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National Survey of Mobile Crisis Programs

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INTRODUCTION

Mobile crisis programs are a critical element of a comprehensive, coordinated crisis response system. Since the launch of the 988 Suicide & Crisis Lifeline in July 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been leading a significant transformation of the behavioral health crisis care system in the United States. SAMHSA envisions three foundational elements within an integrated crisis care system: ***Someone to Contact,*** meaning services like 988 and other behavioral health crisis hotlines (including peer-operated warmlines) that provide immediate, accessible support; ***Someone to Respond,*** which includes services like mobile crisis programs that can deliver rapid, on-site interventions to de-escalate crises and connect people to care and other community-based supports; and ***A Safe Place for Help***, which includes emergency and crisis stabilization services supporting on-demand care and supports in community settings (SAMHSA, 2025a). Communities across the country have made significant investments and seen rapid expansion of their local crisis systems over the last several years.

Despite the expansion of crisis services within the broader behavioral health ecosystem, major gaps in knowledge remain about the composition of mobile crisis programs, what access looks like, and whether and how existing programs are meeting the needs of the countless communities they serve. Prior to the launch of 988 in July 2022, a national convenience sample survey of mobile crisis programs conducted in early 2022 for SAMHSA and Vibrant Emotional Health, the administrator of the National Suicide Prevention Lifeline, found that mobile crisis programs function in highly diverse settings; are operationally and administratively varied; and face a series of challenges, including limited 24/7 availability, limited operational integration with other elements of the crisis care continuum, incomplete metrics data collection, and uneven adoption of clinical best practices (Goldman et al., 2023). More recently, the NASMHPD (National Association of State Mental Health Program Directors) Research Institute (NRI) published a report on mobile crisis programs based on surveying State Mental Health Agencies and found that between 2022 and 2024, the number of mobile crisis programs increased by 56%, the number of clients served increased by 206%, and funding for mobile crisis programs increased by 195% (NRI, 2025). This state-level inventory provides important information about broad indicators of mobile crisis system growth and state support; however, it does not include detailed program-level data regarding how teams are structured and operated across jurisdictions.

The lack of more granular, program-level detail on how teams function in different contexts is a key barrier to developing evidence-informed guidance for providers and policymakers. As one key example, there has been a proliferation of mobile crisis response models—including behavioral health practitioner-only models, law-enforcement-based co-responder models, alternative responder models, and youth-focused mobile response and stabilization services—but model definitions vary, and little is known about how these models differ in practice with respect to staffing, operations, referral pathways, service delivery, and implementation.

This national survey was developed to provide current, detailed program-level information about mobile crisis programs in the United States. We aimed to characterize mobile crisis response

program configurations and operations and examine how program characteristics vary across crisis response models and regions. We also aimed to standardize a mobile crisis survey that can be utilized by states and other system leaders to describe the adequacy of mobile crisis program capacity relative to populations served.

METHODS

Study Design and Oversight

We conducted a cross-sectional national survey of mobile crisis programs in the U.S. between December 1, 2025, and February 28, 2026. The study protocol was reviewed by New York State Psychiatric Institute Institutional Review Board (IRB) (protocol number NYSPI2025-81) and determined to be Not Human Subjects Research (NHSR); as such further IRB review or oversight was not necessary.

Setting and Sample

Target Population

The target population included mobile crisis programs currently operational across the U.S. For this survey, we conceptualized "mobile crisis program" broadly to include any of the model types described below. The first three model types align with SAMHSA's (2025b) model definitions whereas the fourth model type aligns with emerging definitions in the field regarding "alternative" or "community" response (Irwin and Pearl, 2020; Todd et al., 2025; Yamamoto et al., 2026). Programs self-identified as one of the following four model types when responding to the survey

(1) **Behavioral Health Provider Mobile Crisis Program:** This program type has teams (generally 2-person) that include at least one behavioral health clinician. Law enforcement is not considered part of the response team. Teams may self-dispatch or be dispatched through crisis lines (e.g., 911/988/other crisis lines). These programs are referred to throughout this report as BHP-MC programs.

(2) **Mobile Response and Stabilization Service (MRSS)/Intensive Crisis Stabilization Service (ICSS)**: This program type is an intensive, community-based response designed to support children and young people with high-acuity needs and to prevent unnecessary out-of-home placements. MRSS/ICSS teams provide mobile response and time-limited community stabilization services. They typically also include at least one behavioral health clinician with expertise in serving children and adolescents, as well as parent/family advocates.

(3) **Law Enforcement-Based Co-Responder Program:** This program type pairs a law enforcement officer with a behavioral health practitioner. Some teams also include a paramedic or EMT. The teams are typically dispatched by 911. These programs are referred to throughout this report as co-responder programs. Note, we classify teams of

paramedics/EMTs who respond with clinicians but without a law enforcement officer as Alternative/Community Response (see below).

(4) **Alternative or Community Responder Program:** This program type has non-law enforcement teams (generally 2-person) staffed by professionals such as Fire/EMS personnel, peers, nurses, clinicians, and non-clinician community responders. The teams are typically dispatched by 911, although they could be dispatched by other crisis and non-crisis lines (e.g., 988, 211, program hotlines). The teams may respond to a broader set of calls than just behavioral health crises (e.g., social distress, homelessness). These programs are referred to throughout this report as Alternative Responder programs.

Participants and Recruitment

We recruited participants through two primary avenues: (1) partnering with mental health leadership in five states (California, Illinois, Michigan, New York, and Ohio) and (2) notifying multiple provider communities nationally about the open survey. United States territories and tribal lands were not specifically recruited for the survey (one survey response was received from a U.S. Territory and was excluded from analysis since we did not recruit more broadly from the territories).

Partnership with Five States

Given the lack of information about available mobile crisis programs across the country (both in terms of the total number of programs and the specific names and locations of programs), we partnered with mental health leadership in five states in advance of launching the survey to develop a comprehensive list of behavioral health provider mobile crisis programs and MRSS/ICSS programs in each of their states. The five states were chosen for their geographic diversity across counties (from very large metropolitan areas to rural/remote areas) and for our existing relationships with state-level leadership. We focused on behavioral health provider mobile crisis programs and MRSS/ICSS programs for this effort (rather than law enforcement-based co-responder programs or alternative responder programs) because state mental health leadership generally has greater awareness of or even oversight of the former types of programs. By contrast, co-responder programs and alternative responder programs have diverse oversight (e.g., local governments or specific city agencies such as police or emergency services departments). Developing a comprehensive list of co-responder programs would be infeasible given the number of law enforcement agencies across the country (~18,000); other efforts in the field have developed a working list of alternative responder programs, which we explain below. State partnerships included the following:

- *California:* We partnered with the California Health and Human Services Agency and the California Department of Health Care Services to reach out to County Behavioral Health Directors in each of California's 58 counties. Before launching the survey, we emailed each County Behavioral Health Director. We asked them to send program names and contact information for any behavioral health mobile crisis program in their county. The County Behavioral Health Directors Association also emailed its membership about the survey.

Representatives from 53 of 58 counties responded and provided contact information for 70 programs. We emailed each of these programs directly to encourage participation in the survey.

- *Illinois*: We partnered with the Division of Behavioral Health and Recovery within the Illinois Department of Human Services to target state-funded mobile crisis programs for participation. Specifically, we received contact information for 59 operating mobile crisis programs funded by Illinois Program 590 (a grant program to support mobile crisis response) and Program 591 (grants for Certified Community Behavioral Health Clinics). In addition to direct outreach to each of these programs, the Division of Behavioral Health and Recovery emailed programs to remind them about the survey opportunity and one of the Co-Investigators discussed the survey with Illinois Program 590 and 591 providers during meetings related to another project.

- *Michigan*: We partnered with the Crisis Services & Stabilization Section within the Bureau of Specialty Behavioral Health Services at the Michigan Department of Health & Human Services. They provided us with contact information for each of the 46 Community Mental Health Service Programs (CMHSP) across Michigan that oversee a comprehensive range of services to support children, adolescents, and adults with mental illnesses, developmental disabilities, and substance use disorders in all 83 Michigan counties. We emailed each CMHSP Director and asked them to send the program names and contact information for any behavioral health mobile crisis programs in their CMHSP. Representatives from 41 of 46 CMHSPs responded, providing contact information for 44 programs. The Crisis Services & Stabilization Section also reminded programs to complete the survey.

- *New York:* We partnered with the Bureau of Crisis, Emergency, and Stabilization Initiatives within the New York State Office of Mental Health to identify all state-designated mobile crisis providers. We received program names and contact information for 53 operating mobile crisis programs and confirmed the best program contact prior to the survey launch. We also emailed the Director of Community Services (DCS)/Mental Health Commissioners in the 57 counties outside of New York City. In New York State, the DCS has statutory authority and responsibility for oversight of the local mental health system and are thus well-positioned to know about the range of available mobile crisis programs in their county. The Bureau of Crisis, Emergency, and Stabilization Initiatives also reminded programs to complete the survey.

- *Ohio*: We partnered with Clear Pathways, an initiative of Peg's Foundation that catalyzes efforts throughout Ohio to build sustainable and scalable behavioral health emergency response systems. We used the Ohio Crisis Services dashboard, the publicly available listing of Ohio's Mobile Response and Stabilization Services providers, and four publicly available national directories (see the following section for more detail) to create the most comprehensive directory possible for the state. This led to the identification of 69 unique providers, each operating at least one behavioral health mobile crisis program in Ohio (total

programs identified = 94). We reached out to all programs that we had reliable contact information (n = 73). We also emailed all Directors of each Ohio Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) board (local behavioral health authorities) and sent out recruitment emails through two professional organizations, the Ohio Council of Behavioral Health and Family Services Providers, and the Ohio Behavioral Healthcare Provider Network.

Upon launching the survey, each program for which we had contact information across the five partner states received a unique link to the survey and was reminded to complete it through automated REDCap reminder emails as well as through direct outreach from the study team (via emailing programs up to four times).

National Convenience Sampling

In addition to conducting recruitment through our partnerships with five states, we recruited programs to participate in the survey through national outreach via multiple avenues. We targeted Executive Directors, Program Directors/Managers, Clinical Supervisors and/or other supervisory staff to complete the survey and used the following outreach strategies:

- Email outreach to state-designated crisis system contacts shared by NRI based on NRI's 2024-2025 State Profiles of Mobile Crisis Teams
- Email outreach to all 192 individuals who completed the 2022 National Survey of Mobile Crisis Teams and agreed to be contacted in the future
- Partnership with over 30 national organizations (see Appendix A), who emailed their listservs to announce the survey
- Presentations and interviews with the Alternative Mobile Services Association, Crisis Jam, and the CrisisTalk Podcast
- Postings on LinkedIn

Additionally, we conducted more targeted outreach to law enforcement-based co-responder programs and alternative/community responder programs across the country.

- *Law Enforcement-Based Co-Responder Programs:* We utilized the online member directory of the International Co-Responder Alliance to compile a list of 273 unique co-responder programs across the country (all states except Hawaii, Idaho, Louisiana, New York, North Dakota, Rhode Island, South Carolina, and South Dakota, each of which had no entries in the directory). The study team emailed each of these programs up to three times to encourage participation in the survey. Of the 273 programs we identified, 120 (44.0%) responded to the survey.
- *Alternative or Community Responder programs*: We utilized two existing, publicly available directories: (1) Law Enforcement Action Partnership's nationwide directory of community

responder programs (v. 2025); and (2) Indivisible Eastside's 2024 Directory of Alternative Crisis Response programs (v. 2.1.9). We identified 121 programs, 115 of which met eligibility criteria for the study. Of those 115 programs, 51 (44.3%) responded to the survey.

Law Enforcement-based Co-Responder Programs and Alternative or Community Responder programs were reminded about survey participation through a combination of automated REDCap reminder emails and direct outreach from the study team.

Survey Development

The survey was developed through a multistep process. First, eight domains were identified from the 2022 National Survey of Mobile Crisis Teams (Goldman et al., 2023) and additional stakeholder consultation.[1] These domains included: (1) Service Type and Coverage Area; (2) Partnerships; (3) Program Structure; (4) Team Structure; (5) Training; (6) Technology; (7) Financing; and (8) Metrics.

Items were adapted from the 2022 survey and supplemented with newly developed items to capture emerging program models, developments in the field, and feedback from mental health leadership in our five partner states.

The draft survey instrument was reviewed by 3 experts outside of the study team and pilot tested by the study team as well as with 5 programs to assess clarity, feasibility, and length of time to complete. The survey was designed to be completed in less than one hour and teams piloting the survey verified they were able to complete it in that time. Revisions were made based on feedback.

The final instrument included 87 items. The full survey instrument is available as a supplement.

Measures/Items

The eight survey domains included multiple items as described below. All items were required to be answered before moving on to the next item, with the exceptions of annual operating costs and the items in the final section on metrics, which were optional.

Service Type and Coverage Area

We collected information on program type (programs self-identified as one of the four models listed above), coverage area (e.g., entire state, entire county or multiple counties; parts of cities, entire city or multiple cities), size of population served, and type of geographic area served (e.g., urban, suburban, rural, remote).

[1] The 2022 National Survey similarly used a convenience sample and sought to characterize mobile crisis configurations across the United States. However, the current survey is different from the 2022 Survey in several important ways. For example, the current survey had multiple recruitment strategies, including partnership with 5 states; required programs to identify their name and location whereas the 2022 survey was anonymous; and asked respondents to select the model type that best characterized their program. The 2022 findings therefore provide useful context for understanding the broad landscape of mobile crisis services relative to 2025, but differences in sampling, recruitment, and survey design mean that the two surveys should not be treated as directly comparable.

Partnerships

We asked programs to share information about program oversight, any relationship with Certified Community Behavioral Health Clinics (CCBHCs), partnerships with other agencies, program location (i.e., stand-alone or co-located with another agency/service), and community outreach and engagement strategies.

Program Structure

We collected information on hours and days of operation, ages served, how individuals can reach the program, referral sources (including primary referral source), types of calls to which the program responds or to which the program cannot respond, types of sites to which the program responds (e.g., community settings, private homes, schools, emergency departments), what kinds of vehicle the program uses to arrive on scene and provide transport if needed, strategies used for safety on-scene, and follow-up activities.

Team Structure

Respondents reported staffing role types, number of FTE and on-call staff budgeted and filled, the location where team members receive calls or dispatches, how many responders make up a team when going into the field, and any reasons for variation in the number of responders.

Training

Programs shared information on training for staff, including the training modalities used, whether shadowing is included for new team members, and the training topics covered (across a variety of areas such as physical health skills, safety assessment and intervention skills, and evidence-based interventions), and supervision structure.

Technology

Respondents were asked about the technological capabilities their team has, what type of clinical records system(s) they rely on, what devices are used for documentation, and if and how telehealth is used.

Financing

We collected information on which types of insurance are billed, if any, which Current Procedural Terminology (CPT) billing codes are used for initial and follow-up crisis visits, which sources of funding support the program (e.g., federal, staff, county, foundation funds), and annual program operating costs.

Metrics

We asked programs to report whether or not they collect data on 17 key metrics for mobile crisis programs. Programs then had the opportunity to report their data on each of those metrics for the first three quarters of 2025 (January – September) if they were able and willing to do so.

Data Collection Procedures

The survey was administered electronically using REDCap hosted at the New York State Psychiatric Institute. Each program interested in completing the survey filled out a program information sheet with their program name, location (state only), and a contact email where the survey link could be sent. Each program then received a unique survey link. Return codes allowed respondents to complete the survey across multiple sessions. This two-step procedure to access the full survey was taken to reduce the risk of getting invalid responses. All survey respondents had the option at the end of the survey to enter a raffle to win one of 20 gift cards (valued at $50/each). Raffle winners were selected randomly from those who chose to enter.

Data Quality and Total Responses

Appendix B shows a flowchart of survey respondents to document how we arrived at our final sample for analysis. A total of 1,225 records were created in REDCap, but only 745 of those records were complete (n = 603) or partially complete (n = 142). Surveys were considered complete if respondents answered at least the first section of the survey, including their location and coverage/catchment area. Partial responses were included in analyses for variables with available data.

Duplicate responses were identified by identifying programs with the same name and/or same email domain and manually checking the program information entered in the survey; the most complete response was retained for confirmed duplicate responses. In 16 cases where a single program submitted two complete responses, we emailed the respondents directly and asked which record they wanted us to retain for analysis. Only two programs did not respond; the more recent record submitted was retained in those cases. Overall, we received duplicate responses from 47 programs, which were removed.

Logical consistency checks were performed to identify implausible responses (e.g., reporting no staffing, not responding to calls related to mental illness). When inconsistencies were identified, responses were reviewed and resolved by consensus among the research team. Programs were not contacted to resolve unclear or implausible responses. Additionally, 27 programs were excluded for not meeting eligibility criteria (e.g., We excluded programs that did not provide mobile response, responded to overdoses only, or provided homeless outreach only. Fire department-based mobile integrated health programs and similar models that only provide post-crisis follow-up were also excluded from the analysis). The final analytic sample includes 671 programs.

Statistical Analysis

All analyses were conducted using SPSS Version 31. We generated descriptive statistics to characterize all survey variables. Continuous variables were reported as means or medians, as appropriate. Categorical variables were reported as frequencies and percentages.

All data were examined according to three program types: BHP-MC programs (which include MRSS and ICSS programs), Co-Responder programs, and Alternative Responder programs. The decision

to fold MRSS and ICSS programs within the broader BHP-MC category was based on survey findings indicating that 64% of MRSS and ICSS programs reported no age restrictions on the population they serve, suggesting substantial overlap with broader behavioral health mobile crisis service models (rather than being youth-specific programs).

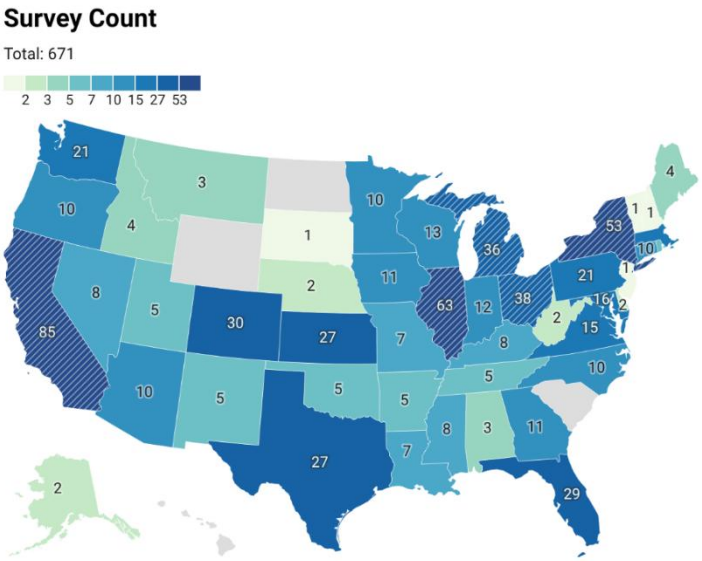
RESULTS

The final sample includes 671 mobile crisis programs broken down as follows: 418 BHP-MC programs (62.3%), 162 Co-Responder programs (24.1%), and 91 Alternative Responder programs (13.6%). Respondents were most frequently Program Directors or Managers (41.1%), followed by Crisis Services Directors or Mobile Crisis Services Directors (16.4%), and Clinical Supervisors (7.0%). Among respondents who chose "Other" (n = 145, 21.6%), approximately half described holding another type of executive-level role (e.g., Chief Operating Officer, Vice President) and 37.9% indicated they were staff within a mobile crisis program (e.g., responding clinician or police officer).

Mobile Crisis Program Geographic Distribution and Areas and Population Served

Mobile crisis programs across the United States serve diverse areas with respect to geographic boundaries, population density, and population size. Figure 1 shows the number of respondents from each state. Responding programs came from 46 states and Washington, D.C. No responses were received from Hawaii, North Dakota, South Carolina, and Wyoming. The highest number of respondents came from our partner states (California (n = 85, 12.7%), Illinois (n = 63, 9.4%), New York (n = 53, 7.9%), Ohio (n = 38, 5.7%) and Michigan (n = 36, 5.4%), followed by Colorado (n = 30, 4.5%), Florida (n = 29, 4.3%), Kansas (n = 27, 4.0%) and Texas (n = 27, 4.0%).

