025, 12 states have enacted 988 surcharges to support the crisis response system (17). Furthermore, 20 states and the District of Columbia have received approval from the Centers for Medicare and Medicaid Services to use the enhanced 85% Medicaid match authorized by ARPA. Two states, Virginia (18) and Illinois (19), have passed legislation requiring the transfer of some behavioral health–related 911 calls to 988. Several states have also amended their Medicaid state plans to make behavioral health crisis transportation a billable service, which may reduce reliance on law enforcement when transport is needed. Aside from Medicaid state plan amendments, several states have used policy actions to enhance non–law enforcement crisis transportation (20).

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At the local level, cities are creating unarmed alternative response teams that are dispatched directly from 911 calls (e.g., Denver's Support Team Assisted Response [21]). These teams respond to mental health crises as well as a broader set of situations related to social vulnerability (e.g., being unhoused). Although some of these teams bill Medicaid, they are typically funded via local taxes, municipal public safety budgets, and state and federal grants (22). The Policing Project estimates that 130 alternative response programs exist across the United States (23).

4 Workforce Issues Impede Shifting Crisis Response

Despite these investments, behavioral health workforce shortages continue to present a challenge to shifting crisis response away from law enforcement, with 34 states reporting deficits in mobile crisis team staffing, particularly social workers and other licensed providers, peers, and bilingual staff (24, 25). Furthermore, behavioral health professionals do not typically receive training in crisis response in their academic programs. Those trained for office-based therapeutic work may feel ill prepared to respond in community-based crisis settings and unsafe doing so without law enforcement. Despite the mismatch of skills, the field has relied on professionals with traditional training and has overlooked a more diverse group of potential responders who may be well suited for crisis roles but lack the resources to pursue graduate education. This obstacle makes recruiting and retaining adequate numbers of crisis responders difficult and may affect the quality and availability of care.

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Existing mobile crisis programs are trying to meet their current workforce needs in the context of limited available guidance. SAMHSA's 2025 guidelines state that "With training requirements and access to 24/7/365 supervision, consultation, and onsite or virtual support by master's-level clinical staff, a variety of backgrounds and degrees can support the services provided by [a mobile crisis team], including master's- and bachelor's-level social workers, peer support workers, certified youth and family peers, and non-degreed trained crisis workers (26)."

However, no established competencies or training standards are available to mobile crisis workers. SAMHSA has provided recommendations for training content in a draft mobile crisis team toolkit, and several states have developed training materials for bachelor's- and master's-level mobile crisis team staff; in most cases, however, agencies must support skill development without external guidance. The same is generally true for alternative response teams, which may include a broader set of professionals and be less focused on clinical credentials, instead prioritizing lived experience (broadly defined). Many alternative response programs develop training in-house that may be ≥6 weeks long, which can be burdensome for smaller programs that hire only a few responders at a time.

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A strategy is needed to rapidly scale up a diverse workforce with the competencies and practical skills needed for behavioral health crisis response. In the sections that follow, we offer a strategy to develop—and discuss the need to ensure sustainable funding—for crisis services. General policy recommendations are provided, each supplemented with either concrete strategies or illustrative examples that could be adapted by other jurisdictions or extended to crisis response.

5 A New Crisis Response Workforce

Skills, Training, and Credentials

Addressing the gap in crisis response requires more than increasing the number of workers in existing professional roles. A new professional role is needed that is rooted in unique competencies rather than attached to existing advanced academic credentials (2). The community behavioral health crisis responder (CBHCR) is a newly envisioned professional role created to meet demand for professionals who are capable of intervening in behavioral health crises and situations where complex social needs may otherwise lead to criminal legal involvement (27). With funding from the National Alliance on Mental Illness, we have developed foundational values, competencies, and skills for CBHCRs. This work, described in detail elsewhere, has involved convening a diverse advisory board, reviewing existing literature, and conducting key informant interviews and focus groups with content experts, frontline responders, people with lived experience, and family members (27).

A new professional role is needed that is rooted in unique competencies rather than attached to existing advanced academic credentials.

