

A Qualitative Systems Analysis of the Illinois Mobile Crisis Workforce: Crisis Program Director Perspectives and Policy Recommendations

Jeremy Fine

jdfine@med.unc.edu

University of North Carolina at Chapel Hill

Maria Guta

University of North Carolina at Chapel Hill

Helen Newton

University of North Carolina at Chapel Hill School of Medicine

Nathaniel Sowa

University of North Carolina at Chapel Hill School of Medicine

Amy Watson

Wayne State University

Kristen Hassmiller Lich

University of North Carolina at Chapel Hill

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Abstract

Mobile crisis teams (MCTs) are an essential component of the expanding crisis continuum in the United States, yet programs nationwide report staffing shortfalls that often leave nobody to respond. The factors shaping entry, retention, and departure in the mobile crisis workforce have not been rigorously studied. We examined Illinois, a state with active policy initiatives designed to scale MCTs staffed by peer support specialists and clinical responders. We used two participatory systems-thinking methods: eleven variable-elicitation sessions with crisis program directors, and a half-day virtual Group Model Building workshop with policymakers, administrators of peer-specialist training programs, and crisis directors. Inductive coding of qualitative data across these sources produced eleven themes: Individual Readiness and Motivation; Pay and Funding; Lack of Role Clarity; Positive and Negative Aspects Inherent to Mobile Crisis Work; Workload and Scheduling; Workplace Environment and Culture; Credentials and Competency; Career Progression; Social Determinants of Employment; and Societal Context. These findings were contextualized with the literature on emergency medical technicians, peer specialists, and the broader mental health workforce, and led to the development of seven policy recommendations and organizational actions based on these findings to strengthen inflow and reduce departure. At the state policy level, recommendations include: increasing Medicaid reimbursement for mobile crisis; creating reimbursement ladders with equity for peer specialists and clinical professionals; updating provider definitions to protect peer scope while aligning with best practices; aligning public payor rules (state grants, Medicaid) with best-practice dyadic response; expanding billable services and team-based/alternative payment models; adopting wage pass-through mechanisms so rate increases reach staff wages; and improving background checks to minimize unnecessary barriers while protecting client safety. Organizationally, mobile crisis programs can bolster retention by establishing internal pay hierarchies, providing robust staff supports, training leadership and clinicians to work effectively with colleagues with lived experience, and adopting flexible scheduling practices, among other solutions. One novel flexible scheduling method, called the Committed Shift model, was reported by one team to significantly decrease departure and is explored in depth.

Introduction

The prevalence of suicidal ideation and the proportion of mental health-related emergency department (ED) visits have both increased (Farooq et al., 2021; Holland et al., 2021). The COVID-19 pandemic increased the already challenging level of demand for mental health crisis services in the US (Kessler et al., 2022; Ma et al., 2021). Even before the pandemic, the proportion of youth ED visits associated with mental health conditions doubled, with suicide-related visits increasing five-fold from 2011 to 2020 (Bommersbach et al., 2023). This high demand has contributed to a national crisis characterized by insufficient inpatient psychiatric resources, causing extended emergency room wait times (American Psychiatric Association, 2022; Ibeziako et al., 2022). Multiple professional leadership organizations have encouraged states to implement mobile crisis teams (MCTs), in part to decrease the need for costly hospital-based psychiatric care when less intensive support is appropriate (Committee on Psychiatry & The Community for the Group for the Advancement of Psychiatry, 2021; National Association of State Mental Health Program Directors, 2018). The Substance Abuse and Mental Health Services Administration (SAMHSA) describes MCTs as an essential element of a modern mental health crisis continuum, offering 24/7 de-escalation, triage, and referral services for individuals in crisis anywhere in the community (Substance Abuse and Mental Health Services Administration, 2020). Evidence suggests MCTs may effectively decrease reliance on hospital-based psychiatric services, including emergency services and inpatient hospitalization (Fendrich et al., 2019; Fine, JF & Peters, RL et al., 2025; Guo et al., 2001).

In the 2020 version of the SAMHSA model, MCTs are deployed in pairs, with one member being an individual trained to use their lived experiences with mental health challenges to support others in recovery (“peer specialists”/“peer support specialists”) and the other being a clinical professional (Substance Abuse and Mental Health Services Administration, 2020). Right now, however, the workforce cannot meet the demand for mental health crisis services like mobile crisis, with 40 of 43 responding states reporting shortages of crisis professionals in a recent Research Institute poll (National Association of State Mental Health Program Directors Research Institute, 2024). The crisis workforce has not been well described in the larger behavioral health workforce literature. While prior studies have documented factors leading to burnout within the mental health workforce and peer specialist workforce (Bell et al., 2025; Morse et al., 2012), no work has specifically looked at problems affecting the capacity of the mobile crisis workforce in particular. This capacity can be understood in terms of the rate of inflow into the workforce and the rate of outflow from the workforce (Cave & Willis, 2020).

To address this gap, this study seeks to understand workforce capacity in terms of its two key determinants – documenting the factors that impact flow of professionals into and out of the mobile crisis workforce.

Illinois (IL) was chosen to study these issues due to its strong workforce policy landscape, the presence of mobile crisis teams facing staffing shortages throughout the state, and the interest of key stakeholders in finding solutions to mobile crisis workforce issues. There are many reasons why IL is a particularly good case study for understanding the challenge of mobile crisis workforce expansion. Illinois is geographically representative of much of the country, given the metropolitan center of Chicago, the sprawling Chicagoland suburbs in the northern third of the state, and the largely rural central and southern thirds of the state. The distribution of racial demographics in IL is within two percent of those of the United States as a whole (*Population Distribution by Race/Ethnicity* | KFF, 2023). However, IL also has one of the lowest levels of per-capita state mental health agency expenditures anywhere in the country, ranking 44th of 50 states in a recent analysis (Ledbetter & Manderscheid, 2025). IL also ranks among the states with the fewest behavioral health services covered by Medicaid (Guth et al., 2023). Therefore, the barriers present in IL may be more apparent than elsewhere in the country, and successful strategies for overcoming these barriers may be scalable in states with higher levels of investment to inform workforce funding, workforce pipeline structure, and organizational policies for mobile crisis teams.

A system dynamics perspective was chosen for this work, which seeks to understand the factors impacting workforce supply and demand (Cave & Willis, 2020). Techniques from this perspective have been used to develop strategies to expand healthcare workforces in the past (Barber & López-Valcárcel, 2010; Brailsford & De Silva, 2015; Cave & Willis, 2020; Taba et al., 2015). In particular, this study uses Group Model Building, a focus-group of experts and practitioners who engage in activities that leverage their collective knowledge to draw out the structure and function of a system.

Policy Context

IL has heeded calls to scale up the crisis workforce. At least two key policies have been enacted by the Illinois Department of Human Services Division of Behavioral Health and Recovery (IDHS-DBHR) in service of this goal.

Policy 1: The CRSS Success Program

Peer support specialists provide a variety of mental health supports to clients (Cabassa et al., 2017), and experts have argued they are the optimal professionals to work on MCTs due to their capacity to foster trust with individuals and de-escalate crises (Carroll et al., 2021). Certification and training requirements for peer support specialists vary widely from state to state (Peer Recovery Center of Excellence, 2023). In IL, there are two peer certifications: a Certified Recovery Support Specialist (CRSS) and a Certified Peer Recovery Specialist (CPRS). CPRS is a certification that more widely recognized in substance use treatment and recovery service settings.

Obtaining CRSS or CPRS credentials involves completing a robust training program with at least 100 hours of course work and 2000 hours of independent work experience, followed by passing a credentialing exam administered by the Illinois Certification Board (ICB) (Illinois Certification Board, 2024; Illinois Certification Board & International Certification and Reciprocity Consortium, 2024). Additionally, to be eligible for CRSS or CPRS credentials, an individual must have experience in recovery from mental health and/or substance use challenges and be at least 18 years of age.

The 2021 Certified Recovery Support Specialist Success Program (CRSS-SP) seeks to formalize the pathway to obtaining a CRSS or CPRS and expand the MCT workforce in IL by funding programs at 10 colleges, universities, and technical schools and 1 community mental health center for students seeking CRSS or CPRS credentials (*2690 CRSS Success Program (814) NOFO*, 2021). Students who complete 100 hours of training in this course and complete 300 hours in a program-sponsored internship are exempt from the 2000-hour requirement set forth by ICB and are eligible to take the CRSS or CPRS exam.

The CRSS-SP provides grant funds for institutions to operate their program without charging students tuition, as well as direct monetary support in the form of an internship stipend to students who are completing unpaid internships. Funds can also be used to support the practical needs of students (e.g. housing, transportation, food, childcare) during their education. According to the ICB, while many individuals had participated in CRSS or CPRS training opportunities between the years of 2007 and 2021, only 224 individuals maintained active CRSS or CPRS certification across the entire state of IL as of September 2021 (*2690 CRSS Success Program (814) NOFO*, 2021). As of July 2024, 872 students were previously or currently enrolled at CRSS-Success Programs at institutions across the state, and of these, 353 had graduated (Watson, 2024).

Many of the CRSS-SP graduates work in mental healthcare and substance use treatment settings, including MCTs. Expanding the MCT workforce of peer specialists was a stated purpose of this grant (*2690 CRSS Success Program (814) NOFO*, 2021). However, this is not the only source of peer specialist labor on MCTs. According to surveys of mobile crisis program directors, only a minority of peer specialists on MCTs participated in the CRSS-SP. Other individuals hired may pursue the 100 hours training independently (e.g. through seminars offered by IDHS-DBHR) and obtain a CRSS or CPRS credential after 2000 hours of work experience if they choose (Illinois Certification Board, 2024; Illinois Certification Board & International Certification and Reciprocity Consortium, 2024).