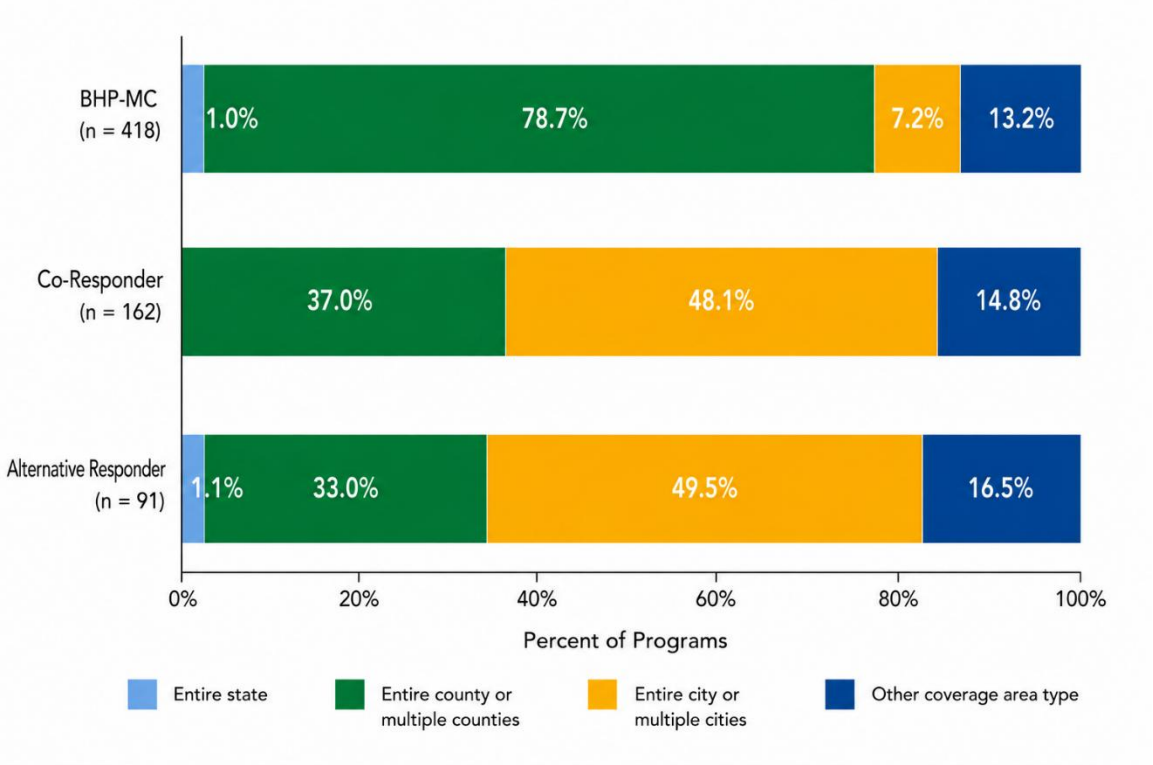
Figure 1. Number of Respondents by State



Note. Blue cross-hatching indicates five partner states with more intensive recruitment efforts.

Most mobile crisis programs (62.4%) serve counties or multiple counties, followed by cities or multiple cities (22.8%). However, coverage area varies by program type; BHP-MC programs are most likely to serve a county or region (78.7%), whereas Co-Responder programs and Alternative Responder programs are most likely to serve cities or multiple cities (48.1% and 49.5% respectively) (Figure 2).

Figure 2. Mobile Crisis Program Coverage Area[2]



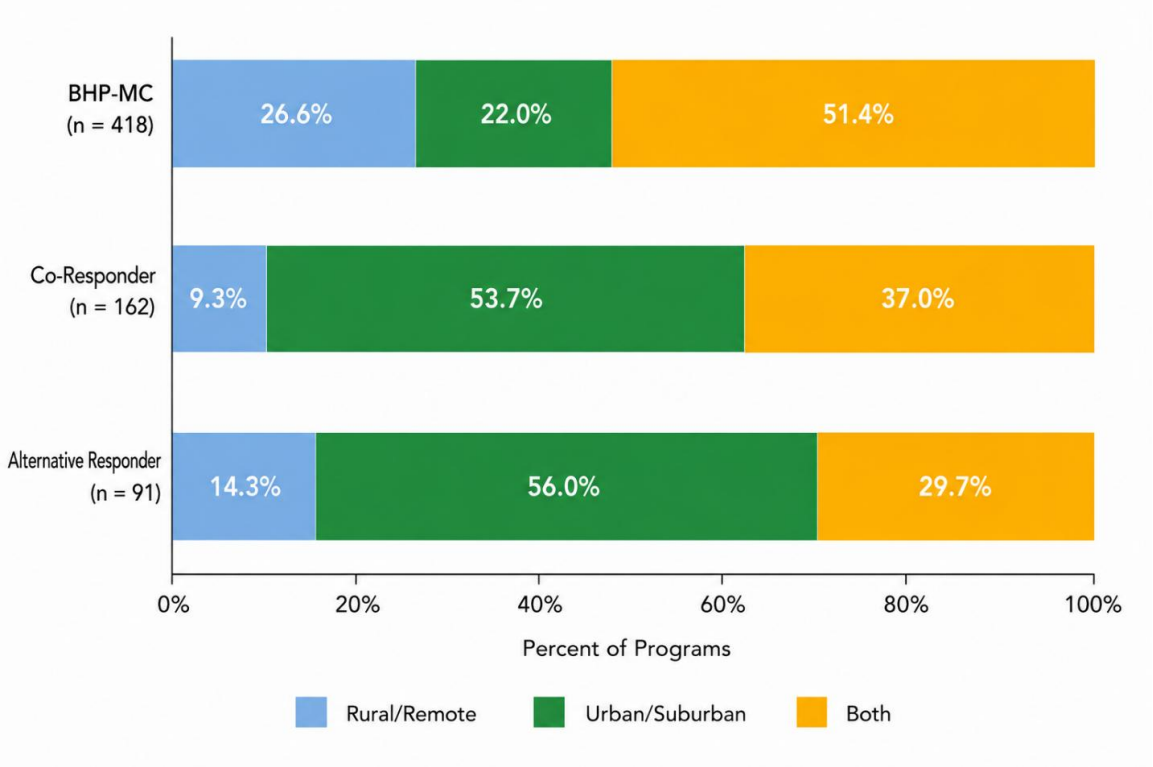
This pattern is also reflected in the population density of the areas programs serve. Programs identifying as BHP-MC programs were more likely to serve both urban/suburban and rural/remote areas (51.4%) whereas the majority of Co-Responder programs (53.7%) and Alternative Responder programs (56.0%) sampled serve urban and/or suburban areas (Figure 3).

There is substantial heterogeneity in the population size of mobile crisis program catchment areas. BHP-MC programs have the highest median (261,371), reflecting their likelihood of serving multiple counties or regions or larger cities. Co-Responder programs have the lowest median population served (154,377)—although there were several larger jurisdictions with Co-Responder programs—reflecting the fact that such programs are often based in law enforcement agencies and most police departments are relatively small. Alternative Responder programs were in the middle with respect to median population served (207,282) and had the smallest range in the population sizes of their catchment areas, reflecting the likelihood that these programs are more likely to be geographically localized. Across program type, 27.3% of respondents cover catchment areas with

[2] All figures were originally created in SPSS and Excel and then enhanced using ChatGPT.

populations of greater than 500,000 people, 47.0% cover areas with 100,000-500,000 people, and 25.7% cover areas with fewer than 100,000 people.

Figure 3. Geographic Areas Covered



With respect to the ages of the population served, most responding programs reported that they do not have age restrictions (85.7%). Only 72 BHP-MC programs (17.3%), 7 Co-Responder programs (4.4%) and 16 Alternative Responder programs (17.8%) reported age restrictions. Among the 95 programs that indicated some type of age restriction, 34 (35.8%) reported an upper age limit of between 17 and 21 years old (i.e., indicating they are youth-specific mobile programs), 35 (36.8%) reported a lower age threshold of 18 years old (indicating they are adult specific programs), and 15 (15.8%) reported a lower age threshold of 5-7 years old. These categories are not mutually exclusive; some programs reported both minimum and maximum age restrictions.

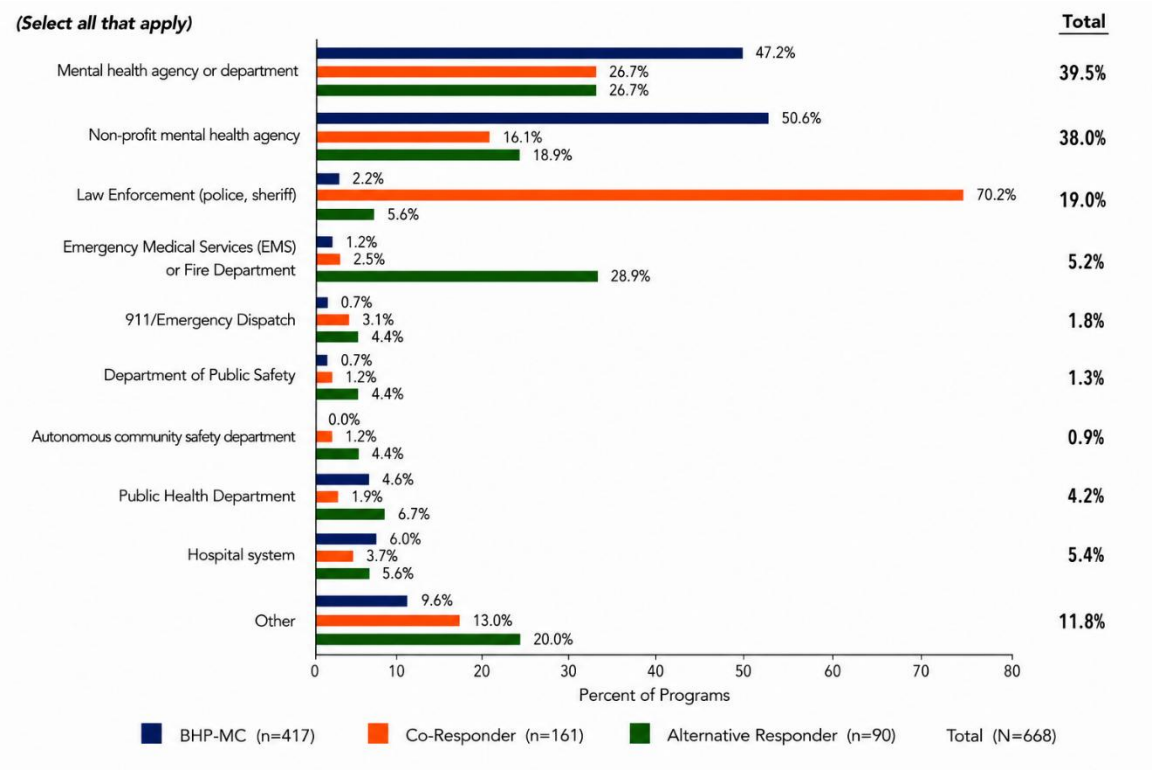
KEY TAKEAWAYS:

Responding mobile crisis programs varied in their geographic coverage areas, population densities, and catchment population sizes. BHP-MC programs provide broad regional coverage across urban, suburban, rural, and remote communities, whereas Co-Responder and Alternative Responder programs tend to be in urban and/or suburban areas. Most responding programs reported serving individuals across the lifespan rather than operating as youth-specific mobile crisis programs despite increasing national attention to youth-focused crisis response.

Mobile Crisis Program Oversight & Partnerships

As expected, there is variation in the types of agencies providing oversight of mobile crisis programs (Figure 4).

Figure 4. Agencies Providing Oversight for Mobile Crisis Programs



Most programs (78.4%) reported a single oversight agency while 16.8% of respondents reported two oversight agencies and another 4.2% reported having three oversight agencies; fewer than 1% reported having more than three oversight agencies. Considering all responses, most BHP-MC programs reported oversight by a non-profit mental health agency (50.6%) and/or public mental health agency (i.e., city, county, regional or state) (47.2%). Most Co-Responder programs reported oversight from law enforcement (70.2%) and/or public mental health agencies (26.7%) and non-profit mental health agencies (16.1%). Alternative Responder programs most frequently reported oversight from Emergency Medical Services (EMS) or a Fire Department (28.9%), and/or public mental health agencies (26.7%) and non-profit mental health agencies (18.9%). Programs reporting "other" oversight most frequently wrote in that oversight was provided by city or county government, or by a university. Programs reporting two oversight agencies (as opposed to only one, or more than two) were most likely to report oversight from a public and a non-profit mental health agency (n = 40, 35.7%) or a law enforcement agency and a mental health agency (either public or non-profit) (n = 27, 24.1%).

Programs also reported on whether they are stand-alone or physically co-located with other service providers (and with what providers they are co-located). Alternative Responder programs most

frequently reported being stand-alone (48.9%) compared to BHP-MC programs (38.5%), and Co-Responder programs (9.3%). With respect to co-location arrangements, BHP-MC programs most frequently reported being co-located with outpatient behavioral health clinics (39.4%), Co-Responders most frequently reported being co-located with a police or sheriff's station (73.9%) and Alternative Responder programs most frequently reported being co-located with a fire station or EMS (23.3%).

As shown in Appendix Figure C1, programs endorsed a wide range of community partnerships (defined as agencies with whom the program engages in regular coordination and/or has formal collaboration), with the most common collaborations between programs and their local law enforcement agencies (84.7%), hospital systems (70.0%) and 911/emergency dispatch centers (67.8%). Programs endorsed partnerships with an average of six external organizations (6.0 for BHP-MC programs, 6.1 for Co-Responder programs, and 6.6 for Alternative Responder programs). Further, 85.9% of programs indicated that the geographic area served by their program has one or more law enforcement agencies with a Crisis Intervention Team (CIT) program. Similarly, programs endorsed a myriad of partnerships with youth service providers, including schools (72.5%), child protective services (60.8%) and juvenile justice providers (44.8%). Most programs take part in local outreach and engagement by attending community meetings (84.0%), taking part in community events (83.7%), and sitting on community coalitions or collaboratives (76.6%).

Beyond these identified partnerships, 29.0% of all programs specified that they are a Designated Collaborating Organization (DCO) of a Certified Community Behavioral Health Clinic (CCBHC), though this was more common among BHP-MC programs (35.3%) than Co-Responder programs (23.0%) and Alternative Responder programs (11.1%).

KEY TAKEAWAYS:

Mobile crisis programs have diverse administrative oversight, physical co-location, and community partnership structures. Oversight and co-location patterns varied by program type, with BHP-MC programs most commonly aligned with behavioral health systems, Co-Responder programs connected to law enforcement agencies, and Alternative Responder programs most commonly connected to either EMS and fire departments or behavioral health systems.

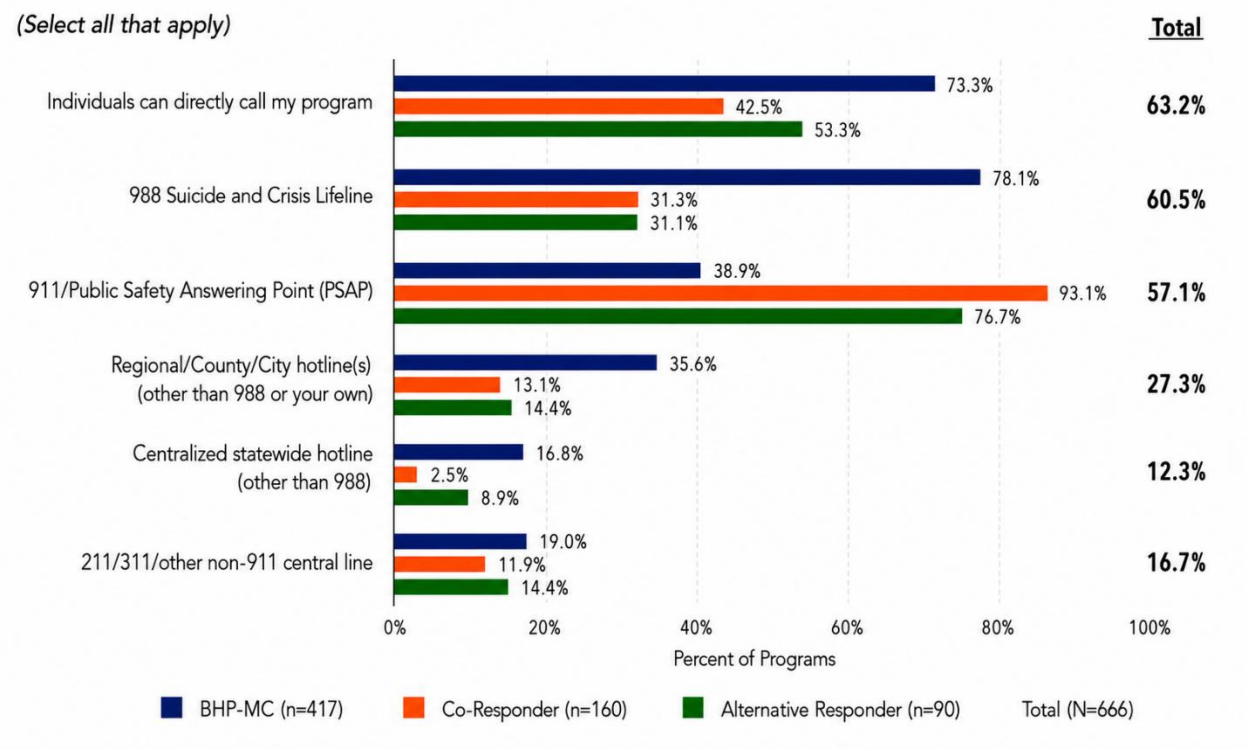
Programs also reported widespread cross-system collaboration, particularly with law enforcement, schools, hospitals, and emergency dispatch systems, highlighting the many systems involved in crisis response work. Nearly one third of responding programs reported serving as a DCO for a CCBHC. Given the requirement that CCBHCs provide 24/7 mobile crisis coverage and recent national data indicating that 21% of CCBHCs provide crisis services through a DCO rather than doing so directly (Mauri et al., 2025), the survey findings suggest that existing community-based mobile crisis programs may be working with CCBHCs to meet crisis service requirements.

Program Operations

How to Reach Programs and Referral Sources

Individuals seeking crisis services can reach mobile crisis programs through a variety of avenues, with 63.2% of programs indicating they can be reached by directly calling their program, 60.5% indicating they can be reached by calling 988, and 57.1% indicating that they can be reached via 911/Public Safety Answering Point (PSAP).

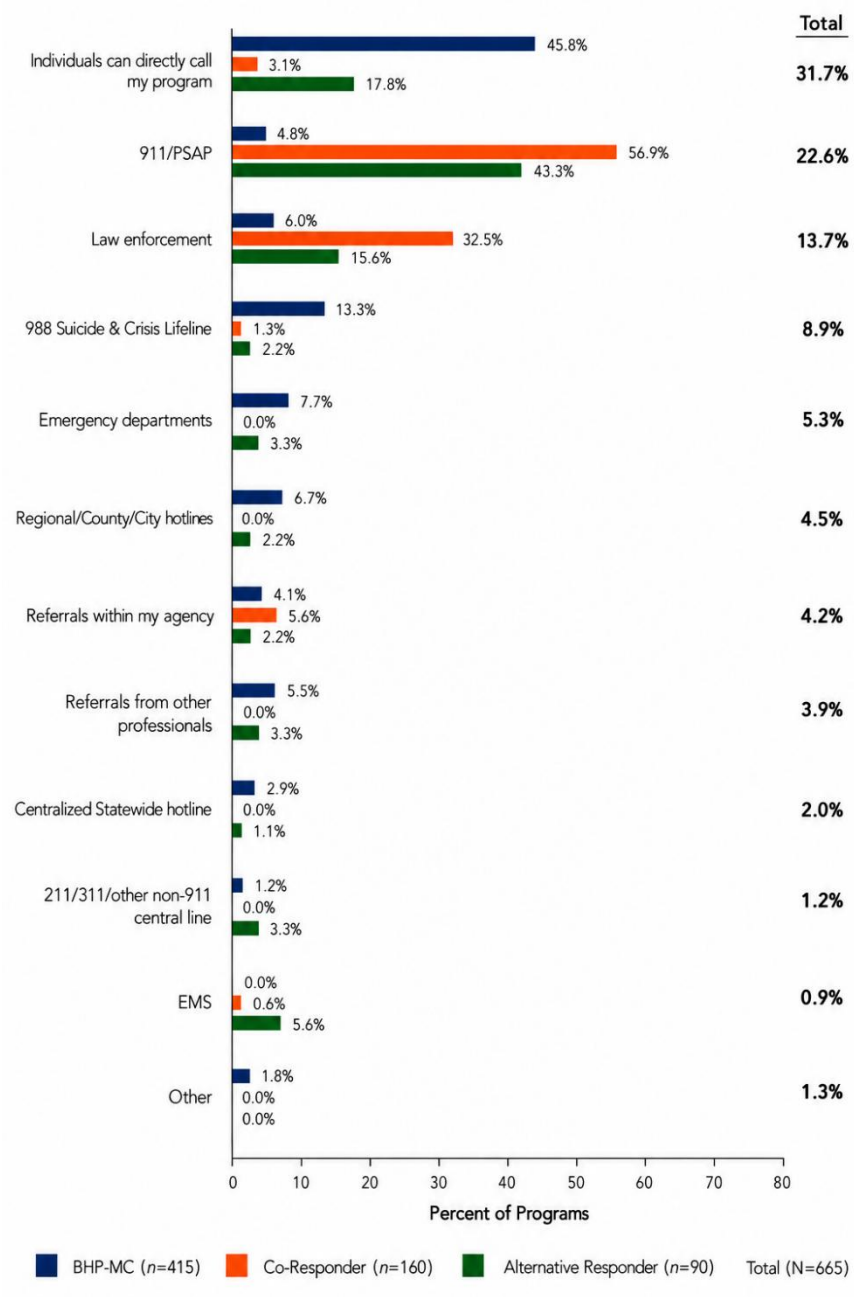
Figure 5. How the Public Reaches Mobile Crisis Programs



However, the avenues through which teams can be reached also vary by program type (Figure 5). For example, nearly 80% of BHP-MC programs can be reached by 988 but only 31.3% of Co-Responder programs and 31.1% of Alternative Responder programs can be reached this way. Conversely, only 38.9% of BHP-MC programs can be reached through 911/PSAPs but 93.1% of Co-Responder programs and 76.7% of Alternative Responder programs can be reached this way.

