Family Service
OF RHODE ISLAND

March 18, 2026

Ashley Deckert, Director
RI Department of Children, Youth, and Families
101 Friendship Street
Providence, RI 02903

RE: 214-RICR-40-00-6 (REG 13460)
Rhode Island Department of Children, Youth, and Families
Mobile Response and Stabilization Services (MRSS)

Director Deckert and members of the DCYF team,

Family Service of Rhode Island (FSRI) appreciates the opportunity to provide written feedback on the proposed amendments to the *Mental Health Emergency Service Interventions for Children, Youth, and Families Regulations for Certification (214-RICR-40-00-6).* FSRI has proudly provided Mobile Response and Stabilization Services (MRSS) since 2021.

FSRI strongly supports the Department of Children, Youth, and Families (DCYF) in establishing best practice and licensing guidelines for MRSS. Mobile Response and Stabilization Services, which is an essential component of the state's System of Care, provides critical, family-centered interventions that prevent unnecessary hospitalizations and out-of-home placements. Establishing a Medicaid rate and licensing standards for MRSS represents a vital step toward ensuring the sustainability and integrity of this model.

Being one of the three current MRSS providers in Rhode Island, FSRI is in a unique position to share practical feedback from direct experience. We strongly believe the state's MRSS system should build upon the robust infrastructure and expertise that already exist, rather than duplicating efforts. Expanding the number of providers without a coordinated structure risks diverting limited resources toward administrative overhead instead of direct care. Current providers have already invested significant time, training, and financial resources to establish highly skilled staff, 24/7 response capability, and strong outcomes. Leveraging this existing foundation will strengthen the system, ensure cost-efficiency, and maintain the continuity and quality of care that Rhode Island's children and families deserve.

FSRI believes that for MRSS to be a successful part of the children's behavioral health care, there needs to be strong and clear guidance regarding what state agency in charge of this system. The regulations, at times, appear confusing around this issue as they incorporate language related to the adult behavioral health system. This could lead to confusion regarding who has authority over children's crisis services including MRSS.

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In addition, it seems that the proposed regulations, are at times, not "in step" with the published MRSS Best Practice Guidelines that have been circulated to MRSS providers or the MRSS model as it is implemented with fidelity. The regulations, for example, do not reference the core principle of the MRSS model- that the crisis is defined by the family. This principle is the foundation of the MRSS model.

After reviewing the draft regulations, FSRI respectfully offers the following recommendations to ensure that MRSS can continue to be delivered effectively and equitably while minimizing barriers for families and maintaining fidelity to the evidence-based model.

Specifically, FSRI recommends that DCYF consider the following areas:

1. **Aligning regulatory language more closely with MRSS Best Practice Guidelines**
2. **Defining child-specific competency more clearly**
3. **Enhancing language related to MRSS infrastructure**

1. Aligning Language with MRSS Best Practice Guidelines

6.1 – General Provisions

Section A.3
The current language limits eligibility to children ages two to twenty-one, which conflicts with MRSS Best Practice Guidelines indicating that services should be available to children and youth ages *zero to twenty-one.*

Recommended text:

"These regulations establish the requirements for a statewide, 24 hours a day, 7 days a week Mobile Response and Stabilization Services (MRSS) system for children, youth, and families experiencing behavioral health crises. The goal is to provide timely, family-centered, trauma-informed, and culturally responsive interventions that reduce emergency department utilization and unnecessary out-of-home placements. A core principle of MRSS is that the crisis is defined by the family."

Section B.f
We recommend revising this section to extend eligibility to children and youth *ages zero to twenty-one* to align with national best practices.

Section C – Definitions

- Add to the MRSS definition that "the crisis is defined by the family," a core tenet of the MRSS model.
- Include definitions for *case managers* and *family partners*, as these are integral members of MRSS teams alongside licensed clinicians.

2. Clarifying Service Standards and Response Expectations

6.2 – Licensure Standards for Mental Health Emergency Service Interventions

Section A
Consider clarifying the description of the 24-hour system to read:

"Telephone crisis hotline support shall be available 24 hours a day, 7 days a week, integrated with

the statewide 988 system, and capable of immediate referral or deployment of mobile response teams."

Section D.1.a
The draft specifies a two-hour response window for face-to-face crisis intervention. The Certified Community Behavioral Health Clinic (CCBHC) standard requires a one-hour response time (or two hours in rural areas). MRSS best practice similarly recommends response within one hour for urgent calls.
Suggested revision: Update the regulation to specify a one-hour response time for urgent calls.

