Mobile Response Team (MRT)

Requirement: 394.495(7), F.S.

Frequency: Monthly and Quarterly

Due Date: 8th day of the month

Purpose:

To ensure the administration of Mobile Response Team (MRT) services, the MRT Network Service Providers are to adhere to the service delivery and reporting requirements herein. Best practice considerations and resources are provided to support continuous improvement of the MRT program; however, these are not contractually required.

Agency	# of MRT Teams	Counties
Alachua County Board of County Commissioners	1	Alachua
BayCare Behavioral Health, Inc.	1	Hernando
Child Guidance Center, Inc.	2	Duval
Children's Home Society of Florida	1	Putnam
Clay Behavioral Health Center, Inc.	1	Clay
LifeStream Behavioral Center, Inc.	2	1 - Citrus and North Sumter ("West") 1 - Lake and South Sumter ("East")
Meridian Behavioral Healthcare, Inc.	3	1 - Meridian East (Baker/Bradford/Union) 1 - Meridian South (Dixie/Gilchrist/Levy) 1 - Meridian North (Columbia/Hamilton/Lafayette/Suwannee)
Nassau County Mental Health, Alcoholism & Drug Council, Inc. d/b/a Starting Point Behavioral Healthcare	1	Nassau
SMA Healthcare, Inc.	2	1 - Volusia, Flagler 1 - Marion
St. Augustine Youth Services, Inc.	1	St. Johns
EPIC Community Services, Inc. (**Adult**)	1	St. Johns

A. Authority

The Marjory Stoneman Douglas High School Public Safety Act, Ch. 2018-3, Laws of Florida, created a statewide network of MRTs. The Florida Legislature appropriated recurring funds to ensure reasonable access to MRT services in all Florida counties. In 2020, s. 394.495, F.S. was amended to include MRTs in the child and adolescent array of services and outlined programmatic requirements included herein.

B. Program Goals

The goals of MRTs are to lessen trauma; conduct an independent assessment to determine if the individual may be safely diverted from emergency departments; prevent unnecessary psychiatric hospitalization; or divert from juvenile justice or criminal justice settings. MRTs are intended to provide on-demand crisis

intervention services in any setting in which a behavioral health crisis occurs, including, but not limited to, homes, schools, the community, and emergency departments. Mobile response services must be available 24 hours a day, 7 days a week. Services are provided by a team of licensed professionals, master's level professionals, and paraprofessionals trained in crisis intervention skills. In addition to helping resolve the crisis, MRTs work with individuals and families to identify resources, provide linkages, and develop strategies for effectively dealing with potential future crises.

Intervention is warranted when a crisis interferes with the ability to function and places the individual at risk of self-harm, harm to others, or disruption of services or living environment. The individual may present with an overt change in functioning or have difficulty coping with traumatic life events. Mobile Response Teams may coordinate in-person services with law enforcement to provide additional safety, when appropriate and necessary.

Supporting the "no wrong door" model, MRTs provide warm hand-offs and referrals to other services in the community to meet the ongoing needs of the individual and will follow-up to determine that the appropriate linkage is made. When the situation warrants, MRTs will assist with the individual being received by a designated receiving facility or a licensed substance abuse provider for further evaluation. Peer support services can be an effective way to connect individuals and families experiencing behavioral health crises with resources, ensure they engage in services, and assist them with navigating the system.

MRTs must be designed to address a wide variety of interventions, including:

- Determine the need for further examination at a Designated Receiving Facility or licensed substance use provider based on a clinical assessment;
- Assess the individual for risk of suicidal and homicidal thoughts or behaviors;
- Assess the individual for mood disturbances such as depression, anxiety, delusional thoughts, or hallucinations that may contribute to and exacerbate the crisis; and
- Identify family or peer conflicts and other disruptive behaviors that are or may contribute to escalating the crisis and consider services and supports available to reduce them.

C. Eligibility

MRTs provide immediate, onsite behavioral health crisis services at minimum to individuals who:

1. Have an emotional disturbance; or
2. Are experiencing a mental health or emotional crisis; or
3. Are experiencing escalating emotional or behavioral health reactions and symptoms that impact their ability to function typically within their family, living situation, or community environment; or,
4. Are served by the child welfare system and are experiencing or at high risk of placement instability.

