



Department of Mental Health and  
Addiction Services

**Mobile Response and Stabilization Services**

**Practice Standards**

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## Overview

The Mobile Response and Stabilization Service (MRSS) Practice Standards are authorized by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and serve as the basis for process improvement and expansion of MRSS to advance behavioral health services for the state's young people. The intent of these standards is to establish expectations for operational components and to guide implementation, while allowing ample flexibility to accommodate county/regional needs and practice innovation. The standards outline the goals, guiding principles, eligibility criteria, service components, implementation of model best practices, roles and responsibilities, data collection and quality assurance initiatives and resources recommended for MRSS. The Practice Standards have been developed through a collaborative process including OhioMHAS staff, Board Authorities, Case Western Reserve University's Child and Adolescent Behavioral Health Center of Excellence (CABH COE), service providers, peer supporters, parents, youth, and national experts in children's mobile crisis and stabilization services. The Ohio MRSS model incorporates national best and promising practices for youth mobile crisis and is informed by statewide or highly established MRSS programs in Connecticut, New Jersey, and Nevada.

### MRSS Within the System of Care

Ohio's MRSS was initially developed and implemented in several counties on a pilot basis in 2018. It was fully implemented in July of 2022 as one component of the OhioRISE (Resilience through Integrated Systems and Excellence) service array. MRSS is integrated as an essential service within Ohio's system of care (SOC) to fill a gap for families seeking services for urgent behavioral situations before they become unmanageable emergencies. MRSS is available to young people under 21 years, and their families in counties with MRSS programming. MRSS is instrumental in averting unnecessary emergency department (ED) visits, inpatient admissions, out-of-home placements and placement disruptions, and juvenile justice involvement, while reducing overall system costs. Operating within a high quality, culturally and linguistically competent children's crisis continuum, MRSS works to keep a child, youth, or young adult safe at home, in the community, and in school whenever possible. MRSS is a cost-saving viable alternative to acute care and has demonstrated improved outcomes and high levels of family satisfaction.

**Note:** Behavioral health treatment services within the overall system of care are not always immediately available to youth and families. MRSS is a brief intervention and stabilization program, and it is important that referents remain mindful of the purpose and scope of the program. Youth and families should be encouraged to access MRSS to address urgent situations. A family should not be referred to MRSS for the sole reason of providing support until other services become available.

**Note:** As part of the effort to launch the next generation of its managed care program, the Ohio Department of Medicaid (ODM) implemented OhioRISE in 2022. OhioRISE is a specialized managed care program for youth with complex behavioral health and multi-system needs. Its services include MRSS, moderate and intensive care coordination, Intensive Home-Based Treatment (IHBT), Psychiatric Residential Treatment Facilities (PRTF), and behavioral health respite.

## **MRSS Within a Crisis Continuum of Care**

MRSS is an essential part of Ohio’s crisis continuum of care and is intended to supplement, rather than replace, other crisis-related programming for youth who present to emergency departments and/or specialized interventions for specific youth populations. Examples of other such programming include telephone-based crisis support lines and walk-in crisis services and screenings. Providers of such services are encouraged to refer families to MRSS (with the family’s permission).

### **MRSS Definition**

MRSS is a structured community-based, in-person intervention and stabilization service for youth and families, provided by certified MRSS teams. While effective in serving youth in acute crisis, MRSS is also an early intervention emergency program that often serves as a gateway to other services across the system of care.

MRSS is designed to promptly address situations in which young people are experiencing emotional symptoms, behaviors, trauma reactions and concerns that compromise or impact their ability to function within their family, living situation, school, or community. MRSS is informed by the unique strengths, need, and culture of each youth and family served.

### **Rationale**

Because options for assistance can be limited when young people experience a behavioral health crisis, families often utilize the options available to them (e.g., law enforcement, hospital emergency departments and inpatient treatment) for help. Primary goals of MRSS include preventing: 1) unnecessary use of emergency departments or acute care services; 2) out-of-home placements and disruptions; and 3) involvement in the child welfare or juvenile justice systems. MRSS services are initiated proactively in response to young people who are experiencing significant emotional and behavioral distress due to trauma, conflict within the family, social challenges (e.g., bullying/cyberbullying), and other situations. MRSS provides an effective and accessible alternative to more restrictive services for youth and families. A hallmark of MRSS is that youth, families, and other referrers define the crisis.

MRSS provides rapid intervention at the time and place the youth or family needs help and is not an office-based or telephonic service. Services are provided where the crisis occurs or at a community location requested by the family or other referrer. The MRSS team works closely with the youth and family to de-escalate and better understand the current crisis and create a safety plan. With the goal of helping families to better manage and prevent future crises, the team assists the family to enhance protective and resiliency factors, develop new skills and link to resources and supports. MRSS provides up to six weeks of stabilization from the date of the initial mobile response. Ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes is available as needed.

## MRSS Goals and Objectives

### A. MRSS Goals

- Mitigate risk and increase safety
- Improve the abilities of families to manage behavior and prevent or effectively manage future crises
- Provide immediate intervention and supports to assist young people, families/caregivers and other youth-serving entities in de-escalating and stabilizing behaviors, emotional symptoms and/or dynamics impacting the young person's life functioning
- Assess, plan, and deliver appropriate interventions to stabilize the current crisis and prevent future crises
- Enhance the resiliency and protective factors of families
- Provide timely community-based interventions, skill building and resource development
- Prevent/reduce the need for care in a more restrictive settings, such as an inpatient psychiatric units, congregate care, and detention centers
- Support the young person to live and function in the least restrictive home, school, and community settings
- Facilitate the young person and caregiver's transition to identified supports, resources, and services (e.g., intensive care coordination, evidence-based and promising community-based treatment services; community-based supports; and natural resources)

### B. MRSS Objectives

MRSS services are guided by twelve objectives in three areas:

#### Young Person and Family Objectives

- Stabilize the presenting crisis
- Decrease risk and increase safety
- Promote/enhance emotional and behavioral functioning
- Empower young people and families to monitor, manage, and cope with situations to decrease the intensity and impact of future destabilizing events