Policy 2: Program 590

In 2021, Illinois implemented Program 590, a state grant program that sought to expand MCT coverage to all Illinoisans by financing 64 mental healthcare organizations throughout the state to deliver MCT services (Illinois Department of Human Services, 2025). These grants mandate that the recipients provide crisis care in dyads as described by the 2020 version of the SAMHSA model. These dyads include: 1) a peer support specialist (termed an “Engagement Specialist”, ES), and 2) a Crisis Counselor (CC), who is an individual who meets the IL Medicaid definition of a Mental Health Professional (MHP) (see **Fig. 1**). CCs provide direct clinical care and make treatment decisions in the field.

Like many states, IL does offer Medicaid reimbursement for short-term crisis interventions, including off-site crisis intervention and mobile crisis team responses. However, reimbursement may not cover care coordination, transportation, and other expenses incurred while delivering MCT services. (*Fee Schedule for Providers of Community-Based Behavioral Health Services*, 2024; Huber et al., 2023) The funds from Program 590 are intended to complement Medicaid reimbursements and may be used to cover any non-billable expenses included in MCT service delivery (*IDHS: 2539 Q&A - Crisis Care System (590)*, 2021; Illinois Department of Human Services, 2025). Importantly, if a service recipient has insurance (e.g. Medicaid), agencies are expected to submit claims for billable services. This ensures all funding streams available to the agency are utilized prior to the grant. Of note, while CRSS services are currently billable to Medicaid at the MHP level on mobile crisis teams, CPRS services are not (Title 89: Social Services Chapter I: Department of Healthcare and Family Services Subchapter D: Medical Programs Part 140: Medical Payment Section 140.453: Community-Based Mental Health Service Definitions and Professional Qualification, 2022).

ESs can join MCTs without a CRSS certification, so long as they are able to obtain their certification within one year of being hired (*IDHS: 2539 Q&A - Crisis Care System (590)*, 2021). During this time, their services can be billed to Medicaid as a Rehabilitative Services Associate (RSA) (*IDHS: 2539 Q&A - Crisis Care System (590)*, 2021; Title 59: Mental Health; Chapter IV: Department of Human Services; Part 132: Medicaid Community Mental Health Services Program; Section 132.25: Definitions, 2019). An RSA is a non-credentialed individual at least 21 years of age who works in a mental healthcare setting. After receiving a CRSS or CPRS credential, services provided by a peer support specialist can be reimbursed at the higher MHP rate by Medicaid.

CC = Crisis Counselor; CFPP = Certified Family Partnership Professional; CRSS = Certified Recovery Support Specialist; CPRS = Certified Peer Recovery Specialist; ES = Engagement Specialist; GED = General Education Development; IL = Illinois; MHP = Mental Health Professional; RSA = Rehabilitative Services Associate

Methods

Data Sources

There were two major streams of data collection for this project: qualitative data collected 1) during 11 stakeholder variable elicitation sessions and 2) during a 4.5-hour Group Model Building (GMB) session. This study was deemed exempt by the Institutional Review Board of the lead author.

Data Source 1: Qualitative Data Collection

Program directors for crisis organizations receiving Program 590 grant dollars from IDHS-DBHR are required to attend monthly “cluster meetings” alongside other regional crisis providers from within their region of the state (Illinois Department of Human Services, 2025). These meetings are convened by an academic partner of IDHS-DBHR that is contracted to assess the implementation of Program 590 (see: **Acknowledgements**). The lead investigator and a research assistant attended all 11 of these 1-hour virtual meetings in February 2025. The meetings began with a brief recruitment pitch to program directors to consider participation in the upcoming GMB session and a general introduction to the system dynamics approach to systems thinking to prime audience members to think about the mobile crisis workforce pipeline from a system perspective. Following this, a real-time survey (using Mentimeter) was developed to collect qualitative data regarding factors and potential policy solutions that impact the inflow and outflow of the ES and CC workforces (Mentimeter, 2025). Participants were first asked to consent to study participation and to select the region(s) served by their crisis organization. Then, for each workforce role (Crisis Counselors and Engagement Specialists), participants were asked about factors that influenced workforce inflow, factors that influenced workforce outflow, and potential policy solutions to increase inflow or decrease outflow. Some organizations had additional members present in addition to the program director, and individuals could respond to the survey multiple times.

Data Source 2: Group Model Building

GMB is a participatory systems thinking technique that has been used to generate consensus and insight into complex workforce issues from a system dynamics methodological approach (Cave & Willis, 2020). During a GMB session, participants engage in several activities that culminate in the group building one or more qualitative maps of the system, called stock-and-flow diagrams. This technique has been hypothesized to increase consensus and foster insight among participants. During the GMB process, a great deal of qualitative data is generated as the group discusses what matters most as they build system diagrams during group activities.

A snowball sampling procedure was used to recruit key informants for the GMB session. Three seed informants guided initial outreach: two deputy directors from IDHS-DBHR and an external evaluator for the CRSS-SP and Program 590. Because the seeds served distinct roles within the crisis service continuum, this approach expanded the participant pool to include administrators of mobile crisis programs, those working at CRSS-SP institutions, and mental health policymakers across multiple departments of government familiar with mobile crisis workforce issues (Kirchherr & Charles, 2018). Emphasis was placed on ensuring balanced perspectives on the ES and CC workforces.

The virtual session followed a structured half-day format that moved participants from individual perspectives toward a shared systems view of the mobile crisis workforce pipeline. It was facilitated by the first and last author, as well as a research assistant (see **Acknowledgements**). The session began with introductions and an initial problem-framing exercise in which participants described workforce challenges, their causes, and possible solutions. Building on these responses, facilitators introduced stock-and-flow diagrams as designed to show how factors and policies impact the inflow and outflow of a particular stock of interest (here, workforce). Participants then chose which part of the mobile crisis workforce to model (e.g. CCs, ESs) and independently created simple stock-and-flow models of their chosen workforce, an example of a which is shown below in **Fig. 2**. After a gallery walk to review each other's work and reflect on additional variable ideas, participants were also shown an initial summary of the results from the stakeholder variable elicitation sessions, to assist them as they convened in smaller groups to construct more detailed models for each of the two studied workforce roles. The morning concluded with group presentations, discussion of leverage points for change, and a repeat of the problem-framing activity to assess changes in perspective. **Supplemental File 1** contains a detailed agenda of the GMB. Two follow-up one-on-one interviews occurred with mobile crisis program directors who participated in the GMB to clarify comments made during the construction of the detailed models.

MCT = Mobile Crisis Team

Data Analysis

Data were gathered from three main sources: direct quotes from the Program 590 Mentimeter data, participant-created variables from the individual stock-and-flow diagrams, and variables synthesized by investigators based on participant discussions during the creation of the two complex stock-and-flow diagrams.

Following the initial data collected via Mentimeter, 8 preliminary codebooks were created in response to the 4 questions regarding each workforce (ES and CC) that participants answered: 1) variables impacting workforce inflow, 2) variables impacting workforce outflow, 3) changes that may increase workforce inflow, and 4) changes that may decrease workforce outflow. Codebooks were inductively created for each question separately in Excel by the first author with the assistance of Chat-GPT 4o and verified in full by the same author. Artificial intelligence (AI) enabled the team to create a preliminary codebook that could be presented during the GMB, which otherwise would have been challenging given the short interval between the qualitative data collection and GMB phases of the study. This process entailed providing each survey question and its de-identified responses to the AI model to create initial qualitative themes. These themes were iteratively refined by the author after a first pass through the AI model, and responses were manually re-labeled to ensure accuracy and

consistency with updated themes. If participants provided a quote about a change that may affect the inflow or outflow, but gave their quote as an answer to the corresponding question regarding variables, the quote was moved to the appropriate section in the analysis. These preliminary, pre-GMB qualitative results are presented in **Supplemental File 2** for confirmability, and a summary of these results were presented following the “gallery walk” activity during the GMB.

Following the GMB, inductive qualitative analysis continued using data collected during the session. This was performed in multiple rounds and utilized multiple coders (the first and second authors) to ensure reliability (Coates et al., 2021). First, the coders mapped the participant-created variables from individual stock-and-flow diagrams and the variables synthesized from the complex-model building discussion into the appropriate analytical group based on the workforce (ES vs CC), flow (inflow vs. outflow), and question type (variable vs. change). The first and second authors then divided the coding of the additional observations. Notably, most new observations fit into existing codes, lending credibility to the data analysis and indicating thematic saturation. To maximize dependability, upon completing the coding of the additional observations, the authors independently reviewed the codes and subcodes given to all observations and discussed areas of disagreement, which led to a small number of observations being given new subcodes. The authors then streamlined existing codes and subcodes by combining duplicative subcodes, regrouping subcodes, and renaming codes to provide the most parsimonious categorization of the data. The high level of consistency of codes and subcodes across all 8 questions led to the 8 individual codebooks being combined into a single codebook. The final analysis is attached for confirmability of the analysis in **Supplemental File 3**. Because factors and policies/solutions were not directly linked in the data, the authors placed policies/solutions next to the most relevant factor subcode. This was done to enhance viewability of the results. However, it is important to note that many of the policies or solutions could be used to impact multiple different factors at the same time.

Results

Regional distribution of organizations with administrators who participated in the data collection are shown below, alongside a map of IL EMS regions with population density, in **Fig. 3**. **Table 1** illustrates the participants of the GMB. **Table 2** indicates the number of responses for each question asked during the Mentimeter data collection.

* This indicates the number of responders to this variable (i.e. age data was collected for 11 of 14 participants, whereas it was missing for 3 participants)

Qualitative data collected from the variable elicitation sessions combined with qualitative data collected during the GMB revealed 11 themes, each with 2–11 sub-themes. Several themes are presented in pairs in this study, as they are interconnected. All the data that was provided for CCs was relevant to both CCs and ESs, whereas the data collected for ESs often had to do with aspects specific to the role of the ES (i.e. associated with living with mental health challenges and providing mobile crisis services). Therefore, sub-themes that are clearly specific to ESs are noted as such in the qualitative results summary data in **Supplemental File 4**. Qualitative results can also be visualized at this link: <https://bit.ly/mobile-crisis-workforce-study-themes-sub-themes-and-solutions>.

