Mobile Response and Stabilization Services (MRSS): Best Practice Installation

A Companion Guide to MRSS Readiness Analysis Report

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Introduction

Mobile Response and Stabilization Services (MRSS) are a continuum of community-based services offering immediate assistance and support to families experiencing crises related to their child's behavioral health needs. As a crucial component of broader state health reform, MRSS design and installation is essential to the development of a robust and comprehensive continuum of services and support within children's systems of care (SOC). MRSS aims to provide universal access, intervening for any child, young person, or family who can benefit from it as soon as a need is recognized, regardless of insurance status, ability to pay, or presenting issue. States and sites working to install best practice MRSS models or enhance current youth crisis services receive support at multiple levels including system design and implementation, capacity building, and practical application of skills within the workforce. The first step in the installation of MRSS with alignment to best practices involves conducting a detailed assessment of the current policies and practices of children's crisis services. Because children's crisis services often involve multiple systems, including children's SOC and lifespan crisis systems, the analysis and installation coalition building must also involve multiple systems.

The Innovations Institute at the University of Connecticut School of Social Work partners with states and sites at all phases of MRSS installation, including readiness, design and rollout, and practice improvement and evaluation. Leveraging a proprietary suite of tools, the Innovations Institute's work is anchored in MRSS best practices shown to improve outcomes for children, young people, and families. Building from implementation science, the Innovations Institute develops strategies aimed at comprehensively reforming systems and reshaping mobile response practice.

This manual serves as a companion to the Innovations Institute's technical assistance and readiness reports, providing state and site guidance. It contextualizes readiness analysis and recommended action steps within MRSS best practices, offering insights into MRSS organizing principles, service continuum, workforce, financing, oversight, and evaluation.

MRSS Organizing Principles

Quality MRSS models are crafted in alignment with SOC values and principles. Those seeking further information related to MRSS and SOC values can enroll in the Innovation's Institute's free online learning module MRSS: A Critical Component in Modern Systems Design. Additionally, best practice models adhere to three organizing principles specific to MRSS (see Figure 1).

a. **Crisis is defined by the caregiver/youth (meets urgency with urgency):** MRSS adopts a broad and person-centered definition of crisis. There is not a single list of criteria, acuity or risk level, or problem set that MRSS defines as a "crisis." Instead, a crisis emerges when a person's or family's usual coping skills or problem-solving strategies prove overwhelming or ineffective in certain situations. Consequently, in MRSS, requests for response are screened in, rather than out, and in-person responses are the norm in homes and other community settings convenient to the family regardless of presenting concern. MRSS is intended as a whole population intervention universally available to any child, youth, young adult, or family that can benefit as soon as they notice a need.

b. **Responses are face-to-face:** Mobile responses occur face-to-face within an hour of the support request, and they remain available 24 hours a day, 7 days a week, 365 days a year (24/7/365). Families who do not receive timely assistance are less likely to engage with follow-up services and are less inclined to seek help in the future. Delaying care can lead

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to worsening problems, potentially necessitating higher-intensity services such as hospitalization. Providing immediate, face-to-face assistance capitalizes on a caregiver's, youth's, or family's receptiveness to support.

c. **Customized for children, youth, and families:** High quality MRSS features a workforce trained and dedicated to working with children, youth, and caregivers. Responses and support are customized for children, youth, young adults, and families; and are delivered in homes, schools, and communities with the belief that safety can often be ensured without resorting to emergency departments or hospitalization. MRSS prioritizes established connections to natural supports and facilitates the return to regular activities, such as school, sports, arts, and social events.

