

Mobile Crisis Units Face Funding Perils



By [Ashleigh Hollowell](#) | May 19, 2025

Mobile crisis teams are facing an era of unprecedented shifts in funding reliability and health care priorities, putting the viability of these “teams on wheels” into question.

The goal of mobile crisis units is to provide on-site behavioral health services to individuals in crisis, reducing reliance on law enforcement intervention and minimizing emergency department boarding of patients with psychiatric needs.

However, staffing challenges and funding woes have historically limited mobile crisis units. Historically, the [model](#) has been challenging to make a business case for due to [unevenly applied](#) clinical best practices and constrained metrics tracking to prove return on investment (ROI).

Funding and policy issues have kept the scale of mobile units relatively small, sometimes limiting them from reaching those who could benefit most. The recent [restructuring](#) of the Department of Health and Human Services (HHS), combined with [reduced budget](#) proposals for agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA), a primary funding source for mobile crisis units, has left many mobile crisis operators perplexed.

“I think everyone’s concerned right now. We don’t know what all the details are going to be, so it’s really hard. It’s typically a bipartisan issue – one that touches pretty much every family in America, crisis services in particular,” Dr. Margie Balfour, chief clinical quality officer of Connections Health Solutions, said. “Not only is there a clinical need for it, but if you want to look at it from a responsible stewardship of taxpayer funds point of view, it keeps people out of emergency rooms, jails and hospitals, which cost more. The SAMHSA block grants fund a lot of this work. We’re definitely keeping our eye on that, but it’s hard to know what we’re facing just yet.”

Phoenix, Arizona-based Connections Health Solutions is a mental health service provider with several brick-and-mortar locations, but the company also operates various mobile crisis teams in places like rural Montana and Pennsylvania.

Proving mobile crisis ROI

For a business model that has been around in some capacity since the 1970s, most would imagine proving a ROI would be relatively straightforward. However, because of the limited resources, and variabilities in data and distribution of mobile crisis teams, calculating their overall value is widely disproportionate.

An NRI [report from 2023](#) found that while mobile crisis units operate in 49 states, some have between one and five teams statewide, while others have between 100 and 363 response teams. While on average, mobile crisis response units served 19,255 individuals per year, the range was also vast. Illinois teams served 187,179 patients in one year, but mobile units only served 25 patients in New Mexico during the same timeframe.

The data these teams collect is not standardized across the board and not all states even report the impact their mobile crisis teams have at all. Others do have ROI metrics they track to make their case for additional funding, but largely, the case for the success and effectiveness of these teams is hard to make. That, combined with large [variability in access](#) to mobile crisis response across the U.S., also hinders their ability to “make their case” despite demand.

Improving these metrics and working toward standardizing their accessibility is something that Dr. Andrew Anderson, an assistant professor at the Johns Hopkins Bloomberg School of Public Health, is currently focused on.

“There are no measures for even studying utilization. There are very few states that have utilization measures, and none of them, to my knowledge, have been validated in any way,” Anderson told BHB. “The literature on this has been focused on specific settings, like a health system that’s connected to a team or a couple of treatment facilities. We don’t know the causal impact of mobile crisis services on things we care about large-scale like when they divert from emergency departments, jails and hospitalizations.”

Because geographically, mobile crisis units also operate so differently regarding how they respond to incidents, whether dispatched along with 911, through a 988 call or by some other means, creating standard definitions and measurements has also been a challenge, he said.

“We don’t have consistent measures, because we also don’t have very clear definitions of what this means. SAMHSA has created clearer [definitions](#), but that has not been translated into a way to measure

it. This also doesn't fully reflect what's happening on the ground," Anderson said. "The evidence for mobile crisis units' impact is pretty slim overall, but what we have is suggestive that it's a good thing, and that's why I think it's been moving forward. But we need better evidence. We do need better system-wide measurements, and we also need not just a good measurement of mobile crisis services, but also how to measure its integration within the crisis continuum."

Funding this research and expanding services is going to be the only way to create a standardized approach, he said.

Developing national standards for metrics, data, distribution of services, support and training to enable a more robust system of mobile crisis teams across the country might be crucial as demand only ticks up.

"It's important to really understand how community, mobile response teams, particularly well-trained ones that are layered with a data component, can make a difference in very challenging marginalized communities," Curtis Penn, division director of Justice Services with the Felton Institute, said. "It's something that is definitely needed and can not only help the communities heal but address some of the city and county and state deficits that are happening across the country...It's something that you don't want siloed. So yeah, putting in place a national standard could help, depending on who is leading it."