Theme 1: Individual Readiness and Motivation

This theme describes factors within an individual that motivate or inhibit their ability to perform mobile crisis work. ESs were noted to face challenges in achieving or maintaining the level of recovery necessary to perform the challenging, high stress work of mobile crisis. Recovery status was closely tied to the potential for re-traumatizing experiences while working in the field. Challenges in recovery maintenance were linked directly to departure. In terms of solutions for these challenges, participants suggested at-work mental health support dedicated to helping ESs maintain recovery, as well as additional required training focused on self-care.

Lived experience with mental health crisis motivates both ESs and CCs to join and remain in the mobile crisis workforce. Empowering staff to use their personal stories to motivate their work was also suggested to increase retention; it was even suggested that organizations can seek out previous clients to work as ESs in their organization.

Themes 2 and 3: Pay and Funding, Lack of Role Clarity

Pay rate and benefits were identified as key factors influencing the recruitment and retention of both ESs and CCs into the mobile crisis workforce. Increasing these, along with offering additional incentives, such as student debt relief, were floated as potential solutions. Heavy reliance on state grant funding—and the uncertainty surrounding its long-term stability—emerged as a significant driver of workforce attrition and a major source of stress.

Lack of role clarity also contributed to individuals leaving the workforce or deterred them from joining in the first place. Meeting the criteria for an MHP allows individuals to perform a wide variety of tasks, and CCs were often assigned responsibilities outside the scope of their intended role, leading to departure. In addition, significant misunderstandings about the role of ESs in the mobile crisis workforce persist, particularly for ESs who possess clinical experience. During the GMB session, participants with CRSS certifications reported being asked to perform tasks they were not comfortable with and that were clearly outside the scope of peer roles (i.e. role drift), such as participating in involuntary commitments or clinical assessments.

Participants also explored structural drivers of role confusion and workforce attrition related to financial incentives. The current Medicaid billing structure for ESs—where individuals bill as RSAs until CRSS certification is achieved, at which point they can bill as MHPs—creates opportunities for ESs to be asked to perform clinical duties. While Program 590 grant recipients are required to deploy dyadic crisis response teams, Medicaid permits billing for crisis services provided by a single MHP. In addition to the confusion that is caused by payors having different service requirements, in low-staffing situations, individuals in the ES role may be asked to take on CC duties to ensure a response occurs, leading to role strain. ESs may also be incentivized to switch into clinical roles based on organizational pay structures, as CCs were often reported to receive higher compensation than ESs.

Implementing a peer-specific organizational pay ladder for peer support specialists who become credentialed (e.g. a CRSS or CPRS in IL) was discussed as a mechanism to maintain a seniority pathway for peer support specialists without contributing to role strain. This would eliminate the financial incentive encouraging peers to transition into clinical roles for which they may not be formally trained.

Additionally, CCs who obtain their master's degree while working for mobile crisis teams are eligible to bill Medicaid at a higher rate as Qualified Mental Health Professionals (QMHPs) for some mental health services (e.g. individual therapy). However, IL Medicaid does not reimburse at a higher rate for mobile crisis provided by QMHPs compared to MHPs. Participants reported that organizations often do not adjust salaries of mobile crisis workers upon receipt of a master's degree, prompting these individuals to leave the mobile crisis workforce for other, better-paying positions like outpatient therapist roles. This was reported to lead to significant turnover of experienced crisis staff.

Organizations with greater resources were better positioned to retain these workers by funding crisis positions for QMHPs with a greater salary compared to MHPs. The same is true for licensed staff, such as Licensed Clinical Social Workers, who in IL are termed Licensed Practitioners of the Healing Arts (LPHAs) in Medicaid parlance. As an added benefit, this keeps more experienced professionals working in crisis, improving quality of care. In a follow up interview, one mobile crisis organization reported running an internal cost analysis comparing the cost of having licensed professionals turnover into other positions (e.g. outpatient therapist) vs increasing their pay to continue providing direct crisis services. Their organization found increasing pay to be more cost-efficient compared to the cost of turnover.

Finally, alternative payment models like the Certified Community Behavioral Health Clinics (CCBHC) model were hypothesized by participants to help improve reimbursement rates (Mauri et al., 2025). IL is one of 10 states participating in the 2024 expansion of the Section 223 Medicaid Demonstration program for CCBHCs (Centers for Medicare & Medicaid Services, 2024). CCBHCs receive monthly episode-based organizational reimbursements from Medicaid based on actual costs, rather than fee-for-service reimbursements. CCBHCs are required to provide a continuum of crisis services, including 24/7 mobile crisis intervention (Mauri et al., 2025). Qualifying organizations who successfully applied to participate in the IL demonstration began receiving payment under this model in IL in October 2024 (Illinois Department of Healthcare and Family Services, 2024b, 2024c). Nearly all of the organizations participating in this initiative are also receiving Program 590 grant funds, allowing for braided funding of mobile crisis services (Illinois Department of Healthcare and Family Services, 2024a; *Provisionally Certified CCBHC Locations*, 2025).

Themes 4 and 5: Positive and Negative Aspects Inherent to Mobile Crisis Work

These themes illustrated the rewarding and challenging parts of working as a mobile crisis responder, and they applied to both ESs and CCs. While policies and solutions were suggested to help ameliorate the negative aspects, by and large these themes discussed topics that can never be truly separated from mobile crisis work and will always be factors that attract or repel people from the workforce. Examples of positive aspects include that mobile crisis responders make a tremendous impact on the lives of the people they serve, they serve and protect their communities, and "every day is different" in the role.

On the negative side, working with individuals in crisis is intense and can be highly stressful. Responders, regardless of their lived experience, may experience vicarious trauma due to constant exposure to highly traumatic situations. Because the roles involve responding to individuals who may be at risk of harming themselves or others in the community, safety concerns also drove folks away from mobile crisis work. Solutions suggested for this were increasing co-response with police officers, ensuring robust policies and procedures exist to protect mobile crisis responders and aid those who are harmed, and offering structured safety trainings. Additionally, burnout/compassion fatigue were frequently cited as common reasons for leaving the mobile crisis workforce. While completely preventing burnout is unrealistic, one potential solution would be to prioritize early identification of burnout among responders.

Themes 6 and 7: Workload and Scheduling, and Workplace Environment and Culture

These two themes relate to organization-level determinants of mobile crisis workforce capacity. Workload and Scheduling focuses on tangible workplace systems and policies that impact both ESs and CCs, that could theoretically be changed by an organization. However, staffing constraints often make improving these issues challenging. On the one hand, participants reported that the flexible schedules that are frequently offered by mobile crisis teams attracted individuals into the workforce. On the other hand, being scheduled to work undesirable hours, frequent on-call duties, administrative burden, and the need to travel long distances to serve rural areas, caused challenges in maintaining work-life balance and drove people away from the workforce. These problems were made worse due to understaffing, particularly for supervisor roles. Participants noted that finding QMHPs willing to work on-call to supervise MHPs was a particular challenge. Solutions were suggested for these issues, including raising on-call stipends and breaking up weekend and holiday shifts, allowing for hand-offs so responders do not have to stay long after their shift waiting for a crisis to resolve, expanding telehealth, and streamlining administrative processes. One particularly innovative solution was explored in depth in one of the two follow-up interviews with one of the crisis program directors who participated in the GMB session. This "Committed Shift" scheduling model may be a best practice for creating mobile crisis schedules and is explored in depth in **Supplementary File 5**.

Workplace Environment and Culture describes the unwritten factors at play within a mobile crisis organization that influence capacity. Insufficient support could drive both ESs and CCs out of the workforce, and offering opportunities for voluntary training and professional development, as well as access to counseling, mental health days, frequent debriefs, and an Employee Assistance Program were suggested as ways to support people in both roles. A collaborative work environment with strong supervision and leadership support were said to help retain the workforce. Leadership understanding of how to support the unique needs of ESs was described as particularly important. The presence of multiple ESs in the workplace also helps to create a lived experience-friendly environment in which ESs feel like they are a meaningful part of the team. Unfortunately, judgmental attitudes and poor understanding of the role of ESs by clinical professionals was also reported to drive ESs from the workforce. Training for clinical staff related to working with individuals with self-disclosed lived experience was one of the solutions offered to help curb mistreatment of ESs by their co-workers.

Theme 8: Credentials and Competency

This theme describes factors related to the required education and skills needed to join the mobile crisis workforce. Required background checks were often cited as a delay or barrier to workforce entry. Waiving or simplifying this process, and promoting transparency around what is being looked for, were put forth as ways to improve the process.

Minimal entry requirements necessary to join the workforce (e.g. as an RSA, or a new college graduate) make entry level mobile crisis positions attractive for a wide swathe of individuals. However, providing on-the-job training to individuals who had never worked in a crisis setting before was reported to be time consuming, especially if an individual joins a small team that gets few referrals, or if they join during a period in which there are few crises.

While the wide entry point was viewed favorably, the plethora of pathways one can take to achieve MHP status was viewed as confusing. Streamlining the process by creating a standard MHP training curriculum or credential, and opening it to more individuals without college degrees, was proposed to increase both workforce size and competency.

The complex model building exercise also revealed several potential pathways to become a peer support specialist in IL, which has led to confusion among crisis teams. The CRSS Success Program was reported to be helpful in creating a workforce training pipeline for ESs. While the Program 590 requirement for individuals to receive a CRSS credential within one year of becoming an ES was sometimes viewed as a barrier to retaining ESs, a solution that is already in place to lower this barrier is the “independent pathway” to CRSS certification. This pathway allows individuals who acquire 1 year of qualified work experience as an ES to qualify to sit for the CRSS exam if they have completed 100 hours of classroom training, which can be from a variety of sources and is offered for free by IDHS-DBHR. For these individuals, credentialing and exam fees can be covered by scholarship funds set aside for this purpose.

