



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 Manual is authorized by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) 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 OhioMHAS staff, 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 youth mobile crisis programs across the country have consistently demonstrated 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.

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 utilize the options available to them, such as, 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, 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 independently licensed MRSS supervisor(s), licensed clinical staff, peer supporters and/or Qualified Behavioral Health Specialists, 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 20 for definitions), to assist the family after the MRSS episode of care is complete. Ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes is available as 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 supporting 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 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. MRSS services can be initiated by:

- a. a young person, family or other youth-serving referrer (after consulting with families when available) calling the call center 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. a 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 Availability

Within one year from the date of initial certification from OhioMHAS, 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.)

E. 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.

F. 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 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.

G. Length of Stay

MRSS screening, triage, and mobile response, can last for up to 72 hours. Stabilization lasts for up to six weeks. MRSS services reimbursed through OhioRISE or through Ohio Medicaid Managed Care Organizations must have prior authorization for services that exceed 42 days. (Other payors may have additional requirements.)

H. Intensity

MRSS services are provided through:

- a. Face-to-face contacts with the family: A member of the MRSS team meets (face to face) with one or more family members.
- b. Telephone contacts with the family: A member of the MRSS team had telephone conversations with one or more family members.
- c. Collateral contacts made with other agencies/individuals: A member of the MRSS team had telephone conversations or meetings with individuals who were not a member of the family system. This could include community members and/or professionals who were contacted during the provision of services.

On average, young people and their families will receive two face-to-face 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 will receive less.

I. 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 evidence-informed 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:

- 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

J. Cultural and Linguistic Competency

- a. The MRSS provider must offer culturally and linguistically appropriate services to all young people and families that receive MRSS. 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 should be written at an appropriate reading level and, where possible, in the language of the youth and family. Materials must be reviewed by and with 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.
- d. Staff have knowledge of unique cultures in their service areas and culture specific values and practices which may impact service delivery.
- e. Agency utilizes current information related to disparities in access, utilization, and outcomes of MRSS services to develop strategies for program improvement.
- f. Interpretation services are available to accommodate the primary language spoken in the home. Professional translation services are required when staff members are unable to accommodate language needs.

K. 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. 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.

L. Telehealth

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. 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 independently licensed clinical supervisor, licensed clinical staff, peer supporter or Qualified Behavioral Health Specialist (QBHS), and ready access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes as needed.

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 licensed by the State of Ohio.

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.

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 diagnose behavioral health disorders under supervision. The licensed staff holds a valid and unrestricted certification or license or work 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.

Licensed Behavioral Health Staff Responsibilities

- a. Provide the mobile response and Ohio Children’s Initiative 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 Children’s Initiative 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 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 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 meet the requirements of 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 practice
- 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. Crisis response and de-escalation

- g. Skill building and skill practice as directed by the MRSS Plan
- h. Role model and provide non-clinical interventions to assist the family
- i. Identify natural resources within the community that can be helpful
- j. Connect the young person and family to resources to help meet basic family needs
- k. 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. Commit to incorporating peer supporters in all aspects of the MRSS program
- b. Hire certified 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

The MRSS team must have access, either through an MRSS staff member or by contract, to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. It is preferable that these consultants have expertise and training in delivering behavioral health and medication management services to 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 high distress situations. 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 Children’s Initiative Brief CANS (certification)
- c. Assess contextual functioning (school, home, community, peers)
- d. Identify early warning signs and emotional escalation cues
- e. Assess needed skill sets/coping strategies
- f. Assess youth/family crisis escalation and distress patterns

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. Cross-system collaboration skills

D. Staff Development and Training

The Child and Adolescence Behavioral Health Center of Excellence, 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 all required trainings. Training will include core training modules and additional training modules delivered at various times and locations throughout the year.

The MRSS team, including the MRSS supervisor, is required to complete the 2-day MRSS Core Training within 60 days of hire or within 60 days of MRSS program start-up followed by a minimum of 2 days of competency and practice-based booster trainings per year. Agency staff performing call triage and/or afterhours mobile response-only services shall receive a minimum of a 4-hour MRSS training.

MRSS Supervisors must also complete 6 hours of MRSS Supervisor training within 90 days of hire or within 90 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 three activities/phases: Screening and 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 and evidence-supported practices are employed in all phases of MRSS and incorporate strengths-based, 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,

referrals and linkages for psychiatric consultation should be initiated as determined by the youth and family team.

A. Screening/Triage

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 and work with the family to determine if the mobile response is to be provided as immediate or non-immediate or if the crisis is an emergency that warrants a 911 response. The expectation for MRSS is that all calls be coded as immediate unless it is an emergency, or the family requests a response at a later time. If the call comes into the call center, then the response “time clock” begins when the call is handed off to the MRSS provider. In most instances, the call will come in through the call center. However, if the call goes direct to the provider the clock for response time begins when the initial call is received and coded.

