American Rescue Plan Act (ARP) of 2021: Section 9813 State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: Mobile Response and Stabilization Services (MRSS) Overview

The purpose of this document is to provide state Medicaid agencies applying for *Section 9813 State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services* with an overview of MRSS under CMS Notice of Funding Opportunity (NOFO): CMS-212-21-001, CFDA#93.639.

MRSS Best Practices

MRSS is a child and family specific crisis intervention model that recognizes the specific developmental needs of children and works with the child specific systems that have shared responsibility for children such as schools, courts, child welfare, and community supports. MRSS is designed to stabilize the early phase of the crisis, commonly understood as pre-crisis. MRSS recognizes that caregivers and children are interconnected in their relationship and thus, crisis situations for children significantly impact the parent/caregiver's ability to respond to the crisis and de-escalate the situation. This component of MRSS is key because research shows that supporting the caregiver's response to their child's behavioral health crisis decreases the likelihood of child welfare and juvenile justice involvement.

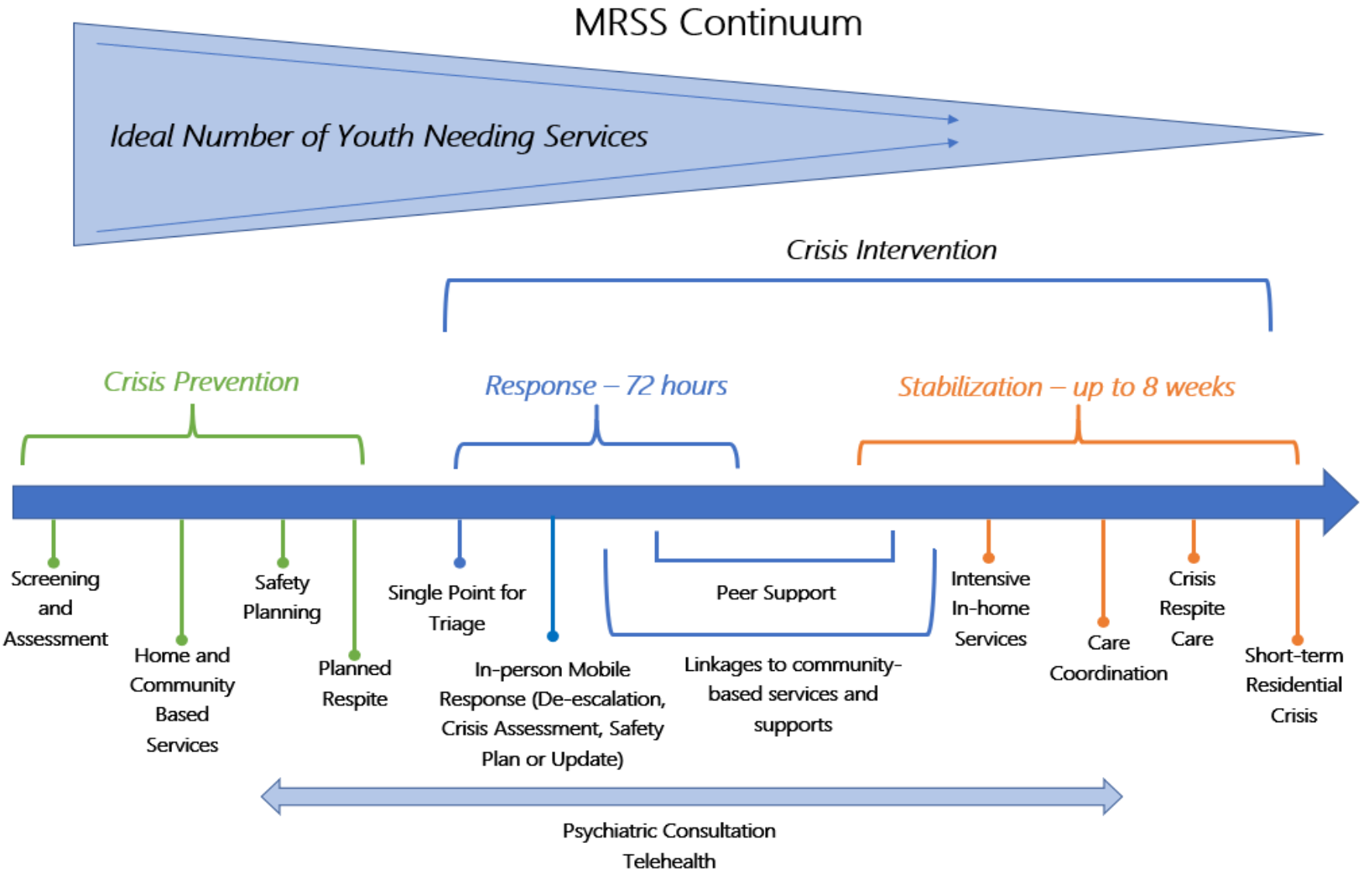
Children are developmentally different than adults and are connected to different systems, such as education, child welfare, juvenile justice and pediatric care. A crisis continuum of care – designed specifically to meet the needs of children and their families– is necessary to deescalate and ameliorate a crisis before more restrictive and costly interventions become necessary, and to ensure connection to necessary services and supports. Engagement is critical in the de-escalation and stabilization activities, including empowering children/families to recognize their own strengths, needs, and resources, which can serve as the foundation for crisis and care planning.