Additionally, shortly before the GMB session, an additional Medicaid qualifying definition for peer professionals called the Peer Support Worker (PSW) was created. Currently, PSW services can be billed at the RSA-level. However, a PSW is defined as requiring more training than an RSA. To qualify as a PSW, one can possess a variety of credentials, some of which also meet the requirements for an MHP. These include: CRSS, CPRS, Certified Family Partnership Professional (CFPP), Certified Veteran Support Specialist (CVSS), or other provider established training curriculums with written approval from the Department (Illinois Department of Healthcare and Family Services, 2025). This discrepancy in the Medicaid definition of a PSW and the requirements for ESs per the Program 590 grant created confusion for some participants in the GMB session.

Furthermore, expanding entry pathways to the crisis workforce for individuals with substance use treatment credentials (e.g. Certified Alcohol and Other Drug Counselors) would help increase the number of crisis responders are skilled in working with individuals in crises with concomitant substance use concerns, as about half of those with mental health conditions also have a co-morbid substance use disorder (*Common Comorbidities with Substance Use Disorders Research Report*, 2020).

Themes 9, 10, and 11: Career Progression, Social Determinants of Employment, and Societal Context

Desire to gain work experience and build skills to further one’s career were cited as common reasons for joining the mobile crisis workforce, as was the fact that the mobile crisis infrastructure is expanding in IL. However, a lack of upward mobility within the crisis space, combined with low pay and the challenging nature of crisis work, led multiple participants to refer to ES and MHP roles as a “stepping stone” for other roles within mental health. To address this, participants suggested building a pathway for promotions and full careers. They also suggested that organizations that have multiple crisis services could allow responders to rotate roles (e.g. between a mobile team, a crisis stabilization unit, etc.). This would allow individuals to gain more experience and may aid in decreasing departure.

Several social determinants were also described as directly related to an individual’s ability to acquire and maintain a job on a crisis team. Unstable housing impacts ES’s ability to retain employment; ensuring ESs are able to access affordable housing can help to retain the workforce. Additionally, owning a vehicle frequently came up as a determinant for mobile crisis employment, as teams reported responders using their personal vehicles to reach individuals in the community in crisis. In other themes, car wear and tear and low gas reimbursement rates demonstrated that owning and being able to maintain a personal vehicle are necessary for mobile crisis work.

Lastly, the societal context of mobile crisis work provides a foundation upon which to understand the workforce capacity. First, mobile crisis was described by participants as only beginning to enter the public consciousness, and in general, crisis teams described a lack of public awareness about roles on their team. This coincides with a perceived lack of appreciation for mobile crisis providers in society. Helping ensure mobile crisis workers are viewed as first responders was thought to help this. On the other hand, national standards and professional organizations for peer support workers are helping to strengthen the ES workforce. Moreover, the decreasing but persistent stigma of mental illness was thought to impact whether potential ESs join or remain in the workforce. Creating a culture in which lived experience is valued and respected was thought to further decrease the stigma. Importantly, fragmentation of the mental healthcare system was also reported to significantly contribute to departure. Given that mobile crisis services tend to work closely with other community services, strengthening these partnerships and increasing resources to which to refer individuals in crisis were viewed as key in workforce strengthening. Given that the crisis team leads also reported an increasing acuity of clients, this is more vital than ever.

Discussion

This study is the first to rigorously investigate factors impacting mobile crisis workforce capacity across one state, as well as policies and solutions designed to strengthen the workforce. This discussion first contextualizes these findings in the literature, and then outlines recommendations for policymakers and mobile crisis organizations.

Themes in Context of the Literature

While ours is the first study to examine factors associated with recruitment and retention of mobile crisis teams, our study findings complement those examining similar workforces, such as the Emergency Medical Technician (EMT), peer support specialist, and non-crisis mental health provider workforces.

In Context: EMT Workforce Literature

Emergency Medical Services (EMS), like mobile crisis, are 24/7 services that involve EMTs entering unknown situations in unfamiliar locations within communities. The major departure is the specificity of cases: while MCTs specialize in mental health emergencies, EMS can respond to all health emergencies. Therefore, comparing the results of this study to similar studies on EMS can help understand which mobile crisis workforce issues relate to the emergency-responder nature of the role, rather than the mental health specialization.

Existing literature suggests that EMS shares many of the same draws to the workforce and challenges associated with MCTs. The work itself is viewed as thrilling and fulfilling (corresponding to *Theme 4*), drawing people to both fields. However, like the unclear pathway for an individual to achieve MHP-status (*Theme 8*), EMTs in a qualitative study described having little guidance throughout the training process and no formal way of ensuring their skills are kept current (Patterson et al., 2005). Additionally, EMTs also reported low pay (*Theme 2*), long hours (*Theme 6*), and low perceived opportunities for advancement (*Theme 9*) (Patterson et al., 2005, 2009). This indicates that it may be worth addressing these issues in tandem (e.g. creating state-funded first-responder training programs, with optional specialization in mental health). Recognition as first responders is reported to play a major role in drawing EMTs into the EMS workforce and keeping them there (Patterson et al., 2005); This underscores that public messaging that appreciates MCT workers for their role as first responders will be critical in growing this workforce (*Theme 11*).

One key finding in the EMT workforce literatures was the view that their team was their family, which led to significant retention (Kamholz et al., 2025; Patterson et al., 2005). While the importance of strong leadership and a collaborative work environment were sub-themes that emerged in this study (*Theme 7*), crisis directors did not highlight a family-type bond as a reason for joining or remaining in the mobile crisis workforce. This discrepancy, and the potential to leverage this organizational environment to improve retention, is worth exploring in future studies.

Noticeably absent in the reviewed academic EMT workforce literature were discussion of role strain (*Theme 3*), and mental health concerns among providers (*Theme 1*), which may indicate that these challenges are associated with the unique aspects of MCTs (e.g. the inclusion of peer support specialists, specialization in mental health emergencies), or that these are also topics ripe for exploration in the EMT workforce literature.

In Context: Peer Specialist Workforce Literature

The findings of this study align with existing literature on the peer specialist workforce. A recent systematic review of 20 articles on workforce challenges among substance use peer supporters, including a couple articles involving peer specialists in crisis settings, also identified role clarity (*Theme 3*), strong supervision (*Theme 7*), collaborative and stigma-free culture (*Theme 7*), sufficient compensation (including reimbursement of peer specialist services) (*Theme 2*), training and advancement opportunities (*Theme 11*), recovery support (*Theme 1*), and flexible scheduling (*Theme 6*) as facilitators for retention and/or job satisfaction (Bell et al., 2025).

Given limited crisis response perspective specifically, there are several sub-themes in this study that are new. For example, the importance of safety concerns (within *Theme 5*) and challenges posed by background checks (within *Theme 8*). Exploring the impact of state-level background check policies may be an important avenue to increase the capacity of the peer workforce. Lastly, while role confusion and drift (*Theme 3*) were themes that emerged from the prior review, drift into clinical roles was not explicitly mentioned. Given that peer specialists are not clinicians in their peer role, understanding this specific type of role drift among peer specialists will be important to ensuring high-quality crisis care.

In Context: Mental Health Workforce Literature

Literature on the mental health workforce offers a useful comparison, highlighting field-specific challenges that may impact both mobile crisis workers and other mental health workers alike. A recent systematic review of quantitative studies impacting turnover in the public behavioral healthcare workforce in the US identified compensation (*Theme 2*), positive organizational culture with strong leadership and supportive colleagues (*Theme 7*), experience in the field (*Theme 1*), role ambiguity (*Theme 3*), career advancement and professional development opportunities (*Theme 8*), and compassion fatigue (*Theme 5*) as key predictors of turnover (Brabson et al., 2020). One theme that arose in their findings but was not emphasized in the current findings was the importance of provider autonomy, which may underscore the team-based nature of mobile crisis work as opposed to settings like individual therapy. A qualitative study on public mental health workforce turnover in Oregon emphasized the role poor administrative and physical infrastructure plays in departure. Given that those interviewed in this study worked directly for the state of Oregon, whereas Program 590 funds independent entities to perform crisis work, this may explain the discrepancy in results (Hallett et al., 2024).

Recommendations for Policymakers

The following policy action items were generated by the research team based on the results of this study. These recommendations can be applied to any state in the country, although specific attention is given to IL due to it being the context studied. State governments like IL cannot directly regulate how much mobile crisis organizations pay or manage their providers. However, they can strengthen the workforce by 1) increasing Medicaid reimbursement levels; 2) implementing Medicaid reimbursement ladders; 3) updating Medicaid provider definitions; 4) aligning public payor rules; 5) expanding billable services; 6) passing wage-pass through laws; and 7) streamlining the background check process. These recommendations are illustrated in **Fig. 4** for Recommendations 1–3 (changes *within* state Medicaid programs) and **Fig. 5** for Recommendations 4–7 (broader legal, administrative, and regulatory changes).

CRSS= Certified Recovery Support Specialist; CPRS = Certified Peer Recovery Specialist; LCPC = Licensed Clinical Professional Counselor; LCSW = Licensed Clinical Social Worker; LMFT = Licensed Marriage and Family Therapist; LPC = Licensed Professional Counselor; LPHA = Licensed Practitioner of the Healing

Arts; LSW = Licensed Social Worker; MHP = Mental Health Professional; QMHP = Qualified Mental Health Professional; RSA = Rehabilitative Services Associate

Recommendation 1: Increasing Medicaid Reimbursement Rates

Recent literature has confirmed that mobile crisis services rely almost entirely on Medicaid reimbursement, federal grant funds, local tax levies, and state general funds for operation, whereas private payors rarely cover crisis services, and Medicare does not (Edmonds et al., 2025; Huber et al., 2023). Medicaid reimbursement is also limited to direct-service provision and limited administrative functions, leaving providers to rely exclusively on other funds for indirect forms of care provision like care-coordination, on-call work, and transit time (Centers for Medicare & Medicaid Services, 2022, 2025a; Huber et al., 2023).

