Ohio | Department of Mental Health and Addiction Services

**Practice Manual**
**Mobile Response and Stabilization Services**
Version 1.0 –September 2021

**Table of Contents**

## Overview

The Mobile Response and Stabilization Service (MRSS) Practice Manual is authorized by the Ohio Department of Alcohol and Addiction Services and serves as the basis for process improvement and expansion of MRSS to improve behavioral health services for the state's young people. The intent of this manual is to establish expectations for operational components and to guide implementation, while allowing ample flexibility to accommodate county/regional needs and practice innovation. The Practice Manual outlines the goals, guiding principles, eligibility criteria, service components, implementation models, best practices, roles and responsibilities, metrics and resources recommended for MRSS. The Practice Manual has been developed through a consensus process including the Ohio Department of Alcohol and Addiction Services, County Board Authorities, service providers, peer supporters, parents, youth and Ohio and national professionals with expertise in children's crisis services and mobile response and stabilization. The practice manual is based on best and promising practices from Ohio and other statewide MRSS programs including Connecticut, Michigan, Maryland, and Nevada.

## MRSS Within the System of Care

MRSS was developed in 2018 as a new service in Ohio's youth behavioral health system of care. MRSS is integrated as an essential service within Ohio's system of care to fill a gap for families seeking services for urgent behavioral situations before they become unmanageable emergencies. Available to all young people and their families across the state, MRSS is instrumental in averting unnecessary ED visits, out-of-home placements and placement disruptions, and in 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 viable alternative to acute care and residential treatment because they consistently demonstrate cost savings while simultaneously improving outcomes and achieving higher family satisfaction.

As part of its effort to launch the next generation of its managed care program, the Ohio Department of Medicaid (ODM) will implement OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multi-system needs. OhioRISE services include intensive care coordination, Intensive Home-Based Treatment (IHBT), Psychiatric Residential Treatment Facility (PRTF), MRSS and behavioral health respite.

## MRSS Definition

MRSS is a structured community based, in-person, intervention and support service for youth and families, provided by a mobile response and stabilization service team. It is a prevention-focused emergency program that serves as a gateway to other services across the system of care; and a diagnosis is not required for eligibility of MRSS services, though a diagnosis may be required by the payor. (Refer to payor requirements).

MRSS is designed to promptly address situations in which young people are experiencing emotional symptoms, behaviors, or traumatic circumstances that compromise or impact their ability to function within their family, living situation, school, or community. The youth and family guide MRSS interventions, with the strengths and needs of the young person and family determining the types and mix of services and supports provided.

**Rationale**

Because options for assistance can be limited when young people experience a behavioral health crisis, families often turn to law enforcement, hospital emergency departments and inpatient treatment for help. The MRSS service delivery model is designed to prevent: 1) the unnecessary use of emergency departments or acute care services, 2) placement disruptions, and/or 3) involvement in the juvenile justice system. MRSS is more than a mental health service as it can intercede proactively with any young person experiencing distress due to acute trauma, such as placement disruption, conflict within the family, or other events in the school or community.

MRSS is different than traditional services: It provides an effective alternative to more restrictive services or inpatient treatment when it is safe to do so. MRSS services are initiated in response to young people who are experiencing significant emotional and behavioral distress. It should be noted that families and other referrers may define "crisis" or the need for services differently than traditional behavioral health professionals.

MRSS provides rapid intervention at the time the youth or family needs help. MRSS is not an office-based service; services are provided where the crisis occurs or at a community location requested by the family or other referrer. The MRSS-trained team — which includes an independently licensed MRSS supervisor, clinicians, peer supporters and other paraprofessional staff, work closely with the young person, family and other supports (such as schools) — to provide immediate, on-site response and de-escalation, followed by up to six weeks of stabilization. The MRSS team works collectively with the youth, family and/or supporters to create a safety plan, set and achieve short-term goals and develop resources, including formal, informal, and natural supports (see page 19 for definitions), to empower the family after the MRSS episode of care is complete. Psychiatric consultation is also available, if needed.

When families are part of youths' lives, MRSS works with young people to resolve their distress in the context of their family, and engages the whole family in planning, skill building and resource development to prevent future crises from occurring.

**MRSS Goals and Objectives**

**A. MRSS Goals**

a. Provide immediate intervention to assist young persons, families/caretakers and other youth-serving entities in de-escalating/ stabilizing behaviors, emotional symptoms and/or dynamics impacting the young person's life functioning ability.
b. Effectively engage, assess, deliver, and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve life functioning.
c. Provide timely community-based interventions, skill building and resource development.
d. Mitigate risk and increase safety.
e. Prevent/reduce the need for care in a more restrictive settings, such as an inpatient psychiatric units or detention centers.
f. Support the young person to remain in, or return to, their present living arrangement and function in school and community settings.

g. Improve caregiver's skills to manage behavior and prevent future crises.
h. Facilitate the young person and caregiver's transition into identified supports, resources, and services: e.g., intensive care coordination utilizing high fidelity wraparound; evidence-based and promising community-based treatment services; community-based supports; and natural resources.