#### Provider Objectives

- Provide behavioral health stabilization services that are delivered in the home, school, and community, and that are responsive to youth and family need
- Provide appropriate screening, early identification, and assessment of risk and safety concerns that minimally include suicide risk, non-suicidal self-injury, abuse and neglect, exposure to violence and/or other types of trauma, human trafficking risk, fire setting cyberbullying, substance use, risk of runaway, and other clinical presentations that pose an immediate or ongoing risk or safety issue
- Incorporate system of care values and principles into all aspects of service delivery
- Coordinate with existing providers and supports or facilitate linkage and transfer to appropriate level of services and supports

### **System Objectives**

- Ensure that young people and their families have access to MRSS in their community
- Whenever safe and possible, maintain youth in their homes and communities and prevent placement in costly, non-medically necessary and restrictive settings (e.g., emergency departments, congregate care, inpatient hospitalization, and incarceration).
- Ensure MRSS is embedded in the youth behavioral health system of care
- Increase community awareness of MRSS by providing education and outreach to families, schools, and communities

### **Intersystem Collaboration**

An overarching goal of Systems of Care (SOCs) is for youth and families to receive the necessary array of services and supports to increase the likelihood of youth with complex behavioral challenges remaining at home and in their local communities. To achieve these aims, local SOC, including care management and coordination entities, child-serving systems and programs, and formal and informal support networks share responsibility for prevention and intervention with youth and families experiencing high levels of distress. MRSS is embedded in the SOC and is an essential part of the crisis continuum of care. As part of a local SOC, MRSS develops collaborative partnerships to assure that services, supports, planning, and linkages are coordinated.

MRSS providers are encouraged to establish formal Memorandums of Understanding (MOUs) throughout the SOC. For example, MRSS providers can establish MOUs with

- local school district(s) to deploy MRSS when a young person is in distress and/or when they are at risk of 911 intervention.
- Children’s Protective Services to deploy MRSS when children are entering out-of-home placements or at risk of placement disruptions.
- local law enforcement to access MRSS as an alternative to an arrest or bringing the youth to an emergency department.

### **Parameters of Operation**

#### **A. Target Population**

MRSS is delivered to any young person under the age of 21 who is experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have impacted their ability to function within their family, living situation, school, or community. MRSS is available to all youth and families (birth, kinship, foster, guardianship, and adoptive) in counties with an MRSS program. Youth need not have had previous behavioral health treatment and current involvement with a specific service or system is not necessary to access MRSS.

## **B. Family/Caller Defined Crisis**

A hallmark of MRSS is that the young person and family and/or another referrer define what constitutes a crisis and their definitions of crises may vary from clinical practitioners. MRSS operates with a “just go” approach to all calls for service. These calls arise from situations, events, and/or circumstances that cannot be resolved with typical resources and coping skills, or that jeopardize the youth’s ability to use adaptive socio-emotional skills and strengths critical for healthy life functioning. Other reasons for initiating MRSS services include helping youth who are destroying property; displaying risky behavior; highly anxious; emotionally dysregulated; traumatized after a personal, familial or community tragedy; threatening self-harm or harm to others; and/or who are significantly withdrawn/ “shut down.”

## **C. Service Availability**

Within one year from the date of initial certification from OhioMHAS, MRSS providers must be available twenty-four hours a day, seven days a week, 365 days a year (24/7/365). MRSS-trained staff must be immediately and directly available to receive calls for service, including speaking with families and other referrers via a warm transfer process, and to respond to the location where the young person is experiencing the crisis or at another community location preferred by the family within in 60 minutes.

During the year of transition to 24/7/365 MRSS availability, the MRSS Call Center will connect callers with the designated after-hours provider. The MRSS Call Center will send notification to the MRSS provider of any callers who had been transferred to the after-hours provider via the MRSS Data Management System (DMS). The MRSS provider should review the DMS system at the outset of their next mobile response period, connect with the after-hours provider to determine the outcome of calls, and follow-up as warranted, including providing an MRSS initial or follow-up mobile response.

## **D. Service Initiation**

Most requests for MRSS shall be initiated via the Ohio MRSS statewide Call Center at **1- 888-418-MRSS (6777)**. MRSS promotional materials must use this number to be in accordance with established best practices. In accordance with a “no wrong door” policy, MRSS may also be initiated by hotlines, warmlines or by directly calling an MRSS provider.

MRSS referrals can be initiated by the young person, family members and caregivers, school staff, other youth serving providers, emergency departments and law enforcement and others. If the referrer is not the guardian, attempts should be made to consult with them to gain permission to request assistance from MRSS. If they are not immediately available, continuous efforts should be made to reach them throughout the intervention. In the event a guardian declines, the intervention ends after immediate high-risk safety concerns are addressed.

A brief screening and triage will take place at the time of referral to rule out the need for a 911 response and to otherwise recommend the appropriate MRSS response. Mobile responses will take place immediately (within 60 minutes) or, if specifically requested by the family or referrer, no later than 48 hours after the request for service.

#### **E. Service Location**

Youth and families in crisis are best served in their homes and local communities. MRSS is not an office-based or telephonic service. Rather, services are provided at the location of the young person in distress or at a community location preferred by the youth, family, or another referrer. The best practice is for the mobile response and ongoing stabilization services to be provided face to face in person and in the community, unless extenuating circumstances (e.g., public health emergency, natural disasters, inclement weather, geographic distance, or other factors) prevent in-person interaction with the young person or family. When such instances occur, MRSS services can be provided via telehealth, as defined in rule 5122-29-31 of the Ohio Administrative Code, and providers must have the ability provide telehealth services when necessary.

#### **F. Intersection with Emergency Departments**

When a youth is seen in an emergency department for behavioral health reasons, and subsequently stabilizes or is otherwise determined by emergency department staff to not need a higher level of care, MRSS may be initiated to provide safety planning, crisis de-escalation and stabilization support in accordance with the family's preferences. The MRSS mobile response may take place at the emergency department, or families may prefer a non-immediate response after the youth's discharge from the emergency department. In such instances, emergency department staff should consult with families to make sure they agree with MRSS being part of the discharge/follow-up plan from the emergency department.

Occasionally, MRSS may refer a youth to an emergency department for further evaluation and consideration as to whether the young person requires a higher level of care. In such instances, MRSS should communicate pertinent information to emergency department staff, including any known risks and the rationale for the emergency department referral. Additionally, MRSS should follow-up with the family and the emergency department regarding the status of the youth. If the emergency department staff determines that the youth will be discharged home or has already been discharged, MRSS should continue efforts to further deescalate and stabilize the youth, as warranted and according to the family's preferences.

