Washington's Crisis Response System Needs the Right Team for Every Call

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CRISIS OUTREACH
RESPONSE AND EDUCATION

Findings from the 2026 Field-Based Mobile Crisis and Co-Response Program Survey | BHCore, University of Washington School of Social Work.

The bottom line – It is estimated, each year, that over a million Washingtonians call 911 to request help in a behavioral health crisis.[1] Approximately 450,000 more request assistance through 988 and regional crisis lines.[2] Not every crisis is the same. Washington needs the right team for each call with enough staff to respond in a timely manner.

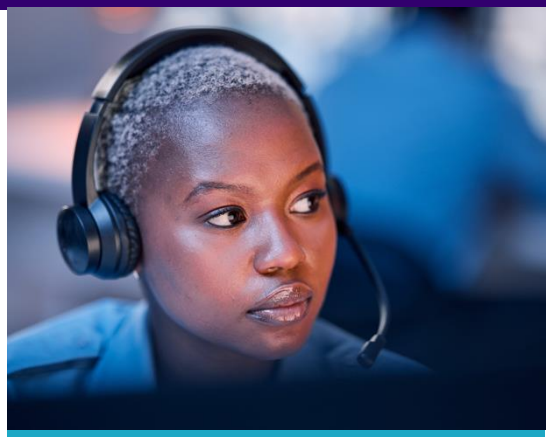
Today: **Over 40% of Washington counties do not have crisis response teams that respond to both 988 and 911 calls for help. 16 of 39 counties rely on a single type of 988/RCL dispatched crisis team that covers a large area.** This means many counties do not have specialized teams to respond to behavioral health emergencies reported to 911 such as drug overdoses and acute suicide threats. This shortage is especially pressing in rural areas.

Behavioral health teams responding to 911 calls experience significant staffing shortages. Co-response programs need **70%** more staff just to meet current demand, and most are not staffed nights or weekends.

The crisis response workforce is under strain.
82% of programs reported verbal assaults on staff in the past year; **26%** reported physical assaults. Rates were highest among Mobile Rapid Response Crisis Teams (MRRCT) and Mobile Response and Stabilization Services (MRSS; youth serving teams), these crisis response teams respond without law enforcement: **90% verbal assaults and 38% physical assaults.**

1. Every Region Needs the Full Functional Mix of Crisis Response Teams, Not Just Any Program
Washington's field-based crisis teams are not interchangeable. Each program type is built for a distinct kind of call:

Law enforcement co-response pairs an officer with a behavioral health professional. It is built for situations involving an imminent safety risk or a potential criminal element. Officers often initiate Involuntary Treatment Act to secure personal and public safety, and they are responding to interpersonal violence and acute suicide risk. In these life or death calls, having a behavioral health professional co-response and follow-up would improve outcomes for individuals and families in crisis and the officers involved. A coordinated and timely response with a Designated Crisis Responder to this higher acuity call may also be needed.



About the Survey

The 2026 Washington Field-Based Mobile Crisis and Co-Response Program Survey was conducted by BHCore at the University of Washington School of Social Work, with the Washington State Health Care Authority, the Behavioral Health Administrative Service Organizations, and the Co-Responder Outreach Alliance (CROA). Of 130 programs in the sampling frame, 105 are represented in completed surveys (81%); five programs that serve all ages were counted separately as adult and youth programs.

Findings reflect survey data as of October 2, 2026. Additional programs may complete the survey after this date, and figures may be updated in future reports and peer-reviewed publications.

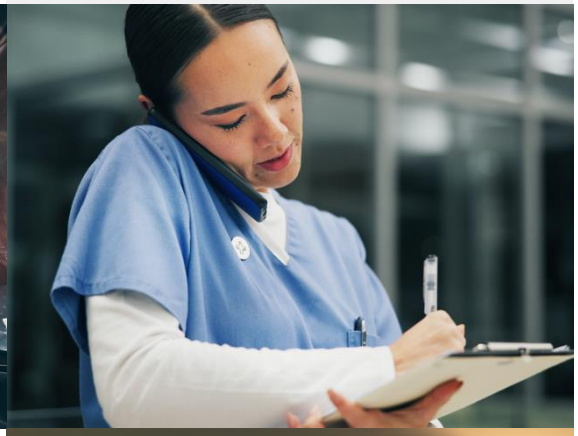
Fire/EMS co-response pairs a firefighter/EMS provider with a nurse, behavioral health professional, community health worker or peer. It is built for crises with co-occurring medical needs. These are also the teams that can provide support and medications during and after overdose and assist with expertise in situations involving geriatric patients. These teams, unlike other crisis response teams, have the potential to address some health needs in the community and divert from emergency services. A coordinated and timely response with a DCR to higher acuity calls may sometimes be needed.