B. **MRSS Objectives**

MRSS clinical services are guided by twelve objectives in three areas: Young Person and Family; Provider; and System.

**Young Person and Family Objectives**

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

**Provider Objectives**

a. Provide behavioral health stabilization services that are delivered in the home, school, and community, and that are responsive to youth and family needs.
b. 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 risk or safety issue.
c. Include family members and informal supports in all aspects of the assessment, planning and treatment process.
d. Link to existing providers and supports, or facilitate linkage and transfer to appropriate level of services and supports

**System Objectives**

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

**Intersystem Collaboration**

The MRSS model requires collaboration across community systems with formal and informal linkages between child-serving agencies and programs, including across administrative and funding boundaries. MRSS exists along a continuum of care, the primary goal of which is to evaluate the situation for safety, followed by efforts to de-escalate behavior and stabilize the family. As the crisis stabilizes, it is essential that a well-developed continuum is available within the community to refer the family for ongoing support and services. In conjunction with other providers and the family, the MRSS provider will

develop a plan for ongoing supports and services after the family transitions from MRSS to address the underlying difficulties that led to crisis and to avert future behavioral health emergencies.

MRSS providers are encouraged to identify how MRSS fills service gaps across child-serving agencies in the community and to establish formal Memorandums of Understanding (MOUs). For example:

- An MOU between the MRSS provider and the local school district(s) to deploy an MRSS team for a mobile response when a young person is in distress.
- An MOU between the MRSS provider and the Department of Children's Services to deploy an MRSS team for a mobile response when children are entering out-of-home placement for the first time or during subsequent placement disruptions, with the goal of smoothing the transition and stabilizing the young person in their new living situation.

**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 Ohio. Families need not be involved with a specific service or system in order 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. Since any of these referrers may define crisis differently than a clinical practitioner, MRSS services may and should be provided in situations that many clinical practitioners would not typically define as a crisis. 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 development of adaptive socio-emotional skills and strengths critical for healthy life functioning. Without intervention, these youth — many with histories of trauma — may be at risk of psychiatric hospitalization, out-of-home treatment, legal charges, or loss of their living arrangement. Examples of a youth- or family defined crisis that prompts a call for help may include when a young person is "out of control" or destroying property; traumatized after a personal, familial or community tragedy; threatening self-harm or harm to others; significantly withdrawn/ "shut down;" and refuses or is unable to come out their room and/or go to school.

C. **Referrals to MRSS**

MRSS services can be initiated by:

a. the young person, family or other youth-serving referrer (after consulting with families when available) calling the call center (once established) and requesting MRSS for a young person in crisis. The call center then conducts a brief triage and connects the caller to a local MRSS provider through a warm handoff; or
b. the young person, family or other youth-serving referrer (with families, as above) calling the MRSS provider about a youth in crisis; or
c. a law enforcement officer contacting the call center or MRSS provider about a youth in crisis.

Once contact with the local MRSS provider is initiated, the MRSS team will conduct a brief triage and will arrange for a mobile response to take place immediately or at a time requested by the family or other referral source.

Note: Most requests for MRSS will be initiated via a single point of access call center, once established.

**D. Service Re-Engagement**

Families who disengage from MRSS are able to re-engage with MRSS at any time. When families chose to dis-engage with MRSS at any point in the service they can re-engage at any time. Families who have been discharged from MRSS service, can initiate another episode of MRSS service at any time. If families are referred to the hospital during MRSS care, upon release, the MRSS provide may re-engage with the family.

**E. Service Availability**

Within one year from the date of initial certification from OHMHAS, providers must have MRSS available twenty-four hours a day, seven days a week, 365 days a year. Trained MRSS staff must be available to receive and triage calls for service and to respond to the location where the young person is experiencing the crisis or where the family requests services, not at a static location where the person must present themselves. Providers will arrive within in 60 minutes for MRSS calls warranting an immediate response and within 24 hours for MRSS calls deemed non-immediate when requested by the family. (See page 15 for definition of immediate vs non-immediate.)

**F. Service Location**

MRSS services are provided at the location of the young person in distress or at a community location preferred by the youth, family or other referrer.

**G. Parental Consent**

While minors usually need the consent of a parent or guardian before receiving medical care, including behavioral health care, a minor with a life-threatening emergency 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, 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 can give consent to services.

**H. Length of Stay**

The MRSS mobile response, safety planning de-escalation phase lasts for up to 72 hours. Ongoing stabilization lasts for up to six weeks. Additional time may need to be authorized by the payor. If a family needs more than six weeks, prior authorization and justification may be needed.

