Community Crisis Response Staffing Framework

Early **community crisis response** programs drew on the mobile crisis model, pairing a licensed clinician with a paramedic/EMT and/or a peer. That model remains common for 988-based mobile responses, but 911-based alternative first response takes many forms.

FRAMEWORK: Align Staffing to Call Types

Match your responder profiles to your actual call volume and community need, **not an idealized model.**

Call Category	Core Skills Needed	Qualifications
Co-response to high risk situations (e.g., brandishing weapons, suicide in progress)	Co-response with law enforcement, de-escalation, clinical assessment, involuntary hold authority	Licensed clinician + Crisis Intervention Training (CIT) officer
High acuity behavioral health crisis	Clinical assessment, de-escalation, involuntary hold authority	Licensed clinician + paramedic/EMT and/or certified peer
Mid to low acuity behavioral health crisis	Rapid assessment, crisis intervention, de-escalation, social service navigation	Bachelor to Masters level or years equivalent in social services or health related field
Welfare checks (e.g., checking on a loved one you're concerned about)	Rapid assessment, rapport-building, resource knowledge, social service navigation	Bachelor to Masters level or years equivalent in social services or health related field
Interpersonal conflict / disturbances	Conflict resolution, mediation, communication skills, social service navigation	Field mediator or Bachelor to Masters level or years equivalent in social services or health related field
Health-related social needs (e.g., wellness checks, basic needs, non-acute care)	Engagement, harm reduction, social service navigation	Associate and Bachelor level or years equivalent, certified peer, community health worker, or outreach specialist
Substance use / overdose	Naloxone administration, harm reduction, medical triage, social service navigation	Associate and Bachelor level or years equivalent, paramedic/EMT, certified peer, community health worker, or outreach specialist
Homelessness outreach	Trust-building, long-term engagement, housing navigation, social service navigation	Associate or years equivalent, certified peer, community health worker, outreach specialist, or housing/care navigator

Credentialing Decisions

Licensed clinicians are a scarce and expensive resource. Deploying them on every call, regardless of acuity, is neither sustainable nor necessary. Programs that reserve licensed clinicians for the situations that genuinely require their skills, such as involuntary holds, clinical supervision, and high-acuity crisis response, free up capacity and reduce costs without sacrificing quality. Community responders, peer specialists, and other professionals bring real skills to the full range of calls that don't require licensure, and programs that recognize this build more resilient, cost-effective teams. Below is a framework for evaluating where licensure is essential and where other qualifications serve the community just as well.

FRAMEWORK: When Does Licensure Matter Most?

Use this framework to evaluate where clinical licensure is essential vs. where other qualifications may serve your community better.

Licensure Likely Essential	Licensure May Not Be Required
☐ State law requires licensure for service type	☐ Scene assessment and triage
☐ Co-response for calls with weapons	☐ Welfare checks
☐ Involuntary hold authority	☐ Mental health assessments
☐ Medicaid billing requires licensed clinician	☐ Safety planning
☐ Clinical supervision	☐ Quality-of-life and public nuisance calls
	☐ Interpersonal conflicts and neighbor disputes
	☐ Homelessness outreach and engagement
	☐ Transport to providers
	☐ Follow-up care coordination and navigation

Note: Watson et al. (2025) argue against requiring master's-level credentials for all responders—ARRC program data supports this finding.

BLIND SPOT: Funding Structures Can Drive Staffing Decisions

When programs depend on Medicaid reimbursement for operating revenue, billing eligibility can quietly shape who gets hired and which calls get prioritized. Programs may drift toward credentialed clinicians and billable call types, even when communities need response to quality-of-life calls, welfare checks, and interpersonal conflicts that fall outside reimbursable categories. A first responder model means responding quickly and assessing the need, not prioritizing billing eligibility. If your highest-volume diversion calls aren't Medicaid-billable, your funding model needs to account for that reality. Otherwise, your staffing decisions will reflect Medicaid regulations instead of community needs.