Programs reported multiple referral sources, or ways their program can be accessed, with the primary referral source varying by program type (Figure 6). BHP-MC programs most frequently reported that self-referrals or referrals from family members, parents, or guardians calling the program directly as their primary referral source (45.8%); only 13.3% of BHP-MCs indicated their primary referral source is 988. By contrast, Co-Responder programs and Alternative Responder programs most frequently selected 911/PSAPs as their primary referral source (56.9% and 43.3% respectively).

Figure 6. Primary referral source



These referral sources also correspond to how programs are dispatched (e.g., by a 988 call center or by 911) (Appendix Figure C2). While more than three quarters of programs reported self-dispatching (i.e., a staff member or supervisor makes the decision), Co-Responder programs and Alternative Responder programs were more likely to report that they are dispatched by 911 (72.5% and 56.7% respectively) compared to BHP-MC programs (13.0%) and only 36.6% of BHP-MC programs reported being dispatched directly by a call center such as 988.

KEY TAKEAWAYS:

Mobile crisis programs can be accessed through multiple pathways, reflecting the highly decentralized status of crisis system access in the U.S. Access pathways and referral patterns differed by program model type, with BHP-MC programs more closely connected to behavioral health access points such as 988 and by calling the program directly, and Co-Responder and Alternative Responder programs more tightly integrated with 911 and law enforcement.

Four years after the launch of 988, nearly 80% of BHP-MC programs report being accessible by calling 988, but only a small portion of programs identify 988 as their primary referral source. Instead, self-referral by calling the program directly remained the primary referral source most frequently endorsed by these programs. Although our survey did not collect data on call volume for

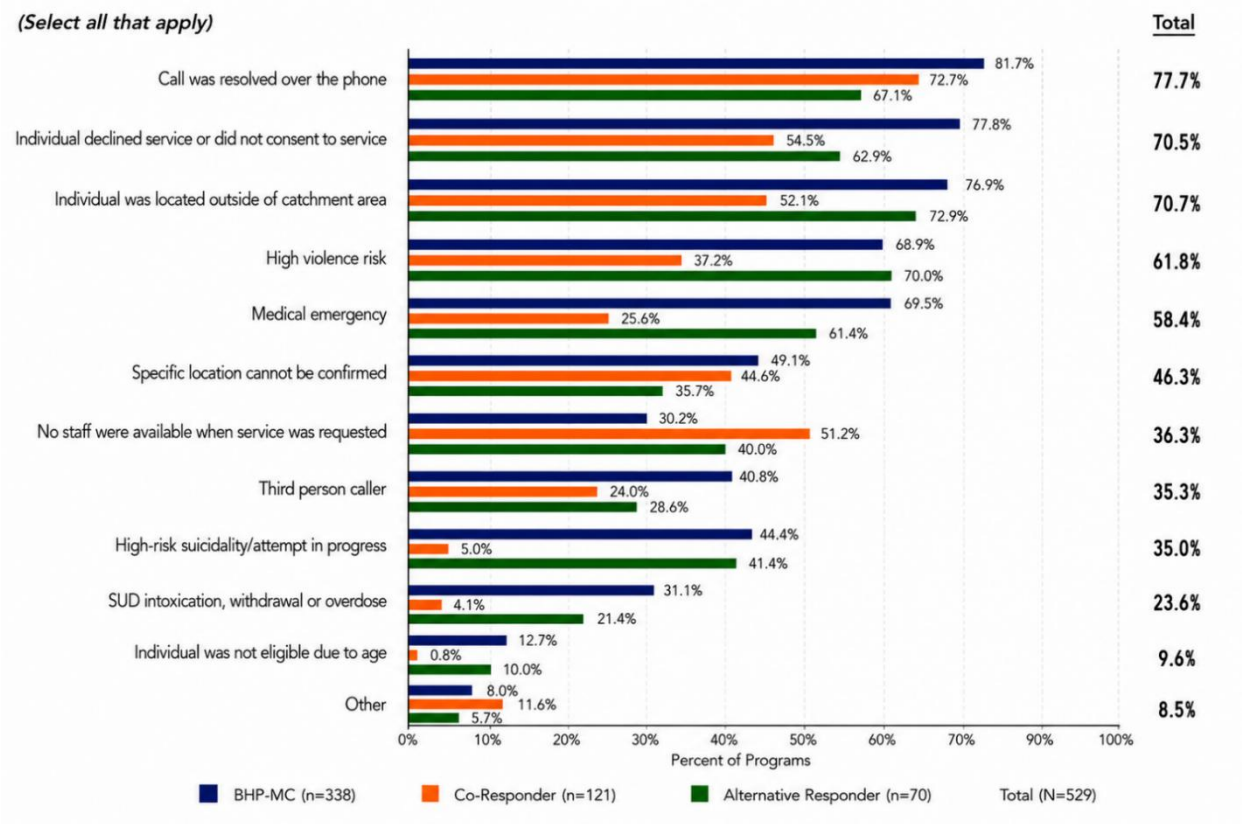
each referral source by program, one possibility for this apparent continued predominance of self-referrals may be that many individuals are still relying on their knowledge of local crisis services and that work remains to link 988 systems to locally developed access pathways for mobile crisis services.

24/7 Operation and Response

Despite the vision of nationwide 24/7 availability of mobile crisis services, only 63.0% of responding programs reported that they operate 24/7. 24/7 operation varies by program type, with 82.4% of BHP-MC programs, 45.6% of Alternative Responder programs, and only 22.5% of Co-Responder programs reporting 24/7 operation.

Regardless of hours of operation, nearly 80% of programs indicated that they can decide not to go out to a requested call. Across program type, programs most commonly reported that they may decline responding to calls when the call was resolved over the phone or an individual was located outside of the catchment area or declined service. Other reasons for not going out on calls varied by program type (Figure 7).

Figure 7. Reasons Mobile Crisis Programs May Not Go Out on a Call



For example, BHP-MC programs frequently indicated they may decline calls when they involve medical emergencies or high violence risk, or the program cannot confirm the specific location of

the person. Further, nearly one third of BHP-MC programs selected substance use intoxication, withdrawal, or overdose as a reason for potentially declining a call (this was true for 21.4% of Alternative Responder programs and only 4.1% of Co-Responder programs).

Notably, over one third of all programs indicated that they may decline calls because they don't have staff available when the service is requested (30.2% of BHP-MC, 51.2% of Co-Responder, and 40.0% of Alternative Responder programs). The ability to decline a call for any specific reason should not be interpreted to mean that programs always decline these types of calls but rather that they have the discretion to decline them.

KEY TAKEAWAYS:

Best practice guidelines suggest that mobile crisis services should be available 24 hours per day, 7 days per week, even if involving law enforcement or other first responders is the only way to feasibly do so (SAMHSA, 2025a). Relatedly, mobile crisis programs must be available 24/7 to qualify for a new state Medicaid option under Section 9813 of the American Rescue Plan Act of 2021 that allows states to receive an 85% Federal Medical Assistance Percentage (FMAP) for Medicaid beneficiaries' mobile crisis response payments. Despite the national policy emphasis on 24/7 mobile crisis availability, more than one third of responding programs reported that they do not currently operate around the clock. Availability differed by program model type, with BHP-MC programs the most likely to report 24/7 operation.

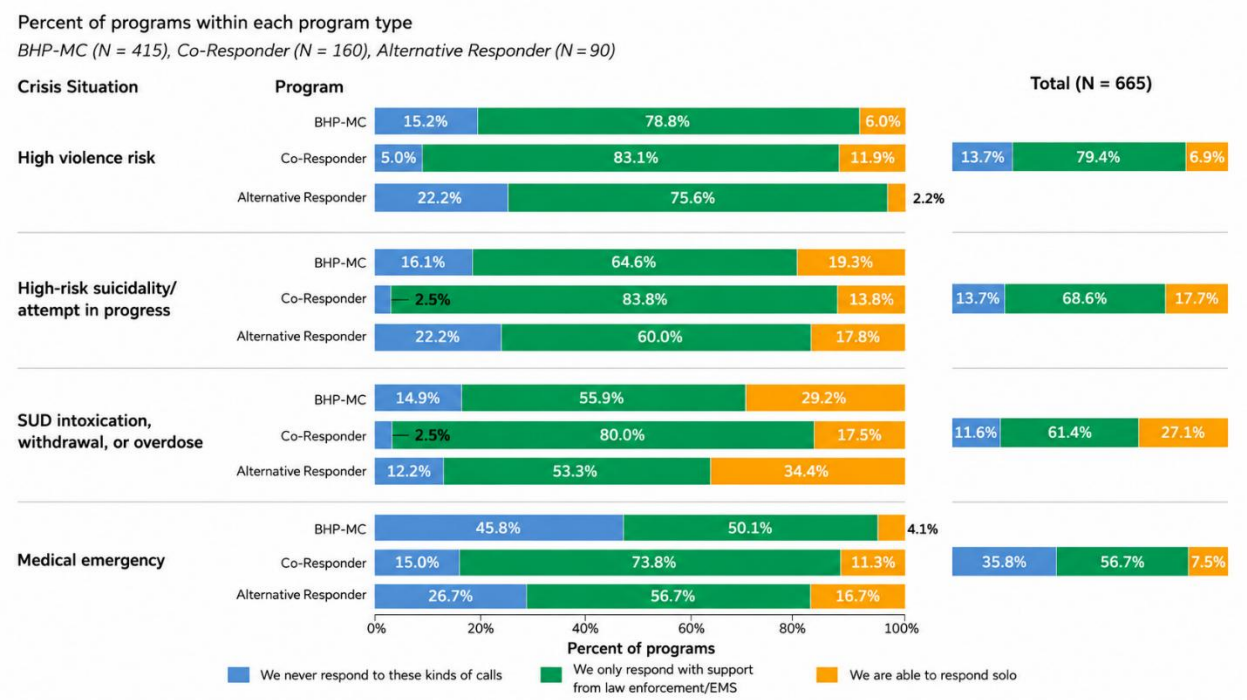
Most programs (79.5%) reported the ability to decline requests for in-person response. Of these, more than one third indicated lack of staff availability as one of the reasons they might decide not to go out on a requested call. Together, these findings suggest that operational capacity constraints may remain a significant challenge within a rapidly expanding crisis response system. Furthermore, coordination across mobile crisis program types and first responder agencies—as well as dispatch hubs via 911 and 988—is critical to ensuring availability of backup referral options when needed.

Call Types

Programs also reported on the types of clinical presentations and call types they respond to and, for a subset of call types, whether they are able to respond on their own or only respond with support from law enforcement or EMS. In addition to responding to calls related to mental illness, Appendix Figure C3 demonstrates that most programs respond to a wide range of call types from suicidal crisis (96.8%), psychosis (93.5%), and stress responses (92.0%) to SUD intoxication and withdrawal (79.8%), crises involving people with intellectual and developmental disabilities (78.8%), and pediatric disruptive behavior (73.8%). Among program model types, Alternative Responder programs were the most likely to indicate they responded to homelessness (85.6%) and broader social service needs (84.4%); this was less common among BHP-MC programs, with only 55.2% responding to homelessness and 59.3% responding to social service needs (Co-Responders were in the middle, with 76.9% responding to homelessness and 71.9% responding to broader social service needs).

A more detailed set of questions about four call types demonstrates the added constraints of responding to call types that might be deemed higher risk (Figure 8). Nearly 80% of programs only respond to calls with high violence risk with support from law enforcement or EMS, and an additional 13.7% indicate they never respond to such calls. For high-risk suicidality calls, 68.6% only respond with law enforcement or EMS and 13.7% never respond. Similarly, 61.4% of programs will only respond to calls involving SUD intoxication, withdrawal, or overdose with support from law enforcement or EMS; 11.6% never respond. Finally, 56.7% of programs only respond to medical emergencies with support from law enforcement or EMS and 35.8% never respond to medical emergencies. The remainder within each call type (6.9%, 17.7%, 27.1% and 7.5%, respectively) represents a minority of programs that are able to respond to these types of calls alone.

Figure 8. Response Capability by Crisis Situation



Programs also vary in their authority to place involuntary psychiatric holds and whether they provide transport for individuals on psychiatric holds. Nearly all Co-Responder programs have staff with authority to place an involuntary hold (95.5%). However, it was less common for BHP-MC programs and Alternative Responder programs to have staff with such authority (78.0% and 54.4% respectively). BHP-MC programs and Alternative Responder programs were also much less likely to report providing involuntary transport (19.3% and 18.9% respectively), in comparison to 74.5% of Co-Responder programs (see Appendix Figure C4).

KEY TAKEAWAYS:

Mobile crisis programs respond to a range of clinical presentations and call types, but Alternative Responder programs were more likely than other model types to report responding to

homelessness and broader social service needs. These differences may reflect some model differentiation as the crisis response ecosystem continues to evolve.

The findings also demonstrate frequent reliance on law enforcement or EMS for call types perceived as higher risk. Most programs reported that they either require law enforcement support or do not respond to calls involving high violence risk, high risk for suicidality, substance use-related risks, or medical emergencies. Similarly, the ability to place involuntary psychiatric holds and transport is more common in law enforcement-based models, although differences may be due in part to state legislation governing custody and transportation during civil commitment (Swartz et al., 2025) as well as variation in staffing in BHP-MC and Alternative Responder programs.

Among these higher risk calls, those involving substance use intoxication, withdrawal, or overdose were most likely to allow for solo response (27.1%), though the data in the previous section found that nearly a quarter of programs may decline calls related to substance use. Further investigation of this issue is warranted given that SAMHSA guidelines suggest that crisis response programs should be able to assess and intervene with a full range of substance use crises (SAMHSA, 2025a).

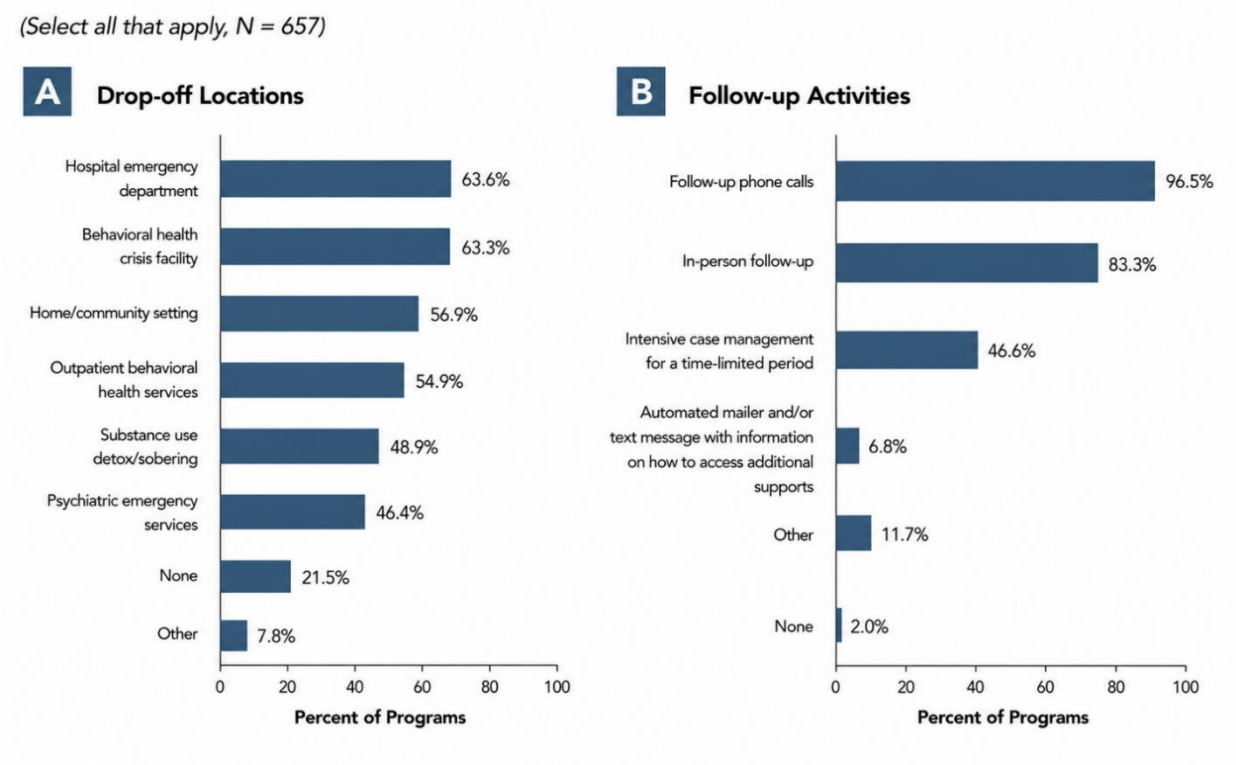
Response Sites & Follow-up

Mobile Crisis programs respond to a variety of settings regardless of program type, such as community settings (including the street), private homes, schools, mental health or other social service sites, shelters, group homes, emergency departments, and jails (Appendix Figure C5). Programs that indicated responding to emergency departments (n = 331, 50.1%) were asked to select the reasons they do so, and responses suggest many mobile crisis programs provide essential services for emergency departments (Appendix Figure C6). This includes providing follow up and/or connections to care for people seen by the emergency department (57.1%), providing direct service if the emergency department concludes an individual would be better served by a mobile crisis program (56.8%), and conducting psychiatric inpatient preadmission screenings (34.1%). Twenty-nine percent of all programs that respond to emergency departments reported that their local emergency department does not have the capacity to do psychiatric evaluations and therefore must call in the mobile crisis program to perform them. As shown in Appendix Figure C6, in almost all cases, BHP-MC programs endorsed these reasons more frequently than Co-Responder or Alternative Responder programs.

Programs reported they can drop off clients at multiple locations as part of their encounter and that they provide a variety of follow-up services (Figure 9). This includes locations further on in the crisis continuum such as emergency departments (63.6%), crisis facilities (63.3%), and outpatient behavioral health services (54.9%). Almost all programs (98.0%) also indicated that they perform some type of follow-up activity, with 96.5% indicating they place follow-up phone calls, 83.3% indicating they do in-person follow-up, and 46.6% indicating they do intensive case management for a time-limited period. Thirty-five percent of programs indicated they collaborate with a dedicated post-crisis follow-up team within their communities and 30.7% indicated that they partner with clinics offering next day appointments for people in crisis. It was more common for Co-

Responder programs and Alternative Responder programs to report having no follow-up partners (28.2% and 29.2% compared to 19.4% of BHP-MC programs).