**I. Intensity**

On average, young people and their families will receive two in-person contacts from the clinician and/or peer supporter for every seven days of service. Response is based on current assessment, acuity of youth and family needs, and agreement with the family. For these reasons, some families will receive more than two visits while others receive one. No family will receive fewer than one in-person visit per seven days of service, except in rare circumstances.

**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 availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for young people and their families (when services are available in the local community) to address their identified physical, emotional, social, and educational needs. 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:

a. Safety planning
b. Defining areas where help is needed
c. Participating in all planning meetings held about the youth and family
d. Goal setting
e. Identifying skill-building opportunities
f. Determining service intensity
g. Determining location of services
h. Identifying referrals to resources post MRSS involvement

**K. Cultural and Linguistic Competency**

a. The MRSS provider must offer culturally and linguistically appropriate services to all young people and families that receive MRSS. The provider also must offer high-quality, effective, equitable, understandable, and respectful care that is responsive to diverse cultural beliefs and practices, preferred languages, health literacy and other communication needs. Culturally competent care includes hiring of bilingual or multilingual MRSS clinicians and peer supporters to meet community needs as well as hiring staff that reflect the demographics of the population being served.
b. All written materials, including MRSS Plans, safety plans and consent forms must be available and understandable to families. They must be written at an appropriate reading level and in the language of the youth and family. Materials must be reviewed and approved by the family to ensure that they are culturally relevant and that they understand the material. If necessary, a qualified translator should be used to assist in this process.
c. Cultural needs and preferences of the young person and family are assessed and incorporated into plans, services provided and linkages to community supports.
b. Staff have knowledge of unique cultures in their service areas and culture specific values and practices which may impact service delivery.
c. Agency assesses factors related to disparities in access, utilization, and outcomes of MRSS services and implements strategies to mitigate their impact.
d. Interpretation services are available to accommodate predominate language spoken in the home. Professional translation services are required when staff members are unable to accommodate language needs.

### 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. Most youth seeking MRSS have experienced significant trauma, and, in turn, many behavioral health crises are rooted in trauma. Crises may be compounded when intervention involves loss of freedom; noisy and crowded environments; and/or the use of restraints, such as what might be experienced in emergency departments, inpatient units or detention centers. These situations can traumatize/ re-traumatize individuals leading to worsened symptoms and a reluctance to seek help in the future. Environments and treatment approaches that are safe and calming, on the other hand, can facilitate healing. Thus, trauma-informed care is an essential element of MRSS, and MRSS providers must ensure that the following principles are integrated into service delivery.

Guiding Principles for Trauma-Informed Care, as established by SAMHSA in 2014:

a. Safety
b. Trustworthiness and transparency
c. Peer support and mutual self-help
d. Collaboration and mutuality
e. Empowerment, voice and choice
f. Ensuring 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.

### M. Telehealth

The best practice is for the mobile response and ongoing stabilization services to be provided 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. 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 to do so.

## MRSS Staffing

### A. Staff Composition

It is essential that the MRSS provider have a fully developed, multi-disciplinary MRSS team to ensure its capacity to provide the appropriate care at the appropriate time. At a minimum, a fully staffed MRSS team includes an MRSS-trained supervisor, clinician, peer supporter or Qualified Behavioral Health Specialist (QBHS) and a psychiatric consultant/ provider.

## Supervisor

MRSS requires both administrative and clinical supervisor responsibilities, which can be carried out by one or more individuals designated as MRSS supervisor and who have appropriate licensure for the responsibilities performed.

### Supervisor Licensure

The MRSS Supervisor must be an independently licensed behavioral health professional.

### Primary Supervisor Responsibilities

a. Supervise MRSS clinicians.
b. Supervise MRSS peer supporters, regardless if hired by the provider or contracted from another agency.
c. Have 24/7 availability for MRSS staff.
d. Train staff on the MRSS model.
e. Ensure the model is being implemented with fidelity.
f. Ensure paperwork is completed with appropriate signatures.
g. Improve quality within MRSS – oversee data input and utilize data for performance monitoring, improvement, and planning.
h. Convene regular, data-driven all-team meetings. Meetings should utilize an efficient, consistent process to allow participants to review progress of high acuity and/or complex youth and make intervention decisions to ensure families meet their identified goals.
i. Provide Initial and ongoing consultation on enrolled youth and families.
j. Provide community education and outreach to child-serving systems and agencies across the service region.
k. Providing a mobile response when other MRSS clinicians are not available.

## Clinician

### Clinician Licensure

A clinician, as identified in rule 5122-29-30 of the Ohio Administrative Code, can either independently diagnose behavioral health disorders or diagnose behavioral health disorders under supervision. The clinician can hold a valid and unrestricted certification or license or can be a bachelor-level clinician working under the supervision of an independently licensed individual who can diagnose. This provider must also demonstrate and maintain competency in the under 21 years of age population.