**Note:** If a youth is enrolled in OhioRISE, the MRSS staff should contact the assigned Care Management Entity or Care Coordinator to notify them of the youth's emergency room involvement.

## **G. Consent**

While minors usually need the consent of a parent or guardian before receiving medical care, including behavioral health care, a minor may receive emergency medical treatment to preserve life and prevent serious impairment without the consent of a parent or guardian. In accordance with the Ohio Revised Code 5122-04 (<https://codes.ohio.gov/ohio-revised-code/section-5122.04>), young people 14 years of age and older can consent for mental health treatment for up to six sessions or 30 days (whichever comes first) and young people between the ages of 18 and 21 and emancipated minors must give consent for services.

MRSS collects data for quality assurance and improvement (QA/QI) purposes. Per OhioMHAS, consent to collect and enter data into the MRSS DMS is not specifically needed. However, OhioMHAS issued the following guidance language for providers to incorporate into consent for treatment: “As a part of my/my child’s treatment, I consent to data related to the Mobile Response and Stabilization Services I/my child receives to be shared with the State of Ohio Mental Health and Addiction Services (OhioMHAS) for quality assurance and program evaluation purposes.” Families should be assured that data used for QA/QI purposes will be de-identified.

## **H. Length of Stay**

An episode of MRSS care should last no more than 6 weeks or 42 days from the date of the initial mobile response and is informed by the youth and family’s unique needs and MRSS goals. MRSS services are reimbursed through OhioRISE or through Ohio Medicaid Managed Care Organizations; prior authorization is needed for MRSS services exceeding 42 days.

## **I. Intensity**

MRSS services are provided through:

- face-to-face contacts with the youth and/or family.
- telehealth (within the parameters defined above).
- telephone contacts with the family following the initial mobile response.
- telephonic or face-to-face collateral contacts.

On average, young people and their families will receive two face-to-face contacts for every seven days of service. The frequency of the response is based on current assessment, acuity and/or complexity of youth and family needs, the goals for the intervention and agreement with the family. For these reasons, some families will receive more than two visits while others will receive less.

## **J. Family Engagement**

Young people and their families are full partners in all aspects of the planning and delivery of their MRSS services. MRSS ensures the voice and choice of the youth and family in the referral and selection of services and supports available in their community. These can include

traditional and nontraditional services, as well as informal and natural supports. The young person and family will participate in decision making regarding all aspects of the services received through MRSS, including, but not limited to:

- safety planning.
- identifying needs and preferences for MRSS service delivery and ongoing support
- convening and participating in all planning meetings, including having voice and choice on which team members they would like to attend meetings.
- goal setting.
- identifying skill-building opportunities.
- determining service intensity.
- determining location of services.
- identifying referrals to resources post MRSS involvement.

#### **K. Cultural and Linguistic Competency**

The MRSS provider must offer culturally and linguistically appropriate services to all young people and families. Agency expectations include:

- hiring of bilingual or multilingual MRSS staff members as well as, hiring staff that reflect the demographics of the population being served.
- provision of written materials, including MRSS Plans, safety plans and consent forms that are understandable to families, written at an appropriate reading level and, when possible, in the language of the youth and family.
- assessment and incorporation of the cultural needs and preferences of the young person and family into plans, services provided and linkages to community supports.
- ensuring that staff have knowledge of unique cultures in their service areas and culture-specific values and practices which may impact service delivery.
- using current information related to disparities in access and outcomes of MRSS services to develop strategies for program improvement.
- using professional translation services when staff members are unable to accommodate to families' language needs, including providing services in the primary language spoken in the home.

#### **L. Trauma-Informed Care Service Delivery**

MRSS ensures that every part of the program incorporates the impact of trauma on the individuals they serve and adopts a culture that considers and addresses this impact. Many youth seeking MRSS have experienced significant trauma, and, in turn, many behavioral health crises are rooted in trauma. While at times necessary, MRSS works to divert children from environments and interventions which may introduce unintentional harm to youth and families (e.g., loss of freedom and separation from loved ones; noisy and crowded environments; exposure to others' crises; and/or the use of restraints), such as what might be experienced or witnessed in emergency departments, inpatient units or detention centers. These situations can traumatize/ re-traumatize individuals, exacerbate symptoms, escalate the current crisis, and may contribute to reluctance to seek help in the future. Trauma-informed care is an essential

element of MRSS. MRSS providers must ensure that the following guiding principles, (established by SAMHSA in 2014) are integrated into service delivery:

- Safety
- Trustworthiness and transparency
- Peer support and mutual self-help
- Collaboration and mutuality
- Empowerment, voice and choice, and
- Ensuring that cultural, historical and gender considerations inform the care provided.

Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves and/or who may be exposed to traumatic experiences when providing MRSS services.

## **MRSS Staffing**

### **A. Staff Composition**

It is essential that the MRSS provider have a developed MRSS team to ensure its capacity to provide high quality mobile response services at the time and place it is needed. An MRSS team includes an MRSS-trained independently licensed clinical supervisor (see below), a licensed clinical staff member and a peer supporter or Qualified Behavioral Health Specialist (QBHS). The team must also have ready access to a psychiatrist, certified nurse practitioner or clinical nurse specialist for consultation purposes when needed.

It should be noted that many of the responsibilities below are not mutually exclusive to a particular role. For example, while only independently licensed clinicians or licensed clinicians working under the supervision of an independently licensed clinician can diagnose a youth, they may carry out most responsibilities noted for peer supporters and QBHS staff. Similarly, any staff, including peer supporters and QBHS staff, who have been certified to administer the Ohio Children's Initiative Brief CANS may do so.

#### **Supervisor**

MRSS requires both clinical and administrative oversight, which can be carried out by one or more individuals designated as MRSS supervisor and who have appropriate qualifications and licensure for the responsibilities performed. The number or allocation of supervisors for the program must be sufficient to oversee or carry out all supervisory responsibilities and may be informed by the total number of staff and/or volume of families served. When more than one supervisor is responsible for oversight of the program, the agency will ensure that supervisor duties are carried out in a coordinated manner.

#### **Licensure**

At least one supervisor must be an independently licensed behavioral health professional licensed by the State of Ohio.