Efforts are under way to develop a training and credentialing process for CBHCRs that is rooted in the identified values and designed to ensure that responders have the competencies and skills needed for effective crisis response. Although the credential will be open to anyone interested in pursuing crisis response work, it is designed to support workforce entry for people without college degrees or with only associate or bachelor's degrees and for those with firsthand experience with behavioral health treatment, housing instability, incarceration, child welfare, and other institutional systems. Future development of advanced CBHCR credentials will create opportunities for career advancement and help the field retain professionals who are committed to crisis response work.

Policy Recommendations for a New Workforce

Invest in workforce development.

Federal and state legislators must protect existing mechanisms that support behavioral health workforce expansion and encourage federal, state, and local agencies to invest in crisis response workforce development. This investment should include provision of training grants. The Health Resources and Services Administration's (HRSA's) Behavioral Health Workforce Education and Training program provides grants to educational and community organizations in order to support training of behavioral health professionals (28) and paraprofessionals (29). Crisis services constitute a high-need area that could benefit from HRSA investment. More locally, state and county behavioral health workforce initiatives could support crisis workforce training.

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Investment is also needed to create registered apprenticeships. State and local workforce initiatives should develop apprenticeships for crisis responders, registered by the U.S. Department of Labor. Although no registered apprenticeship for crisis responders is currently offered, such apprentice-ships have been developed for several other behavioral health roles. For example, Washington State has established registered apprenticeship pathways for roles such as behavioral health technician, peer counselor, and substance use disorder professional (30).

Establish a CBHCR credential.

State mental health agencies as well as independent state and national credentialing agencies should establish and manage a CBHCR credential. Some states are already developing their own certifications. For example, the Utah Office of Substance Use and Mental Health has established a crisis worker certification and training program that is required for staff who work in crisis services (31). The training program consists of 37 hours of virtual and in-person modules as well as training completed at the agency.

In addition, credentialing boards, such as the International Certification and Reciprocity Consortium and its state-level member agencies, set minimum standards for credentials and develop examinations for professionals with specialties such as prevention, substance use disorder, and recovery (https://internationalcredentialing.org). Such agencies are well positioned to develop behavioral health crisis credentials.

Strengthen the role of community colleges in crisis response workforce development.
Community colleges are well positioned to prepare trainees for credentialing and serve as a pipeline for the local crisis response workforce. They are accessible to the public and have infrastructure for workforce development and apprenticeship programs.

Moreover, a state behavioral health certificate may be a useful tool for workforce development. As one example, Southern Maine Community College offers a 1-year behavioral health certificate that is aligned with state requirements for certification as a mental health rehabilitation technician/community, which is required for work as an entry-level mental health practitioner (32). A similar program could be developed to prepare crisis response workers.

Moreover, a state behavioral health certificate may be a useful tool for workforce development.

Establish centers of excellence (CoEs).
Federal and state agencies should establish regional CoEs to support standards, training, and technical assistance focused on crisis response workforce development. CoEs could be housed at community colleges, universities, or other organizations.

Existing federal mechanisms include SAMHSA funding for training and technical assistance centers and for CoEs focused on topics across the behavioral health spectrum (33). HRSA has funded CoEs aimed at supporting underrepresented students and faculty in health professional education programs (34). Similar mechanisms could be harnessed to fund CoEs focused on the behavioral health crisis workforce.

States have also invested in workforce CoEs. For example, the New York State Office of Mental Health has partnered with the New York University McSilver Institute for Poverty Policy and Research to launch the Center for Workforce Excellence in evidence-based practices (35). The Illinois Behavioral Health Workforce Center (https://illinoisbhwc.org) was established by legislation in 2021 and is housed at the Southern Illinois University School of Medicine and University of Illinois Chicago.

5 Ensuring Adequate and Sustainable Funding

A livable wage requires adequate and sustainable funding.

Available Funding Strategies

Although our proposed credentialing approach would expand the pool of people who are eligible to enter the crisis response workforce and allow for more efficient use of licensed clinicians, attracting and retaining staff will require a livable wage commensurate with the difficulty and importance of the work performed. A livable wage requires adequate and sustainable funding. ARPA funding, which supports the enhanced Medicaid match for qualifying mobile crisis teams, will expire at the end of 2026. Furthermore, alternative response programs funded via ARPA or grants are also vulnerable. Thus, states and communities must pursue strategies to ensure adequate funding. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act of 2010 established a mandate for equitable insurance coverage for mental health emergencies, thus providing leverage for funding of mobile crisis response programs. Although enforcement of parity regulations was placed on hold at the federal level in May 2025, states may still determine their own enforcement strategies (36). Likewise, although the Department of Justice has stepped back from pursuing civil rights litigation focused on the overreliance on law enforcement as an ADA violation (37), state attorneys general can play a role in enforcing civil rights laws (38).