- a. Immediate: An immediate response involves deployment of an MRSS team member(s) to the location of the crisis within 60 minutes of when the clock starts as specified above.
- b. Non-Immediate: When a caregiver, youth or other referral source (if caretaker cannot be contacted at time of referral) indicates that MRSS services are requested, but that the arrival of the team within 60 minutes is not desired, the call is coded as “non-immediate.” A non-immediate response involves the arrival of an MRSS team member(s) to the site of the crisis at a time requested by the family or referral source, typically within 8 to 24 hours after the referral is initiated. For example, a family requests the response to occur in two hours instead of sixty minutes because one parent is at work and the family wants both parents to be present. NOTE: Non-immediate should not be selected unless it is specifically requested by the referral source.
- c. Emergency: When the triage process results in a determination of imminent risk to health and safety for the young person or other party due to the impact of the young persons’ behavior, the triage outcome is identified as “Emergency.” The call is transferred to 911 and/or other appropriate emergency services that are deployed with subsequent engagement of the MRSS team.

When families or referrers calling for MRSS service request a response that exceeds 48 hours, MRSS may not be the appropriate service and families should typically be referred to a more appropriate service. 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, MST), 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 continue with the stabilization phase of 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, and establish the initial safety plan.

The initial mobile response typically involves a teamed response, a licensed clinician and either a Qualified Behavior Health Specialist or a Peer Supporter. 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 the supervision of an independently licensed professional.

Afterhours triage and mobile response-only staff are required to be either staff of the agency or contracted to provide services by the agency. Mobile response staff must be staff 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 Introduction to MRSS 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 no later than 24 hours later 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, use or threat of use of a weapon, or if the police are already involved and have requested mental health intervention for the young person and family.

Initial Meeting

The purposes of the initial meeting are multifold. De-escalation, establishing safety and safety planning for the immediate future are clear priorities. It is important that the inherent strengths and unique perspectives of the youth and their caretakers be acknowledged and incorporated into the intervention. Prior to leaving the initial visit, a safety plan, next steps and details for follow-up care should be established.

During the initial meeting, several activities occur including:

- a. Initial crisis stabilization and de-escalation of the presenting concern.
- b. Crisis assessment, including a mental status exam; assessment of risk to self and others; assessment of other high-risk behaviors (e.g., fire setting), 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).
- c. Development of the initial safety plan in partnership with the young person and/or their family, obtaining family approval and supervisor consent, verbally or in writing.

- d. Obtain necessary releases and permissions.
- e. Determine an initial disposition in consultation with a supervisor.

Safety Plan

An initial safety plan is to be completed prior to leaving the first visit with the family and a copy of the initial 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.

First 72 hours

Throughout the first 72 hours additional activities include:

- a. Observation of interactions between family members or other involved people that may contribute to the current crisis or help to mitigate future crises.
- b. Identification of strengths, resiliency factors and needs
- c. Identification of coping strategies and tools used to produce or maintain calm
- d. Identification of triggers to current crisis.
- e. Ongoing risk and safety assessment.
- f. Continued crisis stabilization.
- g. Define goals for preventing future crisis and the evaluating need for ongoing stabilization.
- h. Consult and begin coordination with the school, primary care physician, existing providers/services and other care coordination programs.
- i. Initiate referrals/ linkages to formal, informal and natural supports. (See definitions below.)
- j. Follow-up visits and contact based on acuity, clinical need and family preference.
- k. Begin the development of the MRSS Plan, which includes the safety plan.
- l. Completion of the Ohio Children's Initiative Brief CANS assessment by a certified CANS assessor.

Transition to Stabilization

The mobile response and de-escalation period can last up to 72 hours. Throughout the 72 hours, the MRSS team works with the family to determine their interest in receiving ongoing stabilization services. Families may choose not to enter the stabilization phase of MRSS. After the initial mobile response, families involved in IHBT or similar services are referred back to that service within 24 hours and do not move on to the MRSS stabilization phase

To transition a family to the ongoing stabilization phase, a provider must:

- a. Complete the Ohio Children's Initiative Brief CANS assessment with the family and
- b. Develop an MRSS Plan with the family. (See below.)

Note: Ohio Children's Initiative Brief CANS assessment completed in the last 60 days can be updated and utilized for MRSS.

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

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 promote 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 and evolve over the course of MRSS involvement to de-escalate the crisis, stabilize the young person and family, restore safety, build skills to avert future crises, provide referral, and linkages to appropriate services, and coordination with other systems. The MRSS Plan is not a treatment plan, and a diagnosis is not required to receive MRSS services (though may be required by funders). 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. Incorporates the MRSS safety plan
- d. Identified needs of the young person and family
- e. Young person and family identified short term goals
- f. Interventions to achieve the identified goals
- g. MRSS goals incorporate the young person's assets and strengths
- h. Risks and responses to risks
- i. Natural, family and community supports
- j. Formal and informal linkages needed to be made to ensure sustainability post MRSS involvement
- k. Relevant medical information including a listing of medications and diagnosis if indicated

C. Ongoing Stabilization

Following the provision of the initial 72-hour mobile response, the family engages in on-going stabilization services, lasting up to six weeks or up to 42 days in total.