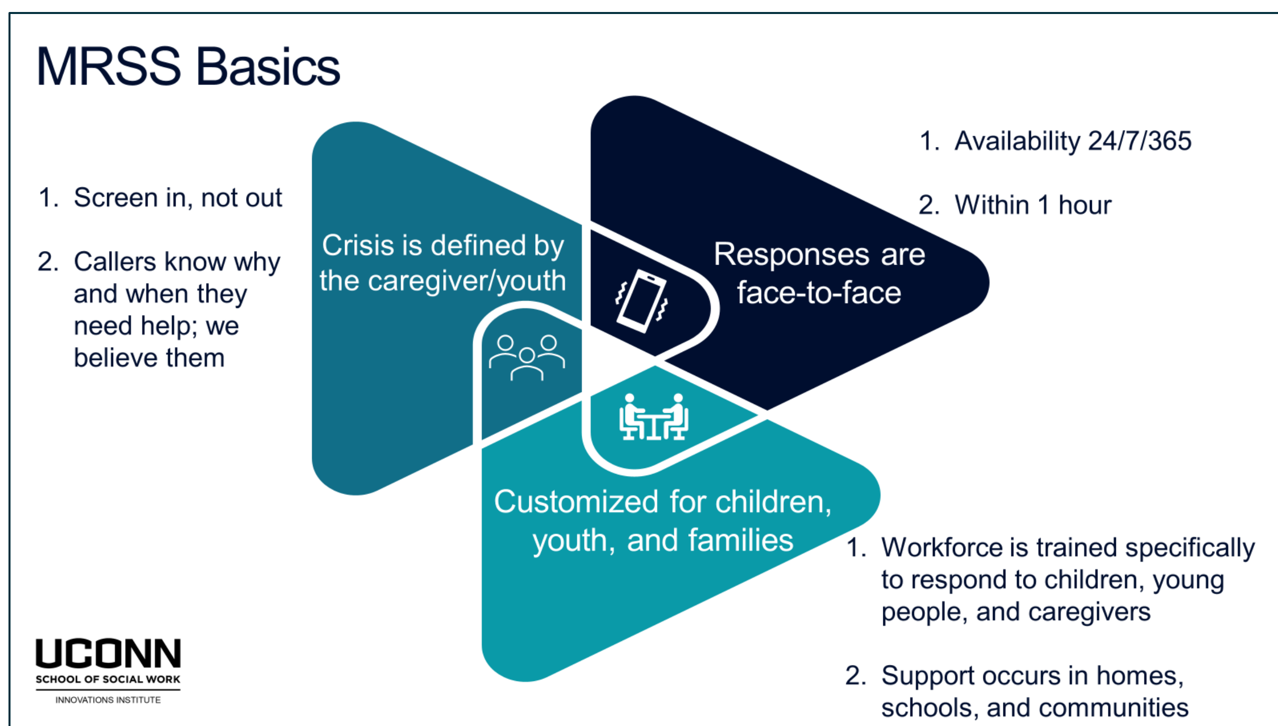

Figure 1 Basics of Mobile Response and Stabilization Services (MRSS)

MRSS Care Continuum

MRSS is an intervention designed to urgently respond to the immediate needs of children, youth, young adults, and caregivers. The MRSS care continuum includes someone to contact (access points), someone to respond (mobile response services), and a system to support (stabilization services) (see Figure 2).

a. **Someone to contact (24/7/365 single point of access):** A best practice MRSS operates a single point of access that operates 24/7/365 and is staffed with a workforce trained in the MRSS model. The single point of access may offer services across the lifespan, but staff are specifically trained and equipped with triage protocols for children, youth, young adults, and families, enabling them to define the crisis and receive immediate face-to-face responses. Staff have immediate and direct access to clinical and psychiatric consultation. Access points are most effective when they offer multiple contact methods including call,

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text, and chat capabilities. MRSS is linked to state 988 centers; if 988 is not the single point of access for MRSS, an efficient, warm handoff process is in place for all children, youth, young adults, and families.

b. **Someone to respond (72-hour mobile response service):** High-quality MRSS operations maintain mobile response teams available 24/7/365. Ideally, teams comprising two workers respond in person, within an hour of the service request, and in homes and communities. Teams have immediate access to clinical and psychiatric consultation. After the initial response, mobile response services, including assessment, brief care planning, and coordination, are provided for up to 72 hours.

c. **A system to support (8-week stabilization services):** Stabilization services are available for up to 8 weeks for children, youth, young adults, and families who have received a mobile response, who can benefit from continued MRSS support, and who are not already receiving care coordination support (e.g., Wraparound). These services focus on helping children, youth, young adults, and caregivers in stabilizing current living arrangements and returning to routine functioning. In addition to evidence-informed care coordination, stabilization services may also include direct support such as skill building, peer support, safety monitoring, and brief clinical interventions. Emphasis is placed on forging connections to natural and community supports. Direct care staff have immediate access to clinical and psychiatric consultation. In a best practice model, the same team that provides the mobile response delivers the stabilization services.