Other strategies include state and local mental health tax levies and dedicated funding lines in state and municipal budgets. Although these steps are likely to encounter resistance, communities may also consider shifting some funds from law enforcement budgets to alternative response programs. Of note, some law enforcement agencies are choosing to no longer respond to behavioral health crisis calls for service unless a crime has been committed (39). In those communities, an argument could be made to shift funds to the services that do respond to these calls.

Policy Recommendations for Adequate and Sustainable Funding

Consider crisis response as a first response.
States and localities should establish community behavioral health crisis response as a core public first-response service similar to police, fire, and emergency medical services. This approach would position crisis response as an independent line item in municipal budgets, increasing the likelihood of adequate and sustainable funding. New Orleans, for example, has recognized its alternative response team, the Mobile Crisis Intervention Unit, as the fourth branch of the city's 911 emergency response system. States have also introduced legislation to extend first responder benefits and protections to behavioral health crisis responders. For example, Illinois proposed to extend first responder disability and death benefits to mental health professionals who respond to mental health emergencies with or without law enforcement (40), although the bill did not become law. Similar legislation that extends first responder status to mental health professionals working with law enforcement as co-responders was recently passed in Washington State (41). The legislation extends privileged communication protections related to peer support services provided by first responders to other first responders and some workers' compensation protections.

Pursue sustainable funding.
States and communities should pursue sustainable funding through varied mechanisms of payment for crisis response. These mechanisms may include harnessing Medicaid, taxes and levies, grant opportunities, and mental health parity.

States and communities should pursue sustainable funding through varied mechanisms of payment for crisis response.

States should submit Medicaid state plan amendments to expand the types of providers eligible for reimbursement for mobile crisis services (including CBHCRs). States such as Michigan and Washington have obtained approval for Medicaid state plan amendments that allow for billable bachelor's-level crisis workers. Twenty-one states have received approval to designate certified peer specialists and recovery support specialists as billable (42). Similar amendments could be submitted to add credentialed crisis responders.

States and localities should consider taxes and levies to fund mobile crisis teams and alternative response programs. Examples include Illinois's use of cannabis tax revenue to support expansion of mobile crisis teams (43) and Olympia, Washington's use of a 2017 public safety levy to fund its alternative response program, Crisis Response Unit (44).

In addition, policy makers should support legislation such as House of Representatives Bill 3658 (45), which would provide federal grants to states and territories to establish unarmed mobile crisis response programs. In the absence of federal enforcement of the MHPAEA, states should take steps to enforce mental health parity.

Pursue violations of state civil rights and disability law.
Although the current federal administration is pulling back from pursuing ADA violations (37), state attorneys general should pursue cases related to discriminatory crisis response practices that subject people with psychiatric disabilities to unnecessarily coercive or police-led interventions.

6 Conclusion

In the past 5 years, progress has been made in the development of behavioral health crisis services and in shifting crisis response away from law enforcement toward unarmed behavioral health and civilian responders. Despite pending Medicaid cuts and uncertainty at the federal level, as well as a shift toward greater law enforcement involvement and more punitive actions to address mental and behavioral health crises, opportunities to build mobile crisis and alternative response programs are available at the state and local levels. This effort requires being strategic about workforce development and sustainable funding. The creation and scaling up of a credentialed CBHCR professional role is one approach to expanding the workforce while ensuring that crisis responders have the required competencies and skills to best meet the needs of the individuals they serve. States and local communities, in addition to federal agencies, can take steps to sustainably expand the workforce. These steps may include investing in crisis response workforce development and training, supporting the development of a CBHCR credential, partnering with community colleges to expand the workforce pipeline, and establishing regional CoEs for training. This effort also includes concrete strategies to ensure adequate and sustainable funding for this new workforce. By elucidating what is needed for a distinct community behavioral health responder workforce and by creating viable pathways for entry, the field can make progress toward the goal of reducing the role of law enforcement and ensuring that people in crisis receive the most appropriate care.

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