Figure 9. Drop-off Locations and Follow-up Activities



KEY TAKEAWAYS:

Mobile crisis programs operate across a wide range of community and institutional settings. Of note is the finding that many programs provide support to emergency departments, including mental health evaluations, inpatient preadmission screenings, diversion from emergency department care, and follow-up services after discharge.

The findings also demonstrate that in addition to field-based supports, many programs are linking people to additional behavioral health services (e.g., outpatient services, crisis facilities) and providing follow-up care. This suggests that some mobile crisis programs are functioning not only as acute crisis responders but also as providers of transitional care to bridge from acute crisis systems to longer-term services.

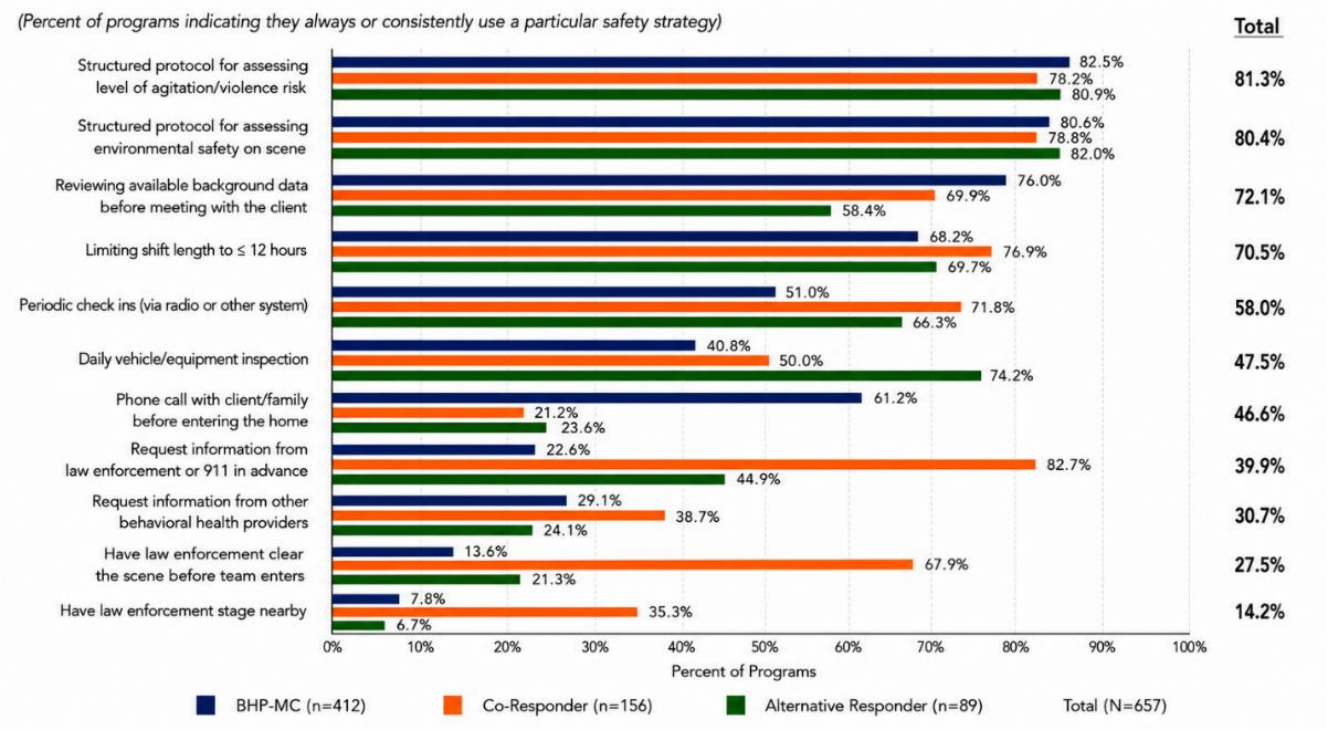
Safety Strategies

Programs reported on the suicide prevention best practices they implement. BHP-MC programs were more likely to report conducting universal suicide screening (93.5%) compared to Co-Responder programs (80.3%) and Alternative Responder programs (76.7%) and safety planning

using a standard template (87.9% compared to 78.3% and 77.8% for Co-Responder and Alternative Responder programs, respectively). Co-Responder programs were most likely to report reducing access to means of self-harm (89.8% compared to 85.0% for BHP-MC and 70.0% for Alternative Responder programs).

As shown in Figure 10, programs reported utilizing a variety of safety strategies in their work. Most programs reported using structured protocol for assessing level of agitation or violence risk (81.3% indicated they always or consistently do this) as well as a structured protocol for assessing environmental scene safety (80.4% always/consistently). Similarly, most programs reported reviewing available background data prior to meeting with an individual client (72.1% always/consistently). Implementation of other safety strategies was more variable by program type. For example, 67.9% of Co-Responder programs reported having law enforcement always or consistently clear the scene before other responders enter but this was true of only 13.6% of BHP-MC programs and 21.3% of Alternative Responder programs. Co-Responder programs and Alternative Responder Programs are more likely than BHP-MCs to request information from law enforcement or 911 in advance of interacting with a person in crisis (82.7% and 44.9% always/consistently versus 22.6%, respectively); they are also more likely to have periodic check-ins via a radio or other system (71.8% and 66.3% always/consistently versus 51.0%). However, BHP-MC programs are more likely to have a phone call with the individual in crisis or their family member before entering a home (61.2% always/consistently) compared to Co-Responder programs (21.2%) and Alternative Responder programs (23.6%).

Figure 10. Safety Strategies Used by Mobile Crisis Programs



KEY TAKEAWAYS:

Most responding programs reported conducting universal suicide screening and safety planning in addition to implementing safety precautions like environmental safety assessments and violence risk assessments "always" or "consistently." However, implementation of other safety approaches varied by program model type. Co-Responder and Alternative Responder programs were more likely to report relying on law-enforcement-based strategies such as scene clearance or advance information from law enforcement or 911, which is reflective of their level of integration within the public safety system. Alternatively, BHP-MC programs were more likely to report using clinically oriented engagement strategies such as phone contact with the client or their family prior to entering the home.

Team Structure

Responding mobile crisis programs reported variable staffing and teams comprised of a range of professional roles. BHP-MC programs reported the highest median number of full-time equivalent staff (FTEs) (11.5 FTEs budgeted, 10 FTEs filled). This was followed by Alternative Responder programs (median: 8 budgeted, 7 filled) and Co-Responder programs (median: 6 budgeted, 5 filled). Programs also reported utilizing on-call staff, although this was more common among BHP-MC programs (68.4%) than Alternative Responder programs (46.1%) and Co-Responder programs (29.8%).

Mobile crisis programs need a minimum of 11 frontline FTEs to operate 24/7 with 2-person teams.[3] However, among programs that reported operating 24/7, only 56.1% also indicated they had 11 or more full-time frontline staff (or the equivalent number of hours staffed) in their programs.

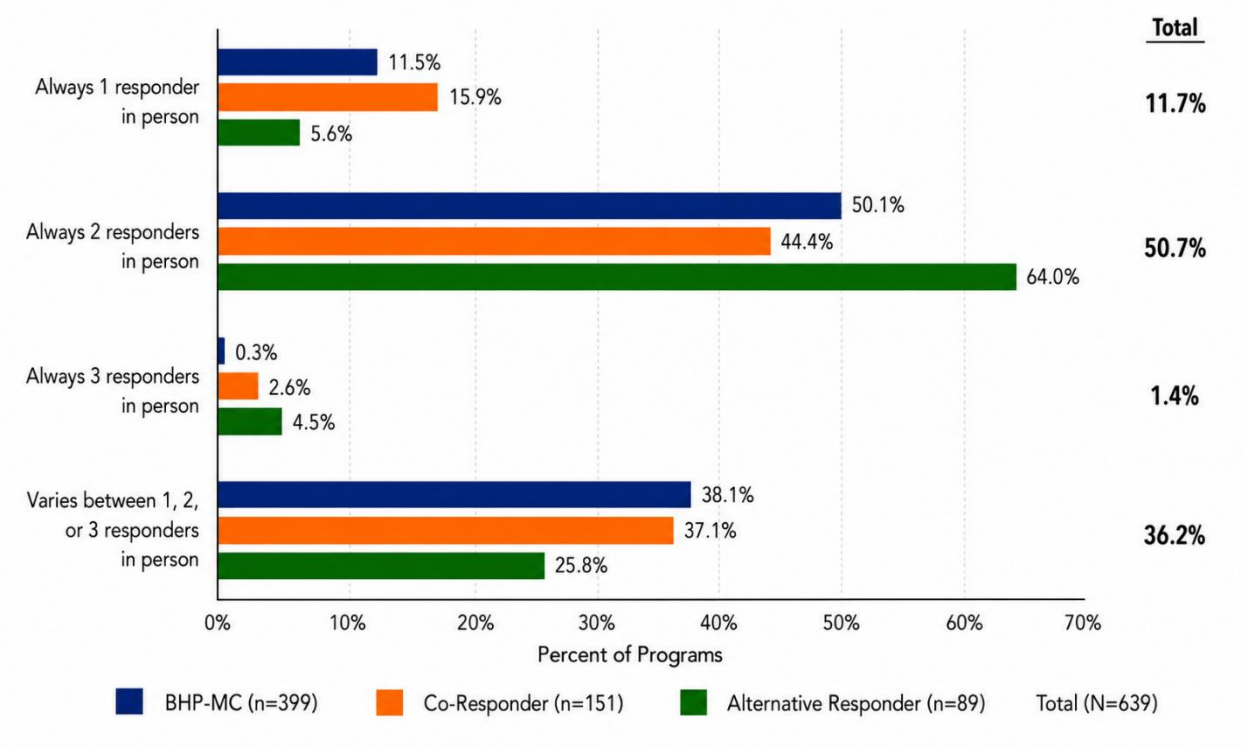
Teams reported the types of Full Time Equivalent (FTE) staff that make up their mobile crisis programs (Appendix Figure C7). For BHP-MC programs, the most common types of staff roles include licensed behavioral health clinician (88.8%), unlicensed behavioral health providers such as bachelor's or master's trained clinicians that are not licensed (75.9%), peer specialists (60.9%), paraprofessionals (e.g., behavioral health technicians) (16.9%), and nurses (12.4%). Alternative Responder programs also reported staffing by licensed (65.2%) and unlicensed clinicians (55.1%) as well as peers (40.4%) but were also likely to report paramedics/EMTs (38.2%) on their teams. Co-Responder programs primarily reported having licensed clinicians (83.6%) and law enforcement officers (58.6%) as team members, followed by unlicensed clinicians (45.4%) and peer specialists (13.8%).

When asked how many responders make up a team when going out into the field, approximately 50% of programs reported always sending two responders out in person. This was most common

[3] We used the following calculation to determine the total number of FTEs required to have 2 responders 24/7/365: 2 responders x 168 hrs/week = 336 hrs/week staff time. 336 hrs/week x 1.3 modifier for staff vacation/sick time = 436.8 hrs/week = ~11 FTE staff x 40 hours (440 hours/week). General calculation is as follows: (responder FTE x 40 hours / 1.3x modifier for staff vacation/sick) / (# hours of operation per week) / (# staff responding). This is the same calculation used by 2022 National Survey (Goldman et al., 2023).

among Alternative Responder programs (64.0%), followed by BHP-MC programs (50.1%) and Co-Responder programs (44.4%) (Figure 11). However, the proportion of programs reporting variation in the number of responders that they send out in person is also notable; 38.1% of BHP-MC programs, 37.1% of Co-Responder programs, and 25.8% of Alternative Responder programs indicated such variation. Multiple reasons for the variation in the number of responders were endorsed, including staff availability (71.4% across program type but most frequently endorsed by Alternative Responder programs (82.6%)), the severity of the call or level of clinical need (70.1% across program type), and location of the response (51.1% across program type) (Appendix Figure C8).

Figure 11. Number of Responders Sent to Crisis Situations



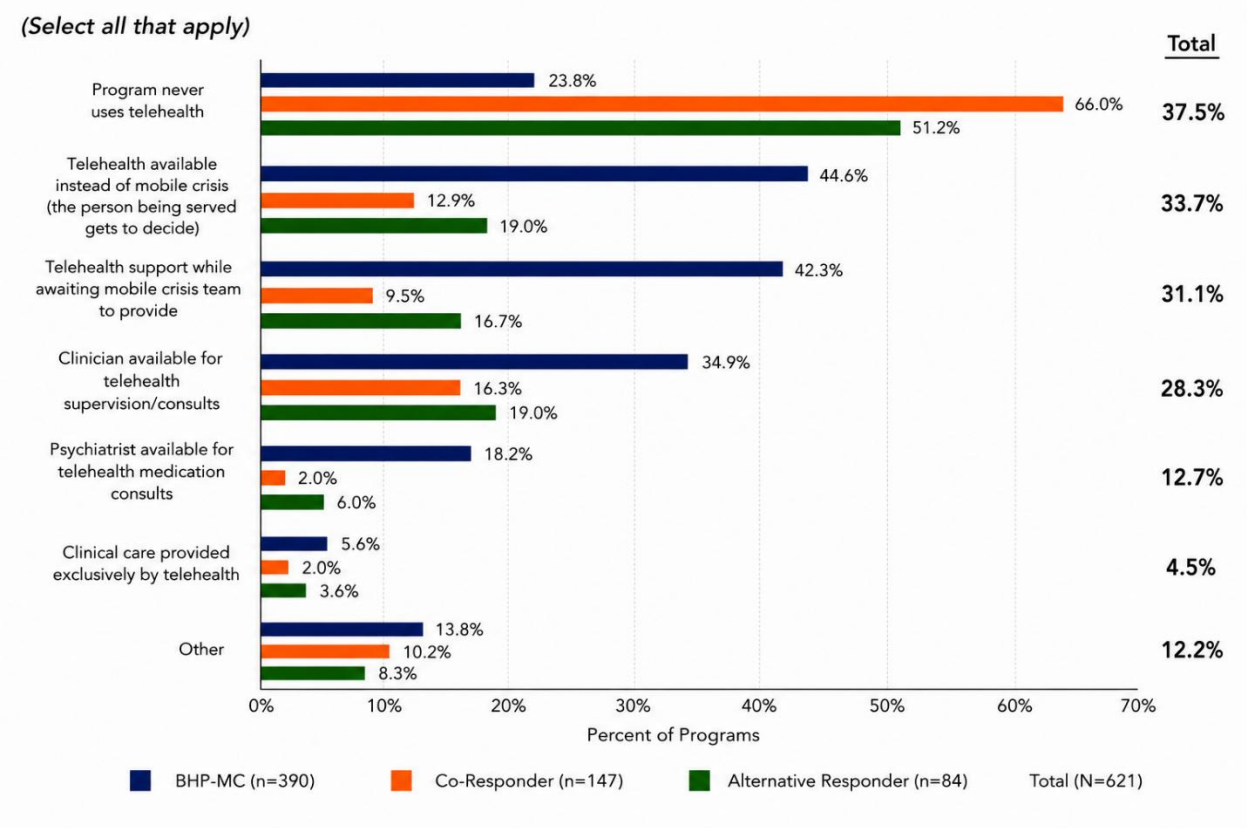
Capacity Enhancers

Capacity enhancers, such as shared staffing with affiliated programs and use of telehealth, were variable across program type. Sharing staff with other programs was more common among BHP-MC programs (43.9%) than Co-Responder programs (17.9%) or Alternative Responder programs (21.3%). BHP-MC programs most frequently reported sharing staff with outpatient behavioral health clinics (20.8%), crisis hotlines (18.8%), and crisis receiving facilities (9%) (Appendix Figure C9).

Programs also make use of telehealth in multiple ways and BHP-MC programs leverage this modality most frequently (76.2%, compared to 34.0% of Co-Responder programs and 48.8% of Alternative Responder programs). Among BHP-MC programs, 44.6% allow clients to choose telehealth for a visit instead of an in-person response, 42.3% have staff available via telehealth to provide support while waiting for the mobile crisis team to arrive, 34.9% make a clinician available

for consult via telehealth, and 18.2% have a psychiatrist available for medication consults via telehealth. All of these telehealth functions were less commonly reported by Co-Responder programs and Alternative Responder programs (Figure 12).

Figure 12. Use of Telehealth



KEY TAKEAWAYS:

Mobile crisis programs are variable with respect to staffing levels, team composition, and deployment to the field. BHP-MC programs generally reported larger staffing structures, with more FTEs and on-call staff, greater use of shared staffing models and more frequent integration of telehealth, reflecting greater integration into the broader community behavioral health system and the fact that they tend to serve larger catchment areas with larger numbers of people.

Team composition also varied across program types, suggesting that different programs rely on different types of professional expertise to provide service to people in crisis. Although SAMHSA best practice guidelines and Medicaid FMAP standards call for two-person teams to be deployed 24/7/365, almost half of teams who reported operating 24/7 also reported staffing levels that do not meet this threshold; many programs reported more variable deployment of staff to the field based on call severity, location, and staff availability. Such variation further underscores the operational diversity of field-based mobile response.

Training

Programs responded to a variety of questions about how staff in their programs are onboarded and trained. Training is done through a variety of modalities, including through on-demand videos (72.4%), self-directed readings (70.0%), classroom simulations (e.g., role plays) (64.1%), classroom instruction (55.9%), and virtual reality (16.0%) (Appendix Figure C10). Almost all programs (94.5%) use internally developed trainings, 83.6% use state-required or state-developed trainings (most often used by BHP-MC programs at 90.0%), and over half (52.8%) use vendor-developed trainings.

As shown in Appendix Figures C11–C14, trainings for mobile crisis program staff cover a range of safety assessment and intervention skills, physical health skills, and other topics relevant to crisis response. The most frequently reported training topics across program type reflect core competencies such as suicide risk assessment and intervention (98.6%), crisis intervention and stabilization (95.7%), trauma-informed care (92.9%), management of agitation and verbal de-escalation (92.8%), and basic knowledge about mental illnesses and substance use disorders (91.7%).

Other types of training were more variable across program types. For example, BHP-MC programs had the most frequent endorsement of training in structured brief interventions (e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT)) (53.5%). Co-Responder programs more frequently reported staff training related to people with intellectual and/or developmental disabilities (92.8%) and youth emotional disturbance (90.2%) in comparison to the other two model types. Alternative Responder programs were most likely to report training staff in working with unhoused populations (88.9%) and harm reduction approaches (82.6%).

In addition to the initial training period, nearly all programs reported that training for new team members includes a shadowing or provisional period; 98.7% of BHP-MC programs, 89.9% of Co-Responder programs, and 95.3% of Alternative Responder programs include a shadowing period. Programs most frequently reported a shadowing or provisional period of one to three months (60.6%), although this was most common among Co-Responder programs (64.7%) and least common among Alternative Responder programs (53.7%). Thirty percent of programs reported a shadowing or provisional period less than one month (31.0%, 24.8%, 37.8% for BHP-MC, Co-Responder, and Alternative Responder programs respectively) and 6.3% reported a shadowing or provisional period of more than three months (6.5%, 6.8%, 4.9% for BHP-MC, Co-Responder, and Alternative Responder programs, respectively) (Appendix Figure C15).