Services for children experiencing a behavioral health crisis must include a continuum of care. Although crisis services may be initiated during a behavioral health emergency, a comprehensive array of interventions is necessary to maintain the de-escalation, to stabilize the child and family, and to engage them in appropriate services and supports.

- The crisis is defined by the parent/caregiver and/or child themselves.
- MRSS is connected to a single point of triage to serve as a centralized call center for triage, dispatch, maintaining contact until MRSS arrives, and providing warm-handoffs.
- There is a distinction between emergent/urgent: the Response Service component (up to 72 hours) and the Stabilization Service component (up to 8 weeks), and they must be connected.
- The Mobile Response Service
    - is delivered in-person;
    - in home or community settings;
    - available within 60 minutes of contact; and
    - with telephonic support until in-person response arrives.
- The Stabilization Service

  - supports child's ability to manage daily activities, and
  - establishes clear connections to treatment services and community supports to reduce the likelihood of ongoing behavioral health crises.
- MRSS goals:
  - Maintain child in their current living situation and community environment.
  - Provide trauma-informed care.
  - Promote and support safe behaviors in home, school, and community.
  - Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
  - Assist child and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.
- Initial Response requires implementation of specific children's assessment, such as the Crisis Assessment Tool (CAT).
- Training, supervision, and mentoring should be clear, consistent, and in line with systems of care and intensive care coordination models of care.
- Mobile response teams should connect to both informal and formal community supports, and connections should be made to higher intensity of services, if needed.
- Outcomes should be collected to demonstrate the reach, benefits, and impact of the MRSS intervention and support provided.

The illustration on the following page provides a graphic of a MRSS Continuum, which includes prevention services and supports.



Source: Adapted from the Wisconsin Office of Children's Mental Health. (2015). 2015 Report to the Wisconsin Legislature. Appendix D4. Retrieved from: http://www.wisccap.org/docs/OCMH%202015%20Annual%20Report.pdf

Alignment with Section 1947(b) Requirements

The table below aligns MRSS components and best practices with activities for providing qualifying community-based mobile crisis intervention services that meet the conditions specified in Section 1947(b) per NOFO p. 15 Work Plan and NOFO p. 20-21 Project Narrative Scored Criteria.

Section 1947 (b) Requirements		**MRSS Components and Best Practices**
Required Service Components	screening and assessment	**A crisis is best defined by the person or family experiencing it;** the workforce development culture attached to triage must reflect this and must give appropriate weight to the perceptions and experience of the parent/caregiver, child, or other caller. Initial Response requires implementation of identified a child-specific assessment tool. An example is the Crisis Assessment Tool (CAT). As the presenting crisis begins to stabilize, the mobile worker/team should use standardized screening and assessment measures to gather additional information to develop and implement a plan of care. Mobile workers/teams should be familiar with various clinical assessment measures that correspond with the most common presenting concerns (e.g. anxiety, trauma, substance use, etc.). Every effort should be made to maintain the child safely at home and in the community. Active involvement and communication with parents, caregivers and other family members is strongly encouraged. Comprehensive screening and assessment per EPSDT requirements are fundamental to determining a child's need for services and supports. Many states have chosen to use standardized tools as part of the assessment process to determine eligibility for behavioral health services, develop plans of care, and/or to report outcome measures. For example, New Jersey uses the Child and Adolescent Strength and Needs (CANS)-**Crisis Assessment Tool (CAT)** "to discuss [the team's] formulation of the treatment needs and care planning with the child/family."[i] Similar standardized assessment tools are in use in the District of Columbia,[ii] Massachusetts,[iii] Georgia,[iv] Nevada,[v] and Oklahoma,[vi] and other states. A common assessment tool allows various child-serving agencies to "speak" the same language and ensures a common understanding of the child and family's strengths and needs. Other assessment tools include the Columbia-Suicide Severity Rating Scale (C-SSRS), used by Connecticut. No-cost tools such as the CANS and C-SSRS may be of particular interest to state and localities with fiscal constraints. Precipitants should be assessed for physical, psychiatric, educational, social, familial, and legal factors. A behavioral health history, including recent medication use and any past admissions, should be taken, as well as a review of the parent or caregiver's stress, strengths, and natural supports. Most literature concludes that the focus needs to be on the assessment of risk, rather than on a specific diagnosable condition or disorder.