### Clinician Responsibilities

a. Provide the mobile response and Ohio Brief CANS assessment, inclusive of a risk assessment for a young person in crisis
b. De-escalate the presenting crisis during the mobile response and subsequent crises during MRSS care.
c. Create a safety plan and an MRSS Plan with the young person and family.

d. Conduct necessary assessments to determine young person and family needs, including the Ohio Brief CANS.
e. 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 are needed.
f. Secure appropriate approvals on plans and plan revisions.
g. Develop a transition plan with the young person and family.
h. Initiate transition to clinical and natural supports throughout the stabilization and transition phases.
i. Ensure materials are culturally appropriate and in language of origin of young person and family.
j. Collaborate with the MRSS peer supporters and paraprofessionals to define and achieve family goals.

**Peer Supporter or Qualified Behavioral Health Specialist (QBHS)**

**Peer Supporter Certification**

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

**QBHS Certification**

The QBHS must hold a valid and unrestricted certification from OhioMHAS in accordance with Ohio Administrative Code 5122-29-30. This QBHS demonstrates competency in the care and services of individuals in the under 21 years of age population and has scope of practice for persons age under 21 with mental health disorders and substance use disorders.

**Peer Supporter or QBHS Responsibilities**

a. Use lived experience to assist young person and family (peer supporters)
b. Provide initial and follow-up responses as available and within scope of role
c. Establish a trusting relationship with the young person and their family
d. Collaborate with all MRSS team members to define and achieve family goals
e. Work with the young person and family to ensure that the care plan is representative of their values and needs
f. Role model and provide non-clinical interventions to assist the family
g. Identify natural resources within the community that can be helpful
h. Connect the young person and family to resources to help meet basic family needs
i. Work with the young person and family to access and utilize cultural supports

**Peer Supporter Role**

A transformative element of MRSS is to fully engage peer supporters with lived experience as core members of the MRSS team's engagement efforts. 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 of the peer modeling, stabilization and future crisis aversion is possible.

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

a. Have leadership and MRSS staff attend the "Engaging Peer Supporters" training
b. Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion and lived experiences.
c. 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.
d. Includes 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**

**T**he MRSS team must have access, either through an MRSS staff member or by contract, to a board certified or board-eligible psychiatrist or psychiatric nurse practitioner during the hours of MRSS operation. The psychiatrist or psychiatric nurse practitioner must hold a valid and unrestricted license to practice in Ohio.

The licensed psychiatrist or certified psychiatric nurse practitioner will be responsible for the psychiatric consultation for MRSS enrolled young people, and, when warranted, psychiatric evaluations, medication assessment and management, and related clinical functions. The psychiatrist or certified psychiatric nurse practitioner generally provides their services at the request of the MRSS therapist or team.

Psychiatrists must be a licensed psychiatrist (M.D.) with board certification or board eligibility in child and adolescent psychiatry; or a licensed psychiatrist with substantial experience in child/adolescent psychiatry. The psychiatrist shall also have residency or subspecialty training and/or fellowship experience. Certified psychiatric nurse practitioners must be licensed, and board eligible/certified with expertise and training in delivering behavioral health and medication management services for children and adolescents.

**B. Staffing Levels**

Staffing levels will be established as necessary to achieve the key benchmarks of response time, mobility, the provision of stabilization services and family engagement. 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 be able to achieve short-term goals within a crisis driven environment. 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 changing circumstances and client needs. Collectively, MRSS teams and provider agencies must possess the following competencies.

**Core Competencies:**

a. Cultural competency
b. Trauma informed care
c. Marketing and communication – communicating the MRSS service
d. Care management, linkage and referral
e. Family engagement

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

a. Conduct crisis assessments, including mental status, diagnostic and lethality assessments
b. Stabilize and de-escalate youth and/or family crises
c. Develop actionable safety plans in partnership with youth and family
d. Monitor youth and family safety
e. Implement means reduction and safety precaution plan
f. Effectively engage with youth and family
g. Co-develop the MRSS Plan with the team members and the young person and family

**Assessment Competencies:**

a. Functional analysis
b. Conduct Ohio Brief CANS (certification)
c. In absence of CANS assessment, needs, strengths and supports assessment
d. Assess contextual functioning (school, home, community, peers)
e. Identify early warning signs and emotional escalation cues

f. Assess needed skill sets/coping strategies
g. Assess youth/family crisis escalation and distress patterns, utilizing the Contextual Crisis

**Crisis Prevention Competencies:**

a. Ability to teach caretakers to identify early warning signs and develop strategies for preventing further escalation
b. Ability to implement a youth and family support plan
c. Ability to design and implement strategic accommodations based on functional needs

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

a. Social problem solving and decision-making
b. Coping skills
c. Youth and family communication skills
d. Parenting skills
e. Collaborative problem solving
f. Emotional regulation and distress tolerance skills
g. Family co-regulation skills
h. Family remediation following a crisis

**Transition Competencies:**

a. Ability to develop effective transition plans (linkages, supports, services)
b. Meeting facilitation skills

**D. Staff Development and Training**

The Ohio Center of Excellence at Case Western Reserve University, the state-designated training center, in partnership with OhioMHAS, 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 all required trainings. Training will include core training modules and additional training modules delivered at various times and locations throughout the year.