Reimbursement rates contribute to an organization's revenue, which in turn impacts employee wages (Feng et al., 2010; KFF, 2022; Zhu et al., 2023). Multiple states, including IL, have increased their Medicaid reimbursement rates for behavioral health services in recent years (Saunders et al., 2023). Comparing the "Fee Schedule for Providers of Community-Based Behavioral Health Services" from 4/1/23 to that on 8/1/2024 indicates that the fee-for-service Medicaid reimbursement rate for a 60-minute mobile crisis team intervention (procedure code S9484) nearly doubled from 2023 to 2024, from \$327.92 to \$527.92 (*Fee Schedule for Providers of Community-Based Behavioral Health Services, 2023; Fee Schedule for Providers of Community-Based Behavioral Health Services, 2024*). Manual review of each state's fee schedules would be necessary to determine how IL ranks among other states in terms of its Medicaid reimbursement rates for mobile crisis services, and unclear if this increase impacted wages. Additionally, as suggested by participants in the GMB, expanding the implementation of the CCBHC program among behavioral health organizations in IL may also be an effective way of further increasing reimbursement for crisis services (Jonathan Brown et al., 2021). It is worth noting that many CCBHCs contract with external organizations to provide mobile crisis services (Mauri et al., 2025); it is not clear how wages of mobile crisis providers under contract with CCBHCs differ from those that provide mobile crisis services directly through the CCBHC.

Overall, it will be important for IL and states around the country to continue to increase the reimbursement rates for crisis organizations to boost their ability to pay responders fair wages, which will help ensure workforce sufficiency by attracting, retaining, and preventing the departure of new and experienced staff. This may be done either by implementing the CCBHC model or changing rates under the current system. These changes can be completed via the State Plan Amendment process by which states update and negotiate their contracts with the Centers for Medicare & Medicaid Services (Centers for Medicare & Medicaid Services, 2025b).

Recommendation 2: Establishing a Distinct Classification for Peer Specialists While Redefining Clinical Roles to Include Addiction Professionals

Ensuring certified peer specialists can only bill Medicaid for peer support services and removing them from the standard definition of MHP (or the equivalent term in other states), may help to decrease role strain and departure caused by allowing peer specialists to bill for clinical tasks despite being non-clinical professionals. This can be operationalized by the creation of a parallel Medicaid definition for those with a CRSS or CPRS certificate and removing the CRSS credential from the definition of MHP. As discussed, the reimbursement rates for this provider should be equivalent to those of an MHP to prevent dissatisfaction among peer specialists. This new definition must align with the requirements set forth by state grant funds for peer specialists able to work on a mobile crisis team, and both definitions should be aligned with best practices.[*] Across states, disentangling peer services from clinical services in Medicaid definitions by giving a distinct billing category for peer services may help to prevent role strain among peer providers. Other state Medicaid programs already separate these services while requiring that peer support specialists have personal lived experience with a behavioral health challenge, such as in Minnesota, although the effects of these policies on role strain and departure have not been measured. (Minnesota Department of Human Services, 2025; PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE., 2025). Lastly, policymakers in IL could consider creating pathways for substance use professionals like Certified Alcohol and Drug Counselors to join the mobile crisis workforce (e.g. by creating a path for them to meet the definition of MHPs); policymakers in other states may consider creating similar pathways.

Recommendation 3: Implementing Medicaid Reimbursement Ladders

Pay ladders, which allow individuals to work toward earning higher levels of compensation over time, have been demonstrated to decrease turnover in healthcare workforces and improve quality of care (Bukach et al., 2017; Dill et al., 2021). To ensure individuals remain working on MCTs, it will be important that rungs on the pay ladder not be associated with movement to roles elsewhere in the organization, as previous work and this work supports that mental healthcare providers tend to leave entry-level roles after advancing (e.g. obtaining a master's degree or clinical licensure) (Bukach et al., 2017).

Pay ladders in Medicaid reimbursement schedules can offer financial flexibility to organizations to create their own internal wage ladders, using the higher rates to boost the salaries of higher-level providers. Pay ladders already exist in Medicaid reimbursement rates for behavioral health. For example, IL's 2024 Medicaid fee schedule for on-site individual therapy services indicates that QMHPs (i.e. Masters-level providers without licensure) are reimbursed at a rate of \$34.84 per 15 minutes for on-site individual therapy, whereas entry-level MHPs are reimbursed at a rate of \$27.32 for the equivalent service (*Fee Schedule for Providers of Community-Based Behavioral Health Services, 2024*). IL is not alone: many other states have tiered Medicaid definitions for behavioral health providers. (Behavioral Health Service Provider Report, 2018) Right now, however, there is no such reimbursement ladder for provision of mobile crisis services in IL. Incorporating these ladders into reimbursements may encourage providers with higher credentials to continue providing direct mobile crisis services, and would likely improve quality of care for patients, who will receive care from more experienced professionals. This would align with evidence that Medicaid rate increases for primary care services led to an increase in patient-reported health outcomes (Alexander & Schnell, 2024). Organizations may also benefit financially from retaining senior providers. Evidence from emergency room physicians supports that productivity increases based on experience in the role (Vukmir & Howell, 2010), and that turnover is expensive for healthcare organizations (Waldman et al., 2004).

Reimbursement ladders can also be used to reinforce pay equity between peer specialists and clinicians. Disparities between peer support specialists and their co-workers are a documented cause of dissatisfaction in the peer support workforce, which comports with the results of this study (Felton et al., 2023).

Ensuring reimbursement of services provided by entry-level peer support specialists and entry-level clinicians at parity may support organizations in paying peer support specialists with equity. To further support organizations in retaining experienced peer support specialists, states might consider establishing higher reimbursement rates for those with additional experience or credentials—essentially creating a counterpart to the clinical billing definitions of QMHP and/or LPHA.

Recommendation 4: Passing Wage Pass-Through Laws

While many states are attempting to use higher reimbursement rates to increase their behavioral health workforces (Saunders et al., 2023), one issue raised during the GMB was that increasing reimbursement rates does not necessarily translate to higher wages for responders. In other areas of healthcare, many states have created “wage-pass through laws” that ensure Medicaid reimbursement rate increases are directly tied to wage increases. These have been implemented with moderate effectiveness for high-shortage professions like long term support service professionals in nursing homes and direct support professional services for individuals with intellectual and developmental disabilities (Block, L., Maxey, H., Medlock, C., Johnson, K., Nielson, B., 2022; Feng et al., 2010). Such laws may help states like IL bridge the gap between reimbursement and wages.

Recommendation 5: Aligning Public Payor Rules

The presence of multiple payors with varying service definitions is already known to be a significant burden for behavioral health providers, especially in the context of team-based care (Huber et al., 2023). Program 590 does not allow for crisis response by one individual, which is designed to enhance the safety of providers and effectiveness of care via the inclusion of peer support specialists on the teams (2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, 2025). However, individual mobile crisis responses can still be billed to IL Medicaid, leaving open the possibility that mobile crisis responses are occurring that break the terms set forth by Program 590 grant. Therefore, aligning these definitions with best practices and each other will be vital for ensuring the highest quality care is provided, and minimizing providers’ confusion caused by discrepant rules.

Billing complexity was anecdotally reported to leave Medicaid resources untapped, as providers (especially in smaller organizations) may have relied on Program 590 grant dollars without billing Medicaid for appropriate services. Further investigation is needed to determine how often this occurs. Like federal Mental Health Block Grant funds, Program 590 funding is intended to be used as the “payor of last resort” to fund care that cannot be compensated for by other payors (e.g. Medicaid, private insurance) (Illinois Department of Human Services, 2025; Treatment Improvement Protocol (TIP) Series, No. 45, 2006). This ensures all funds are used to their fullest extent before relying on finite and potentially short-term state grants, which helps to increase the perception of long-term job security among providers (Felton et al., 2023).

Recommendation 6: Expanding Billable Services

As of this writing, in IL, peer support services are billable to Medicaid only for services supporting individuals with substance use disorders in substance use care settings (as MHPs) and for CCBHCs (as PSWs), which does not include all mobile crisis service providers (Illinois Department of Healthcare and Family Services, 2025; Public Act 102–1037, 2022). Across states, including peer support services for both mental health and substance use services in mobile crisis settings would help to reimburse organizations for providing these services and decrease the ongoing reliance on State-based grant funds (Huber et al., 2023). Moreover, while not explicitly mentioned by participants in the current study, ensuring that state-regulated plans offered by private insurers (e.g. health insurance plans on state-based exchanges) cover crisis services, including those provided by peer specialists, is one option to diversify funding for mobile crisis services. Such legislation was recently introduced in IL but has yet to be brought to the floor of the General Assembly (INS-BEHAVIORIAL HLTH SERVICES, 2025).

Even though many states also have peer support services that are billable to Medicaid (Behavioral Health Service Provider Report, 2018), ensuring that such services can be billed for in the crisis context is a known challenge (Hodgkin et al., 2024). This is because insurers are traditionally designed to reimburse for discrete services that are directly provided by individuals (e.g., fee-for service), rather than team-based care (Huber et al., 2023). Alternative payment models, including enhanced fee-for-service billing, bundled payments, capitated per-member-per-month payments (e.g. for CCBHCs), along with contract-stipulations for MCOs to cover team-based care, are all potential ways to ensure that crisis care is covered for Medicaid recipients (Huber et al., 2023). It is worth noting that many CCBHCs utilize designated contracting organizations to provide mobile crisis services, who would also be subject to the same requirements as the CCBHCs (Mauri et al., 2025).

Recommendation 7: Streamlining Background Checks

*The “Two Regions” category includes organizations serving Regions: 2 & 7; 5 & 10; 4 & 5; 4 & 6; 5 & 6; 6 & 7[‡]; 7 & 11[‡]; 7 & 11; 9 & 10[‡]; and 10 & 11. The “Three Regions” category includes organizations serving Regions 1, 6 & 9 and 4, 5 & 6. The symbol [‡] indicates the multi-region organization did *not* participate.