## **Primary Responsibilities**

### *Clinical*

- Supervise MRSS staff, including MRSS peer supporters, whether hired by the provider or contracted from another agency
- Provide clinical consultation and oversight on the care of enrolled youth and families and associated documentation
- Have 24/7 availability
- Oversee the service delivery quality
- Provide a mobile response when other MRSS clinicians are not available
- Convene regular team meetings, using an efficient, consistent process, to review progress of high acuity and/or complex youth and make intervention decisions to ensure families meet their identified goals

### *Administrative*

- Assure that staff are trained in the Ohio MRSS model
- Ensure the model is being implemented with fidelity and in accordance with applicable rules and regulations
- Oversee timely data collection, data input and utilization of data for performance monitoring, improvement, and planning
- Oversee and/or provide community education and outreach to child-serving systems and agencies across the service region
- Serve as conduit for communication from OhioMHAS, the COE, the MRSS Call Center and others to the team

## **Licensed Behavioral Health Staff**

### **Licensure**

The MRSS licensed behavioral health staff is an individual, as identified in rule 5122-29-30 of the Ohio Administrative Code, who can either independently diagnose behavioral health disorders or can diagnose behavioral health disorders under the supervision of an independently licensed staff. The licensed staff holds a valid and unrestricted certification or license or works under the supervision of an independently licensed individual who can diagnose. This staff provider must also demonstrate and maintain competency in the under 21 years of age population.

### **Primary Responsibilities**

- Provide initial and ongoing mobile responses, inclusive of risk assessments for a young person in crisis
- Attend to safety and clinical concerns that require additional clinical intervention or assessment.
- De-escalate the presenting crisis during the initial mobile response and subsequent crises during MRSS care
- Co-create and update safety and MRSS Plans with the young person and family.

- Conduct necessary assessments to determine young person and family needs, strengths, and protective factors, including the Ohio Children’s Initiative Brief CANS
- Work with the youth and family to establish and achieve family defined goals; develop skills to prevent future crises; and determine what other types of services and supports are needed
- Secure appropriate approvals on plans and plan revisions
- Co-develop and initiate a transition plan to clinical and natural supports
- Ensure materials are culturally appropriate and in language of origin of young person and family
- Collaborate with the MRSS peer supporters and paraprofessionals to define and achieve family goals

## **Peer Supporters and Qualified Behavioral Health Specialists (QBHS)**

### **Peer Supporter Certification**

The MRSS Peer Supporter must have a valid and unrestricted certification from OhioMHAS in accordance with Ohio Administrative Code 5122-29-15.1. The peer supporter must be a parent, caregiver or young adult peer and demonstrate competency in the care and services of individuals under 21 years of age and has scope of practice for persons under 21 with mental health disorders and/or substance use disorders.

### **QBHS Certification**

The QBHS must meet the requirements of Ohio Administrative Code 5122-29-30. This QBHS demonstrates competency in the care and services of individuals under 21 years of age and has scope of practice for persons age under 21 with mental health disorders and/or substance use disorders.

### **Peer Supporter or QBHS Responsibilities**

- Use lived experience to assist young person and family (peer supporters)
- Provide initial responses with licensed behavioral health staff when available and it is beneficial to do so
- Provide follow-up responses within their scope of practice
- Follow the MRSS Plan regarding the type and frequency of interventions
- Inform licensed behavioral health staff of new or increased risks and changes in young people’s presentations during the MRSS episode of care
- Support the family including providing or assisting the family to access additional supports
- Collaborate with the youth and family and other MRSS team members and to define family goals and to ensure that the MRSS Plan is representative of the family’s values, preferences and needs
- Crisis response and de-escalation
- Provide interventions including skill building, psychoeducation, role modeling, and advocacy

- Identify and connect the young person and family to natural and other resources, including resources to meet basic needs.
- Work with the young person and family to access and utilize cultural supports

### **Integration of Peer Supporters**

A transformative element of MRSS is to fully engage peer supporters with lived experience as core members of the MRSS team and the team’s service delivery. Peer supporters are an integral part of the MRSS team and should be included in all aspects of care. They foster a collaborative partnership with the young person, family and service system and support families in exploring options that may be beneficial to returning to emotional and physical wellness after a crisis. Peer supporters share their personal journey with purpose and intent and use their lived experience to coach young people and their families to advocate for their needs. Peer supporters can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with clinicians and other service providers. Through the unique power of bonding over common experiences, while adding the benefits peer modeling, stabilization and future crisis aversion are possible.

To ensure the inclusion of peers as an equal part of the team, MRSS providers will:

- commit to incorporating peer supporters in all aspects of the MRSS program.
- hire certified peers with lived experience that reflect the characteristics of the community served as much as possible.
- develop support and supervision practices that align with the needs of the peer supporters engaged in the MRSS team whether the peer supporters are staff members of the MRSS provider or contracted through another agency.
- include peers as a vital part of the MRSS team to emphasize engagement as a fundamental pillar of care, including
  - co-training peers and clinicians supporting the team model.
  - having peers serve as one of two team members during the mobile response, when possible.
  - integrating peers into ongoing assessment, planning and intervention with the young person and family, in a manner consistent with their training and scope of practice.
  - including peers in MRSS team meetings.

### **Psychiatric Consultant/ Provider Responsibilities and Certifications**

The MRSS team must have timely access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. This provider may be a staff of the provider agency or may be contracted to provide consultation. The psychiatrist or certified nurse practitioner or clinical nurse specialist must hold a valid and unrestricted license to practice in Ohio and be familiar with the operations and aims of the MRSS program (e.g., diverting from ED and inpatient care). It is preferable that these providers have expertise and training in delivering behavioral health and medication management services to children and adolescents. Of note,

MRSS provider agencies are encouraged to establish a means for youth to be directly assessed by a psychiatric provider on an emergency basis. At times, the provider may provide transition care for youth until their care can be transitioned to an ongoing provider.

## **B. Staffing Levels**

Staffing levels will be established as necessary to achieve the benchmarks, including providing home and community-based mobile responses and stabilization services within established timeframes and based on family needs. There should be capacity to respond to multiple calls for MRSS services at the same time.