KEY TAKEAWAYS:

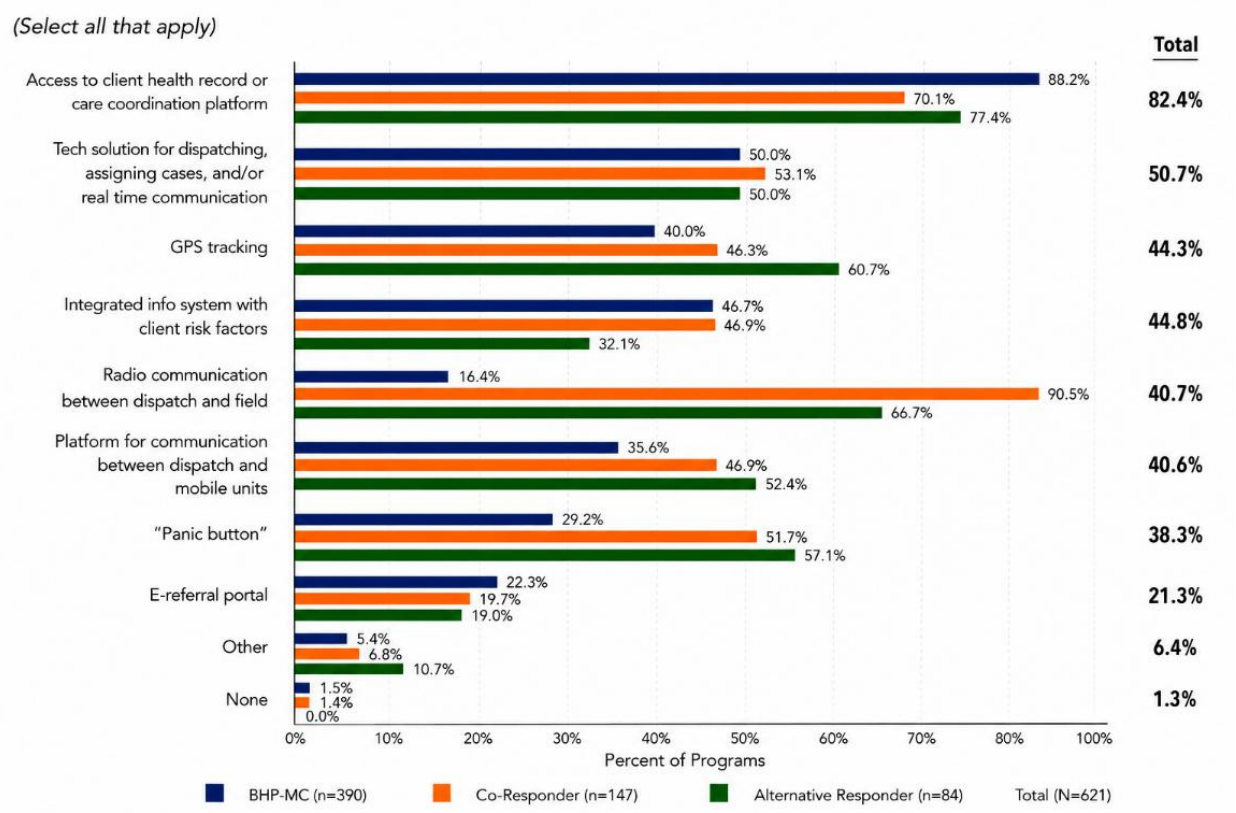
Mobile crisis programs train staff using multiple modalities across a broad range of core crisis competencies. This training takes time, as demonstrated by the variety of training topics endorsed by respondents and the fact that most programs include some period of shadowing in the field; these data may suggest that experiential onboarding is seen as a key element of workforce preparation. Although many training topics were frequently endorsed across all program types, some topics were concentrated by program type. These training variations may reflect the different

types of professional expertise on teams as well as the specific populations programs expect to serve in their communities.

Technology Leveraged by Programs

In addition to asking programs about their use of telehealth, described above, programs were also asked to report on the types of technological capabilities they leverage for their work. The most commonly reported technological capability endorsed was access to a client health record or care coordination platform (endorsed by 82.4% of all programs). About half of all programs also have a technological solution for dispatching and assigning cases. Meanwhile, only 21.3% of programs reported using an e-referral portal to communicate with other providers. Other technological capabilities vary by program type in ways that reflect program design. For example, 90.5% of Co-Responder programs and 66.7% of Alternative Responder programs use radios for communication but only 16.4% of BHP-MC programs do so. Whereas 51.7% of Co-Responder programs and 57.1% of Alternative Responder programs have a "panic button" to alert law enforcement if additional help is needed, this is true of only 29.2% of BHP-MC programs (Figure 13).

Figure 13. Technological Capabilities



Clinical record systems remain variable. Most programs rely on stand-alone electronic health records, although this is more common among BHP-MC providers (79.5%) in comparison to Co-Responder programs (63.3%) and Alternative Responder programs (65.5%). It is less common for

programs to have electronic health records integrated with other behavioral health systems (reported by 24.4% of BHP-MC programs and only 17.7% of Co-Responder and 16.7% of Alternative Responder programs). Across the three program types, programs most frequently reported relying on wireless tablets in the field for documentation (77.1%).

KEY TAKEAWAYS:

Mobile crisis programs reported widespread use of technology to support their work. However, integration remains limited across behavioral health, emergency response, and broader systems of care. Technology infrastructure also differed by program type in ways that reflect operational realities. While BHP-MC programs more commonly utilized technologies aligned with behavioral health service delivery and clinical care coordination, Co-Responder and Alternative Responder programs more commonly relied on technologies that are linked to the public safety infrastructure.

Funding

Financing of mobile crisis programs is highly variable. Most mobile crisis programs are supported by braided funding sources, meaning they rely on some combination of federal, state, county, or city funds, CCBHC funding, or foundation grants. This is true of 65.5% of BHP-MC programs, 57.5% of Co-Responder programs, and 58.3% of Alternative Responder programs (Figure 14). However, there are also some notable exceptions. For example, 18.6% of BHP-MC programs are funded entirely by state funds and 17.9% of Alternative Responder programs are funded entirely by city funds. The median annual operating costs for programs was $1,115,910 for BHP-MC programs, $400,000 for Co-Responder programs, and $1,000,000 for Alternative Responder programs.

Programs also vary with respect to billing insurance. Over 80% of BHP-MC programs bill insurance, but this is true of only 23.3% of Co-Responder programs, and 40.5% of Alternative Responder programs. Programs that bill insurance most frequently endorsed billing Medicaid (billed by 79.6% of BHP-MC programs, 21.9% of Co-Responder programs, and 40.5% of Alternative Responder programs) (Figure 15). This was followed by private insurance (44.3%, 13.7%, and 13.1% across BHP-MC, Co-Responder, and Alternative Responder programs respectively), and Medicare (40.7%, 12.3% and 11.9% across BHP-MC, Co-Responder, and Alternative Responder programs respectively). The most common insurance codes used for an initial crisis visit were reported as H2011 (*crisis intervention service,* reported by 37.4% of programs), S9484 (*crisis intervention mental health services,* which is a temporary Healthcare Common Procedure Coding System (HCPCS) “s-code” reported by 9.6% of programs), and 90839 (*psychotherapy for crisis,* reported by 8.4% of programs). Additionally, 11.5% of programs reported using an “Other” code for an initial crisis visit.

Figure 14. Funding Sources Outside Insurance

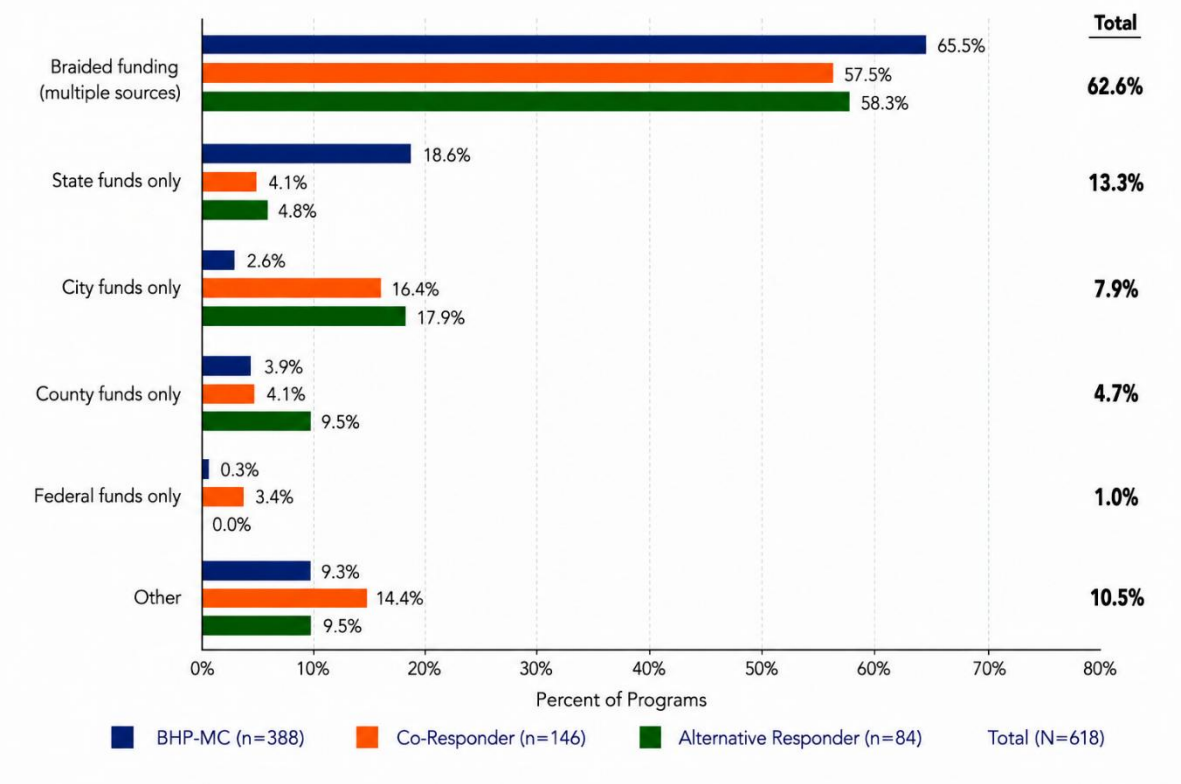
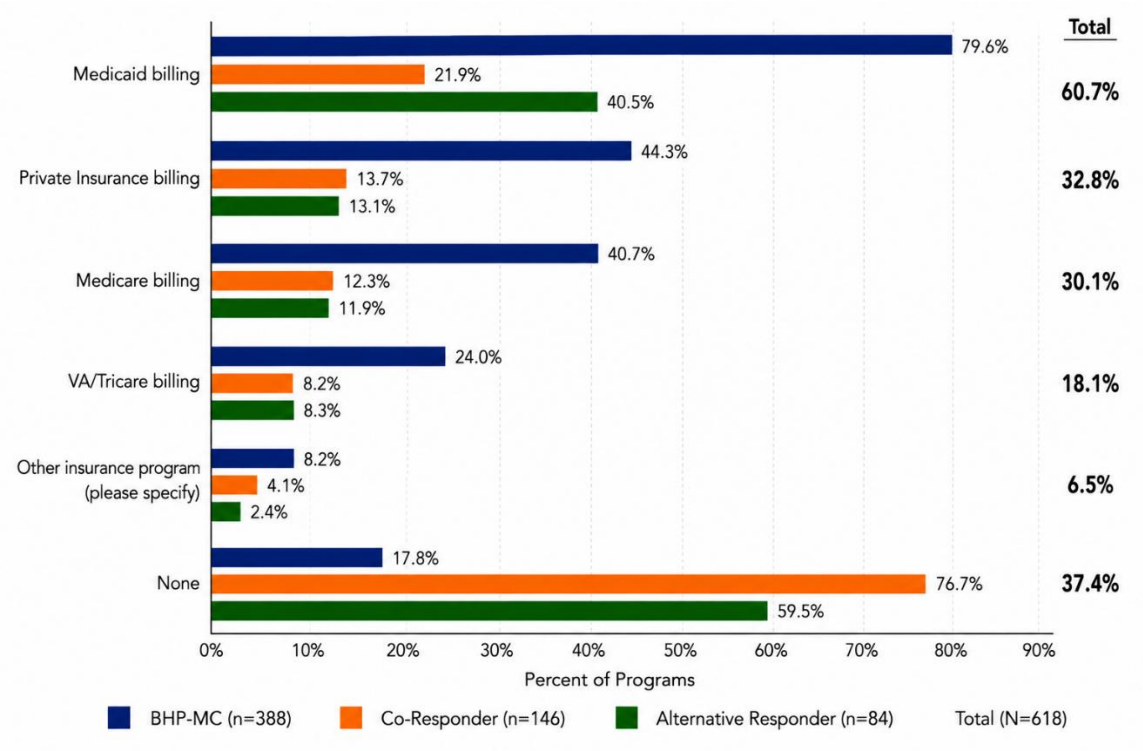


Figure 15. Insurance Billing



KEY TAKEAWAYS:

Mobile crisis programs reported diverse financing structures, with most relying on braided funding approaches. BHP-MC programs are more likely to bill insurance, which may make sense because they are commonly operated by mental health agencies that routinely bill insurance for other services. By contrast, large percentages of Co-Responder and Alternative Responder programs do not bill insurance and approximately 1 in 6 of these programs is dependent entirely on city funding.

Metrics

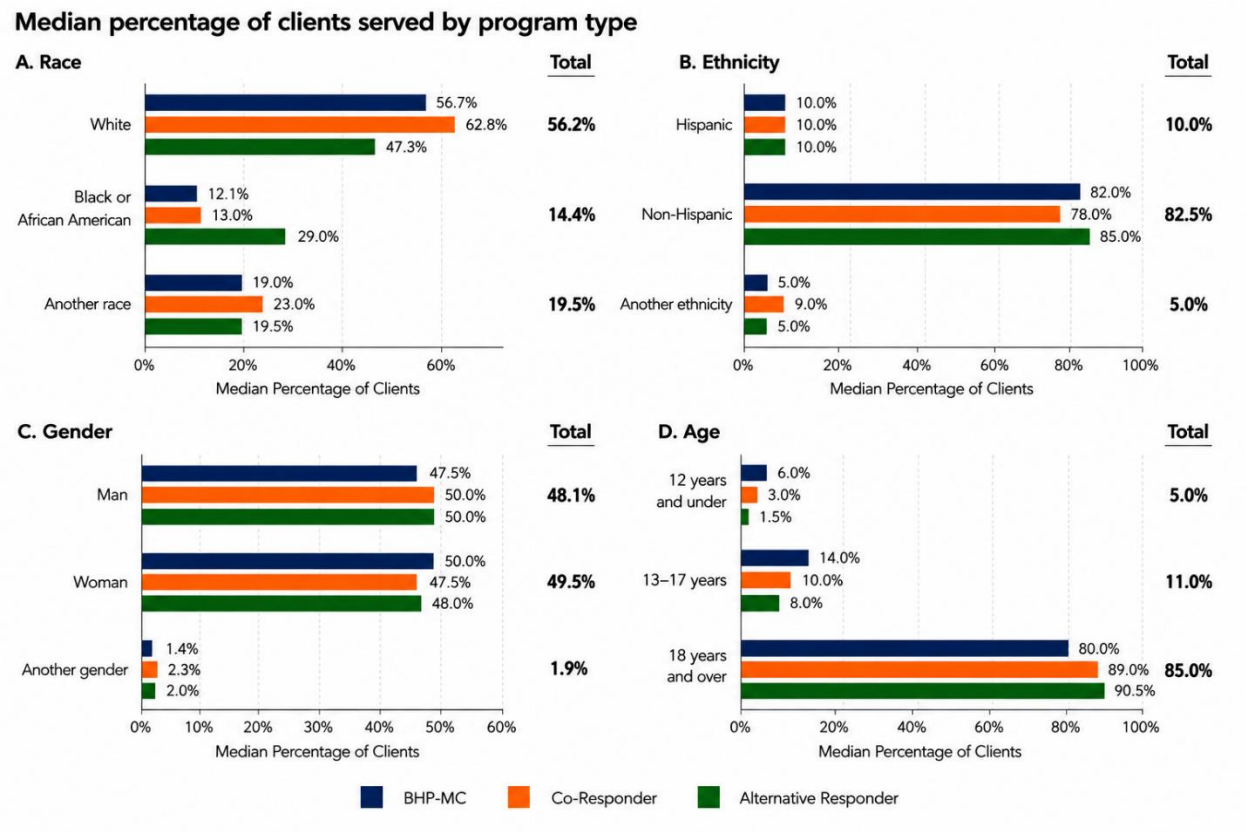
The final section of the survey instrument asked programs to report the types of metrics they collect and, when possible, to enter program data on each specific metric for the first three quarters of 2025 (January 1, 2025 – September 30, 2025). Data were entered in a structured way to promote consistency and comparisons across programs.

Eighty-seven percent of responding programs reported on at least some of the kinds of data they collect to track program operations. Among programs providing this information, 88.1% collect data on the number of mobile crisis service responses they provide, 79.5% collect data on the number of face-to-face encounters, and 79.0% collect data on the number of inbound requests for mobile crisis services (inclusive of those requests that do not receive a mobile response). Additionally, most programs track some form of call resolution, including 70.0% collecting data on the number of calls stabilized in the community (i.e., resolved on the scene), 65.7% collecting data on the number of calls resolved with transport to the emergency department or a crisis center, and 55.8% collecting data on the number of involuntary holds they place (Appendix Figure C16). Appendix Figure C16 shows the number of programs that report collecting data on each of the 17 metrics asked about in the survey.

A subset of teams also provided actual program data for the first three quarters of 2025. With respect to demographics, 39.9% of programs (n = 268 programs) reported at least some demographic data on the population served during the first three quarters of 2025 (Figure 16). The data suggest some racial differences in the population served across program types, particularly for Alternative Responder programs. Alternative Responder programs served the most racially diverse client populations, with the highest median percentage of Black clients (median percentage = 29.0%, n = 39 programs reporting) and the lowest median percentage of White clients (median percentage = 47.3%, n = 38 programs). Conversely, Co-Responder programs had the highest median percentage of White clients (median percentage 62.8%, n = 38 programs) and a lower median percentage of Black clients (median percentage = 13.0%, n = 39 programs). The median percentage of clients of another race was relatively consistent across program types. Across program types, programs reported serving predominantly non-Hispanic clients (median percentages = 78-85%, n=174 programs reporting). The reported gender composition of clients was also similar across program types, with overall median percentages of 48.1% men, 49.5% women, and 1.9% another gender (n = 256 programs reporting percentages of men and women served; n=189 reporting the percentage of another gender served).

Additionally, programs across model types primarily served adults ages 18 years and older, with a median of 85.0% of clients in this age group (n = 268). The median percentage of clients ages 18 and older was particularly high among Co-Responder programs (89.0%) and Alternative Responder programs (90.5%). By comparison, BHP-MC programs served younger populations, with median percentage of 80% adults ages 18 and older (n=179 programs), 14.0% adolescents ages 13-17 (n=171), and 6.0% children ages 12 and younger (n=170). The younger populations served by BHP-MC programs at least partially reflect the fact that this program category includes MRSS and ICSS teams, which are intended to serve youth specifically.

Figure 16. Demographics of Clients Served (January 2025 - September 2025)

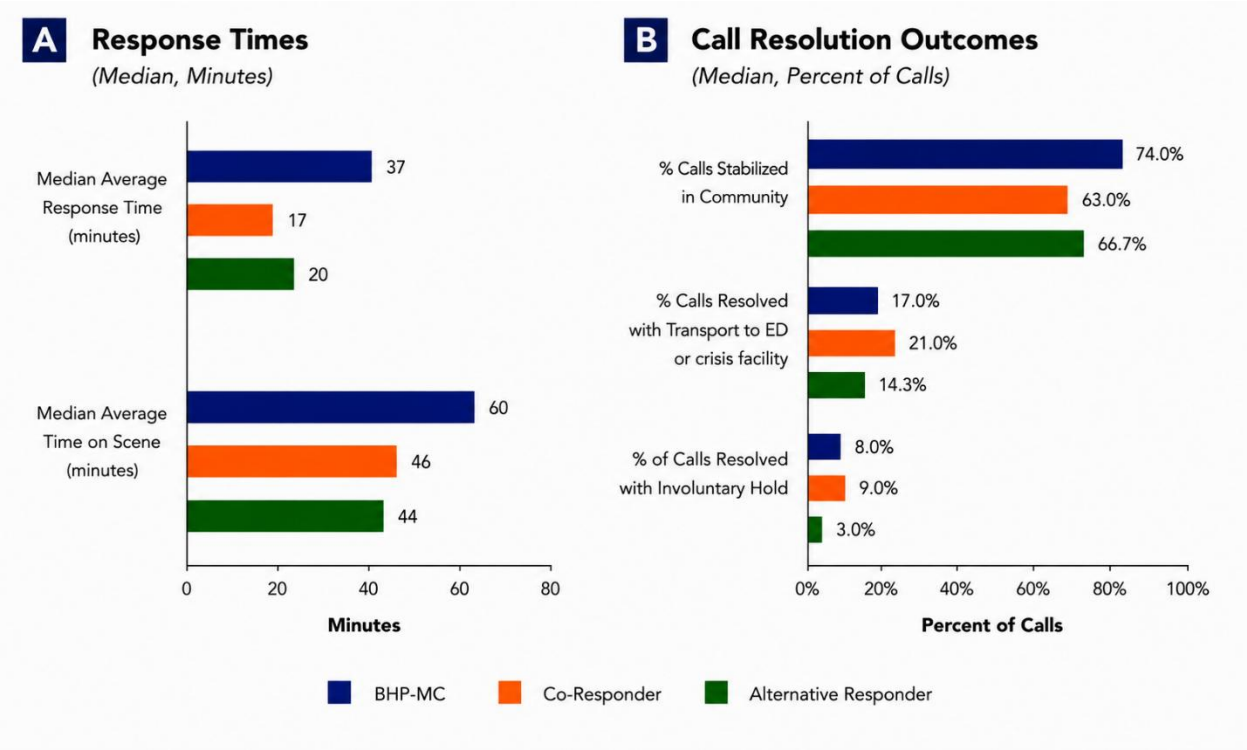


Note: Denominators vary because not all programs reported each measure. Panel A: White (BHP-MC *n* = 146, Co-Responder *n* = 38, Alternative Responder *n* = 38); Black (144, 39, 39); Another race (145, 37, 38). Panel B: Hispanic (118, 26, 30); non-Hispanic (116, 28, 30); Another ethnicity (96, 21, 22); Panel C: Man (170, 44, 42), Woman (170, 44, 42), Another gender (130, 30, 29); Panel D: 12 and under (170, 43, 36); 13-17 (171, 42, 37); 18 and over (179, 49, 40).