Anyone who is providing MRSS services is required to complete the 2-day MRSS Core Essentials Training within 60 days of hire or within 60 days of MRSS program start-up followed by a minimum of 3 days of competency and practice-based booster trainings per year.

MRSS Supervisors must complete the 2-day MRSS Core Essentials for Supervisors within 60 days of hire or within in 60 days of MRSS program start-up. Supervisors and clinicians are encouraged to attend the Engaging Peer Supporters training within six months of program start-up.

MRSS providers must incorporate OhioMHAS approved trauma-informed care training and cultural competency training into each team member's new-employee orientation with booster sessions delivered as needed.

**MRSS Service Delivery**

MRSS consists of primary activities: screening/triage, mobile response, and ongoing stabilization. Some young people will complete screening/triage and the mobile response but may not need, or choose, to

move on to stabilization. Youth and families who do not move on to stabilization are still considered MRSS to have received the service.

Evidenced-based practices are employed in all phases of MRSS and incorporate strengths-based, solution-focused, youth and family centered/driven, trauma-informed and culturally responsive care. MRSS is time-limited (up to six weeks). Goals and interventions should be achievable during this time period, and linkages and referrals should be initiated early. In addition to MRSS team interventions, psychiatric consultation and interventions should be implemented as warranted throughout MRSS involvement.

**A. Screening/Triage**

MRSS services may be initiated by calling the local MRSS provider or by calling the MRSS call center (once established). Calls made to the call center will be warm transferred to the local team. Upon receiving a call for MRSS service, the MRSS provider conducts a brief triage to gather information on the crisis and determine an appropriate response. If 911 is not indicated, the MRSS team should conduct a mobile response. Prior to traveling to meet with the youth, the MRSS team should ask the caller about potential safety concerns such as the presence or intoxicants, weapons, and/or uncontained animals and work with the caller to ensure the team's safety.

MRSS is often initiated by a caretaker. When a request for MRSS is made by another party – such as a school staff – efforts should be made to reach the youth's caretaker. It is noted that at times family members are unavailable when a crisis occurs. Continuous efforts should be made to contact them prior, during and after the mobile response.

When a call for MRSS is received by the call center or the MRSS provider, the person receiving the call will triage the call and work with the family to determine if the mobile response is to be provided as immediate or non-immediate. Ultimately, it is the family who determines if the mobile response needs to be immediate or non-immediate. Based on family preference, the call is coded as immediate or non-immediate and once the call is coded, the clock for response time begins. An ***immediate*** response involves deployment of an MRSS team member(s) to the location of the crisis within 60 minutes of the call. A ***non-immediate*** response involves the deployment of an MRSS team member(s) to the site of the crisis at a time requested by the family, but not to exceed 24 hours after the contact with the family. For example, a call that may be coded as non-immediate involves a family who may request a later response because one parent is at work and the family wants both parents to be present, so they ask for the response to occur in 2 hours instead of sixty minutes. It is expected that all MRSS calls will be ***immediate*** unless the young person or family requests a ***non-immediate*** response. For calls that are coded immediate, the person receiving the call will connect the family directly to the MRSS staff person who will be providing the mobile response. It is expected that the family will not have to wait for a call back from the MRSS team member. Any circumstances where an MRSS team member(s) is not deployed within 60 minutes for an immediate response or 24 hours for a non-immediate response must provide documented justification for the delay.

With limited exception, all non-immediate calls must be responded to within 24 hours. When requests for responses exceed 48 hours, families or other referrers may benefit from referrals to

more appropriate services. Referrers are encouraged to call MRSS back if a crisis requiring a timelier response occurs.

If a young person is already involved with an intensive home-based service (IHBT, ICC or MCC), the MRSS team is dispatched to de-escalate the presenting crisis. After the first mobile response visit occurs, the family is re-connected with the existing service within 24 hours and does not move on with the MRSS service.

## B. Mobile Response

The mobile response and de-escalation period can last up to 72 hours. The goals of the mobile response are to assess and address immediate safety concerns, de-escalate the crisis, provide stabilization, establish a safety plan and arrange for follow-up care.