## **C. Staff Competencies**

To be successful, the MRSS team must be skilled in child-focused crisis response and ongoing crisis support and interventions. MRSS team members must be able to work with young people and families in collaboration with other team members. Successful MRSS team members are innovative in their approach to meeting the needs of the young person and family and can integrate non-traditional and natural supports into care plans. MRSS team members must have the capacity to be flexible and adapt to the changing circumstances of youth and families. Collectively, MRSS teams and provider agencies must possess the following competencies.

### **Overarching Competencies**

- Cultural competency
- Trauma-informed care
- Care management, linkage, and referral
- Family engagement

### **Crisis Assessment, Stabilization and Safety Planning Competencies**

- Conduct crisis assessments, including mental status, diagnostic and lethality assessments
- De-escalate and stabilize youth and/or family crises
- Develop actionable safety plans (inclusive of means reduction strategies) and MRSS Plans in partnership with youth and family
- Continuous assessment and monitoring of youth and family safety and well-being, including changes that may warrant increased intervention
- Effectively engage with youth and family

### **Additional Assessment Competencies**

- Conduct Ohio Children's Initiative Brief CANS assessment, with appropriate certification
- Assess individual, family, community, and school risk and protective factors
- Assess the triggers, crisis cycle patterns and interactions that may impact the presence or resolution of a youth and family crisis and otherwise serve as a basis for the MRSS Plan to achieve stabilization and prevent future crises
- Assess current and needed skill sets/coping strategies

### **Crisis Prevention Competencies**

- Ability to teach parents and caregivers to identify early warning signs and develop strategies for preventing further escalation and future crises
- Ability to implement a youth and family MRSS plan
- Ability to design and implement strategic accommodations based on functional needs

### **Skill Building Competencies to Teach/Practice/Generalize Skills with the Youth and Family:**

- Social problem solving and decision-making
- Coping skills
- Youth and family communication skills
- Parenting skills
- Collaborative problem solving
- Emotional regulation and distress tolerance skills
- Family co-regulation skills
- Family remediation following a crisis

### **Transition Competencies**

- Ability to develop effective transition plans (linkages, supports, services)
- Cross-system collaboration skills

## **D. Staff Development and Training**

The Child and Adolescent Behavioral Health Center of Excellence (CABH COE), OhioMHAS' state-designated training center, will develop and coordinate the delivery of all required trainings for MRSS staff, administrators, and community partners. The MRSS provider will ensure that all members of their team complete required trainings. Training will include core training modules, role-specific training and additional training modules delivered at various times and locations throughout the year. The following describes training requirements.

- MRSS team members, including MRSS supervisors who oversee MRSS as part of their day-to-day activities, are required to complete the two-day MRSS Training (Day 1: MRSS Core Training and Day 2: Crisis Assessment, Stabilization and De-Escalation Strategies) within 60 days of hire or within 60 days of MRSS program start-up, followed by additional competency or practice-based booster trainings within reasonable designated timeframes as established by the Center of Excellence.
- MRSS supervisors must also complete a four hour of MRSS Supervisor training within 90 days of hire or within in 90 days of MRSS program start-up.
- Afterhour supervisors and per diem, ad hoc and afterhours staff who provide only triage and mobile response services must attend the 4-hour training tailored to the services they will be providing and are encouraged to attend the 2-day training described above.
- MRSS Call Center staff must complete the two-day MRSS training described above and call center specific training, inclusive of role plays. Call Center staff may also be required to receive training on topics deemed necessary by OhioMHAS and the CABH COE.

**Notes:**

- MRSS providers must incorporate OhioMHAS approved trauma-informed care training, and training on cultural humility and responsiveness into MRSS employee orientation, with booster sessions delivered as needed.
- Staff members of entities providing MRSS triage and referral functions (e.g., local hotlines and warmlines), should be familiar with the MRSS model and its underlying premises including that families define the crisis, youth and families are best served face-to-face in the homes and local communities and that mobile responses should be provided for virtually all youth related calls. Staff members from such entities should watch the two-hour MRSS orientation training as it is made available.

**MRSS Service Delivery**

MRSS services are strengths-based, youth and family centered and driven, trauma-informed and responsive to the youth and family's culturally and linguistic needs and preferences. Evidenced-based, evidence-supported, evidence-informed strategies and nationally established best practices for providing crisis intervention to youth and families are implemented in all phases of the MRSS model. MRSS is time-limited (up to six weeks from the time of initial face-to-face intervention). Goals and interventions should be achievable during this timeframe. As MRSS is a brief program, linkages and referrals should be initiated early in the episode of care.

MRSS consists of three phases: Screening and Triage, Mobile Response, and Ongoing Stabilization. Some young people and families will complete screening/triage and the mobile response but may not need, or choose, to move on to the stabilization phases.

**A. Screening/Triage**

Screening and triage processes should pass a parent defined "litmus test." They should be:

**Consistent** Calls are answered, questions and disposition standards are uniform; virtually all requests for help result in a mobile response.

**Rapid** Calls are answered rapidly, questions are minimal, a call record system is used to save the family from having to repeat their "story" each time they call, resulting in a quick warm transfer to local MRSS provider.

**Compassionate** Staff are warm, non-judgmental, empathetic. They are well-trained in MRSS and typical presentations of youth in crisis and understand that crises are defined by the family and not based on adult standards.

**Successful** Call results in an MRSS team arriving to the location of the youth within 60 minutes of the call for immediate help.

To best achieve these aims and to be consistent with national MRSS best practices, Ohio:

- established the MRSS Statewide Call Line Number 1-888-418-MRSS (6777).
- implemented the MRSS Call Center, with the infrastructure and trained staff to conduct the screening and triage functions in accordance with the standards above.
- implemented the MRSS Data Management System (DMS) to be used, in part, as the call record system.

When a call for MRSS is received by the call center or the MRSS provider, the person receiving the call will conduct a brief triage to rule out the need for a 911 or urgent medical response and to otherwise determine the appropriate MRSS response. When the triage process results in a determination of imminent risk to health and safety for the young person or other involved party, the triage outcome is identified as “Emergency.” The caller is transferred to 911 and/or other appropriate emergency services unless the caller prefers to make the call themselves and it is safe to do so. After ruling out imminent risk concerns, call center staff will gather pertinent information (e.g., nature of the request, findings of the triage assessment, key contact information, address for mobile response), communicate the information to MRSS providers by phone and then connect callers to local MRSS providers to finalize details for the MRSS intervention.