D. Network Service Provider Responsibilities

The Network Service Provider shall:

1. Ensure access to MRT services 24 hours a day, 7 days a week in person;
2. Collaborate with local and county governments to ensure the process to access MRT services is addressed in county transportation plans and Behavioral Health Receiving System plans;

3. Allow the Managing Entity to monitor MRT Network Service Provider data quality, response process, customer satisfaction, community collaboration, and warm hand-offs to community service providers;
4. Notify the Managing Entity of changes to MRT providers, including the number of teams per provider or updates to MRT contact information;
5. Submit Monthly Report to the Managing Entity no later than the 8th of the month following services (See the Required Reporting section for more details);
6. Work with school districts to establish and obtain parental or guardian consent as part of the annual student registration process for follow up behavioral health services that may be needed after the initial MRT crisis assessment in coordination with other routine health screenings;
7. Network Service Providers providing MRT services shall:
    a. Adhere to the criteria in Sections C, E, F and G herein.
    b. Participate in all MRT program conference calls, meetings, or other oversight events scheduled by the Department.
    c. Make Mobile Response Team services available 24 hours per day, 7 days a week.
    d. Establish response protocols with local law enforcement agencies, 9-1-1 dispatch, 2-1-1 call centers, 988 Florida Lifeline centers (9-8-8), local community-based care lead agencies, child protective investigators, the Department of Juvenile Justice, and local schools, including public K-12 schools, colleges, and universities.
    e. Have a licensed mental health professional on staff or access to a licensed mental health professional with 24/7 availability; at least (1) master's level professional.
    f. Have a Certified Recovery Peer Specialist, or someone who is working toward credentialing, on staff.
    g. Have access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner at all times via an on-call schedule for each MRT.
    h. Provide an array of crisis response services to eligible persons and their families, designed to address individual and family needs, including screening, standardized assessments, crisis de-escalation, safety planning, and linkage to community services as necessary to address the immediate crisis event and ongoing behavioral health needs. Screenings and assessments shall be completed for the presence of an emotional disturbance, serious emotional disturbance, substance use, or mental illness including depression and risk for suicide.
    i. Adhere to standards for informed consent and confidentiality compliance, including parental consent when appropriate.
    j. Establish formal Memorandum of Understanding or agreements with the local school district(s) that identify roles and responsibilities of schools and MRTs when responding to schools to provide services. MRT providers shall not require schools to obtain parental consent to conduct an initial assessment and crisis intervention when school personnel believe that the student has suicidal ideation or behavior or homicidal ideation or behavior. This agreement must include requirements for obtaining parental consent when the MRT

responds to children 13 or younger or with unlicensed mental health professionals for ongoing treatment or services after the initial crisis intervention.

k. Establish formal and informal partnerships with key entities providing behavioral health services and supports to eligible persons and their families to facilitate warm hand-offs for continuity of care.

l. Coordinate with the Community-Based Care (CBC) Lead Agency in the Network Service Provider's area to provide MRT services to children served by the child welfare system who are experiencing a behavioral health crisis.

E. MRT Provider Responsibilities

Mobile Response Teams shall:

1. Display the number to their MRT on the start page of their public-facing website.

2. Ensure their local 2-1-1 and 988 Florida Lifeline center provider(s) have information on the MRT and how to refer individuals in need.

3. Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response.

4. Conduct screening and assessment of individuals that may be a danger to themselves, or others as established by s. 394.463, F.S.

5. Provide in-person response to calls meeting the clinical threshold within 60 minutes after prioritization. While in-person responses may be provided via telehealth, teams are expected to respond to the location where the crisis is occurring when determined safe.

6. Provide behavioral health crisis-oriented services that are responsive to the needs of the individuals and their family or other natural support system.

7. Utilize evidence-based practices to deescalate and respond to behavioral health challenges and to reduce the potential for future crises. When evidence-based practices are not available, the MRT shall use approaches based on clinical judgement and within the scope of their practice.

8. Provide a warm handoff to referred services and brief care coordination by facilitating the transition to ongoing services for at least 72 hours. Warm handoff means that the MRT provider actively connects the individual to another service provider. The facilitation of a warm handoff requires consent from a parent or guardian.

9. Coordinate with the CBCs to provide information about the MRT services to foster parents.

10. Report to the Managing Entities on the performance outputs in Section G and the number of individuals who did not require an involuntary examination that were actively linked to the appropriate level of care with a community provider for ongoing behavioral health services.

