

A Guide for MRSS Leaders: Articulating the “Why” Responses to Common Questions and Challenges

This document is a companion to [Mobile Response & Stabilization Services National Best Practices](#).

Elevator Pitch

Mobile Response and Stabilization Services (MRSS) is an intervention designed to respond with urgency to the immediate needs of children, youth, young adults, and their caregivers. MRSS emphasizes access, not only in the immediacy of its responses, but in eligibility for services which are universal and blind to insurance, income, or other typical exclusions. For many families, MRSS will be their first contact with public systems and will inform their understanding of how these systems work. For other families, it may be a lifeline that they call on more than once during some of their most challenging moments. In either instance, MRSS is there for families, meeting their sense of urgency with urgency, believing them when they say they need help, and providing the ongoing connection and support necessary to stabilize children and young people in their homes and communities. The bottom line is that MRSS saves lives and changes life trajectories for children and young people.

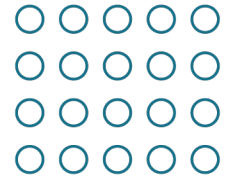
If a family is calling a public system for help, they need help. MRSS screens in, not out, and allows families to define the crisis while offering face to face responses as soon as young people and their caregivers request help.

- Children are not small adults. A customized, developmentally informed approach which recognizes the unique needs of young people, and their families is necessary.
- MRSS is part of the larger state health reform and is an intentional and necessary design element within Systems of Care (SOC) that improves outcomes for children, young people, and their families.
- Early and immediate access to care through MRSS is a cost-effective intervention and prevents the unintended harms associated with more restrictive interventions like law enforcement responses, emergency department visits, and inpatient care.
- Half of all lifetime mental health conditions emerge by age 14 and early identification and intervention can make all the difference. MRSS is uniquely designed to meet this need.¹

Return on Investment

When MRSS is implemented with model fidelity, states and jurisdictions have seen a reduction in the use of

¹ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.



emergency departments, inpatient hospitalizations, psychiatric residential treatment facilities and other residential and congregate care settings. They have also seen a reduction in other costly interventions with unproven outcomes for children and young people such as the use of juvenile law enforcement. Such restrictive interventions may cause unintended harm, including the trauma of separation from home, school, and caregivers. States and jurisdictions should consider collecting baseline data that might include:

- Number of emergency department visits by young people for behavioral health reasons
- Number of inpatient and PRTF annual bed-days
- Number of residential and congregate care annual bed-days
- Number of children who get stuck in child welfare offices overnight
- Number of juvenile school-based arrests

Additionally, costs associated with these high levels of care can be calculated as avoided costs to show the state's own return on investment from the successful implementation of MRSS. For example:

- Connecticut: Over the course of four years in CT (FY2016-2019), 2,212 children served by MRSS were diverted from inpatient hospitalizations - 61% (1,359) of those children were Medicaid enrolled. The averted costs for Medicaid only children on just this one data point were \$15,720,154. ²
- Connecticut: A study found CT's MRSS system had a 22-25% reduction in ED utilization compared with initial ED users, over an 18-month timeframe. ³
- New Jersey: Since the year 2015, 98% of young people who received a mobile response remained in their home.
- New Jersey: The daily population of young people in residential interventions has reduced by 51% since the year 2000 and there are no out of state residential interventions.
- New Jersey: Over \$68 million return on investment was reinvested into services for young people and their families. ⁴
- Oklahoma: 2023 data shows that 83% of children, youth, and young adults receiving MRSS were diverted from a change in placement or living environment.
- Oklahoma: 2023 data shows that out of 5218 students at risk for school disruption, 81% were able to return to class. ⁵

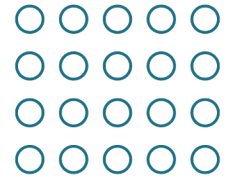
² Combined data from CT data reports (Section IV: Referral Sources; FY16-FY19) found at:

<https://www.chdi.org/publications/#ftid=22&cat=0&yrs=&q=>

³ <https://www.chdi.org/index.php/publications/issue-briefs/mobile-crisis-services-effective-approach-reducing-emergency-department-utilization-among-youth-behavioral-health-conditions>

⁴ <https://www.nj.gov/dcf/childdata/continuous/index.html>

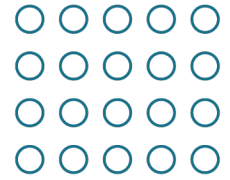
⁵ <https://eon.eteam.ou.edu/pages/oksoc>



Language

The words we use matter. MRSS has adopted language that is child, young person, and family-centered and grounded in SOC values. Sometimes others in crisis and behavioral health fields may use similar language that has a different meaning or may call similar services or components something different. The chart below begins to sort through some of the common language we should and should not use when talking about MRSS.