	stabilization and de-escalation	There is a distinction between the **Mobile Response Service component (up to 72 hours)** and the **Stabilization Service component (up to 8 weeks)**, and they must be connected. **Mobile Response Service** is delivered in-person, in a home or community settings, available within 60 minutes of contact, with telephonic support until the mobile worker/team arrives. Mobile response provides interventions to de-escalate and stabilize the behavioral health crisis in the home or community rather than a focus on determining need for a restrictive setting. Each mobile response addresses the specific needs of the child in crisis, with priority given to stabilizing the acute behavioral health need before administering screenings, assessments, or referrals to other levels of care or services. In conjunction with the child and family, the mobile worker/team identifies any potential circumstances that may precipitate a crisis for the child and/or family. The family's definition of a crisis, as well as risks and triggers that could lead to a crisis, are identified and recorded in a crisis plan. The mobile worker/team, child, and family work together to define elements of a supportive crisis plan, which includes, at a minimum: • What a crisis would be for the child/family • Communication challenges and strengths • Risk factors and triggers that precipitate crises • Concrete, functional strategies that reduce the likelihood of, or the severity of, a crisis • Resources that may help them in a crisis • Functional strengths of the child and family and how they can assist in a crisis situation • Multiple strategies to use in a crisis situation - the strategies should be specific to the crisis situations identified by the child/family and include responses to triggers for both child and the family The goal of crisis planning is to assist the families with strategies and supports that can be used to respond at the earliest sign of escalation, and to foster and practice skill building that enables the child and family to move toward managing crises on their own. **The Stabilization Service** supports child's ability to manage daily activities and establishes clear connections to treatment services and community supports to reduce the likelihood of ongoing behavioral health crises. MRSS may be a child and their family's first contact with the behavioral health system. Beginning with the first contact, the MRSS worker/team must engage to build a trusting relationship of mutual respect to facilitate moving toward an individualized care plan with goals jointly developed by the child, family, and treatment providers. The immediate goal is to address the most pressing concerns to stabilize the crisis before entering into future safety

		planning. In states and localities with intensive care coordination (ICC) using Wraparound, the goal should be to connect families with Wraparound quickly, if appropriate to their needs, in order to engage the Child and Family Team (CFT) – of which MRSS is a part – so the MRSS responders do not come to be viewed as the primary service provider, but are rather viewed as part of a cohesive whole. The continued role of the ICC CFT is to monitor the progress and adapt the comprehensive care plan, as needed, to address the child and family needs. Regardless of whether the child is enrolled in ICC, effective, ongoing stabilization requires the development of a crisis/safety plan, which may include – depending upon the child and family needs – family and youth peer support; in- or out-of-home respite, intensive in-home services such as Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multidimensional Family Therapy, or Multisystemic Therapy. The primary emphasis of the stabilization and transition-planning phase is on meeting child and family needs in a way that stabilizes the current crisis and prevents further crises from occurring, connecting to community supports, and referring to ongoing treatment services, as needed. The results of all assessment measures administered should be shared with the family, the child (if appropriate), and the original referrer (if different than the family and upon execution of an appropriate release of information). Additionally, ensuring that Medicaid agency health plan partners receive this information will support member oversight and access to network services. Sharing this information helps empower families to join as active partners in the care plan for their child; it should include an overall conceptualization or clinical formulation that is derived from the mobile assessment in its entirety. The team should work with the child and their family to develop symptom- and solution-focused goals that are integrated into a comprehensive care plan that conforms to the standards of relevant accrediting, licensing, and funding entities. The mobile worker/team addresses the factors contributing to, or maintaining, the presenting crisis or situation. Often, this involves identifying unmet needs and underlying concerns such as parent-child conflict, in-school behavior problems, anxiety, depression, academic issues, failure to take prescribed medications, symptoms related to trauma exposure, social or peer problems, or others. In addition, mobile worker/team should engage in strengths discovery to ensure that strengths are incorporated into the comprehensive care plan and subsequent service delivery. The mobile worker/team should work with the child, family, and referrer to develop coping strategies and solutions that address any underlying factors. Mobile worker/team should be trained to deliver and/or refer to trauma-informed interventions throughout the duration of the intervention and use that training to review with the child and families the traumatic events to which children have been exposed. The crisis/safety plan is a part of the comprehensive care plan developed to help stabilize the child's immediate crisis, or situation, and to put formal and informal services and supports into place that address the factors that contribute to, and maintain, crises or current situation, and therefore prevent further recurrence of crisis events. This helps