Programs also varied with respect to key outcome measures, including average response time and time on scene, percent of calls stabilized in the community, percent of calls resolved with transport to an emergency department or crisis facility, and percent of calls involving an involuntary hold (Figure 17). Among programs reporting average response time, the median of programs' reported average response times was shortest for Co-Responder programs (17 minutes). Among programs reporting average time on scene, the median of programs' reported average times on scene was longest for BHP-MC programs (60 minutes).

Among programs reporting the percentage of calls stabilized in the community, the median percentage was 74.0% for BHP-MC programs, 63.0% for Co-Responder programs, and 66.7% for Alternative Responder programs. Among programs reporting the percentage of calls resolved with transport to emergency department or crisis facility, the median percentage was 17.0% for BHP-MC programs, 21.0% for Co-Responder programs, and 14.3% for Alternative Responder programs. Finally, among programs reporting the percentage of calls resulting in involuntary holds, the median percentage was 8.0% for BHP-MC programs, 9.0% for Co-Responder programs, and 3.0% for Alternative Responder programs.

Figure 17. Selected Outcomes (January 2025 - September 2025)



Note: Denominators vary because not all programs reported each measure. Panel A: response time (BHP-MC *n* = 196, Co-Responder *n* = 32, Alternative Responder *n* = 42); time on scene (164, 41, 41). Panel B: calls stabilized in the community (156, 47, 33); transport to ED/crisis facility (132, 47, 32); involuntary hold (108, 41, 23).

KEY TAKEAWAYS:

Most mobile crisis programs reported collecting some type of data related to their program operations; the most frequently reported metrics collected related to service requests, face-to-face encounters, and call disposition outcomes. However, at least in part because providing actual data was optional, fewer than half of responding programs provided demographic or outcome data for analysis.

Among programs reporting demographic and outcome data for the populations served in the first three quarters of 2025, differences across program types also emerged. Alternative Responders reported serving the most racially diverse client populations, whereas Co-Responder programs

reported serving the highest median percentage of White clients. BHP-MC programs also served younger populations overall. These findings should be interpreted with caution since the demographics of clients served likely reflect underlying differences in program catchment areas and the survey is not nationally representative.

Outcomes also varied across programs. It is notable that a large majority of calls across program types were stabilized in the community; these findings may serve as a benchmark for on-scene resolution rate, which has not been previously described at the national level. However, a small but not negligible portion of calls still result in more restrictive care pathways through involuntary holds. Given our earlier findings about how only 19.3% of BHP-MC programs provide involuntary transport, many of these involuntary holds likely result in engagement with law enforcement to provide transport.

DISCUSSION

This national survey of mobile crisis programs is the most comprehensive national survey to date and provides rich, program-level information about the landscape of mobile crisis response systems across the U.S. Six key areas were identified for further discussion.

Diversity and Local Adaptation

First, mobile crisis programs are incredibly diverse and understanding any one mobile crisis program requires knowledge of the context in and for which it was developed. Our survey demonstrates that programs within the umbrella of "mobile crisis" serve various geographies and population sizes, have diverse administrative oversight and co-location arrangements, are accessed by the public in different ways, and are embedded in different response systems ranging from mental health to public health, to law enforcement, to EMS and Fire. One size does not fit all; mobile crisis programs are designed and implemented in dynamic environments that require communities to balance local context with emerging best practices and standards for care. While this local adaptability has advantages, the public may experience this as inconsistency and even unreliability; proactive communication about mobile crisis service availability is therefore critical to ensuring transparency and managing expectations. Further, while the fragmentation of the crisis response system allows for programs to best meet the unique needs of the various communities they serve, centralized resources focusing on increasing the accessibility of these services will help reduce the burden on community members.

Differentiation Across Crisis Response Program Types

Second—and related closely to the issue of diversity—mobile crisis programs have many different names and some of our data suggest the field may be moving toward crisis response systems that individuate different models for different needs. Our survey required respondents to select from one of four model definitions that best reflected their program type: behavioral health provider led mobile crisis programs (BHP-MC), mobile response and stabilization services (MRSS), law-

enforcement based co-responder programs, and alternative or community responder programs. We chose these models to align with current SAMHSA definitions (SAMHSA, 2025b) and common nomenclature in the field, while recognizing that such model types and definitions have limitations and may mean different things to different respondents. As one example, the data reported on the number of programs that have law enforcement officers as full time equivalent staff was surprising. On the one hand, Co-Responder programs, which, by definition, include law enforcement officers as part of the response team, reported having FTE law enforcement officers less than expected. We suspect this reflects the fact that some respondents may have reported only on the behavioral health staff involved in the Co-Response partnership. On the other hand, BHP-MC programs and Alternative Responder programs reported employing FTE law enforcement officers more often than expected, despite these models generally being conceptualized as alternatives to police.

At the same time, our data demonstrate that there are important distinctions between these broad model types. Chief among them is the broader systems within which these models are embedded, with BHP-MC programs largely embedded in behavioral health systems, Co-Responder programs embedded in law enforcement agencies, and Alternative Responder programs occupying a distinct position, often embedded in EMS/Fire systems but generally dispatched through public safety systems. In turn, these models have different relationships with 988 and 911, as well as different staffing models. Notably, each program type is distinct in some ways and overlaps with other program types in other ways. Practically, this means that when a region has only one program, there may be some core functions that the program needs to cover entirely, whereas when multiple programs co-exist there is a need for coordination and synergy across programs, ideally in ways that limit law enforcement involvement to only when it is absolutely necessary.

Mobile Crisis Standards and Operational Reality

Third, there remains a gap between the SAMHSA vision of 24/7 mobile crisis coverage and the practical feasibility of providing coverage at this scale. Only 63% of responding programs indicated they operate 24/7 and, among those teams operating 24/7, only 56% of programs have the minimum required staffing to send out 2-person teams around the clock. Workforce shortages remain, as evidenced by the disparity between budgeted and filled positions reported. That said, programs also indicated there may be other practical reasons for the variation in number of staff sent out into the field, including the severity of the call or clinical expertise required. Still, two-person response teams continue to be promoted as best-practice by SAMHSA (SAMHSA, 2025a) and many states have amended their Medicaid State Plans to require two-person teams in order to claim the enhanced Federal Medical Assistance Percentage (FMAP) through Medicaid, which provides a higher federal Medicaid reimbursement rate for qualifying mobile crisis services (Compton et al., 2025). Additional work is needed to understand whether and how flexibility on the number of responders should be built into national standards for mobile crisis as well as the consequences of more or less flexibility.

The Enduring Role of Law Enforcement in Crisis Response

Fourth, law enforcement remains a common partner in certain kinds of crisis situations, even among programs where law enforcement is not officially part of the model (i.e., does not include law enforcement as staff). Fewer than one third of teams respond solo to substance use intoxication, withdrawal, or overdose, fewer than 20% of teams respond solo to calls involving high-risk suicidality or an attempt in progress, and even fewer respond solo to calls involving medical emergencies or those involving high risk for violence (7.5% and 6.9% respectively). Even non-law enforcement-based teams (i.e., BHP-MC programs and Alternative Responder programs) reported always or consistently having law enforcement clear the scene before the team enters (13.6% of BHP-MC programs and 21.3% of Alternative Responder programs). Further, fewer than 20% of BHP-MC programs and Alternative Responder programs provide involuntary transport suggesting that these programs likely call law enforcement to provide such transport (as may be required by state statutes in some states) (see Swartz et al., 2025 for a useful resource on state laws regarding transport for involuntary commitment). These data resonate with findings from the 2022 survey of mobile crisis programs that found that mobile crisis programs rely on law enforcement for multiple key functions (Erickson et al., 2025). While there are many reasons for strong law enforcement partnerships and delegating calls to law enforcement when their involvement is required, further work is needed to define consensus criteria for when law enforcement involvement is appropriate, understand how these crisis situations unfold, and strategize public messaging about the kinds of professionals who may respond to a crisis.

The Evolving Crisis Care Continuum

Fifth, the actualization of a full continuum of crisis care—where people can move through the phases of someone to call, someone to respond, and somewhere to go as needed—remains in progress. Mobile crisis programs can be reached via multiple access points, including by directly calling programs, by calling 988 and 911, and by calling additional hotlines such as 211, 311, and other regional or state lines. Four years after launching 988 as the three-digit number to reach the Suicide and Crisis Lifeline, nearly 80% of BHP-MC programs reported that they can be reached by calling 988. However, only a small portion of programs describe 988 as a primary referral source (13.3% of BHP-MC programs and 8.9% of all programs). Once mobile programs arrive on scene, they not only provide immediate crisis response but also connect people to needed services and provide follow-up. This includes dropping people off at outpatient services, crisis facilities, substance use detox or sobering facilities, and hospital emergency departments; conducting follow-up over the phone and in-person; and even providing time-limited intensive case management in some cases. At the same time, digital integration remains limited across systems. Additional research that further explores how people move through this continuum—both what their experience is and what outcomes they have—is warranted.

Data and Measurement

Last, while most programs collect at least some metrics related to their process, performance, and outcomes, the breadth and depth of data collection is variable. Further, comparison of program data across jurisdictions remains challenging given the different contexts in which programs operate and the multiple ways specific metrics are defined in the field. There is emerging guidance in the field related to how programs can measure what matters to their community, build a data infrastructure for measurement, and leverage data to strengthen their programs (SAMHSA, 2025a; Yamamoto et al., 2026). For example, a handful of Alternative Responder programs across the country have also developed public-facing data dashboards to increase transparency and understanding about how their programs are functioning (see, for example, the New Orleans Mobile Crisis Intervention Unit data dashboard). Even so, the field would benefit from more robust, longitudinal data collection that moves beyond cross-sectional surveys and tracks team functioning in the field, how responses vary, and with what outcomes.

LIMITATIONS

There are limitations to the survey that should be acknowledged. First, the responding mobile crisis programs may not accurately represent the wider population of mobile crisis programs across the U.S. The national survey was limited to a convenience sample, and we oversampled in five states to support comprehensive state-level analyses in places where we could maximize recruitment efforts. Even so, our survey respondents offer remarkable diversity with respect to geography and organizational and operational characteristics.

Second, although we did extensive work to identify and recruit programs to participate in this survey, there is no comprehensive national registry of mobile crisis programs. Therefore, not all programs could be identified or directly invited to participate.

Third, as noted above, we required programs to select one of four program types (defined for respondents in the survey). These model types are necessarily oversimplified given the heterogeneity in the field. Some respondents may not have felt any definition accurately defined their program and some respondents may have chosen the program type that aligns with their own definition of that type despite the definition provided. Drawing conclusions about differences between program types should therefore be done with this context. Future analyses, including a planned latent class analysis, may provide a more detailed and nuanced understanding of the subgroups within the umbrella of mobile crisis response.

Fourth, this report is limited to descriptive statistics that provide a broad overview of the mobile crisis landscape but does not present inferential statistical analyses to compare responses across program types or conduct other analyses. Given the length of the survey, our goal in this report was to present data on all survey variables. Additional analyses are underway for peer-reviewed publications.

CONCLUSION

This survey fills an important knowledge gap about mobile crisis programs across the United States, providing the most comprehensive picture to date about how mobile crisis programs are structured, accessed, and operate in the diverse communities they serve. Our findings highlight both the growth and continued evolution of mobile crisis within the broader crisis continuum. They also underscore the diversity of existing models and programs, the importance of local context, the gaps between existing standards and operational realities, and the need for continued research, standardized measurement, and policy development that can strengthen crisis response systems. Future work can build on this survey to track changes over time and deepen understanding of the evolving mobile crisis landscape.

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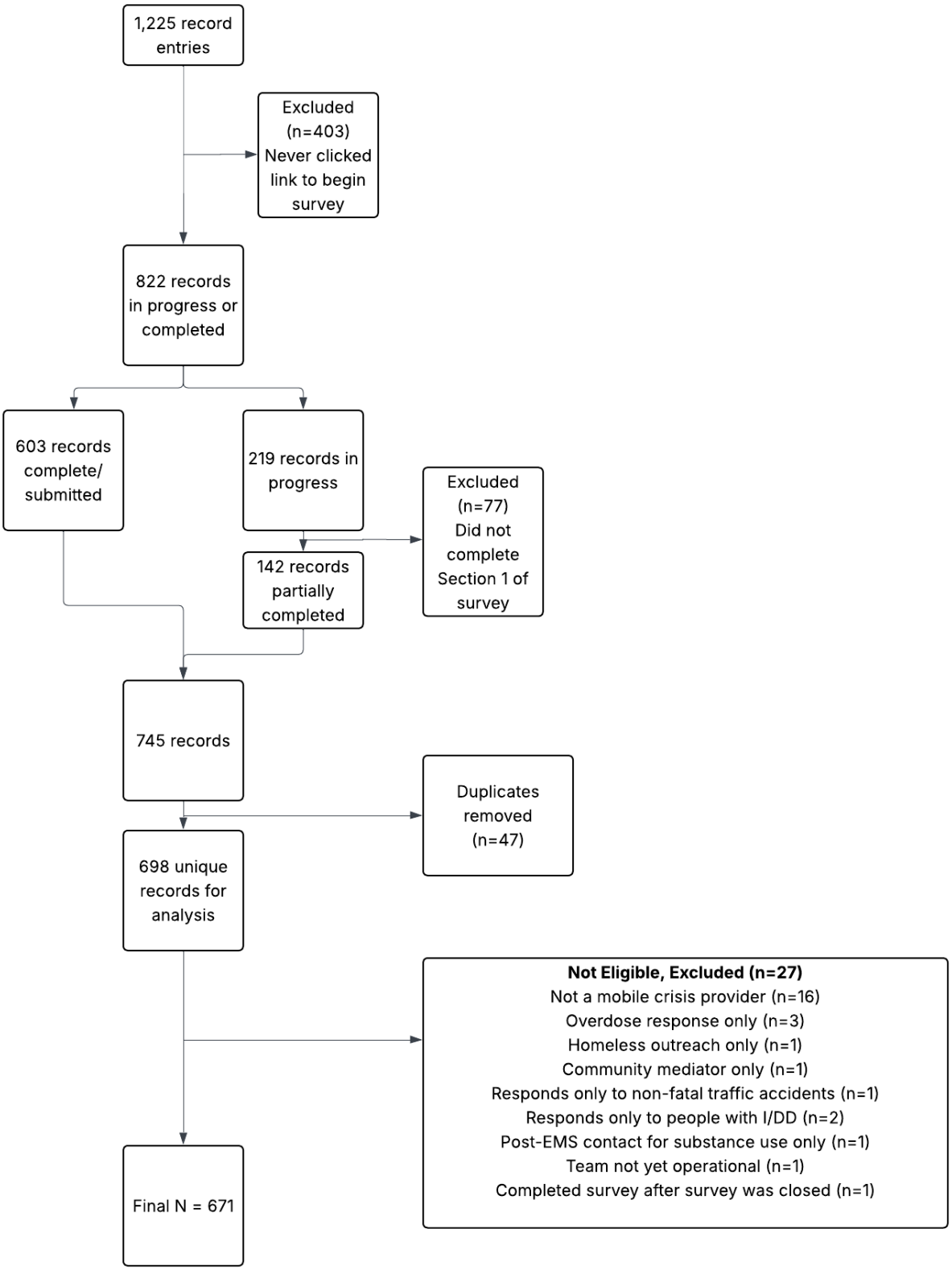
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Appendix A. Dissemination Partners for National Survey of Mobile Crisis Programs

Alternative Mobile Services Association
American Association for Emergency Psychiatry
American Foundation for Suicide Prevention
Behavioral Health Link
Center for Innovations in Community Safety
CIT International
Connections Health Solutions
Council of State Governments
Crisis Jam
Crisis Residential Association
Fourth Branch Institute
Government Performance Lab at Harvard Kennedy School
Health Lab at University of Chicago
International Association of Chiefs of Police
International Co-Responder Alliance
International Council for Helplines
International Crisis Response Association
Law Enforcement Action Partnership
Meadows Mental Health Policy Institute
National Action Alliance for Suicide Prevention
National Association of County Behavioral Health and Developmental Disability Directors
National Alliance on Mental Illness (NAMI)
National Association of State Mental Health Program Directors
National Collaborative for Transformative Youth Policy
NRI
Police, Treatment, and Community Collaborative (PTACC)
Policing Project at NYU
Right Response Network
SAMHSA CSR-TTAC
Sozosei Foundation
Vera Institute of Justice
Vibrant
Zero Suicide