The best practice is for a team — typically a clinician and a peer supporter — to respond to all requests for MRSS services. If the response is done by a single team member, that team member must be a licensed clinician who can either independently conduct assessments and diagnose behavioral health conditions or who can do so under supervision by an independently licensed professional and must have completed the MRSS Core Essentials Training.

After hours and immediate response staff are not required to be members of the full-time MRSS team, but, either staff of the agency or contracted to provide services by the agency, these providers must be a licensed clinician who can either independently conduct assessments and diagnose behavioral health conditions or who can do so under supervision by an independently licensed professional and must have completed the required MRSS Core Essentials Training.

The mobile response team member(s) will mobilize to arrive at the location of the behavioral health emergency, or a location specified by the family within 60 minutes for MRSS calls warranting an immediate response and within 24 hours for MRSS calls deemed non-immediate. (See page 15 for definition of immediate vs non-immediate.).

The MRSS team responds without law enforcement accompaniment unless special circumstances warrant inclusion to support the MRSS team member(s) and ensure safety. Such circumstances can include, but are not limited to, domestic violence, a weapon in the home, or if the police are already involved and have requested mental health intervention for the young person and family.

### Initial Meeting

The MRSS team member(s) should glean information from everything they see. Team member(s) should also hear the perspectives of both the young person and caretakers and, with permission, other involved people. Prior to leaving the initial visit, next steps and details for follow-up care should be established.

During the initial meeting, several activities occur including:

a. Crisis assessment, including a mental status exam; assessment of risk to self and others; assessment of other high-risk behaviors (e.g., fire setting); medical/physical

concerns, including alcohol or substance use; and other psychosocial factors that may contribute to the current crisis (e.g., current or historical trauma, family involvement, conflicts and support, legal involvement, and school/ vocational functioning, and social supports).

b. Observation of interactions between family members or other involved people that may contribute to the current crisis or help to mitigate future crises.
c. Identification of strengths, resiliency factors and needs
d. Identification of coping strategies and tools used to produce or maintain calm
e. Identification of triggers to current crisis.
f. Development of safety plans in partnership with the young person and/or their family, obtaining family approval and supervisor consent, verbally or in writing. All families should be provided a copy of safety plans.
g. Obtaining necessary releases and permissions.
h. Determining an initial disposition, in consultation withs supervisor.

**First 72 hours**

Throughout the first 72 hours additional activities include:

a. Ongoing risk and safety assessment.
b. Continued crisis stabilization.
c. Define goals for preventing future crisis and the evaluating need for ongoing stabilization.
d. Consult and begin coordination with the school, primary care physician, existing providers/services and other care coordination programs.
e. Initiate referrals/ linkages to formal, informal and natural supports. (See definitions below.)
f. Follow-up visits and contact based on acuity, clinical need and family preference.
g. Prepare for transition to the Ongoing Stabilization phase of MRSS including:
    - Administration of the Ohio Brief Child and Adolescent Needs and Strengths (CANS) tool including an assessment of young person and community safety, caregiver capability, and clinical risk, social and natural supports. This must be performed by a provider who is a qualified CANS assessor. Note: Ohio Brief CANS assessments completed in the in past 60 days can be updated and utilized for MRSS
    - Development (with the youth and family) an MRSS Plan. (See below.)

Note: If the mobile response results in hospitalization of the young person, the stabilization phase can be initiated upon release from the hospital stay.

- **MRSS Plan**

  MRSS requires the development of an MRSS Plan with the young person and family, which includes an achievable number of goals and objectives that are designed to ensure safety and build distress tolerance and self-regulation skills, while initiating linkage to longer-term supports when family need indicates. An MRSS Plan shall be developed to de-escalate the crisis, stabilize the young person and family, restore safety, provide referral, and linkages to appropriate services, and coordination with other systems. (OAC 5122-29-10) The MRSS Plan is not a treatment plan, and a diagnosis is not required to receive MRSS services

(though may be required by funders and/or agency for credentialing purposes). If a child has an existing treatment plan, the MRSS Plan should be aligned with that treatment plan.

Components of the MRSS Plan should include:

a. Demographic information
b. Family crisis cycle
c. Identified needs of the young person and family
d. Young person and family identified short term goals
e. Interventions to achieve the identified goals
f. Young person assets and strengths
g. Risks and responses to risks
h. Natural, family and community supports
i. Formal and informal linkages needed to be made to ensure sustainability post MRSS involvement
j. Relevant medical information Including a listing of medications and diagnosis if indicated

**Additional Mobile Response Episodes**

Additional mobile response episodes may be provided during the ongoing stabilization period when circumstances warrant such episodes.

**C. Ongoing Stabilization**

Based upon need and willingness of the young person and their family, MRSS participants enter stabilization following the completion or review of the Ohio Brief CANS and the development of an MRSS Plan. (See above.) Unless a new crisis emerges, interventions during stabilization are typically specified on the MRSS PLAN.