The expectation is for youth and families not requiring an emergency response, to receive an “immediate” response (arrival of the MRSS team to the site of the child within 60 minutes). If a family or other referrer specifically requests for an MRSS mobile response outside of the 60-minute time period, the MRSS team will provide a “non-immediate” response. In such instances, the mobile response should occur within 8-24 hours and must occur no later than 48 hours after the initial call for help. The “time clock” for the mobile response begins when the call center staff connects the caller to the local MRSS provider. If the call for MRSS is made to the provider directly, the “time clock” begins at the conclusion of the initial call for help.

MRSS providers are expected to be immediately available to receive referral calls. When there is a possibility of providers missing a call from the MRSS Call Center, they should provide viable back-up numbers via the DMS system to assure that families can be directly connected to a MRSS provider rather than waiting for a call back.

**Note:** When requests for MRSS services exceeds 48 hours, families should typically be referred to a more appropriate service.

## **B. Mobile Response**

The Mobile Response phase lasts for up to three days from the date of the first face-to face assessment with the youth. MRSS may respond in teams of two staff members. When there is more than one MRSS team member present at the initial response, one team member must be a licensed behavioral health provider and that staff member must conduct the clinical portions of the assessment (e.g., mental status, lethality/risk assessment, determination of diagnoses),

and ensure that the disposition and safety plan are clinically appropriate given current risks and protective factors.

A key aim of MRSS is to provide an alternative to the use of law enforcement as a response to youth and families in crisis. Additionally, MRSS is a trauma-informed service and recognizes that many youth and families may experience fear or trauma in the presence of law enforcement. As such, the MRSS staff members should respond without law enforcement unless essential for safety reasons, include the family in the decision to do so, and ensure that the family is aware that law enforcement will be responding prior to their arrival.

### **Initial Mobile Response**

The mobile response team member(s) will arrive at the location of the behavioral health crisis, or a location specified by the family immediately (within 60 minutes) and no later than 48 hours when the family or other referrer specifically requests a non-immediate response. A primary focus of the initial response is to restore calm and safety when situations are escalated or potentially unsafe. During the initial mobile response, the MRSS team will also:

- Assess precipitating events and responses; mental status; potential lethality to self or others; other safety and risk factors; past and current trauma; past and current substance use; contributing medical/ physical factors; and cultural considerations and preferences for care (within the team member's scope of practice)
- Utilize initial information, inclusive of strengths and protective factors, to determine a disposition about safety and to inform the safety plan
- Co-develop a safety plan with the youth and family, to be provided to the youth and family by the end of the first face-to-face contact

### **Additional Mobile Response Activities**

Beginning with the initial mobile response and throughout the Mobile Response 72-hour period, activities include:

- Ongoing risk assessment and safety planning
- Engaging the family to determine priorities goals and considerations for the MRSS stabilization phase and their interest in receiving ongoing stabilization services. (Families may choose not to enter the stabilization phase of MRSS.)
- Initial exploration of the young person's and family's strengths, needs, resiliency and protective factors, coping skills, and social support network
- Follow-up visits and contact based on acuity, the complexity of the family's needs and family preference
- Youth and family peer support
- Intervention and de-escalation, using strategies appropriate to meet the unique needs of the youth and family
- Initial use of MRSS tools (e.g., the crisis cycle, safety mapping and the contextual functional analysis)
- Identification of early cues and triggers to current crisis
- Identification of coping and de-escalation strategies to restore calm
- Seeking psychiatric consultation when indicated

- Consultation and coordination with the school, primary care physician, existing providers/services, and other care coordination programs
- Initiation of referrals/ linkages to formal, informal, and natural supports
- Administration of the Ohio Brief Child and Adolescent Needs and Strengths (CANS) assessment by a qualified CANS assessor prior to the family moving into the stabilization phase of MRSS and otherwise when adequate information is obtained to complete the assessment
- Initiate an individualized MRSS plan, prior to the stabilization phase, which is inclusive of the safety plan. (An individualized MRSS plan is valid for up to forty-two days from the date of the initial mobile response or until the end of the MRSS episode of care if the MRSS episode ends before then and should be updated or modified as indicated during this time period.)

#### **Notes**

- While QBHS and peer supporter staff may inquire about needs, risks, preferences and priority foci for MRSS services and may carry out activities within their scope of practice in both the MRSS Response and Stabilization phases, they must: 1) consult with licensed behavioral health staff regarding the necessity, type and frequency of interventions, 2) inform licensed behavioral health staff of new or increased risks and changes in clinical presentations during the MRSS episode of care and 3) follow steps, recommendations or directives provided to them by the licensed staff. Further, they may not make independent determinations about initial or modified safety plans or MRSS Plans.
- Providers of intensive home-based treatment, as designated in OAC 5122-29-28, are on-call 24/7 for crisis response to families they serve (with the exception of Functional Family Therapy). In the event that MRSS is called to respond to a young person of family currently receiving intensive home-based treatment, the MRSS team should assess and de-escalate the presenting crisis and immediately reconnect the family to the existing IHBT program.
- When IHBT services are involved, MRSS stabilization phase services are not eligible for Medicaid reimbursement.

#### **C. Ongoing Stabilization**

Stabilization services are provided by the MRSS team as documented in the initial or updated MRSS Plan and focus on building the skills and supports necessary to help the family avoid or effectively manage future crises. The MRSS Plan, including the safety plan, should be monitored, and updated as warranted throughout the stabilization phase. Updates should incorporate newly identified risks, safety needs, safety prevention and coping strategies, resources, and supports.

Stabilization interventions are provided face-to-face and, in the home whenever possible. They will vary in focus, intensity, duration, and type based on the acuity and/or complexity of the

youth and family's presenting concerns. The foci of the MRSS Plan should be collaboratively established and be driven by the family's needs and preferences.