<table>
<tr><td></td><td></td><td>contribute to ongoing stabilization of the child and their family. The comprehensive care plan should be a living document updated in response to the acuity level, child's progress, and strengths.

The mobile worker/team may also need to provide care coordination activities in order to assist families in completing their care plan, accessing, and coordinating needed services, supports, and system partners. These care coordination activities do not duplicate the role of other Medicaid funded services such as MCO care management or case management, but are specific to the crisis, linking with other Medicaid funded care management as needed to ensure the needs of children and families are met. Mobile response coordination includes, but is not limited to, attending school-based meetings, connecting or re-connecting to formal and informal services and supports in the community, ensuring systems collaboration, reviewing insurance and/or entitlement eligibility, and linking families to resources in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. Mobile worker/team may need to support families to enhance readiness for following through with their ongoing care plan. In this effort, clinicians may also review with the child and their family the gains and successes that were achieved during participation in mobile response services.

The table below summarizes the timeframe for providing the stabilization service.
<table>
<tr><th>State/Locality</th><th>Stabilization Phase</th></tr>
<tr><td>Connecticut</td><td>Up to eight (8) weeks</td></tr>
<tr><td>Community Behavioral Health, Philadelphia, Pennsylvania</td><td>Up to eight (8) weeks</td></tr>
<tr><td>Milwaukee, Wisconsin</td><td>Up to eight (8) weeks</td></tr>
<tr><td>Rural Nevada Mobile Crisis Response Team</td><td>Up to 45 days of post-crisis stabilization services</td></tr>
<tr><td>New Jersey</td><td>Up to eight (8) weeks</td></tr>
<tr><td>Oklahoma</td><td>Up to eight (8) weeks</td></tr>
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</td></tr>
<tr><td></td><td>coordination and referrals to health, social and other services, as needed</td><td>Communication with both the formal and informal supports for the child is very important for sharing care plan strategies, generalizing treatment gains to other settings, and building a positive reputation for collaboration with community partners. Communication and collaboration with family members is a necessity, but mobile worker/team should be encouraged to communicate regularly with other collateral contacts, including Medicaid managed care organizations. Activities may include regular phone contact, written communication of progress, sharing the care plan, or attendance at all relevant meetings (with appropriately executed releases of information). Mobile worker/team should assist children and families to transition to other services and supports, as needed.</td></tr>
<tr><td colspan="2">Services are provided to individuals who reside in the community and outside of a hospital or other facility-based setting</td><td>There should be an expectation that the mobile intervention and assessment will occur face-to-face in homes, schools, EDs, or other community locations. MRSS teams must demonstrate an ability to serve children and families in their natural environments; employ staff with specialized training that emphasizing resiliency and is not adult-centric; identify and build on natural support structures, while reducing reliance on unnecessary acute care;</td></tr>
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<tr><td></td><td>and establish a partnership with families during crisis response, through treatment planning, and into post-crisis stabilization and referral.</td></tr>
<tr><td>Services are provided by a multi-disciplinary team that includes professionals and paraprofessionals who have appropriate expertise in behavioral health care and, at a minimum, includes one behavioral health care professional who is qualified to provide an assessment within scope of practice requirements under state law</td><td>An essential component for any mobile response system is a network of providers that is sufficiently staffed, resourced, and configured to meet the demand for services within their catchment area. Recognizing mobile response services frequently provide a referral and linkage function to ongoing care within the service array, staffing should be sufficient to address the need and demand for services, particularly at peak-volume times (e.g., immediately before and after school, during the spring and fall seasons).

For mobile response systems covering a large geographic area, more than one location may be needed in order to ensure the capacity for providing a timely response to all referrals. Mobile response systems operating in rural and frontier states are increasingly incorporating tele-health capabilities to complement in-person mobile response.