Adult/Other Crisis Models	Child/MRSS Best Practice Model	More Information
Client, person served, person in crisis, case, consumer	Child, young person, parent, caregiver, partner family	In MRSS, we acknowledge young people and their families as full partners in our work. This includes system level work like design, implementation and evaluation and practice level work including crisis, safety, and care planning. MRSS responds to families as a whole rather than focusing on an identified client or consumer. This includes young people, their caregivers, siblings, and others in the household, acknowledging the impact crisis or stressors have on the entire family.
Mobile Crisis	Mobile Response	MRSS eliminates the word crisis, encouraging young people and those who care about them to reach out as soon as they need it. Use of the word crisis may lead some people to self-screen-out and wait to access services until the concern worsens, leading to the use of more intensive or restrictive services. Shifting to the language of mobile response services means those with acute needs and self-defined crises will still access the services while additionally supporting access for early identification and intervention needs.
Stabilization: A Place to Go	Stabilization: A System to Support	In the children’s world, stabilization means in home and in their community. Many crisis models use the term stabilization to refer to facility-based care including 23-hour observation day beds or chairs and short-term residential stabilization services. “Stabilization” in MRSS refers to community-based care, most frequently delivered in homes or other locations convenient to the family. Stabilization services include short-term (usually 6-8 weeks) evidence-informed care coordination services. MRSS shifts from a risk averse medical model that requires evaluation and treatment of children in facility-based care when certain risk factors exist, to assessing for and creating safety for children, even those with some level of risk, in homes and communities. Most children can be kept safe at home. Their outcomes are more likely to improve when an evidence-based care coordination model is implemented versus treatment in acute care settings.
Intercepts/ Sequential	Interruption Points/Care	Whereas adult and historical crisis models tend to focus on intercepts during moments of crisis as methods of diversion

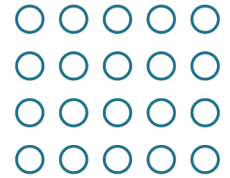


Intercept Model	Pathways	from police interactions, arrest, and sometimes higher levels of care, MRSS conceptualizes a care pathway design with intentional interruption points. This difference comes from the MRSS goal to intervene sooner, often before a full-blown crisis occurs. Care pathways can be thought of as opportunities to change the story for a young person by setting them on the right course of intervention quickly and efficiently. Potential care pathway interruption points may include early childhood centers, schools, pediatricians/primary care, and outpatient mental health. For those youth already deeper in systems, interruption points may also include law enforcement and hospital emergency departments.
Case Management/ Follow-up	Care Coordination	Young people and their families are not cases to be managed. MRSS does not dictate services and ongoing contact is more than just a “check-in.” Rather, the goal is to partner with young people and their support systems to understand their strengths, needs, preferences, and what will be helpful to them. Priority is given to establishing connections with natural and informal supports and when needed to formal professional services and systems supports.
Crisis Hotline/ Warmline/ Lifeline	Access Point	MRSS prioritizes face-to-face responses. Whereas crisis lines may have the goal to resolve as many calls as possible by phone without additional intervention, MRSS does not. All families are offered face-to-face responses. We know that young people and families who are offered immediate, face-to-face help are more likely to follow-through with services, access services again when needed and report satisfaction with the services they receive. When a parent or caregiver reaches out for help, rarely is it only the young person who can benefit from support. In person responses allow for a comprehensive approach inclusive of all family members across multiple needs and systems.

Responses to Common Questions and Challenges

Q. We do not have the ability to implement the full model immediately. What are the minimum components required to launch MRSS?

A. Immediate access to care is foundational to the MRSS model and it is important that systems work with this end-goal in mind when designing MRSS. Systems that are not operational 24/7/365 risk young people and their families who need immediate care returning to less desirable and more harmful or costly options like police responses and emergency department visits. This results in poorer outcomes for children, youth, and families and a reduction in return on investment. **For minimum components required to launch your service, and refer to it as MRSS, see: [Innovations Institute, University of Connecticut School of Social Work. \(2023\). MRSS Model Design and Roll-Out Decision Table. In Partnership with Child Health and Development](#)**



[Institute.](#)

Q. We do not have the workforce capacity to roll-out MRSS.

A. MRSS allows for a flexible staffing model. More important than licensure, degree, or authority are traits and skills, training, and value-based competencies. Trained peers, as well as associate and bachelor's prepared workers can all perform MRSS duties with the right supervision and training. The creation of capacity building centers can support systems and the workforce through standardizing and disseminating curriculum, defining and tracking competencies, and monitoring outcomes and quality.

Q. Why is it so important that the crisis is defined by the young person and/or their caregiver?

A. MRSS is built on SOC values. Primary to these values is the principle that care be youth- and family-driven. Allowing the young person and/or caregiver to define the crisis for themselves means that responses are tailored to their needs and no more or less than what they require and desire. Services are voluntary and noncoercive. This does not mean that partners, such as schools, cannot reach out to support and identify young people and families who may benefit from MRSS. It means that when they do, we defer to the young person and their family to understand the needs and the best response.