MRRCT and MRSS are behavioral health–led and respond without law enforcement, often including peers. They are built for behavioral health crises when public and personal safety are secured. These teams respond to lower acuity calls when imminency and safety risks are believed not to be a factor and when transport is not needed. Alternative response teams dispatched by 911 can also play this role. Crisis counseling through 988 calls and texts can also be helpful for many crisis calls while providing anonymity and privacy.

When only one type of team covers an area, that area is not fully equipped to respond to all behavioral health emergencies and crises. A team can serve only the calls it is built for; while other calls go unmet, are delayed, or default to a response that doesn't fit the need.

"There are certain cases where the level of potential safety hazards are high and law enforcement is either unable/unwilling to respond. This leaves us in a place of not being equipped to handle certain things alone. There are times where a client meets criteria to be brought into the emergency department for further evaluation by a DCR, and law enforcement will not transport them."

— MRRCT, 2026 survey respondent



Rural counties: half rely on a single team type

Every Washington county falls within an MRRCT service area. But in rural areas, MRRCT is often the only option leading to delays and unanswered calls. Washington has 30 rural counties.[3] Ten have county-wide co-response, and 4 more have co-response in a single city or a small group of neighboring communities only.

In the remaining 16 (53%), no co-response program was reported. In these counties, MRRCT (and MRSS where available) is the only field-based crisis option: Adams, Asotin, Ferry, Franklin, Garfield, Grant, Grays Harbor, Klickitat, Lincoln, Pacific, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum, and Whitman.

The consequence is fewer services, not just fewer teams. The survey asked about the availability of 20 field-based crisis services on scene, including de-escalation, follow-up, connection to care, treatment and medications, and health and safety. In these rural counties, residents on average can receive **8 of 20** services, compared with about **17 services** in non-rural counties.[4] Services that usually come with Fire/EMS co-response teams are thin or missing. No field-based crisis teams in these counties offer fall prevention, wound care, or medication management, which 79% of Fire/EMS co-response teams provide.

2. Existence Isn't Capacity: Programs Need the Staff to Actually Respond

A program on the map is not the same as a program that can answer every call. Washington's field-based crisis programs report **776 responder FTE**. Programs estimate they need **304 more FTE (39% growth)** just to meet current call volume. These figures likely understate the statewide totals because 19% of programs did not complete the survey.

The workforce shortage gap is more acute in co-response. About half of co-response programs (52%) report that they sometimes or regularly cannot respond, compared with 13% of mobile crisis teams. Every program that *regularly* cannot respond is a co-response program. Co-response programs need **272 additional FTE, or 70% growth**, while mobile crisis teams report a combined gap of 32 FTE (8%).[4] King County alone accounts for 160 of the additional 272 FTEs needed statewide.[5]

Hours matter as much as headcount. Fewer than 1 in 10 co-response programs operate around the clock (24/7), compared with more than four in five mobile crisis teams (81%). Co-response programs are staffed a median of 53 of the week's 168 hours; three in four have no overnight coverage, and two in three are not staffed on weekends. 911 calls that come in during those hours will not receive a response from a co-response team for higher acuity call types.

Responding is not the same as responding in a timely way. One in four programs that say they respond to every call still report needing more staff to keep up with current demand. In two of the MRRCT-only counties named above, providers describe a system with no margin for error: *"...we only have one on-call DCR per shift that serves as the DCR and mobile crisis."* — MRRCT, 2026 survey respondent

In some rural counties, local providers rely on neighboring agencies to cover part of the week, often by telehealth. One such agency reports that, during call surges, *"we get backed up and don't respond as timely as usual."*

3. The Workforce Is Under Real Strain
Adding staff will not close the gap if the people already doing this work cannot stay in it. In the past 12 months, **82% of programs** reported at least one verbal assault on staff, **26%** reported at least one simple physical assault, and **8%** reported at least one aggravated or weapon-related assault. **Mobile crisis teams, which operate without police, reported the highest rates of both verbal (90%) and physical (38%) assault.**

The toll is psychological more than physical. In 26% of programs, at least one staff member took time off in the past year related to their experience as a crisis responder. Among those programs, the most common reasons were traumatic events or vicarious trauma (48%), general mental health challenges (48%), and burnout (44%); only one program cited a physical injury. This kind of strain likely makes recruitment and retention harder, adding to the staffing gaps described above.