The San Francisco-based Felton Institute is a provider of mental health and social services throughout the Bay Area. It currently operates two mobile crisis units in Antioch and Vallejo, California.

Finding footing for longevity

The American Rescue Plan Act of 2021 [allocated](#) \$15 million in planning grants to 20 states to expand mobile crisis services. However, staying afloat and continuing to fund the work these teams do sustainably has been complicated from a billing perspective.

In 2023, the NRI report shows that 34 states with mobile crisis teams spent \$704 million supporting their operations. This figure, however, mirrored the variables in geographic access, ranging from \$65 million in New Jersey, which has 15 teams, to a low of \$578,085 in Arkansas, where there are just two mobile crisis teams.

A lot of the work these teams do is not reimbursable, and many times, they also don't have eligible staff for billing.

Mobile crisis teams typically serve a large portion of the uninsured and Medicaid population, but crisis response in and of itself is not a covered Medicaid service, even if components of related care are.

Although the Rescue Plan Act did help, it incentivized a fee-for-service model that just isn't realistic, Balfour explained.

"That incentive worked for creating mobile crisis teams, but doing it just purely fee-for-service, whether you're doing it via Medicaid or these other sources, is really challenging for most programs," she said. "If you are just looking at it from a pure fee-for-service model, one of the challenges that places are having when trying to figure out how to fund mobile is the Medicaid psychotherapy codes. So it becomes similar to trying to cram the square peg in the round hole to make fee-for-service billing the engine that funds

mobile. So, doing these braided funding models and doing things with capacity funding is really important for standing up a sustainable mobile crisis program.”

Partnerships with local organizations and other entities help, but are not the answer long-term.

“There are a lot of things that we do that don’t fall into anyone else’s bucket,” Ryan Mattson, director of social services for Connections Montana and leader of its mobile crisis response team, said. “It’s important to have those pieces, because it really puts a huge burden on the mobile teams to try to be creative outside of the box for care, which we do, but then you’re going to always have people that do need that next level that we can’t provide. Mobile is key, but it’s not the answer in and of itself, for everything.”

Identifying sustainable billing practices for mobile crisis teams and investing in the infrastructure to support that, is also key, Jackie Giarratano, director of behavioral health for Mission Mobile Medical, told BHB.

Mission Mobile Medical, based in Greensboro, North Carolina, operates more than just mobile crisis services, but also offers other mobile healthcare options.

“If we look at sustainability, it’s making sure that we’re billing for every opportunity, every unique visit, every encounter that comes onto the mobile clinic. I think it’s easy in this space to say, ‘we’re just going to wrap our arms around you, and the money part doesn’t matter’ because the care is the most important part,” Giarratano said. “But we have to be able to identify those billable opportunities. Specifically for the behavioral health space, but it’s true for all care models, that we can be sustainable with billing if the patient census count is right, and if we’ve done the right things to bring attention, maintain attendance and adherence and reduce the turnover rate. If we’re doing these things, we can get there.”

What the future holds

Even as the rest of the behavioral health industry struggles with staffing issues, many mobile crisis operators told BHB that, in general, they don’t have issues finding staff who want to work in this capacity.

“People want to work on mobile,” Giarratano said. “Some of our clinics have waiting lists for the staff who want to work on the mobile clinic, which is pretty neat.”

Penn noted a similar appetite for this in his region and hinted at a possible future endeavor he and the Felton Institute may undertake: establishing a “mobile crisis training academy” specifically tailored to working on these units.

The idea came from Penn’s previous background as a firefighter. He said establishing a three-to-four-week academy for individuals interested in doing community mobile crisis response would increase the pipeline of prepared professionals and better prepare them for the challenging call types they may go on. It’s something he plans to explore further as part of his doctoral dissertation.

“I believe that because you have people from the community and from these marginalized communities, solving problems within their own community – that means a lot,” Penn said, “That goes a long way. It

not only supports job growth, but it really gives a different public safety element to community mobile response teams.”

The demand for these services has already been felt nationwide and is only growing, so meeting that demand is going to be important for all communities, agencies and other entities to work together and find continuous funding solutions.

“In the future, as these services continue to grow and expand, it is important to keep in mind that it’s not the final solution,” Mattson said.

Practically, mobile crisis units from a business perspective are hard to maintain and expensive. Some have turned to a regional-resources sharing model, and more may do so in the future, to help maintain their ongoing role in the continuum of crisis care, leaders told BHB.

“We would be in a really good place if we had one mobile clinic in every community across the country,” Giarratano said. “It takes a village.”