Q. Why can't we de-escalate most calls by phone? It seems like this would save time and money and is less invasive to the people we serve.

A. Children and families are not the same as individual adults. It may make sense to prioritize resolution by phone for adults who are often calling hoping for that outcome. Individual adults reaching out for help are more likely to be able to articulate their needs and participate in collaborative planning and resolution by phone.

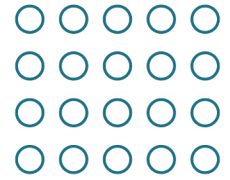
By contrast, parents and caregivers often reach out for assistance when they do not know what to do to help their child. The multiple needs and perspectives (of the parent, the child, siblings, and others in the household) are difficult to assess and support by phone. When in the middle of challenging moments, such as a young person experiencing intense emotional escalation, many parents are also experiencing some level of escalation. Immediate, face-to-face responses allow for mobile responders to not only assist in de-escalation and assure safety, but to begin a partnership with all members of the family and household. As soon as this first meeting, planning can begin -- not only for the crisis, but for underlying contributing factors, which can help to prevent future crisis.

Families who do not receive the help that they need when they need it will try something else. For a young person in crisis, this often means emergency department visits. When a provider triages which calls qualify for face-to-face response, that may seem like an opportunity for cost savings, but when those young people end up in emergency departments and residential settings it is more costly.

If the young person or caregiver prefers a phone or telehealth resolution, or a deferred response to account for work or school schedules or an alternative community location, they are accommodated.

Q. Why can't we use a law enforcement co-responder model? Our law enforcement responders are Crisis Intervention Team (CIT) Trained and it's safer for our staff in the field.

A. Law enforcement co-responder models should be reserved for those instances where there is a true risk for loss of life. For example, a person brandishing a firearm with intent to harm. This is not the case for most MRSS calls.



Using a law enforcement response often unnecessarily criminalizes the mental health needs of young people and their families. Young people who need care may be subjected to being handcuffed and transported in police cars, traumatizing them and their families. Historically marginalized groups, and in particular black and brown boys and young men, and people in LGBTQ+ communities, continue to experience harm through carceral systems and will be less likely to access services when the initial response includes police.

Eliminating a co-responder model does not eliminate the need for conversations and partnerships with law enforcement agencies. Indeed, law enforcement is an important partner in helping communities shift from 911 and emergency departments to MRSS. Much of the advocacy for moving away from police responses for behavioral health crises originates from law enforcement agencies themselves. Responding without law enforcement means police can allocate their resources to their intended role of public safety and leave the public health work to those best trained and positioned to perform it.

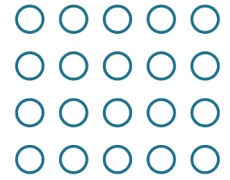
Visit <https://bit.ly/MobileCommunityResponse> to learn more about why CIT international does not promote an embedded co-responder model.

Q. Why is a single assessment tool so important? Our providers already have tools that they use and like.

A. A single and consistent assessment for MRSS and other behavioral health services in the same state or system creates a common tool for communication. Selecting a single developmentally appropriate and validated tool not only assures that providers will be using a common instrument for children and young people, but it also allows for shared data, planning, and outcomes tracking. Selecting a tool that focuses on strengths, needs, and understanding the young person and their family across multiple domains allows for greater flexibility within your workforce and helps staff understand young people in the context of their family, community, development, culture, and functioning.

Q. Why is it important that stabilization occur in homes? Our child and adolescent crisis center is open 24/7 for walk-ins and includes 23-hour stabilization services.

A. Maintaining children in homes and schools is a primary goal of MRSS. As noted in the language table above, MRSS shifts from a risk averse medical model that requires evaluation and treatment of children in facility-based care when certain risk factors exist, to assessing for and creating safety for children, even those with some level of risk, in homes and communities. Most children can be kept safe at home. Their outcomes are more likely to improve when an evidence-based care coordination model is implemented versus treatment in acute care settings. For more information on stabilization services, please see [the NASMHPD publication A safe Place to Be](#).



Produced by the *National Mobile Response and Stabilization Services Quality Learning Collaborative*, a partnership of [Innovations Institute](#), University of Connecticut School of Social Work; [Child Health and Development Institute \(CHDI\)](#); Contributions by: Innovations Institute – Liz Manley, Denise Sulzbach, Sarah Quinn, Michelle Zabel, Lena Bilik, with consultants Tim Marshall and Sheamekah Williams; CHDI – Kellie Randall, Kayla Theriault, Jeff Vanderploeg, with consultant Sarah Becker.

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