The primary objectives of stabilization include addressing the young person and family's needs and helping to facilitate successful transition to identified supports, resources and services in their community. This may involve linking the family with wraparound services, outpatient services, long-term counseling, evidence-based services and community-based supports. Interventions must be strengths-based, youth centered, family-driven, trauma-informed and culturally and linguistically competent. Interventions will vary by setting, intensity, duration and identified needs.

Stabilization Interventions typically include skill building of the young person and family, capacity building to prevent future crisis, facilitating an ongoing safe environment, linking the person to natural and culturally relevant supports and promoting the young person and family's resilience.

Stabilization activities include but are not limited to:

a. Continued assessment and ongoing monitoring of the safety plan.
b. Solution-focused interventions (reframing, rating scales, "miracle questions," etc.).
c. Teaching new communication, problem solving, coping and behavior management skills.
d. Psychoeducation.
e. System navigation.
f. Caretaker support, advocacy and empowerment.
g. Referral for psychiatric consultation and medication management if indicated.

h. Advocacy and networking by the provider to establish linkages and referrals to appropriate natural and clinical supports and services that will sustain engagement post MRSS (See below.).
i. Coordination of specialized services to address the needs of young people with co-occurring intellectual/developmental disabilities and substance use.
j. Convene or participate in planning meeting(s) with the young person, family and cross system partners for the purpose of developing linkages to ongoing services and supports when family need indicates.
k. Care coordination (see below); and
l. Review of progress/gains made during stabilization by youth and family, focusing on youth and family's role in achieving gains. (See below.)

**Use of Evidence Based Practices**

It is expected that stabilization will include Evidence Based Practices (EBP's) and strategies to ensure young people and their families efficiently and effectively achieve their stated goals. Due to the multiplicity of presenting concerns (e.g., family dynamics, trauma histories, developmental stages, cognitive abilities, and diagnoses) of the youth and families served in MRSS, the MRSS team should have the capability to provide an array of evidence-based and best practices that are matched to and address these issues. MRSS clinicians will evaluate the efficacy of these practices for the young person and their family based on information gathered through the assessment. Best practices are to be incorporated during the stabilization period and when considering services that will support the families beyond MRSS involvement.

While it is beyond the scope of this manual to list all possible EBP's for the multiplicity and combinations of concerns that youth and families present with for MRSS, the following are some examples that could be implemented within the MRSS framework: 1) motivational interviewing; 2) collaborative problem solving; 3) skills and techniques from solution-focused therapy; 4) skills/techniques from parent-child interaction therapy (PCIT); 5) assertiveness training (communication skills); 6) cognitive behavioral therapy (CBT)-suicide prevention; 7) trauma-focused CBT; 9) dialectical behavior therapy (DBT); 8) Collaborative Assessment and Management of Suicidality (CAMS)

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

When implementing evidence-based practices, specialized training and certification in these areas is generally required.

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

During stabilization, the MRSS team will work with the young person and the family to identify and link to formal (when necessary), informal and natural supports that will engage 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.
- ***Informal resources and supports*** are resources that already exist in the family, their support network, or in their community. They often cost little or nothing and provide support to the family. For example, a community may have a strong community center or library that provides activities that the family likes to do.
- ***Natural 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, etc.

Warm hand offs to both clinical and natural supports and services may take time. The young person and family to the supports and services they will utilize post MRSS involvement should begin early in the MRSS intervention.

**Ongoing assessment and planning**

The MRSS PLAN and safety plan should be reviewed and updated frequently — typically once each week — for ongoing identification of youth and family risks, needs, strengths, and barriers, as well as needed resources and community supports.

**Facilitated Youth and Family Planning Meetings**

When available, coordination meeting(s) (e.g., wraparound or similar) should be convened with family approval and participation to facilitate post-MRSS supports and services for the youth and family. When service coordination is unavailable in the community, an MRSS staff member who is trained in facilitation will lead youth and family planning meetings. Facilitated youth and family team meetings should occur as soon as possible during MRSS, but no later than the third week of stabilization to ensure that service connections occur.

**Transition**

With the family's permission, the MRSS team will share information with other service providers, including by video and/or telephone, and with the young person and/or family present. Transition out of MRSS includes reviewing newly formed coping skills and how future crises can be managed more effectively. Emphasis should be placed on what the family did for themselves to bring about change. 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 finalize a transition plan, including but not limited to the following action items:

a. A list of all upcoming appointments and activities includes the type of service, location, time, and contact information (i.e., name, phone numbers).
b. Follow-up items and actions that the young person and/or their family are responsible for arranging and/or accessing.
c. The safety plans.

Prior to discharge, the MRSS clinician will complete the MRSS discharge form.