Appendix B. National Mobile Crisis Survey Flowchart & Final Sample



Appendix C. Additional Figures

Figure C1. Mobile Crisis Partnerships

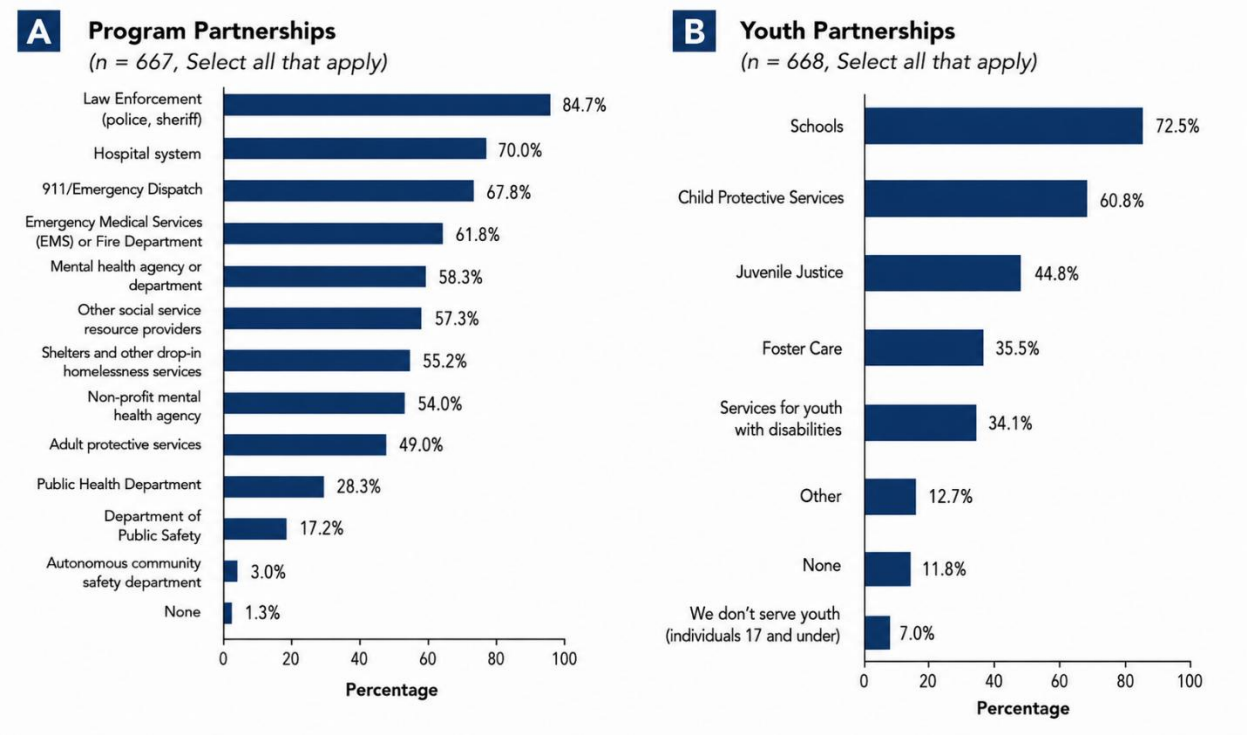


Figure C2. Party Responsible for Dispatch Decision

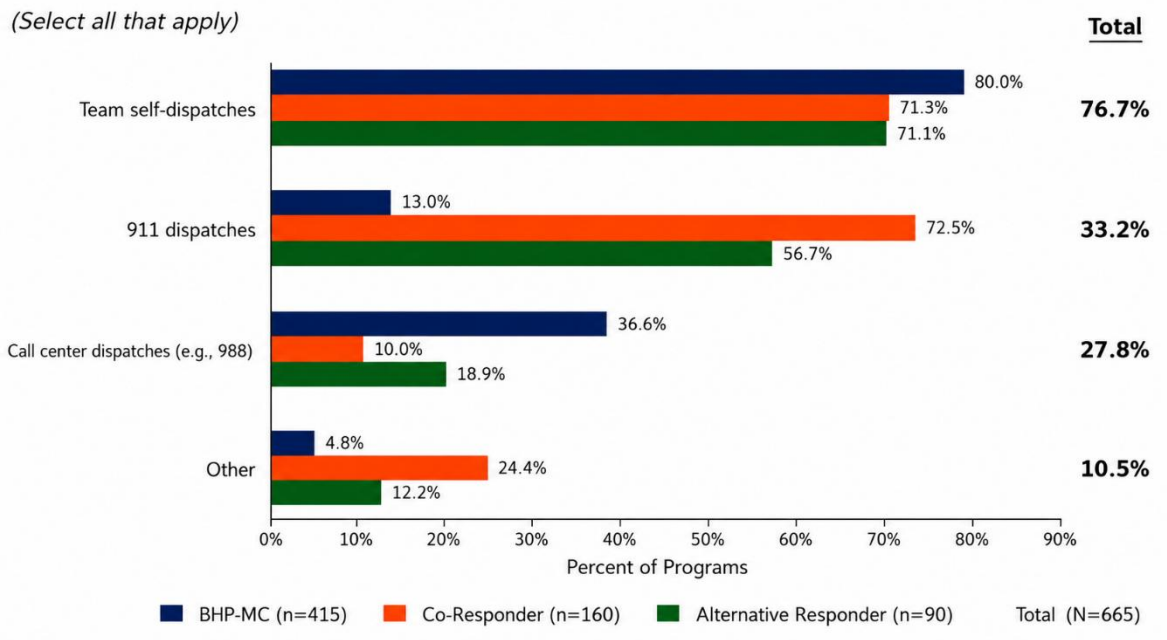


Figure C3. Mobile Crisis Response Call Types

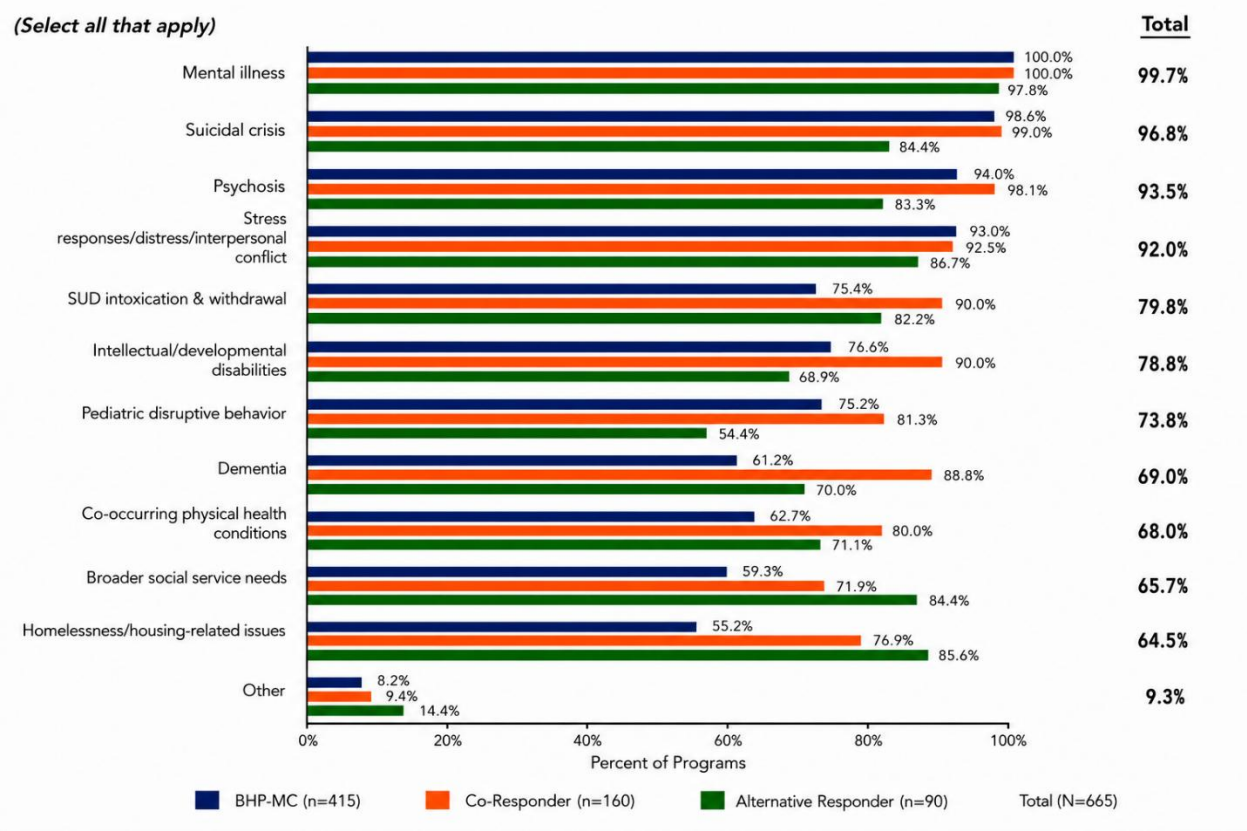


Figure C4. Involuntary Holds and Transport

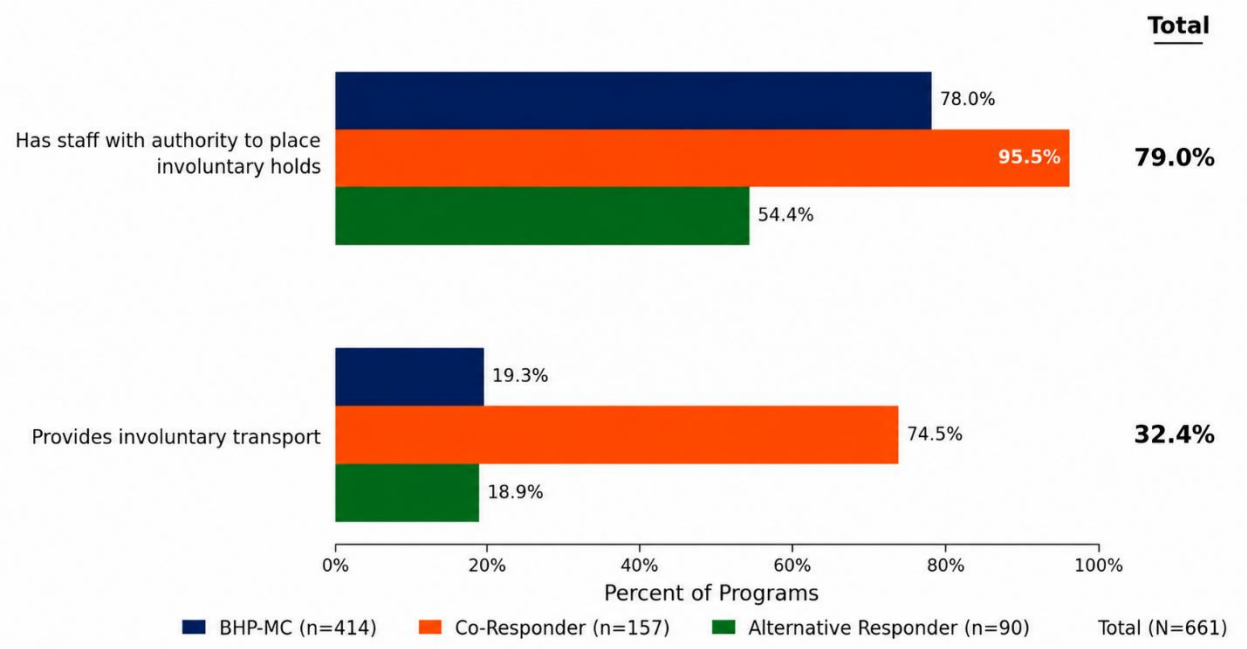


Figure C5. Where Mobile Crisis Programs Respond to Calls

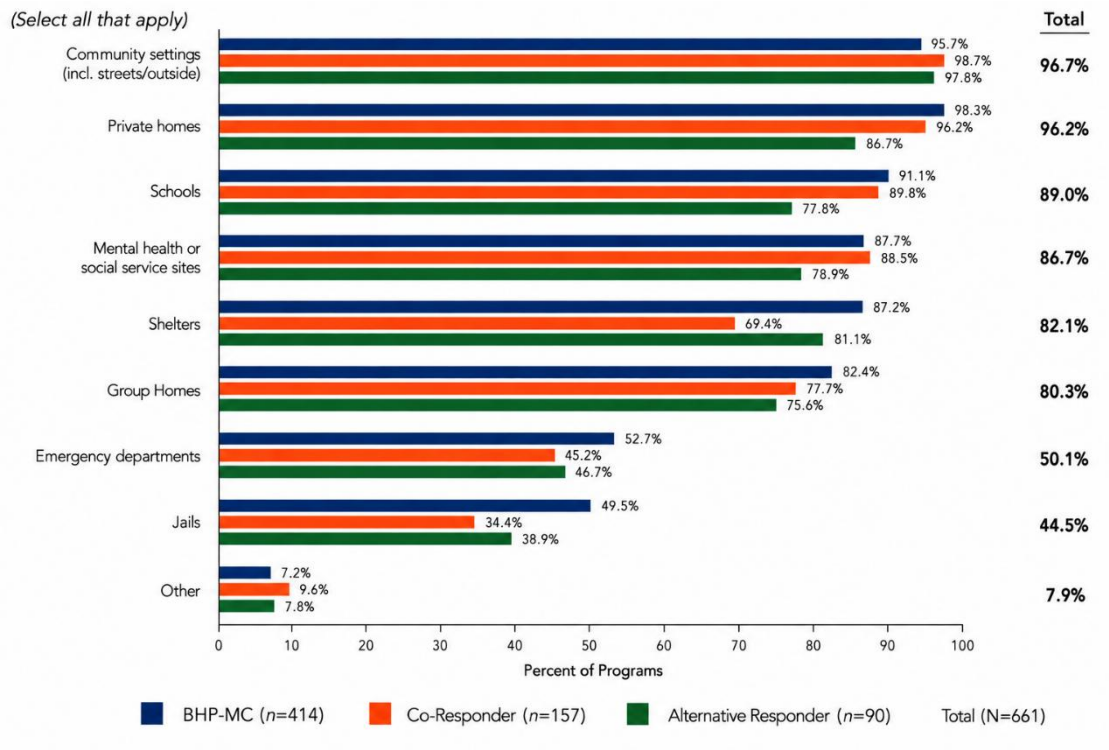


Figure C6. Reasons Mobile Crisis Programs Respond to Emergency Departments

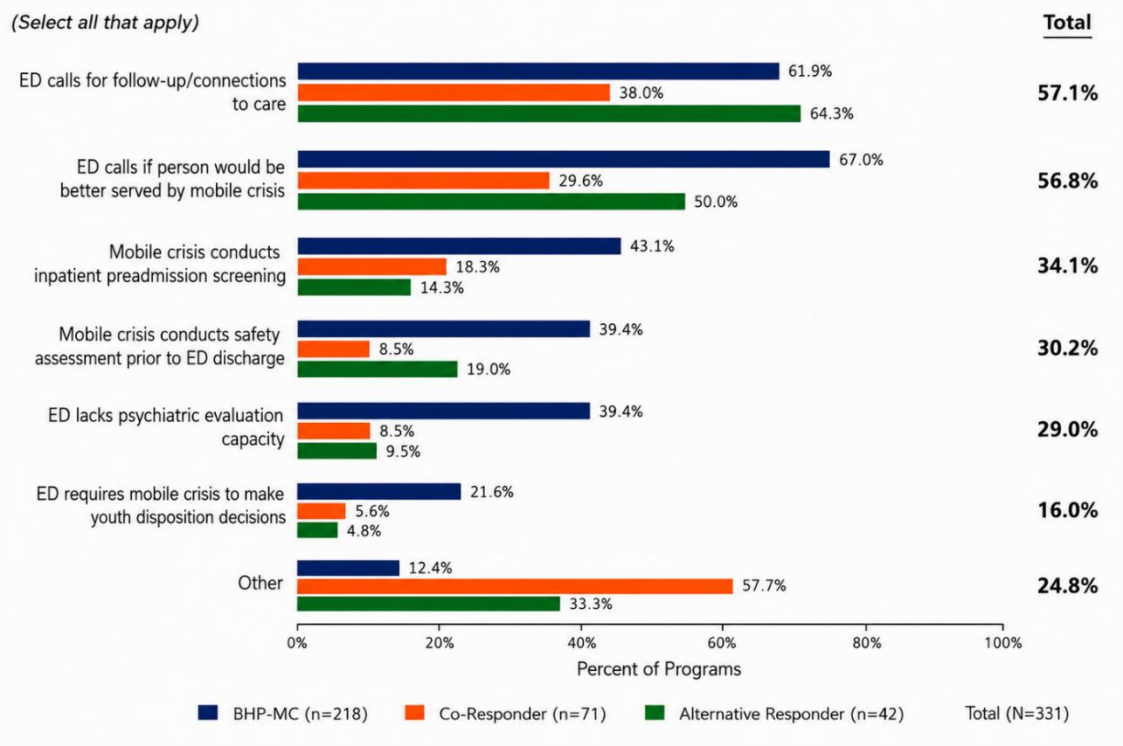


Figure C7. Professional Roles for FTE Staff in Mobile Crisis Programs

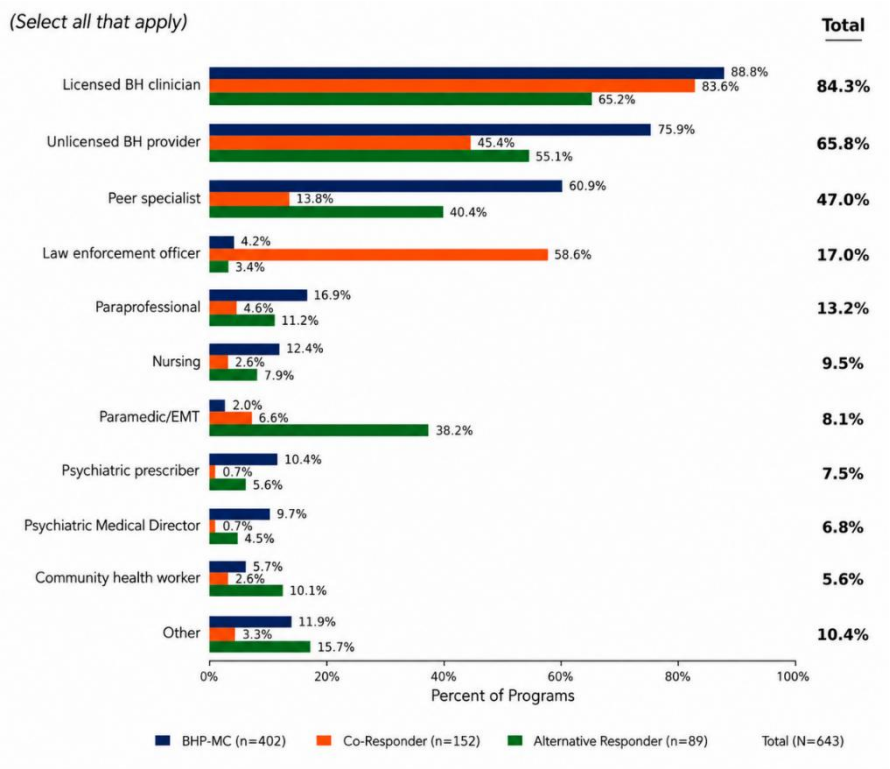


Figure C8. Reasons for Variation in Number of Responders Sent to Crisis Call

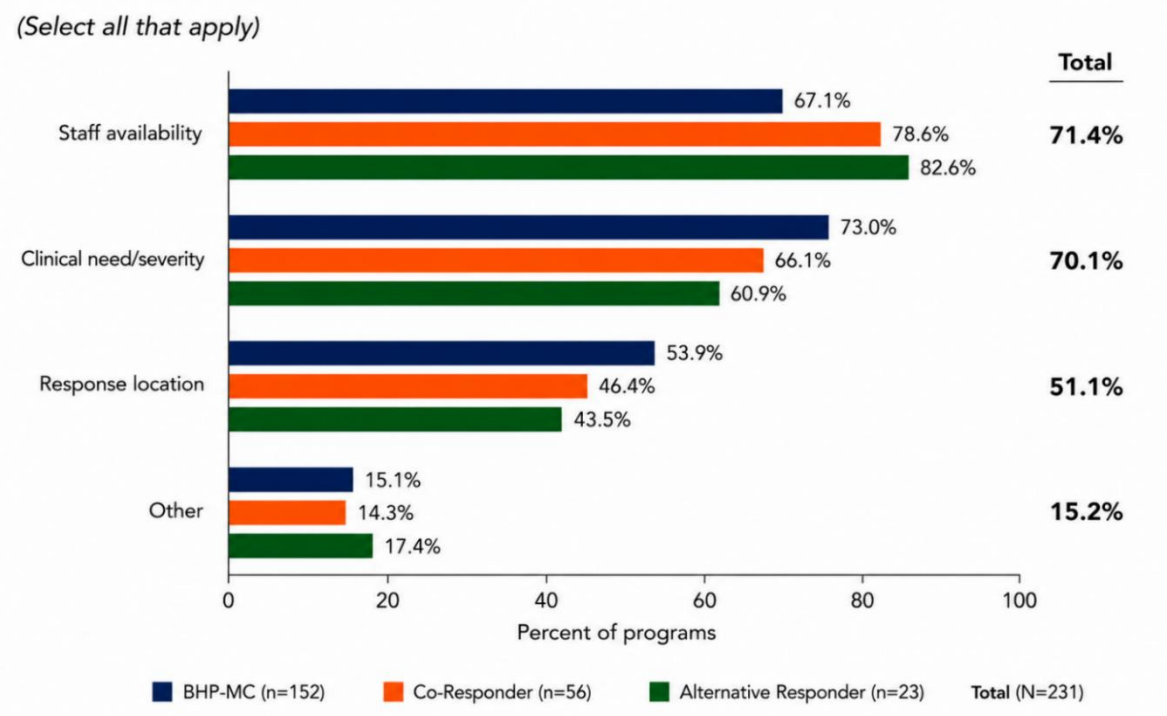