Recommendations

1. Ensure that every region has the full functional mix of crisis teams. Every region should have access to all three team types: law enforcement co-response, fire/EMS co-response, and behavioral health mobile crisis (MRRCT/MRSS). We recommend focusing on the 16 rural counties where MRRCT is the only option, using regional or shared models where a single county cannot sustain its own program. The State should be looking at all options to fund these teams through rural transformation dollars, insurance, and through 988 line fees. Cities and counties need to continue and grow their investments for these teams. Teams also need to collaborate in the field and be able to refer to one another for follow-up.

2. Fund capacity, not just existence. A program on the map must have the staff to operate 24/7 and reach the entire service area, starting with the 272 additional FTE co-response programs report they need to meet current demand.

3. Protect the people doing this work. Responder safety depends on the right backup being available: mobile crisis teams, which report the highest rates of physical assault, need reliable access to law enforcement or Fire/EMS partners when a scene is unsafe or when there are co-occurring medical and substance use issues. Every program should also offer critical incident debriefing, opportunities for peer support, and access to mental health support for staff. All teams need adequate training in safety and situational awareness like POISE -BHCore's crisis responder certificate program,
which builds de-escalation, situational awareness, on-scene safety skills and collaboration for **field-based** teams.

4. FTE needs are program-reported estimates. Many programs, specifically MRRCT and MRSS programs, were surveyed for the first time in this effort, and their reported need may understate actual staffing needs given high responder turnover. These figures should not be read as evidence that any program type is adequately staffed.

5. Keep the statewide picture current. Conducted by BHCore with support from HCA, the BH-ASOs, and CROA, the 2026 Landscape Survey is the first statewide effort to map co-response and mobile crisis programs together, and it reached 80% of programs. Making it a recurring assessment, with every program across crisis response continuum taking part, would support efforts to increase collaboration and provides the state with important information about whether gaps are closing and if direct investment are happening where they are needed most. Public and private facing versions of the crisis services landscape map would support coordinated services and increase access for individuals and families in crisis.

Notes

1. Stuber, J., Klein, R., de Haan, B., & Kitajo, J. (2023). Co-response: An essential crisis service — A landscape analysis for the Washington State Legislature (Report submitted June 30, 2023, in response to SSB 5644). https://croawa.com/wp-content/uploads/2023/07/SB-5644-Report-to-Legislature-Executive-Summary.pdf

2. Prevention--8430 PHI and V. 988 Suicide & Crisis Lifeline Data Dashboard | Washington State Department of Health. Accessed September 28, 2026. **https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/988-suicide-crisis-lifeline-data/988-suicide-crisis-lifeline-data-dashboard**; Washington State Department of Health. (2025). 2025–27 first supplemental budget session: Policy level CC — 988 call centers.

3. Rural counties meet the criteria in RCW 43.160.020 as amended in 2026: population density below 100 per square mile, land area below 225 square miles, or no city over 45,000 residents, based on OFM April 1, 2026 official population estimates. Frontier counties: density below 50 per square mile. Population-weighted mean services per resident were calculated as the sum of (county population× county mean number of services) across counties in each group, divided by the group's combined population. Unlike an unweighted mean, which treats every county equally, the population-weighted mean estimates the average number of services available to a resident — giving more populous counties proportionally greater weight. Excludes Grant, San Juan, and Skamania where the MRRCT did not complete the survey. Some services may be available through providers outside field-based crisis responses.