## Administration

### A. Selection and Approval of MRSS Providers

To be certified as an MRSS provider, a community mental health services or addiction services provider must have the following MHAS certifications.

a. General services as defined in rule 5122-29-03 of the Ohio Administrative Code.
b. Substance Use Disorder (SUD) case management services as defined in rule 5122-29-13 of the Ohio Administrative Code.
c. Peer recovery services as defined in rule 5122-29-15 of the Ohio Administrative Code.
d. Community psychiatric supportive treatment as defined in rule 5122-29-17 of the Ohio Administrative Code.
e. Therapeutic behavioral services and psychosocial rehabilitation as defined in rule 5122-29-18 of the Ohio Administrative Code.
f. The community mental health services or addiction services provider must be able to provide all allowable services by telehealth as defined in rule 5122-29-31 of the Ohio Administrative Code.

Providers considering implementation of MRSS should be able to build organizational capacity to begin a new service, strategically manage growth to accommodate the service from start up to full service, understand how MRSS is different than other crisis services and be willing to champion the service both within the organization and externally across community partners. Ideally, MRSS providers will have a comprehensive set of services available to the young person and family.

### B. 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.

Many communication tools, including press releases, brochures and videos, have been developed by OhioMHAS and agencies already implementing MRSS in Ohio. These tools were designed to be shared across communities and are customizable to each MRSS provider.

### C. Data Management

Data collection and management are integral components of the MRSS provision. Data is used to identify quality improvement opportunities, system and model development needs, and to enhance many aspects of program operations including:

a. Identifying training and supervisory needs.
b. Monitoring and oversight of staff performance.
c. Measuring service delivery in accordance with fidelity measures.

d. Ensuring cultural and linguistic competency.
e. Demonstrating the need for collaboration and system alignment.
f. Administrative decision making.
g. Program effectiveness.

MRSS providers are required to complete the MRSS intake and discharge form and/or any other data collection forms. Data from these forms must be entered into the MRSS data management system within 10 days of intake and 10 days of discharge, and no later than the 10th of each month for the previous month. Data compiled in the MRSS data management system will be analyzed, disseminated, and utilized for program monitoring, program improvements and assessing fidelity to the model. Quarterly reports will be autogenerated for providers and boards

MRSS providers will work with the evaluator and the data collectors to oversee data management. Providers will be trained in data management, evaluation tools, the data management system, data entry, corrections, and reports, including customized reports. MRSS providers will receive monthly, quarterly, and yearly service delivery reports as well as biannual and self-assessment reports.

Data collectors with lived experience will collect outcome and satisfaction data and feedback about the MRSS service itself from consenting families. This outcome data will be linked to the provider by ID# and will be shared with providers and boards on a quarterly basis.

## D. Fidelity

Fidelity will be assessed using an OHMAS approved set of benchmarks based on the following indicators:

a. Response Coding: MRSS call for services is coded as immediate or non-immediate through the initial triage.
b. Response Time: Response time is within 60 minutes for immediate calls and within eight to 24 hours for non-immediate calls.
c. Duration of service delivery: Young people and their families are discharged within the six-week timeframe of MRSS.
d. Service intensity: Families receive an average of two visits per seven days of service.
e. MRSS Core Services: Services provided are comprehensive, as per model guidelines, and broad enough to meet families' needs.
f. Referrals and Linkages: Young people and their families are connected to formal, informal and natural supports.
g. Inclusion of Family: Family members input, and participation is integrated throughout MRSS involvement – in care planning, at team meetings and at any decision-making points during care.
h. Family Satisfaction Young people and their families report achieving goals through MRSS.

The MRSS self-assessment tool allows providers and their boards to assess organizational capacity and agency readiness to build MRSS, as well as to monitor progress towards fidelity standards. Providers can use the MRSS self-assessment tool to track their progress through the implementation of the MRSS with the understanding that it will likely take a year or more to

achieve full capacity. The MRSS self-assessment tool also can be used to establish benchmarks and timelines for implementation and to establish a guide for planning, coaching and support to implement with fidelity.

### E. Ohio Center of Excellence

The Ohio Center of Excellence is delivered through the Center for Innovative Practices at the Begun Center for Violence Prevention, Research and Education at Case Western Reserve University. The overarching role of the CABH COE is to assist the state in supporting system transformation efforts, building and sustaining capacity for evidence-based (EBP) and evidence-supported practices (ESP), and expanding service and care coordination capacity for children with complex behavioral health needs and their families. The key functions include: training, fidelity monitoring, professional development, coaching and consultation, evaluation, telehealth technical assistance, strategic business supports, health information technology, and Family First supports. The core services supported by the COE include: MRSS, Intensive Home-Based Treatment (IHBT); High-Fidelity Wraparound, Multisystemic Therapy, Functional Family Therapy, Ohio START, and early childhood best practices. The COE will coordinate the required training for the MRSS service in Ohio.