Section E – Crisis Response Best Practices
Add language to ensure MRSS programs demonstrate:

- Multidisciplinary teams trained in child development, crisis de-escalation, suicide-safer care, and trauma-informed practice
- Inclusion of family and youth voice and choice in program development and feedback
- Cultural and linguistic competence, including language-access capability and workforce training
- A strengths-based, family-defined approach that prioritizes stabilization in the least restrictive environment

3. Service Access and System Coordination

6.3 – Licensure Standards for MRSS Interventions

Section A.3
Replace existing text with:

"MRSS providers shall serve all children and youth presenting with behavioral health crises, as defined by the youth or family, regardless of insurance status, coverage, or ability to pay."

Section A.4
Amend to extend eligibility to *children and youth ages zero to twenty-one* to align with MRSS best practice standards.

Section B. b

Amend to specify that "providers must deploy a two-person mobile crisis team, including a child-family competent clinician and another clinical or paraprofessional staff member, with a Qualified Mental Health Professional (QMHP) available to each team."

Requiring that each two person team can only operate with a QMHP would limit our ability to utilize MRSS clinician who are in the process of obtaining their QMHP- this would hinder access to care for children, youth, and families. The purpose of MRSS is to ensure that the crisis is stabilized in the least restrictive environment, as a result, our reliance on QMHPs is not an essential component of the MRSS program. While it is important that each team has access to a QMHP in the rare occurrence that we would have to involuntary certify a child or youth to a psychiatric hospital, we do not think it should be a requirement of each two-person team. While FSRI ensures that all of our MRSS clinicians do become QMHPs, it takes time to complete the training.

Section C – Service Areas, Statewide Capacity, and Mutual Aid

C.1.a-c Clarify if there can be multiple MRSS providers for each CCBHC region as their primary region. This section is not clear.

C.3.a Clarify whether a Designated Collaborating Organization (DCO) agreement is required to conduct mutual aid among MRSS providers. In addition, the way this section is written seems to disincentivize mutual aid.

4. Defining Child-Specific Competency

6.2 – Licensure Standards for Mental Health Emergency Service Interventions

Section F
Add an explicit requirement that MRSS providers demonstrate competency in delivering the MRSS model with fidelity. Including ensuring that the crisis is defined by the family.

Section F.1.k
Create a separate bullet emphasizing training in trauma-informed and trauma-focused care—not limited to Adverse Childhood Experiences (ACEs)—and inclusive of understanding trauma's impact on child development and symptom presentation.

5. Strengthening MRSS Infrastructure Requirements

6.4 – Licensure Process for MRSS Providers

Section D – Additional Requirements
Include the following to reinforce infrastructure and quality expectations:

- Demonstrated ability to deploy mobile crisis teams in community settings
- Demonstrated capacity to deliver effective stabilization services following the initial crisis intervention

Conclusion

Family Service of Rhode Island commends DCYF for its leadership in advancing MRSS as a cornerstone of Rhode Island's children's behavioral health continuum. We appreciate the Department's commitment to aligning licensure standards with best practices and ensuring families can access responsive, equitable, and high-quality crisis care. We believe that more work needs to be done on these regulations to ensure that they are clear and are aligned with MRSS best practices, especially when it comes to family voice in defining the crisis.

We thank DCYF for the opportunity to provide feedback and stand ready to collaborate further to ensure that these regulations support the strongest possible MRSS system for Rhode Island's children, youth, and families.

Thank you,
Sarah Kelly-Palmer

Sarah Kelly-Palmer, LICSW
Chief of Behavioral Health

May 20, 2025 – House Finance
H5527 – Letters of Support
https://www.rilegislature.gov/Special/comdoc/Pages/House%20Finance%202025.aspx

The following, in addition to FSRI (Margaret Holland McDuff) and Tides (Beth Bixby) submitted letters of support in 2025 to establish a sustainable, statewide Mobile Response and Stabilization Services (MRSS) program:

1. Dr. Amy Goldberg – Aubin Center, Hasbro Children's Hospital
2. Dr Jessica Farrell and Dr. Alexandra Labovitz – Pediatric Associates
3. Dr. Karim Khanbhal – Children Choice Pediatrics
4. Sid Wordell – RI Police Chiefs Association
5. Colonel Michael Correia – Barrington Police Department
6. Colonel Oscar Perez – Providence Police Department
7. Chief Ryan Duffy – Newport Police Department
8. Chief Thomas Oates III – Woonsocket Police Department
9. Mayor Roberto DaSilva – East Providence
10. Sandra Forand – East Providence School Department
11. Mayor Maria Rivera – Central Falls
12. Patricia Martinez – Central Falls School District
13. Robert Robillard – Town of Coventry, Department of Human Services
14. Kevin Lamoureux, Principal – Ricci Middle School, North Providence
15. Michaella Costa, LICSW – Old County Road School, Smithfield
16. Shelley Bigelli, Special Education Administrator – Cranston Public Schools
17. Dawn Allen – Thrive
18. Kate Brewster – Jonnycake Center
19. Robert Hicks - Washington County Coalition for Children
20. Michaela Carroll – RI KIDS COUNT