11. Use the same suicide risk assessment instrument adopted by the district school board pursuant to s. 1006.07(11), F.S., and approved by the Department of Education pursuant to s.1012.583, F.S. The MRT provider will accept suicide risk assessments completed by qualified school staff pursuant to s. 394.495 (3), F.S., on the same day of the response to avoid duplication of assessment on the youth. Approved instruments are available at: https://www.fldoe.org/schools/k-12-public-schools/sss/suicide-prevent.stml

The provider will follow performance measures as outlined by LSFHS's As Negotiated Targets document.

F. MRT Service Components:

Mobile response services encompass an array of crisis interventions including:

1. Evaluation and assessment,
2. Development of safety or crisis plans,
3. Providing or facilitating stabilization services,
4. Supportive crisis counseling,
5. Education,
6. Development of coping skills,
7. Care Coordination
8. Linkage to appropriate resources, and
9. Connecting individuals who need more intensive mental health and substance use services to the appropriate level of care.

Telehealth is an important asset for increasing the capacity of MRTs especially in rural areas, geographically large counties, or urban areas where congested traffic patterns make meeting the 60-minute response time a challenge. Telehealth can be used to provide assessments, follow-up consultation, and initial triage to determine if an in-person response is needed to individuals via video-teleconferencing systems, phones, and remote monitoring.

An MRT's ability to successfully divert inpatient admissions depends on service availability. MRT staff who are not actively responding to calls or providing follow-up services must not have other duties and responsibilities within the Network Service Provider. MRT staff should be conducting outreach to community partners, key stakeholders, and the general public to educate the public on the availability of and how to access service, during "down time". This guidance should not be understood to prohibit MRT staff from being cross trained with, and utilized in, Central Receiving Facilities or other on-site emergency services, particularly during evening, overnight and early morning hours when the provision of outreach to community partners, key stakeholders, and the general public to educate the public on the availability of and how to access services, is impractical.

G. Performance Outputs

The Network Service Provider shall meet the following targets for MRT services:

1. Average response time within 60 minutes.
2. A minimum of seven (7) formal outreach activities conducted annually. This may include activities such as presenting at School Board meetings, community health fairs, and community partner meetings. Targets for outreach activities may include detoxification programs, emergency departments, schools and colleges, community behavioral health providers, law enforcement and other first responders, child protective investigators, dependency case managers, parents, family and youth run organizations, Agency for Persons with Disabilities, Department of Juvenile Justice, group homes, foster care organizations, 2-1-1 and other social service type call centers, as well as community leaders such as county commissions and city government. Providers may also utilize local media outlets, including television and radio, to advertise for and inform the general public about MRT services available.

3. A negotiated minimum annual number of unduplicated persons served. "Served" means the MRT has responded to an acute care crisis and engaged with the individual and, if applicable, their family and caregivers.

H. Best Practice Considerations and Guiding Principles:

The System of Care values and principles are the foundation of MRTs. The core values include:

- **Strength-based** – move the focus from the deficits of the individual and family to focusing on their strengths and resources related to the goal of recovery. This includes viewing the individual and family as resourceful and resilient.
- **Family-driven and youth-guided** – recognize that families have the primary decision-making role in the care of their children. The individual's and family's preferences should guide care.
- **Community based with an optimal service array** – provide services in the least restrictive setting possible and ideally in the community. Individuals should be able to obtain any behavioral health service they need in their home community. Peer support is an important component of services.
- **Trauma sensitive** – respond to the impact of trauma, emphasizing physical, psychological, and emotional safety for both service providers and individuals and create opportunities for individuals to rebuild a sense of control and empowerment.
- **Culturally humble and linguistically competent** – be respectful of, and responsive to, the health, beliefs, practices, and cultural and linguistic needs of diverse individuals. "Culture" is a term that goes beyond race and ethnicity to include characteristics such as age, gender, sexual orientation, disability, religion, income level, education, and geographical location. Cultural humility is a long-term process of self-reflection and discovery to understand oneself and then others in order to build honest and trustworthy relationships (Tervalon & Murray-Garcia, 1998)[1]. Cultural competence applies to organizations as well as individuals. Cultural competence is a set of behaviors, attitudes, and policies that come together in a system to work effectively in multicultural situations. Linguistic competence is the ability to communicate effectively in a way that can be easily understood by diverse audiences.
- **Coordinated** – provide care coordination for individuals with serious behavioral health conditions with an emphasis on individualized services across providers and systems. At the system level, leverage resources by analyzing funding gaps, assessing the use of existing resources from all funding streams, and identifying strategies to close the funding gaps, including the options of blending and braiding funding sources.
- **Outcome-focused** – ensure that programmatic outcome data is accessible to managers, stakeholders, and decision makers, and that the data is meaningful and useful to those individuals. Collect feedback from each individual and family regarding the service delivery to improve outcomes of care that inform, individualize, and improve provider service delivery.