Stabilization services and activities include:

- Continuation of Mobile Response activities
- Continued monitoring, updating, coordination, and implementation of the individualized MRSS plan, inclusive of the safety plan
- Identification, psychoeducation, and enhancement of the young person's and family's coping, behavior management, problem solving and effective communication skills.
- Youth and family peer support
- Referral for psychiatric consultation and medication management, if indicated
- Advocacy and networking by the provider to establish linkages and referrals to appropriate community-based services and natural supports
- Coordination of services to address the needs of the young person or family.
- Linkage to the natural and clinical supports and services to maintain engagement and sustain the young person's or their family's stabilization post MRSS involvement
- Coordination with OhioRISE care coordination and/or Family and Children First service coordination
- Participation in Child and Family Team meetings
- Transition planning

#### **D. Additional Service Standards**

##### **Use of Evidence-Based Practices**

It is expected that MRSS services will include evidence-supported and evidence-based practices (EBPs) and strategies to ensure young people and their families efficiently and effectively achieve their stated goals. Due to the multiplicity of presenting concerns of the youth and families served in MRSS, the MRSS team should have the capability to provide an array of such practices and strategies.

Visit the following EBP websites for information on additional evidence-based practices:

- The California Evidence-Based Clearinghouse for Child Welfare: <https://www.cebc4cw.org/>
- Office of Juvenile Justice and Delinquency Prevention Model Program Guide: <https://www.ojjdp.gov/mpg>
- The National Child Traumatic Stress Network: <https://www.nctsn.org/treatments-and-practices/trauma-treatments>
- SAMHSA EBP Resource Center: <https://www.samhsa.gov/ebp-resource-center>

**Note:** When implementing EBPs, specialized training and certification in these areas may be required.

## **Individualized Safety Plans and MRSS Plans**

### **Individualized Safety Plan**

A safety plan developed with the youth and family must be completed prior to leaving the first visit. A copy of the safety plan should be provided to the family at the time of its development or be immediately accessible to the family after its completion. Safety plans are to be reviewed and modified as needed throughout the entire MRSS service and will become a component of the MRSS Plan. If a safety plan is updated, then the latest version needs to be provided to or made available to the family immediately. Safety plans should include:

- emergency contacts
- informal supports
- safety concerns
- crisis prediction and prevention strategies
- signs of distress
- individual coping strategies
- stabilization and support strategies
- safety and means reduction precautions

### **Individualized MRSS Plan**

MRSS requires the development of an individualized MRSS Plan. The plan should focus on strategies that will assist the family in preventing further crises or to make them more manageable should they occur. Plan development must be initiated prior to the youth's transition to the MRSS stabilization phase; incorporate the safety plan; be developed with the young person and family; and be informed by their priorities. The plan should be enhanced or modified as necessary throughout the stabilization phase and should include a limited and achievable number of goals and objectives that are designed to:

- restore and promote safety
- further de-escalate and stabilize the crisis
- build youth and family skills, including distress tolerance, coping, self-regulation, and self-care skills, to better manage and/ or avert future crises
- identify, refer, link, and coordinate with existing or new longer-term supports, services and systems as family need indicates
- enhance protective and resiliency factors

The individualized MRSS Plan should be informed by priorities, needs, strengths, protective factors and cultural considerations of the youth and family and include:

- the safety plan
- young person and family identified MRSS goals
- MRSS interventions to assist in goal achievement and
- plans to link to necessary formal, informal, and natural supports to help ensure sustainability post MRSS involvement

## Linking Young Person and Family to Ongoing Services and Supports

Throughout the MRSS service, the MRSS team will work with the young person and the family to identify and link to formal (when necessary), natural and informal resources who will further support the young person and family after they have transitioned out of MRSS.

**Formal services and supports** are provided by professionals under a structure of requirements for which there is oversight by county, state or federal agencies, national professional associations, or the public arena.

**Natural and Informal resources and supports** are individuals or organizations in the family's community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors, local businesspersons, or shopkeepers.

Connection with natural supports and formal services may take time. Linking the young person and family to the supports and services they will utilize post MRSS involvement should begin early in the MRSS intervention.

## Facilitated Youth and Family Planning Meetings

MRSS providers actively engage families in family team planning meetings, which often includes cross-system partners for the purpose of developing linkages for on-going services and supports. This may include a meeting convened by the MRSS team, an OhioRISE care coordinator or by another cross-system partner. The meetings must include additional system/agency partners, in addition to the MRSS staff and the family, to be considered a cross-system planning meeting. All meetings should include family members and family members should have voice and choice about meeting attendees.

## Transition from MRSS

Transition out of MRSS includes reviewing newly formed coping skills and how future crises can be effectively managed. Emphasis should be placed on what the family did for themselves to bring about change. The MRSS team will work with the family to transition the safety plan, as well as the responsibility for regularly reviewing it. Additionally, the team will provide the family and, with permission, providers and others identified by the family:

- A list of all upcoming appointments and activities including the type of services/ activities, locations, times, and contact information (i.e., name, phone numbers)
- Recommended follow-up actions for the family, care coordinators, and providers
- The most recent MRSS Plan, including the safety plan

If the youth is eligible for OhioRISE and/or local care coordination and has an assigned care coordinator, the care coordinator is typically responsible for facilitating all needed transition to community-based services and supports and for monitoring the safety plan with the family after the family transitions from MRSS care. As MRSS is a brief service, the connection between MRSS

team and the care coordinator should occur as soon as possible during or following the MRSS initial mobile response. When a timely connection is not made, the MRSS team may necessarily provide transition support to ensure the youth may be discharged in a timely manner. For family's not involved in OhioRISE and/or local care coordination, the MRSS team, with family permission, will share information with other service providers, with the young person and/or family present (in-person, by video and/or by telephone).

### **Additional Crisis Situations/ Re-Admissions to MRSS**

At any time during the MRSS service, a youth and/or their family may experience episodic crisis situations. During these times, MRSS team member(s) should respond as clinically indicated to de-escalate the crisis, increase safety, and revise the MRSS plan as needed.

Families cannot be admitted, discharged, and re-admitted to MRSS within 72 hours of the initial intake, as any needs and services during this time are part of the Mobile Response phase. Otherwise, families who have been discharged from MRSS services can initiate another episode of MRSS service at any time. Each episode of care begins with screening and triage followed by a mobile response. Families who are re-admitted to MRSS must complete screening and triage prior to entering stabilization. It is important to note that a re-admission cannot be initiated until a discharge date from the previous episode of care is documented in the MRSS DMS.