Background checks are a common requirement for individuals entering the mental health workforce, despite having limited demonstrated effectiveness for preventing patient harm due to implementation challenges and validity (Dunlap B, Basye A, Skillman SM, 11/21). Otherwise qualified individuals applying to mental health roles, and especially peer support specialists roles, may have a history of criminal-legal system involvement due to offenses committed while struggling with behavioral health challenges, potentially discouraging them from applying to mental health roles or preventing hiring (Stack et al., 2022). Having such a history may even be a strength for peer support specialists, allowing them to empathize with their clients in a way other healthcare providers likely cannot (Barrenger et al., 2019). There are a host of potential solutions that can help ensure that clients remain safe while also not preventing the workforce from including qualified applicants with criminal histories, and policymakers may find the reports from the Collateral Consequences Resource Center (Margaret Love & David Schluskel, 2020) and the Center for Health Workforce Studies at the University of Washington (Dunlap B, Basye A, Skillman SM, 11/21) useful in designing solutions that have been implemented around the US.

Recommendations for Organizations

This study also revealed several key practices that mobile crisis organizations can incorporate within their institutions to strengthen their ability to hire and retain mobile crisis responders. On the hiring side, organizations can work towards making mobile crisis an attractive field for potential candidates. Advertising campaigns that make the public aware of the existence of mobile crisis services, describe mobile crisis responders as “first responders,” and highlight lived experience with mental health challenges as a valuable skill, may deepen the applicant pool. Additionally, clearly describing the nature of the role may help prevent turnover shortly after hiring. One crisis service organization reported that, after beginning the practice of explicitly discussing potential response scenarios (e.g. in homes, jails, hospitals) during interviews, they significantly decreased the number of new hires that left their roles.

There are also institutional policies on wages and the workplace that can help to significantly improve retention of mobile crisis responders. The financial recommendations for organizations align with the recommendations for policymakers, but unlike policymakers, organizations make the final decision on the exact wages to pay peer specialists and their clinical counterparts. Organizations may also decide to shoulder the cost of paying higher wages for direct crisis service provision to master’s-level or licensed providers, despite Medicaid reimbursing them at the same level as entry-level crisis professionals. Other solutions mentioned by participants, like offering robust mental health supports to all members of the team, using flexible scheduling methods like the “Committed Shift” strategy outlined in **Supplemental File 5**, training clinical professionals on how to work with individuals with lived experience of mental health challenges, and supportive leadership who value and understand the role of peer specialists, may be vital in creating an environment in which staff can thrive.

One novel solution suggested at the Medicaid-level in *Policy Recommendation 2* that can be applied at the organizational-level is the creation of *advanced* peer support positions within organizations. Such a position would create an opportunity for peer specialists to gain additional training, higher wages, and create a sense of professional advancement within a particular organization for a role that currently has a short career ladder (**Figure 4**). Mobile crisis organizations and peer specialist professional organizations may wish to explore the feasibility and utility in creating such a credential moving forward.

Future Directions

The qualitative nature of this study provides a broad foundation for future research. Quantitatively testing the impact of scheduling strategies like the “Committed Shift” model, changes to Medicaid, and even different mobile crisis organizations with different workplace policies, can help begin to strengthen the evidentiary foundation put forth in this study.

Whether an organization decides to increase pay for more advanced professionals to provide direct crisis care may largely depend on the resources of that organization. In this study, the organization that implemented this policy was a large, consolidated organization, which may have been better positioned to make this decision. The recent National Survey of Mobile Crisis Teams revealed that over half of the 381 responding organizations across the country have operations with more than 11 full-time equivalent employees, and that many mobile crisis teams share staff with other mental health services (i.e. crisis stabilization unit, outpatient therapy) (Goldman et al., 2023). For such organizations, creating an intra-organizational pay ladder seems like a feasible solution. This is consistent with a recent report that described larger crisis organizations with well-established billing departments as being better equipped to bill Medicaid (Edmonds et al., 2025).

Furthermore, the CRSS-SP was qualitatively reported to effectively increase the number of certified peer support specialists in the mobile crisis workforce. Future work may follow participants in this program to quantitatively measure its impact on the workforce. In contrast, no equivalent program exists designed to train MHPs working in clinical roles (e.g. as CCs on mobile crisis teams). While such a program would help ensure that all MHPs new to the workforce have the same knowledge and skills, whether the current quality of care provided by MHPs meets the needs of the people of IL is beyond the scope of this study. Future studies should study the effectiveness of different training pathways for MHPs on system-level and patient-level outcomes, including whether specific training pathways increase perceived role preparedness and workforce retention. Finally, replicating this work in other states with distinct mobile crisis delivery systems and mobile crisis workforce policy contexts will help generate a broader understanding of how such policies ultimately impact the workforce.

Limitations

This study has a few key limitations. First, the challenges faced by mobile crisis teams in IL may not be fully representative of teams across the US. While adequate staffing of mobile crisis teams is a nationwide issue, teams are structured in a variety of ways, and not all states require the presence of a peer support specialist alongside a clinical professional. Moreover, the number of responses for the eight questions asked during the cluster meeting data collection tended to be fewer for ESs than CCs. This may be attributed to ordering bias, as questions for CCs were asked before questions for ESs. This may have led participants to not duplicate responses that could apply to both groups. Alternatively, there may have been participant fatigue causing responses to decrease toward the end of the sessions. Future data collection efforts may benefit from question order randomization to ensure these biases do not skew results.

Additionally, the qualitative observations collected during GMB often tended to be more specific and higher-level than those in the Mentimeter data collection, which led to a few new codes being added toward the end of the qualitative data collection process. This makes sense given that sample included many individuals working in mental health policy roles, alongside crisis program directors and other participants. This means that it is possible that more data from a broader range of participants could have led to the creation of additional themes. While this does not threaten the conclusions of this study, it does indicate that additional data collection in IL may be warranted to ensure that all themes have been fully fleshed out.

In addition to sample differences, the GMB and Mentimeter data collection methods were not the same. The Mentimeter collection strategy allowed participants to input data in their own words in response to specific questions. In contrast, the GMB data collection involved the authors summarizing the

observations discussed in the group and sorting them into categories. It is the belief of the authors that merging these data sources makes for a more robust dataset. However, it is possible that, in summarizing participant statements captured during GMB, the authors did not accurately represent the intended meaning of the participants' statements. To address this concern, two follow-up interviews were conducted to clarify observations that were not immediately clear.

Additionally, a key limitation of the Mentimeter data is that the level of agreement with visible responses was not measured (i.e., once participants saw a response, they did not vote to demonstrate their level of agreement). This means that participants may have agreed with the existing responses and chose not to write those responses themselves because they were already included in the data. While some responses were clearly given more frequently than others— especially responses related to needing higher pay for mobile crisis staff— overall the frequency of responses could not be used as an indicator for the level of agreement with any of the responses due to this limitation. Therefore, the themes in this study should not be considered ranked in order of importance. Future work should consider utilizing upvoting features to gauge agreement among participants to act as an indicator of importance.

Finally, while all regions of the state were represented, not all teams in IL participated in the study. It is possible that those that did not attend the sessions were systematically different than those that did participate, which would mean that the data collected and conclusions drawn may not be representative of all teams in the state.

Conclusion

The mobile crisis workforce in the US is insufficient to address the increasing rate of mental health crises. By learning from directors of mobile crisis teams across the state of Illinois and other key stakeholders in the mobile crisis workforce pipeline, this study revealed factors key to understanding and addressing the causes of mobile crisis workforce insufficiency. In addition to the inherently intense and rewarding nature of crisis work, as well as the slowly evolving societal perspectives on mental health, policy and organizational levers can be pulled to increase inflow into the workforce and retention. Boosting awareness of mobile crisis responders as “first responders,” building pay-ladders into crisis service reimbursement rates, aligning rules of all payors with best practices, and utilizing flexible scheduling techniques in a communicative and accommodating work environment, are a few key strategies that arose from this work that may help increase mobile crisis workforce inflow and retention. Ultimately, implementation of these recommendations may begin to put states on a path toward a crisis workforce that can more effectively meet the needs of those in crisis.

Declarations

Competing Interests

Author AW reports an ongoing contract with the Illinois Department of Human Services Division of Behavioral Health and Recovery to collect data related to its 9-8-8 and mobile crisis (Program 590) grant programs; this relationship did not provide funding for the present study. Authors KHL and HN report work related to mental health crisis systems in North Carolina, funded by the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Use Services; these relationships did not provide funding for the present study.

Author Contribution

J.F. and K.H.L. contributed to conceptualization. J.F. and K.H.L. contributed to methodology and investigation. J.F. led project administration. J.F. and M.G. conducted the formal analysis. J.F. wrote the original draft of the manuscript and prepared all figures and tables. J.F., M.G., H.N., N.S., A.W., and K.H.L. reviewed and edited the manuscript.

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Data Availability

All data supporting the findings of this study are available within the paper and its Supplementary files.

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Footnotes

[*] While the new PSW criteria does expand the ability for organizations to bill IL Medicaid for peer specialist services, crisis teams receiving funds from Program 590 are required to hire ESs that either have a CRSS/CPRS certification or will receive one within a year of employment. Therefore, while the PSW title may decrease reliance on grant funding for peer support specialists in other areas of mental health, as of this writing it will not impact the ability of individuals to enter the mobile crisis workforce as ESs. The CFPP and CVSS credentials required for the PSW title differ from that of the CRSS/CPRS in terms lived experience, and therefore PSWs on crisis teams would still need to qualify and obtain a CRSS/CPRS certifications, which they may or may not qualify to obtain if they do not have personal experience with a behavioral health challenge (*Credentialing | Illinois Certification Board, Inc.*, n.d.).

Tables

Tables are available in the Supplementary Files section.