Research suggests that best practice is to provide continued crisis intervention and care coordination services as indicated for up to 72 hours. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises.

[1]Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

MRTs facilitate "warm handoffs" to community services, and other supports. Facilitating a warm handoff means actively connecting an individual to another service provider. This process goes beyond simply providing a referral name, phone number, and appointment time. Particularly for individuals in crisis, it has been shown that a referral alone is not adequate. Warm handoffs are a transfer of care between two providers in the presence of the individual and their family. This can involve an introduction to the new service provider during a short meeting with the crisis counselor. It is important to explain the process the individual should follow, what to expect during their first appointment, and allow them to ask questions. For additional information and resources to implement or improve the use of warm handoffs, the Agency for Healthcare Research & Quality provide resources for clinicians, staff, and a Quick Start Guide.[2]

Once this occurs, it is expected that either the crisis has resolved naturally, the individual is connected to a community-based provider who will engage the individual in services, or the individual was assisted with access to further evaluation at a designated receiving facility. MRTs will need to establish protocols for working with existing care coordination teams for individuals who are not already connected to behavioral health services, for those that are eligible.

In 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the Model Standards for Crisis Care Workers. This model articulates the vision that crisis care should be available 24/7 and wherever the person in crisis is located. Put simply, crisis care should be available to anyone, anywhere, at any time. This model identifies best practices for mobile crisis teams. SAMHSA identifies the mobile response teams to respond in two person teams for safety reasons. The minimum expectations are:

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals;
2. Respond where the person is and not restrict services to select locations within the region or particular days/times; and
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation.

The best practices include:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion and may include MRT transporting the person served, at the provider's discretion, to an acute care setting under the Baker Act in accordance with F.S.394.462(1)(f);
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; and
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm hand-off in order to support connection to ongoing care.

The model is available at: https://library.samhsa.gov/sites/default/files/advisory-model-standards-crisis-care-workers-pep25-07-017.pdf.

[2] https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html

Below are some exemplary models of MRTs developed in other states.

State of New Jersey

The Mobile Response and Stabilization Services (MRSS) System delivers mobile response services to children/youth/young adults experiencing escalating emotional and/or behavioral reactions and symptoms that impact the youth's ability to function typically (at baseline) within their family, living situation, school and/or community environments. Mobile response services are available 24 hours per day, 7 days a week, year-round, are delivered by MRSS staff and include both initial (within 1 hour) face-to-face intervention wherever the youth's need presents, and follow-up interventions, services and coordination for up to 72 hours after to the initial intervention. If at the end of initial mobile response services an individual continues to exhibit patterns of behavioral and emotional needs that require continued intervention and coordination to maintain typical functioning and prevent continued crisis reaction at the end of initial mobile response services, they may be transitioned to Mobile Response Stabilization Management Services that can continue to serve the individual for up to eight weeks. More information may be found at: https://www.nj.gov/dcf/about/divisions/dcsc.

State of Massachusetts

In Massachusetts, Mobile Crisis Intervention (MCI) is provided to youth (under the age of 21) by all emergency service program (ESP) providers. MCI provides a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, where one exists. This service is provided 24 hours a day, 7 days a week and includes: A crisis assessment; engagement in a crisis planning process that may result in the development or update of one or more crisis planning tools (e.g., Safety Plan; Advance Communication to Treatment Providers; Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family; up to 7 days of crisis intervention and stabilization services including on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care. More information may be found at: Mobile Crisis Intervention | Mass.gov.

Milwaukee County, Wisconsin

Milwaukee County in Wisconsin has a nationally respected and effective crisis response model for children in their region. The program is called the Mobile Urgent Treatment Team (MUTT) and its primary focus is to keep children at home with families and out of hospitals. MUTT provides MRSS services for children and adolescents (up to age 18) and addresses a family's immediate concerns about their child by phone or by responding to them in the community or in their home. Services are available 24 hours a day, seven days a week. Once called, the MUTT team immediately travels to the location where a crisis may be occurring. The team assesses the situation, including the potential for danger that the child poses to himself or others. Based on the assessment, the team weighs intervention options, including keeping the child home (with adequate support services), temporary placement in a crisis group home or other emergency setting, or hospitalization in a psychiatric facility. The team can provide short-term case management services as necessary and frequently acts as a liaison between the family and available community services. For more information, please visit: https://county.milwaukee.gov/EN/DHHS/BHD/Childrens-Services.