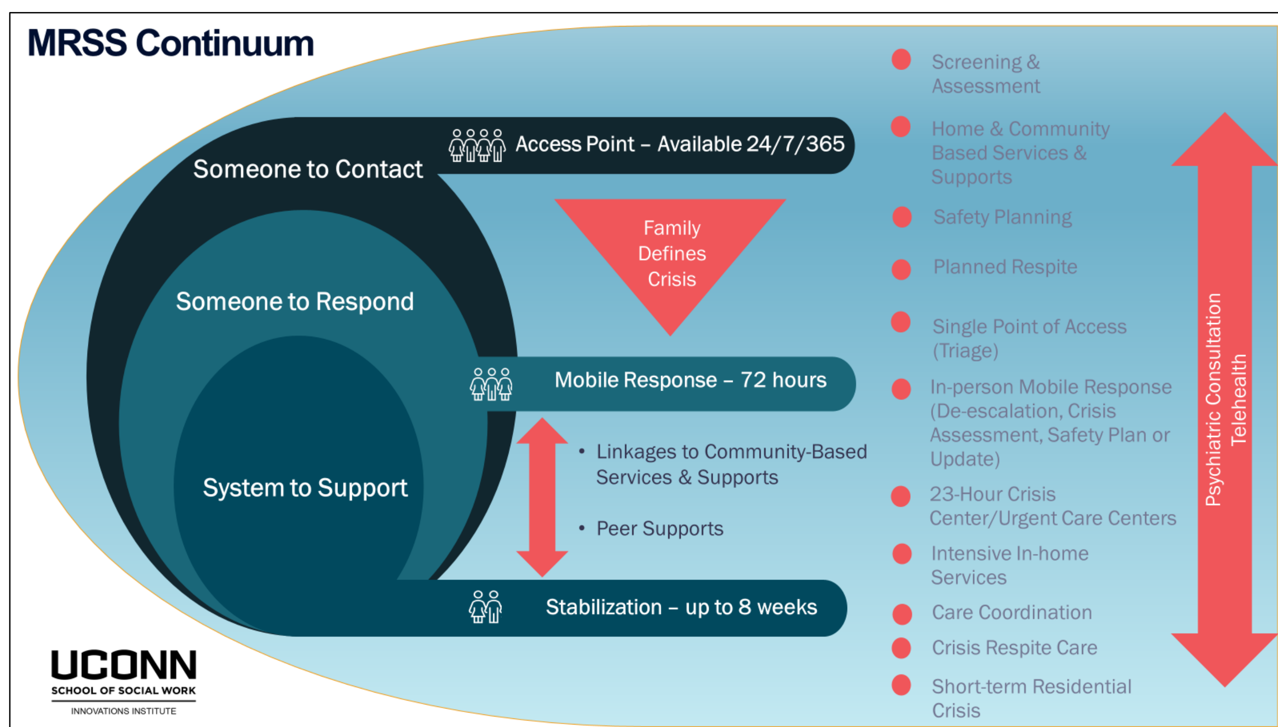

Figure 2 Continuum of Mobile Response and Stabilization Services (MRSS)

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MRSS Workforce Model and Support

MRSS models utilize direct care mobile response and stabilization workers along with clinical supervisors as staffing best practices. Staff have access to psychiatric consultation on demand and as needed. The MRSS workforce is set up for success through the definition of core competencies and the dissemination of training and coaching. Often, this is accomplished by establishing a center of excellence or other workforce development center.

a. **Direct care MRSS staff:** MRSS offers flexible staffing options for direct care, including non-degreed, bachelor's, and master's level human service professionals, as well as professional peers with lived and living experience. The MRSS best practice model emphasizes that the traits, qualities, and values of the hired staff are more important than their educational background or professional title. Staff who enjoy community-based work with children and families, who are not overly risk averse, and who are flexible, empathetic, and reliable can usually be taught the skills necessary to provide high-quality MRSS. While solo responses may sometimes be appropriate or preferred (e.g., when responding to schools, clinical settings, or familiar families), it is recommended that a team of two staff are available for responding to new young people and families, at locations without additional professional support available onsite, and/or when indicated for staff or family safety.

b. **Supervisors:** MRSS supervisors, at a minimum, hold a master's degree in a human service field and are clinically licensed in the jurisdiction where their MRSS program operates. They are available 24/7/365 to provide consultation, supervision, and responses to address complex needs. Staffing levels for supervisors are adequate to cover their personal time off, ensuring that there are no on-call requirements when they are on leave. Additionally, there is continuous 24/7/365 coverage for clinical consultation for MRSS staff and in instances where staff do not report to work. Supervisor-to-staff ratios are maintained at levels no greater than 1:6.