Empirical evidence and discussions with New Jersey and Connecticut point to some common characteristics of successful crisis responders, which may promote stability and staff retention:
• Seasoned and supportive supervisors, with a 6:1 staff to supervisor ratio to promote ongoing professional development and coaching; and
• Low worker to child/family ratio to allow time and space for a deliberative, thoughtful crisis response that is able to develop a truly individualized plan of care and sustain ongoing stabilization services.

The below are recommended minimum qualifications for staffing:
<table><tr><th>Response Worker*</th><th>Supervisor</th></tr><tr><td>Bachelor’s Degree
• In behavioral health or related human services field; and
• One year related work experience; or
• Possess a master's degree in a behavioral health or related human services field
*See CAT under Assessment – can be Bachelor’s must be certified to administer and have clinical supervision</td><td>Master’s Degree, Licensed Behavioral Clinician
• Is licensed in a behavioral health field, including, but not limited to: psychiatry, social work, counseling, psychology or psychiatric nursing; and
• Three years of clinical and supervisory experience</td></tr></table>Medical practitioners, including psychiatrists and advanced practice registered nurses (APRNs), are accessed, as needed, for clinical consultation.

Several states include family and youth peer support providers on MRSS teams.</td></tr>
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Georgia permits certified peer specialists (CPS) (parent and/or youth) as an addition to mobile crisis and “strongly” encourages CPS employment in crisis stabilization units “as part of their regular staffing compliment, and utilize them in early engagement, orientation to services, family support, skills building, individualized recovery plan development, discharge planning, and aftercare follow-up.”[vii]
Kentucky requires certified peers, including youth, as part of its residential crisis stabilization programs.[viii]
New York requires crisis intervention services be provided through a multi-disciplinary team noting, “[t]eams are encouraged to include a range of service providers…to promote the multi-disciplinary approach, such as, the inclusion of a Credentialed Family Peer Advocate or CASAC [Credentialed Alcoholism and Substance Abuse Counselor].”[ix]
Virginia permits community mental health and rehabilitation service providers, which include crisis intervention and crisis stabilization to employ credentialed family support partners.[x]

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<tr><td>All members of the multi-disciplinary team are trained in trauma informed care, de-escalation strategies, and harm reduction</td><td>
All personnel providing mobile response services should be required to complete initial and ongoing training and professional development to ensure their skills and competencies are sufficient to address the needs of the target population. Unlike some treatment models that are specific to a particular condition, mobile response providers provide services to children with a variety of presenting challenges. The most important areas of competency for mobile response providers include, but are not limited to, engagement skills with both the child and family, crisis assessment and intervention skills, proactive and reactive crisis safety planning, suicide assessment and intervention, violence assessment and intervention, trauma, and responding to children with intellectual and developmental disabilities. Psychiatrists and APRNs providing clinical consultation to MRSS workers/teams should also receive training in MRSS and community de-escalation.

States and implementing agencies must prioritize the support of crisis workers via initial and ongoing training and coaching, including support for secondary traumatic stress (STS). STS “is the emotional duress that results when an individual hears about the firsthand trauma experiences of another…. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life.”[xi]

See page 15 for examples of training and certification requirements from New Jersey and Connecticut.
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<tr><td>Community-based mobile crisis intervention services teams respond to crises in a timely manner</td><td>
MRSS response should be within 60 minutes.
<table>
<tr><th>State/Locality</th><th>Initial Response Time</th></tr>
<tr><td>Connecticut</td><td>Within 45 minutes. For SFY 2018, 86% of all mobile responses were achieved within the 45-minute mark. The median response time for SFY 2018 was 30 minutes.</td></tr>
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	Philadelphia, Pennsylvania	Within 60 minutes
	Milwaukee, Wisconsin	Within 60 minutes
	Rural Nevada Mobile Crisis Response Team	Rural clinician intervenes via telehealth and case manager from the rural community responds in-person or via phone.
	New Jersey	Within 60 minutes
	Oklahoma	After triage, if determined to be emergency, within one hour. If non-emergency, with 24 hours.