King County, Washington

The Children's Crisis Outreach Response System (CCORS) in King County, Washington provides crisis outreach and stabilization services 24 hours a day, 7 days a week to all residents of King County regardless of income. Specific services include mobile crisis outreach, which consists of specially trained teams available to respond in the child or youth's natural environment to de-escalate the situation. The team conducts mental health and suicide risk assessments and works with the family to implement ongoing services and supports to prevent future crises. CCORS also provides non-emergency outreach appointments, available within 24-48 hours for families who are not in immediate crisis but require timely support and linkages to services. Crisis stabilization services in the form of in-home support are available for up to 8 weeks following the initial acute crisis. Intensive crisis stabilization services (90-day in-home support) and crisis stabilization beds are also available to specialty populations. More information may be found at: https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/CrisisOutreach.aspx.

Maine Behavioral Health Care Crisis Team

After police respond to a call involving a juvenile, the officer completes a police juvenile reporting form and sends it to the Maine Behavioral Healthcare crisis team. A clinician then calls the family to arrange an assessment, provide resources and services and provide later follow-up to ensure the family has engaged in referred services. The reporting form captures critical information for tracking and accountability. In addition, parents of juveniles in crisis use the form as a tool to convey concerns and record problem behavior to mental health professionals. With parental consent, they use the information to inform the school system and help prepare an appropriate response to the child's needs. The result is a program that recognizes juveniles at risk at the earliest possible stage, captures relevant and useful information, secures an appropriate referral network and tracks results for mutual accountability. The results of the program were decisive—86 percent of the families reported that only one response was needed to receive the appropriate resources. More information may be found at: Mental Health Crisis Services | MaineHealth.

Central Ohio

Brings together crisis intervention specialists, therapists, case managers, and other staff members who pair up to visit teens and young adults in schools, jails, hospital emergency rooms and other places to connect them with mental health services. Initially contacted through the community crisis hotline, the flow with a 2-1-1 call that is triaged and sent to a helpline. Appropriate calls are sent to the behavioral health provider crisis staff who again triages and responds in-person with a secondary staff person, who may be a therapist or case manager.

I. Additional Resources

There are many resources available online related to mental health services. This is not meant to be an all-inclusive list, but rather a starting point for additional resources.

The Substance Abuse and Mental Health Services Administration (SAMSHA) has a resource tool on screening for behavioral health risk in school, available at: https://www.samhsa.gov/sites/default/files/ready_set_go_review_mh_screening_in_schools_508.pdf

The U.S. government has sponsored a Stop Bullying campaign with tips and information at: https://www.stopbullying.gov/

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools; a toolkit is available at:

http://zerosuicide.edc.org/toolkit

Department-sponsored webinars on mobile response services, provided at no cost to the provider, are accessible by creating a free account with the Florida Behavioral Health Association/Florida Alcohol and Drug Abuse Association at: Florida's Learning Management System for Behavioral Health and searching for the title of the webinars below:

- Responding with Compassion: Identifying and Treating Crisis Needs in Our Senior Communities (2025)
- Introduction to Mobile Response Teams (2019)
- Mobile Response Teams: Strengths-Based Crisis Planning (2019)
- Mobile Response Teams: Crisis Assessment and Intervention (2019)
- Building Partnerships with Local Resources for Crisis Response (2019)

J. Required Reporting

- **Monthly Data Report**: In order to assist the Department with system-wide programmatic analysis of the MRT model, the Network Service Providers must submit monthly supplemental data on the ME's template into LSF Health Systems data system by the 8th of the month.
- **Outreach Report**: To conduct system-wide programmatic analysis of the MRT model, the Network Service Providers must submit monthly program position data on the ME's template into LSF Health Systems data system by the 8th of the month.
- **Monthly Program Staffing Report**: To conduct system-wide programmatic analysis of the MRT model, the Network Service Providers must submit monthly program position data on the ME's template into LSF Health Systems data system by the 8th of the month.
- Ad Hoc and additional reporting may be required as determined necessary by LSF Health Systems or the Department of Children and Families.

Mobile Response Teams (MRT) will be administered according to DCF Guidance 34, which can be found at following link using the applicable fiscal year: https://www.myflfamilies.com/services/samh/providers/managing-entities