c. **Psychiatric consultation:** MRSS has access to psychiatric consultation 24/7/365. These services may be contracted with an external provider. Utilizing telehealth and phone consultation can increase access and leverage resources across regions.

d. **Training and core competencies:** Regardless of degree, educational or experiential background, those employed in MRSS require specialized training. Important competencies and skills include crisis de-escalation, safety and risk assessment, suicide screening, intervention and postvention, substance use screening and intervention, crisis and safety planning (including counseling on access to lethal means), understanding SOC values and MRSS design, care planning and evidence-informed care coordination, situational awareness and staff safety, supervision, trauma-responsive care, and culturally humble and linguistically competent care.

The Innovations Institute disseminates an MRSS Best Practice Model Curriculum to interested sites and states. Participating states and sites have access to:

- Innovations Institute MRSS Best Practice Curriculum training
- Individualized coaching focused on transfer of learning
- Innovations Institute MRSS Practice Improvement Tools
- Opportunities for local coach and trainer certification to build internal capacity

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MRSS Financing, Oversight, and Evaluation

While many financing configurations are available to states, states must provide oversight, monitoring, and sufficient funding to ensure timely response as well as adequate staffing models, including two-person response teams, to provide face-to-face response and support 24/7/365.

a. **Financing:** Use of Medicaid financing (e.g., State Plan Amendments, 1115 Demonstration Waivers, administrative claiming) for both mobile response services and stabilization services enables greater sustainability of MRSS programming. When drafting policy, avoid requiring preauthorization or specific acuity or diagnostic codes; instead, allow the caregiver/young person to define the crisis. In addition to Medicaid, funding is identified to ensure that MRSS is universally available to children, young people, and families, including those who are uninsured and commercially insured and for whom MRSS may not be a covered service.

b. **Oversight and evaluation:** States must ensure oversight and evaluation by requiring reporting on basic data elements including numbers of calls received, face-to-face responses, time to response, diversion from higher levels of care, and connection to services or coordination with existing supports. Regular review of these elements is essential. Monthly reporting and review are likely necessary in the beginning phases of installation. Evaluation includes fidelity of practice to the model and system-level outcomes.

Examples of fidelity to practice elements

- Organizations are meeting basic principles and service component definitions.
- MRSS staff regularly demonstrate skills and competencies necessary to effectively partner with young people and families.
- Young people and families move through care pathways as expected and designed (system, organization, and individual level).

Examples of system outcomes elements

- Fewer children are assessed and boarded in emergency departments.
- Fewer children are placed in inpatient and residential settings for behavioral health care.
- Fewer children miss school (absences, suspensions, expulsions) due to behavioral health needs.
- More children have access to behavioral health services; there are reductions in disparities.
- Children in foster care have greater placement stability and are more likely to be in family settings.
- Fewer children are arrested or detained as a result of requesting a crisis response.

Conclusion

The *Mobile Response and Stabilization Services (MRSS): Best Practice Model Installation Companion Guide to Readiness Analysis Report* serves as a comprehensive resource for states and sites embarking on the implementation or enhancement of MRSS programs within their communities. Developed by the Innovations Institute at the University of Connecticut School of Social Work, this guide offers invaluable insights into the principles, practices, and strategies essential for the successful establishment of an MRSS aligned with best practices.

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By outlining the organizing principles, service continuum, workforce model, and support structures inherent to MRSS, this guide equips stakeholders with the necessary tools to effectively navigate the complexities of youth crisis services. Through a focus on person-centered care, immediate response, and customized support for children, youth, and families, MRSS emerges as a vital component of modern systems design, promoting timely intervention and improved outcomes for those in need.

Furthermore, the guide emphasizes the importance of financing, oversight, and evaluation in sustaining MRSS programs over time. By advocating for Medicaid reimbursement, promoting oversight mechanisms, and fostering continuous evaluation of fidelity to practice and system-level outcomes, states can ensure the long-term success and accessibility of MRSS for all children, youth, and their caregivers in crisis.

As states and sites engage in the implementation process, this companion guide stands as a beacon of guidance and support, facilitating the transformation of youth crisis services and the creation of a more responsive and inclusive system of care for children, young people, and their families across the nation.

With a commitment to excellence and innovation, the Innovations Institute remains dedicated to advancing the field of children's behavioral health and supporting communities in their efforts to provide compassionate, effective, and accessible care to those in need.

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