Figures

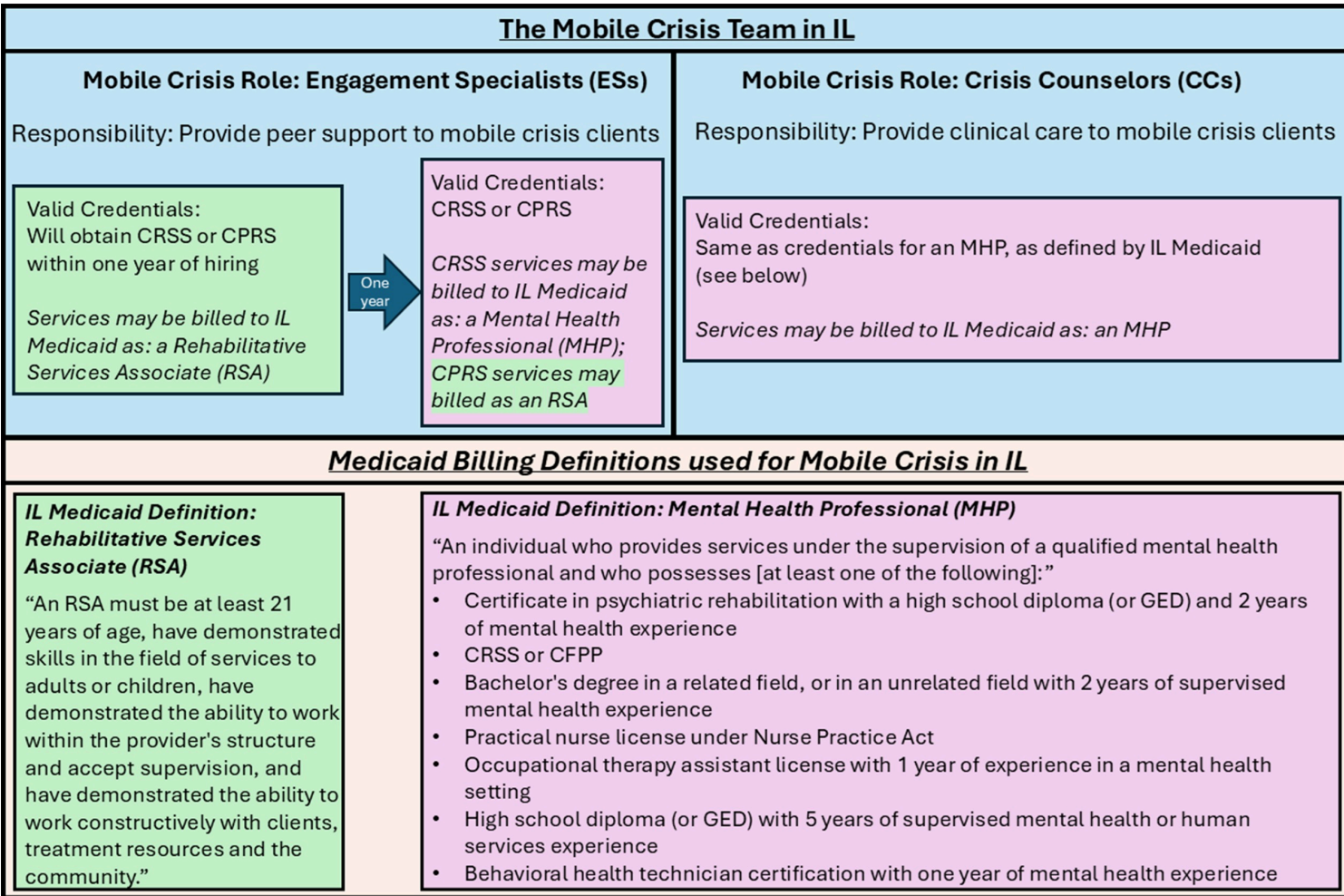


Figure 1

Mobile Crisis Roles and their Relation to Medicaid Definitions in Illinois

CC = Crisis Counselor; CFPP = Certified Family Partnership Professional; CRSS = Certified Recovery Support Specialist; CPRS = Certified Peer Recovery Specialist; ES = Engagement Specialist; GED = General Education Development; IL = Illinois; MHP = Mental Health Professional; RSA = Rehabilitative Services Associate

Sources: Title 59 Ill. Adm. Code 132.25, and Title 89. Ill. Adm. Code 140.453

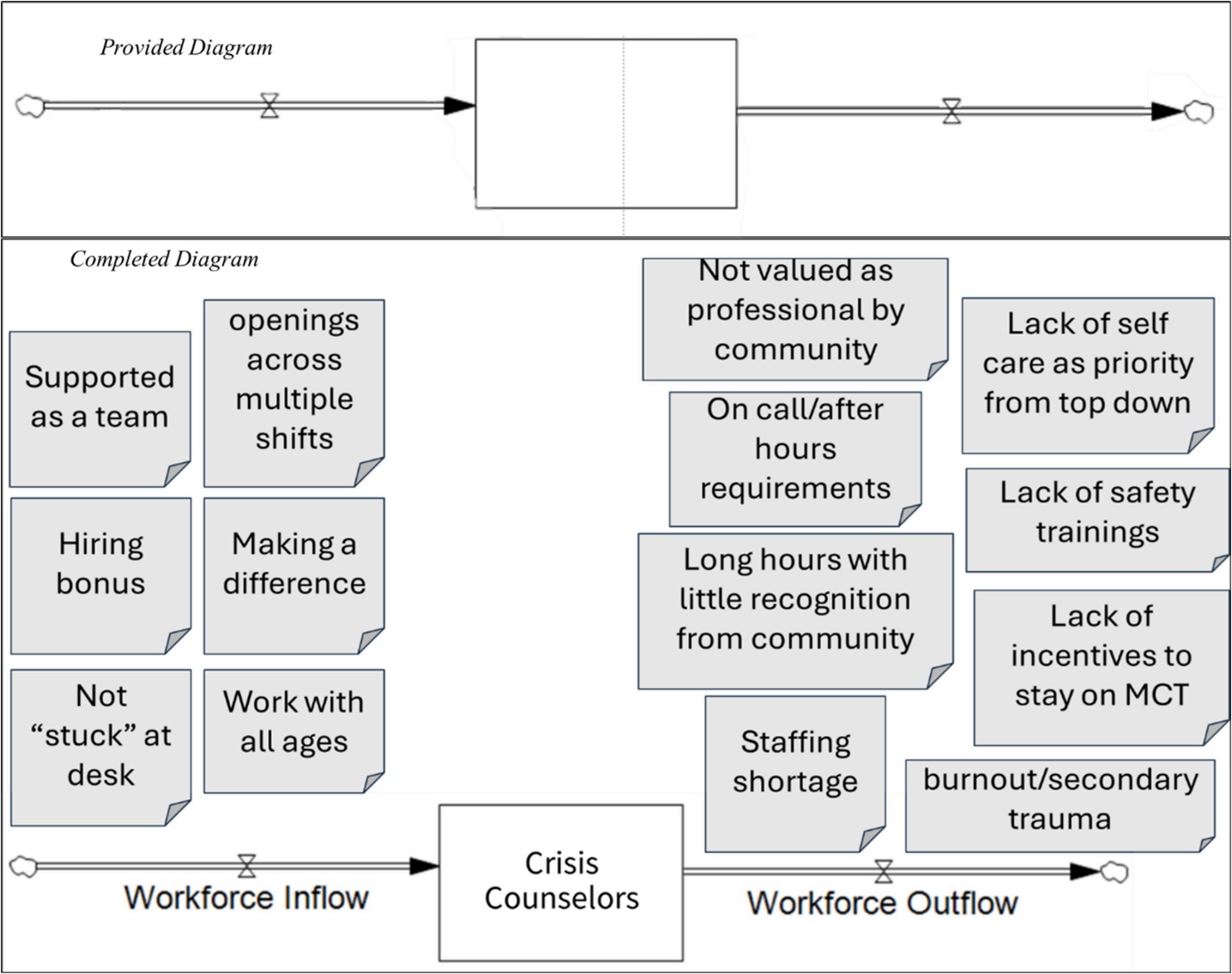


Figure 2
Example of Initial and Final Stock-and-Flow Diagrams Generated by a GMB Participant
MCT = Mobile Crisis Team

Region	Number of Organizations Providing Mobile Crisis Services (<i>n</i> = 64)	Number Organizations with at least 1 Representative Participating in Data Collection (<i>n</i> = 45; 70.31%)
1	2	2 (100.00%)
2	7	4 (57.14%)
3	4	4 (100.00%)
4	4	3 (75.00%)
5	6	3 (50.00%)
6	3	1 (33.33%)
7	4	3 (75.00%)
8	5	4 (80.00%)
9	5	4 (80.00%)
10	1	0 (0.00%)
11	11	8 (72.73%)
Two Regions*	10	7 (70.00%)
Three Regions*	2	2 (100.00%)

*The "Two Regions" category includes organizations serving Regions: 2 & 7; 5 & 10; 4 & 5; 4 & 6; 5 & 6; 6 & 7[‡]; 7 & 11[‡]; 7 & 11; 9 & 10[‡]; and 10 & 11. The "Three Regions" category includes organizations serving Regions 1, 6 & 9 and 4, 5 & 6. The symbol [‡] indicates the multi-region organization did *not* participate.