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 OhioRISE care coordination, FCFC service coordination, counseling, evidence-based and evidence supported services and community-based supports. Interventions are 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 for 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 may include but are not limited to:

- a. Continued assessment and ongoing monitoring of the safety plan.
- b. Solution-focused interventions
- 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 and evidenced-supported practices 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 licensed staff 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.

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.

- a. **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.
- b. **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.
- c. **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. Linking 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, including the safety plan, should be monitored and updated as warranted, and should incorporate newly identified risks, safety needs, as well as, new safety strategies, coping strategies, resources, and supports.

Facilitated Youth and Family Planning Meetings

MRSS providers actively engage families in a System of Care MRSS Family Team planning meeting which 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 or a meeting convened by another cross-system partner. The meetings must include additional system/agency partners, in addition to the MRSS staff and the family, to qualify as cross-system planning meeting.

Transition

If the youth is eligible for OhioRISE and/or local care coordination, and has an assigned Care Coordinator, the Care Coordinator is responsible for facilitating all needed transition to community-based services and supports. The Care Coordinator is also responsible for monitoring the safety plan with the family after the family transitions from MRSS care.

For family's not involved in OhioRISE and/or local care coordination, 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 including the type of services/ activities, locations, times, 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.

Re-Engagement

Families who have been discharged from MRSS services can initiate another episode of MRSS service at any time. If youth are referred to the hospital during MRSS care, the MRSS provider may re-engage with the family upon discharge.

Additional Crisis Situations

At any time during the MRSS service, a youth and/or their family may experience episodic crisis situations as defined by themselves or others. 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.

Administration

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.

A. Provider Certification

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.

An MRSS provider must submit application for Interim Certification to OhioMHAS' Office of Licensing and Certification to add MRSS as a new service. Upon approval, the Department shall issue an interim certification for one hundred eighty days. The interim certification can be renewed twice, if necessary, but it is expected that the MRSS program will qualify for Full Certification within the first 6 to 12 months of operation. Within three years of initial certification, an MRSS provider can apply for full certification once the agency has achieved a fidelity score of 26. For continuing certification, an MRSS provider will maintain a minimum fidelity score of 26.

B. Fidelity

The MRSS provider must have received an interim certification from OhioMHAS for service provision of MRSS prior to requesting a fidelity review. The MRSS program must be well-established and functioning for at least 6 months before requesting a fidelity review. Once it is decided the organization is ready for a fidelity review, the MRSS provider requests a review from the Center of Excellence at Case Western Reserve University.

MRSS providers shall have an initial fidelity review no more than twelve months from the date of initial certification. MRSS providers shall have regular repeat fidelity reviews, no more than twelve months from the report date of the previous fidelity review, by an independent validation entity recognized by the department.

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

Fidelity will include the assessment of an OhioMHAS approved set of benchmarks based on the following indicators:

- a. Response Time: Response time is within 60 minutes for immediate calls and within eight to 24 hours for non-immediate calls.
- b. Duration of service delivery: Young people and their families are discharged within the six-week timeframe of MRSS.
- c. MRSS Essential Services: Services provided are comprehensive, as per model guidelines, and broad enough to meet families' needs.
- d. Referrals and Linkages: Young people and their families are connected to formal, informal and natural supports.
- e. Service Availability: MRSS is available 24 hours a day, seven days a week, 365 days a year.

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.

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.

D. Data Management for Benchmarks

MRSS data management, data management training and technical assistance for MRSS Benchmarks is provided by the Center of Assessment and Evaluation Services at Bowling Green State University (BGSU). MRSS data collection and reporting may involve multiple individuals within the MRSS provider agency including clinicians, administrators, peers, data entry staff, quality improvement staff and others.

MRSS providers must complete the following for each family referred for MRSS:

- a. MRSS Intake Form – To be completed for each family referred for MRSS
- b. MRSS Discharge Form – To be completed for each family who receives services beyond the initial mobile response

Data from these forms must be entered into the MRSS data management system within 10 days of intake and 10 days of discharge. (Refer to the MRSS Data Collection Manual for additional instructions and data dictionary). BGSU will download and send each MRSS provider an Intake and Discharge Quarterly Report on the 15th of the month after the quarter has ended. These quarterly reports will provide the data necessary to monitor performance, track benchmarks, assess fidelity and implement quality improvement strategies.

E. 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.