Figure C9. Staff Sharing Arrangements

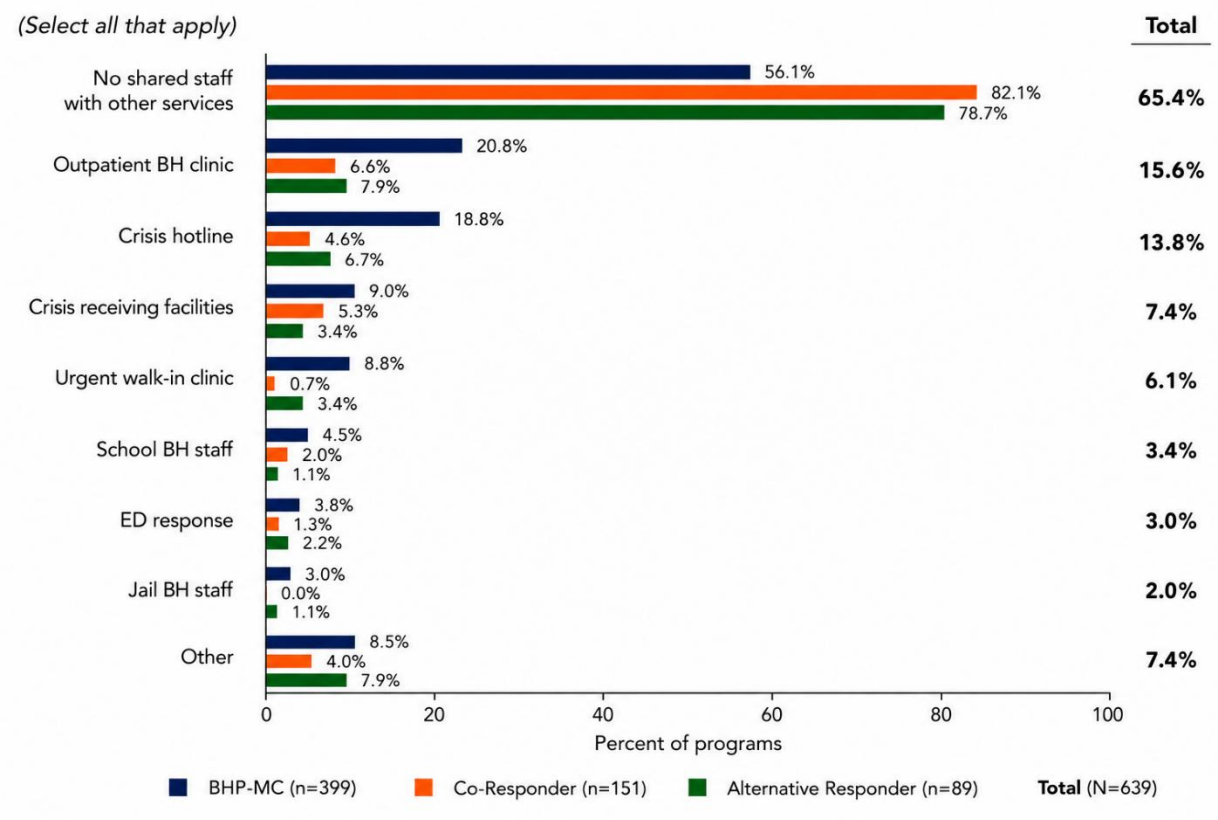


Figure C10. Training Modalities Utilized for New Mobile Crisis Staff

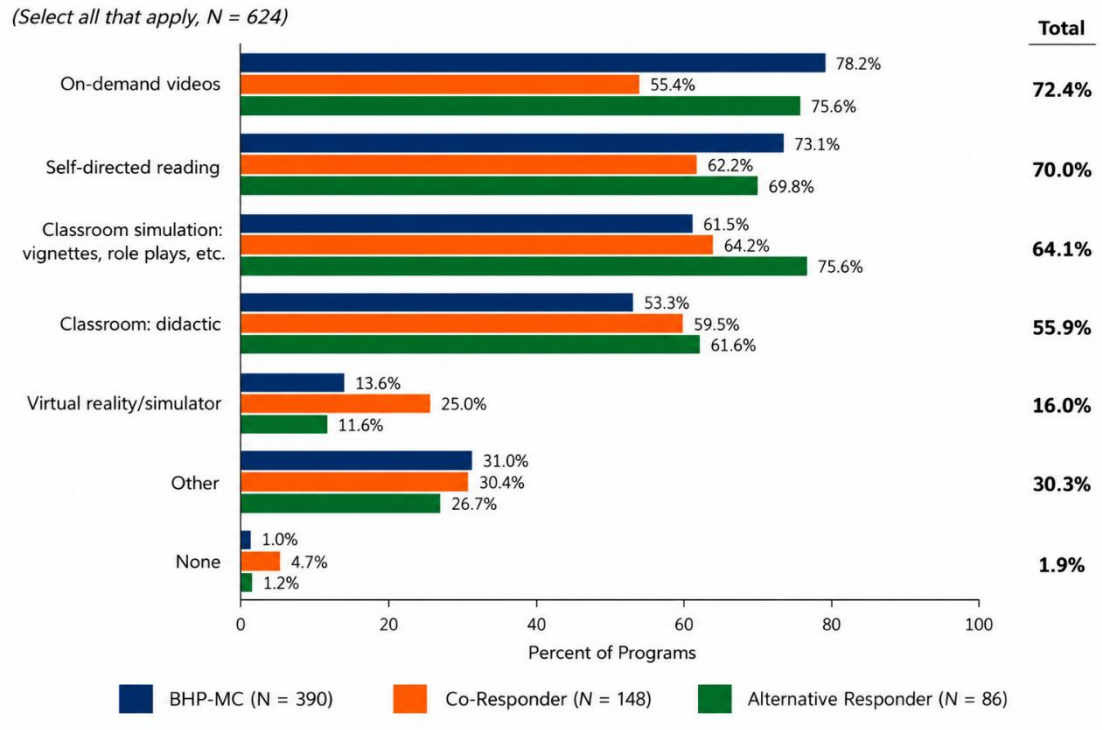


Figure C11. Basic Areas Covered in Training Curriculum

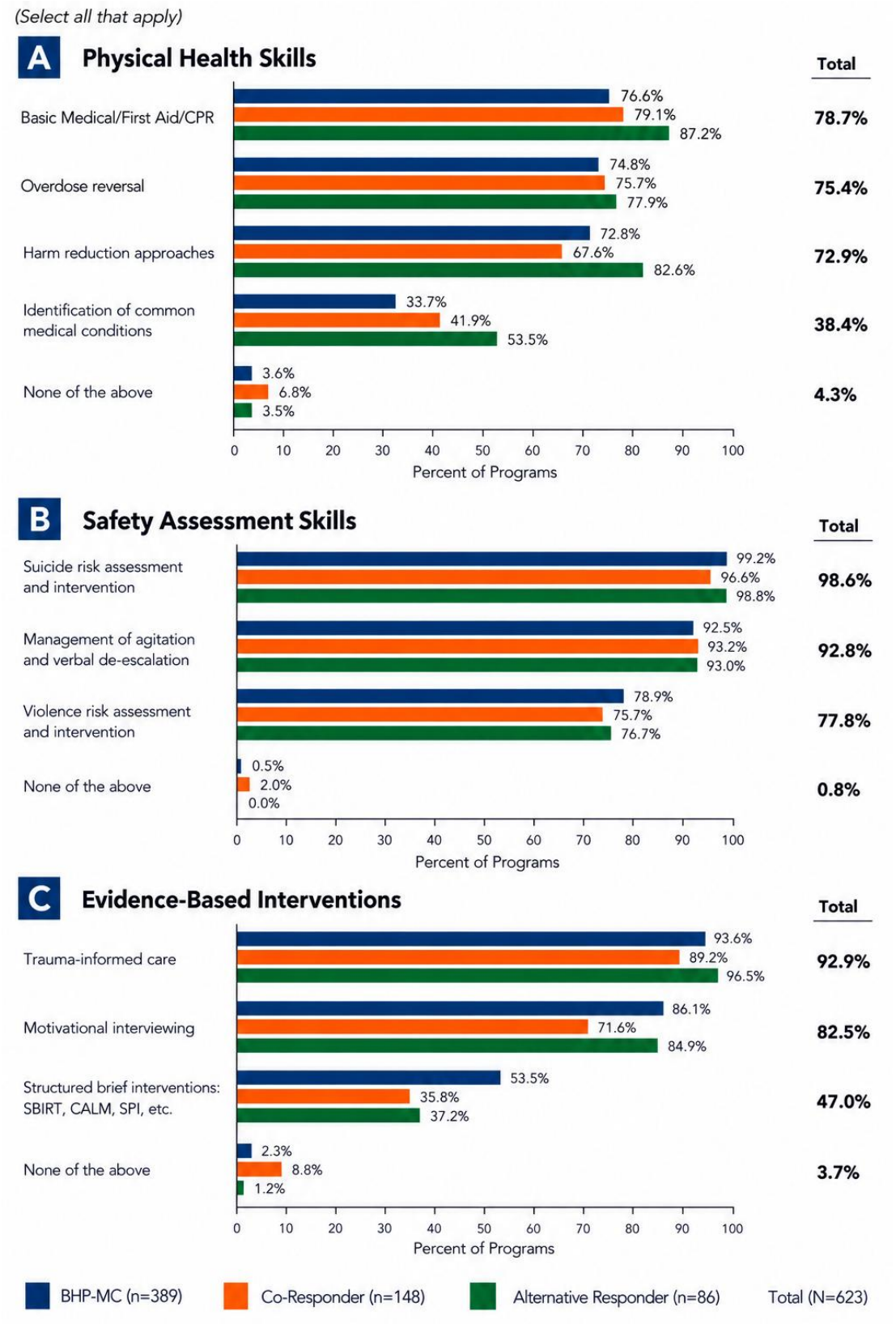


Figure C12. Additional Areas Covered in Training Curriculum

(Select all that apply, N=624)

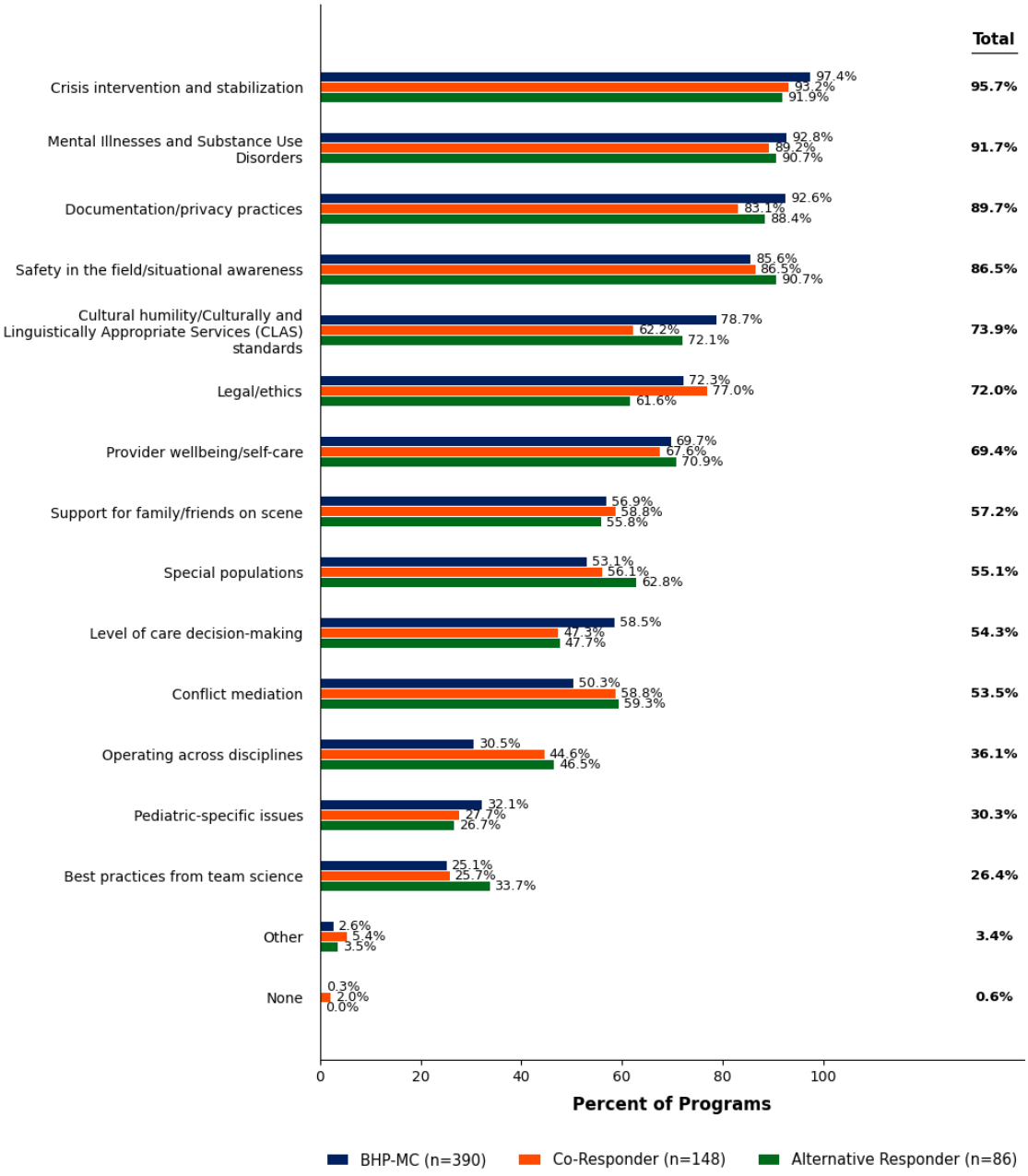


Figure C13. Pediatric-Specific Training

(Select all that apply, N = 188)

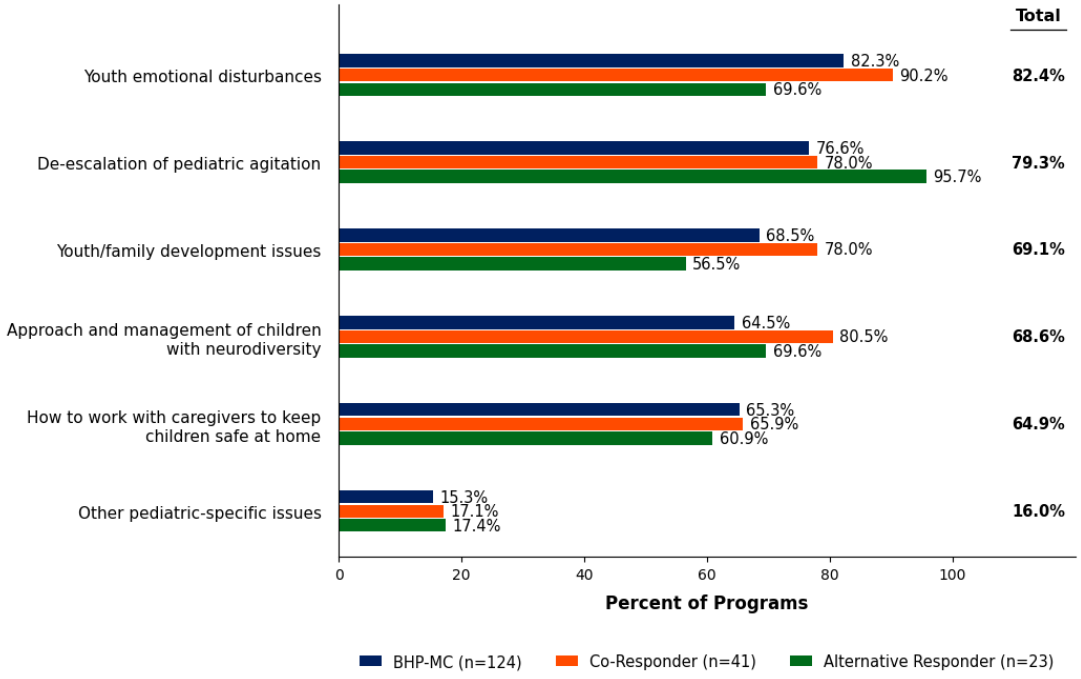


Figure C14. Additional Training for Special Populations

(Select all that apply, N = 343)

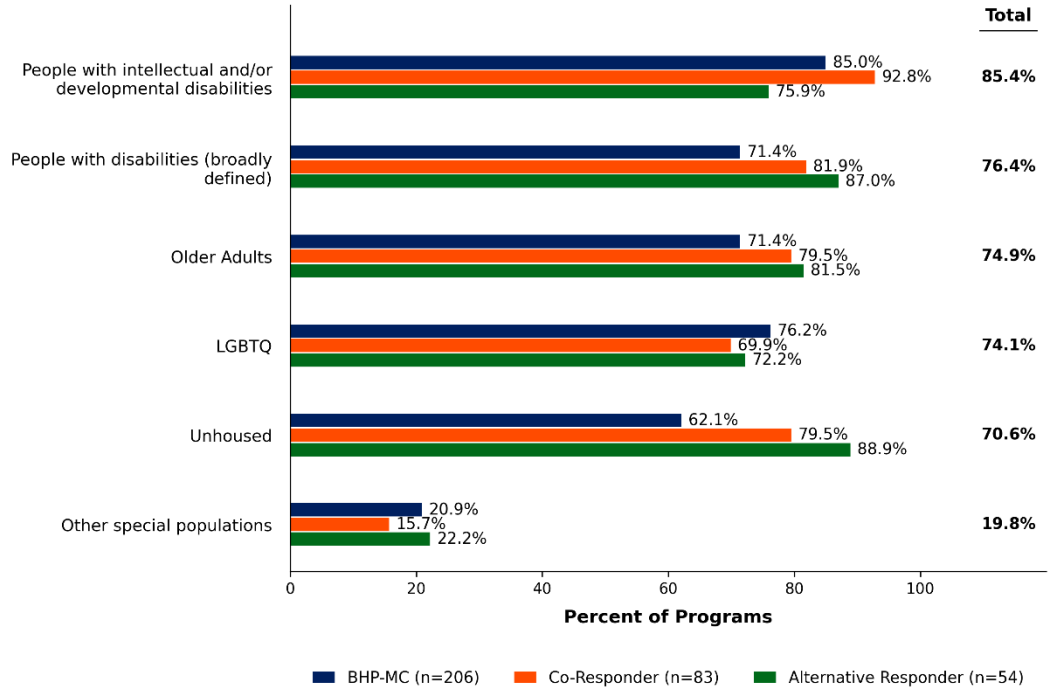


Figure C15. Length of Shadowing or Provisional Period for New Mobile Crisis Program Staff

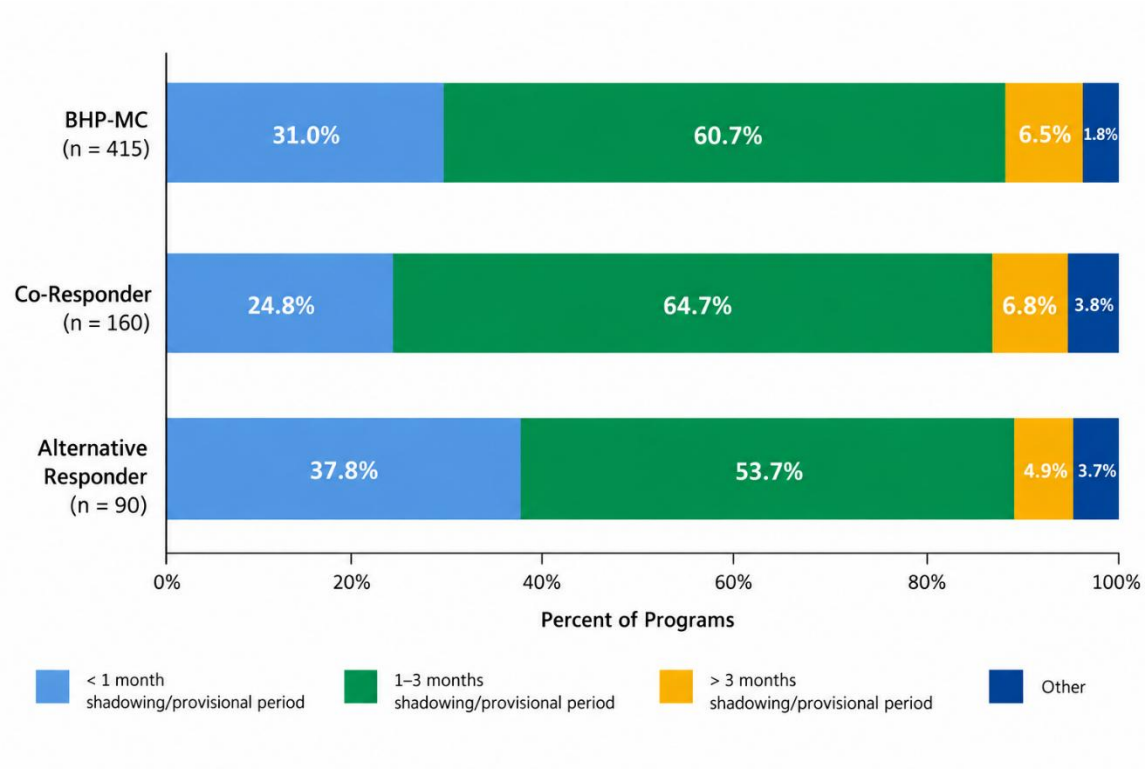


Figure C16. Number of Programs Reporting Data Collection on Key Metrics