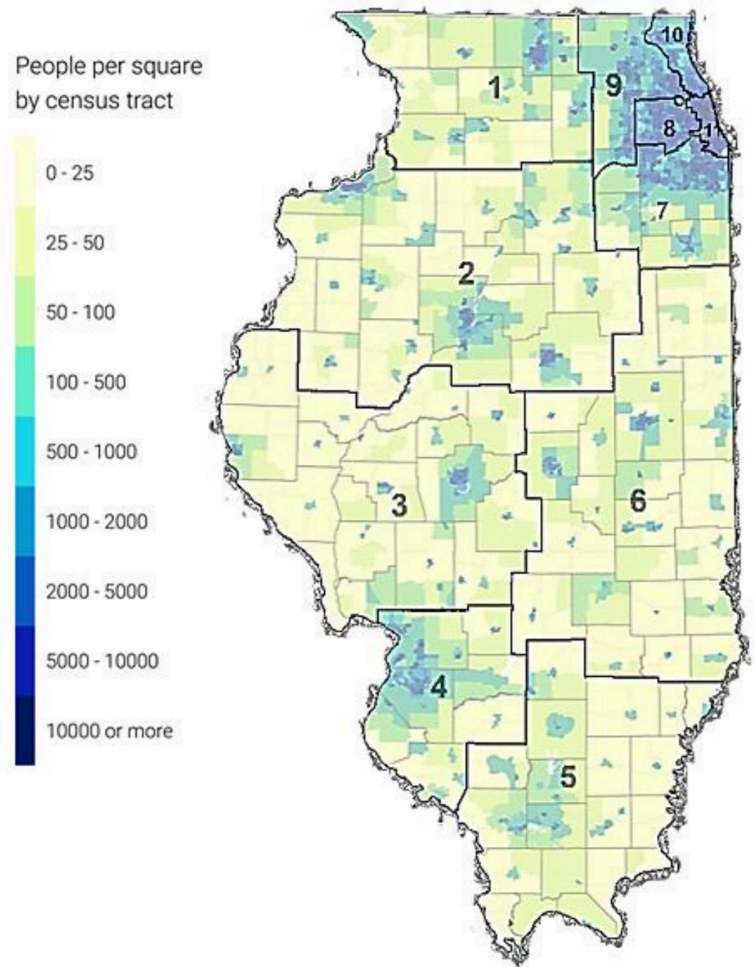
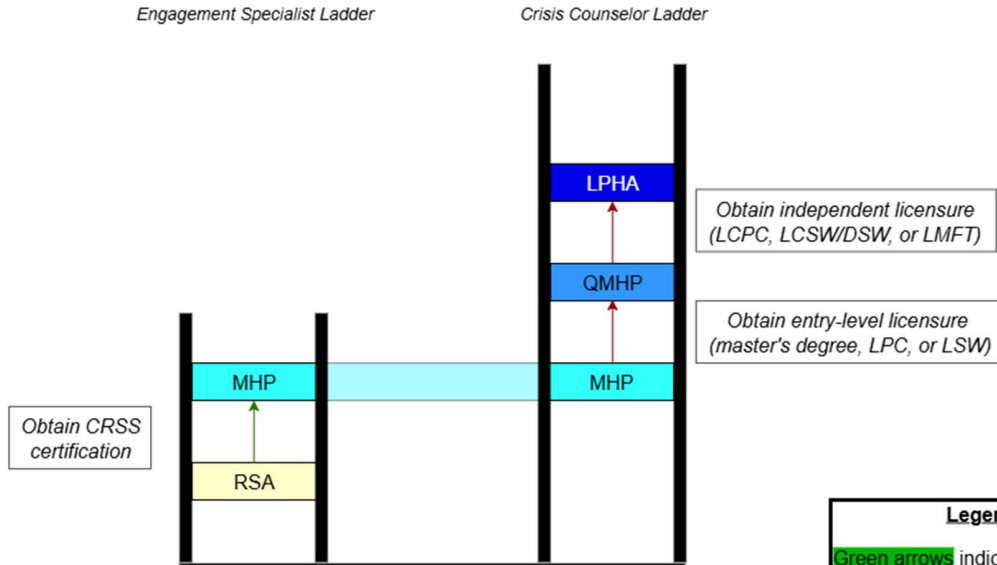


Figure 3

Mobile Crisis Organizations Represented in Data Collection by IL EMS Region

*The "Two Regions" category includes organizations serving Regions: 2 & 7; 5 & 10; 4 & 5; 4 & 6; 5 & 6; 6 & 7[‡]; 7 & 11[‡]; 7 & 11; 9 & 10[‡]; and 10 & 11. The "Three Regions" category includes organizations serving Regions 1, 6 & 9 and 4, 5 & 6. The symbol [‡] indicates the multi-region organization did *not* participate.

Current Medicaid Roles and Reimbursement Hierarchy for Mobile Crisis Responders



Recommended Medicaid Roles and Reimbursement Hierarchy for Mobile Crisis Responders

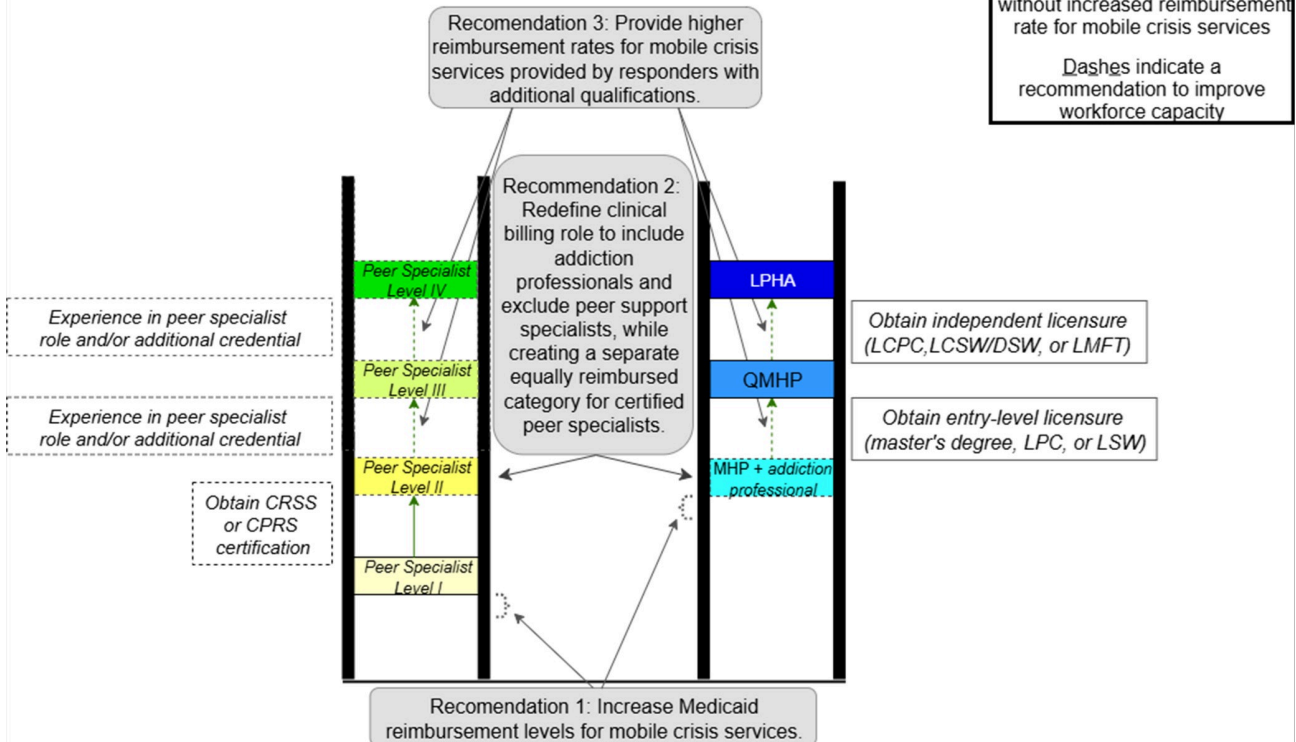


Figure 4

Recommendations for Medicaid Changes to Strengthen Mobile Crisis Workforce

CRSS= Certified Recovery Support Specialist; CPRS = Certified Peer Recovery Specialist; LCPC = Licensed Clinical Professional Counselor; LCSW = Licensed Clinical Social Worker; LMFT = Licensed Marriage and Family Therapist; LPC = Licensed Professional Counselor; LPHA = Licensed Practitioner of the Healing Arts; LSW = Licensed Social Worker; MHP = Mental Health Professional; QMHP = Qualified Mental Health Professional; RSA = Rehabilitative Services Associate

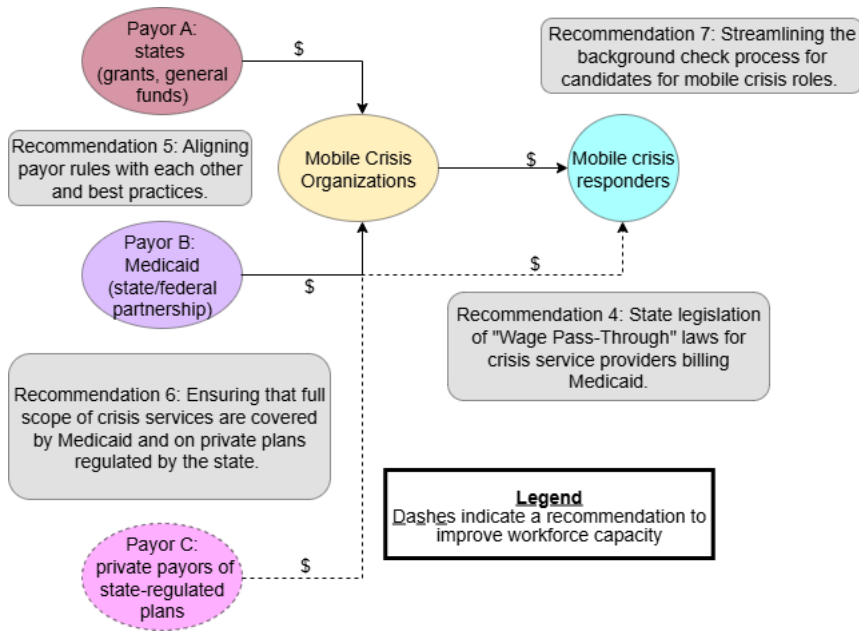


Figure 5

Legal, Administrative, and Regulatory Recommendations to Strengthen Mobile Crisis Workforce

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [SupplementalFile1GMBMethods.docx](#)
- [SupplementalFile2PreGMBCodebook.xlsx](#)
- [SupplementalFile4QualitativeResultsSummary.docx](#)
- [SupplementalFile5CommittedShiftModel.docx](#)
- [SupplementalFile6GroupModelBuildingInitialProblemFramingActivity.pdf](#)
- [Tables.docx](#)