### **Emergency Department and Behavioral Health Inpatient Admissions**

If a youth becomes a patient of an emergency department or an inpatient behavioral health service during the mobile response phase and: 1) it is clear the youth will not return home during the phase and, 2) the necessary admission requirements for the stabilization phase have not been completed, the episode of care typically ends. If the youth is admitted to either placement during the stabilization phase and the anticipated length-of-stay will be brief, the MRSS episode of care may remain open, with the MRSS team continuing to support the family as they prepare for the youth to return home. In other instances, and in consideration of family preference, the provider may discharge the young person from MRSS and re-admit the young person to MRSS, if needed and desired by the family, when the child returns home.

Note: Services provided to youth and families while a youth is a patient of a behavioral health inpatient unit are not currently Medicaid reimbursable.

## **Administration**

Providers considering implementation of MRSS should begin to build organizational capacity to start a new best practice service, strategically manage growth to accommodate the service from start-up to full service, understand how MRSS is different than other crisis services, coordinate with other crisis services to ensure that families are seamlessly served, and be willing to champion the service both within the organization and externally across community partners.

## A. Provider Certification

A provider must submit application for interim certification to OhioMHAS' Office of Licensing and Certification to add MRSS as a new service via the Licensure and Certification Tracking System (LACTS) and provided verification of policies/procedures and staffing plan. Additionally, a provider will need to meet the requirements outlined in the OhioMHAS Rule 5122-29-14, (E). Upon approval, the Department shall issue an interim initial six-month certificate.

MRSS providers will have an initial fidelity review no more than twelve months from the initial date of interim certification and can achieve full certification once the agency has passed a fidelity review within three years from the date of interim certification. For continuing full certification, each MRSS provider will achieve and maintain a minimum benchmark score of twenty-six as a component of overall fidelity. Once a provider has achieved full certification, subsequent fidelity reviews will take place annually and be based on performance from the previous 12 months.

Providers can remain in interim status up to 18 months (1<sup>st</sup> interim certificate is for six months and can be extended for up to two additional six-month periods). An onsite survey is scheduled based on when the provider has enough clinical charts to review for MRSS and the five required services. The provider stays in interim status up to 18 months until the onsite survey and any subsequent findings from an onsite survey have been corrected.

## B. Fidelity Reviews

The fidelity reviews will be conducted by Case Western Reserve University's CABH COE, delivered through the Center for Innovative Practices at the Begun Center for Violence Prevention, Research and Education.

The MRSS provider will:

- Have an initial fidelity review no more than twelve months from the initial date of MRSS interim certification issued by OhioMHAS.
- Be operational for at least three months prior to requesting a fidelity review.
- Have provided at least ten episodes of MRSS care beyond the Screening and Triage phase, of which at least five must include episodes with both the Mobile Response and Ongoing Stabilization services.
- Have regular repeat fidelity reviews, no more than twelve months from the report date of the previous fidelity review.

Providers are encouraged to consult with the Center of Assessment and Evaluation Services at Bowling Green State University (BGSU) and the Case Western CABH COE to determine readiness for the fidelity review. Once ready, the provider will request a review through the CABH COE.

Fidelity reviews will include the assessment of the OhioMHAS approved set of benchmarks and fidelity measures. Benchmarks and fidelity measures may be updated as necessary to address network trends or new areas of focus. When such changes occur, fidelity reviews will be based

on measures in place at least six months prior to the review. The MRSS Fidelity Tool can be found at: <https://mrssohio.org>.

At any time after certification of the MRSS service, OhioMHAS may request a new fidelity review based on specific findings of non-compliance.

### **C. Marketing**

MRSS fills a gap in the continuum of crisis services for young people and their families. Informing the public of this service requires intentional marketing and communication planning to disseminate materials across community systems and groups, through mass communication channels and one-on-one or group meetings. Examples of community systems and group outreach opportunities include kinship navigator support meetings, local school district staff and parent meetings, law enforcement roll calls, children’s services team meetings, hospitals, Board of Developmental Disabilities team meetings, among others.

All marketing should promote the MRSS Statewide Call Line Number 1-888-418-MRSS (6777) and include the OhioMHAS approved MRSS logo.

### **D. Data Management**

All MRSS referral, intake and discharge data must be entered into the MRSS DMS. Such data will be utilized to monitor overall service delivery, identify areas for improvement, track progress towards achieving benchmarks and monitor many of the MRSS fidelity measures. Additionally, data can be used: 1) by providers to inform and strengthen program operations and to generate site or county specific reports; 2) by OhioMHAS and other state partners to identify system trends, gaps and needs; and 3) by Case Western Reserve University’s CABH COE to identify and oversee training needs and other quality improvement activities.

Once a provider agency has received an interim certification to provide MRSS, a lead agency administrator should request access to the MRSS DMS from OhioMHAS. After provider-level access is obtained, the provider will be responsible enrolling and granting access to the DMS for their MRSS staff or other agency staff, as appropriate.

The MRSS provider is responsible for ensuring that all team members are trained in the data management system, understand the importance of accurate, timely and thorough data entry, and demonstrate proficiency in using the system. Recorded trainings on the MRSS Data System are available via the Ohio MRSS website (<https://mrssohio.org>). MRSS team members are also encouraged to attend the monthly Data Learning Community provided by Center of Assessment and Evaluation Services at Bowling Green State University (BGSU). Additional MRSS data management training, support and technical assistance is provided by BGSU and Accenture and may be requested by contacting OhioMHAS.

OhioMHAS, as referenced above, can be contacted at [OhioMRSS@mha.ohio.gov](mailto:OhioMRSS@mha.ohio.gov).

## E. Quality of Care and Quality Improvement

National best practices for high-quality MRSS services include quality assurance and improvement processes and activities, frequently administered by a “lead quality entity.” The CABH COE, in conjunction and at the request of OhioMHAS, will be responsible for coordinating and overseeing such activities.

### Notes:

- Additional MRS resources, upcoming trainings and events, and requests for consultation and technical assistance can be found by visiting the MRSS Ohio website at
  - <https://mrssohio.org> or by contacting OhioMHAS at [OhioMRSS@mha.ohio.gov](mailto:OhioMRSS@mha.ohio.gov) .
- Please reference the Ohio Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual for guidance on billing Medicaid for MRSS services. [https://bh.medicaid.ohio.gov/Portals/0/BH%20Manual%20v%201\\_25.pdf](https://bh.medicaid.ohio.gov/Portals/0/BH%20Manual%20v%201_25.pdf)