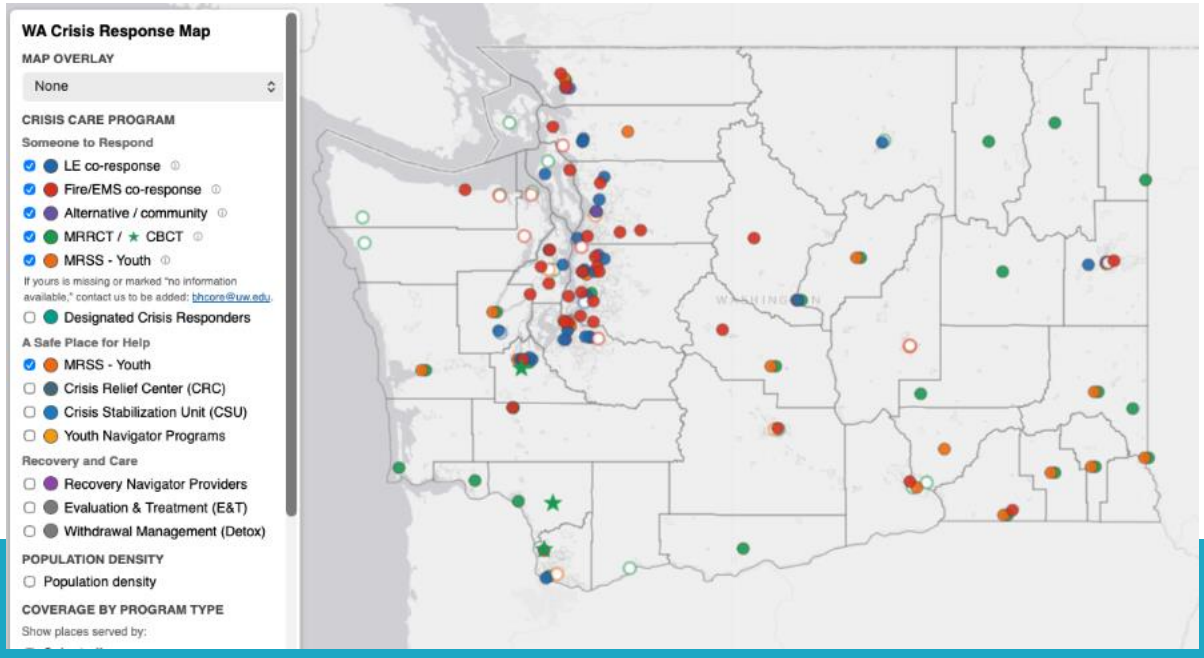


Figure. Washington State field-based crisis response programs, 2026. Each marker shows a program's location, colored by type: law enforcement co-response, fire/EMS co-response, alternative response, adult mobile crisis (MRRCT/CBCT), and youth mobile crisis (MRSS). Hollow markers are programs known to operate that did not complete the survey. Additional services in the crisis response continuum are available on the interactive map. Source: 2026 Field-Based Mobile Crisis and Co-Response Program Survey, BHCore, University of Washington School of Social Work (data as of October 2, 2026).

Explore the interactive map: https://bhcore.github.io/CrisisMap/

Definitions

Co-response: A multidisciplinary partnership between first responders (public safety telecommunicators, law enforcement officers, firefighters, EMTs, and paramedics) and human services professionals (social workers, behavioral health clinicians, nurses, community health workers, and peer support specialists). Co-response teams respond to emergencies involving behavioral health crises and complex medical needs, and they may also provide follow-up care such as case management, resource navigation, and transportation (HB 1811).

MRRCT (Mobile Rapid Response Crisis Team): An adult mobile crisis service that offers voluntary, community-based help wherever the person is, including home, work, school, or courts. Teams are two-person units made up of a behavioral health clinician and a certified peer counselor, and they respond without law enforcement unless special circumstances call for it.

MRSS (Mobile Response and Stabilization Services): A voluntary, community-based crisis care model for youth and families. When a young person, caregiver, or third-party requests help, usually through a regional crisis line, a team goes in person to wherever the youth is, including homes, schools, and emergency departments. The team pairs a clinician with a parent and/or youth peer and provides developmentally appropriate de-escalation and crisis intervention.

HCA (Washington State Health Care Authority): The state's largest health care purchaser, its Medicaid authority, and its behavioral health authority. HCA administers Apple Health (Medicaid) and health benefits for public and school employees, and it provides behavioral health prevention, crisis, and recovery support to all Washington residents.

BH-ASO (Behavioral Health Administrative Services Organization): A regional organization, funded through state and federal block grants, that helps people navigate mental health and substance use disorder services. BH-ASOs provide crisis services to anyone in their region regardless of insurance or income, including a 24/7 regional crisis hotline, dispatch of mobile crisis outreach teams, short-term substance use crisis services, and Involuntary Treatment Act assessments.

CROA (Co-Responder Outreach Alliance): A statewide, nonpartisan organization, founded in 2018, of first responders, behavioral health professionals, and project managers who work in co-response. It represents police and fire agencies across Washington and works to improve understanding of co-response, promote its use, and advocate for supportive laws and policies.

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