Community-based mobile crisis intervention services teams are maintaining relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care plans (if applicable)	Apart from direct service provision, the provision of MRSS must be well coordinated with other child-serving system partners and with Medicaid managed care or other Medicaid vendors. When a child experiences a behavioral health crisis, the family is apt to engage with multiple child-serving entities (e.g. pediatricians, schools, child welfare, law enforcement, etc.). These system partners must work together to maximize the availability and accessibility of services – particularly when fiscal resources and human capital are scarce – and to minimize re-traumatization and unnecessary duplication of assessments, care plans, and direct services. Unlike traditional crisis intervention, MRSS are responsible for facilitating the child's transition from acute intervention or crisis stabilization to the community. To do so, they may provide behavioral health education, help identify and develop relationships with formal and/or natural supports, assist the family with navigating the system, and provide medication management services.[xii] For example, Oklahoma uses behavioral health aides (BHA)[xiii] as part of the MRSS team to focus on developing community connections. The BHA builds a relationship with the child and provides behavioral skills development services, secures natural supports, and assists with respite services to families, as needed. MRSS teams may collaborate with, or provide education and training for, emergency responders, including police and emergency medical responders, residential treatment providers, school personnel, and local child welfare and juvenile justice agencies. Examples of training provided by MRSS include education to local police departments around trauma and crisis response specific to children and may assist in developing protocols to meet community-specific challenges.[xiv] MRSS teams also train child-serving system partners on topics such as Mental Health First Aide, trauma, crisis intervention, and suicide prevention activities.[xv] Strategies for connecting with the community include: co-location of MRSS teams with system partners like community mental health centers and/or law enforcement agencies; locating staff in the community (and into in organization headquarters); the use of paraprofessionals on MRSS teams who understand the culture of the community and/or can provide peer support.[xvi]

Partnerships with Emergency Departments (EDs):
As ED volume continues to increase, health systems must create alternative models for responding to, and stabilizing, pediatric psychiatric crisis, including MRSS capacity; on-call or after hours outpatient service capacity, whether in-person or via telehealth; and crisis units designed for short-term stabilization. Communities that create MRSS capacity are able to rapidly deploy care and divert families from costly ED and inpatient care. A review of Connecticut's Mobile Crisis found that MRSS was associated with a 25 percent reduction in subsequent ED visits among children (over an 18-month period).[xvii]

Partnership with Law Enforcement:
MRSS teams do not include law enforcement. However, partnership with law enforcement is essential. Law enforcement needs appropriate resources, or training, to identify children and young adults with mental health needs to avoid being placed in unnecessarily restrictive settings, beyond what is necessary for maintaining their safety, or the safety of the community. Ongoing training, communication, and support for law enforcement personnel is essential to a well-coordinated crisis continuum.[xviii] MRSS training and supporting of local law enforcement can result in better coordination, identification, and connection to appropriate supports and services.[xix]

Partnerships with Schools:
Schools typically identify students with mental health needs via two pathways: (1) reports from key informants such as teachers, paraprofessionals, school resource officers, and others who interact with students on a daily basis and (2) data, including screening tools and administrative records (including disciplinary referrals). Some research suggests that teachers might be some of the most effective people in connecting adolescents to mental health services and may even contribute to reducing ethnic and racial disparities in service access.[xx]

Historically, teachers may once have referred students to the school counselor. Today, nearly all states are experiencing widespread shortages of qualified school counselors. The American School Counselor Association reported on the 10-year trends in student-to-counselor ratios, from 2004-05 to 2014-15, and found that only three states (New Hampshire, Vermont, and Wyoming) met their recommended ratio of one counselor for every 250 students. The national average is nearly double that, at 482:1, with some states having a single counselor for nearly 1000 students (924: 1 in Arizona).[xxi] Unmet behavioral health needs pose barriers to learning and social-emotional development.[xxii]

For children experiencing a behavioral health crisis in school, MRSS provides a viable alternative to emergency medical services and/or law enforcement. Several states and localities have MRSS teams that respond to school-based crises, including:

	• Arizona • Cuyahoga and Stark Counties in Ohio • Georgia • Massachusetts • New Jersey • Oklahoma The Marjory Stoneman Douglas High School Public Safety Act, (Ch. 2018-3, Laws of Florida) was passed during the 2018 legislative session following the school shooting in Parkland, Florida. The law "provides intent for the creation of a statewide network of mobile response teams through a competitive procurement process…[including] the following minimum requirements for competitive bidding procurements…[r]equire the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents."[xxiii] Osceola County, Florida was one entity that used the state funding to contract with a community provider organization to establish MRSS that will collaborate with schools, and a crisis intervention team with the Osceola County Sheriff's Office, Kissimmee Police Department, and St. Cloud Police Department.[xxiv] In its 2018 needs assessment, Cuyahoga County, Ohio reported that parental/guardian consent to complete an assessment of a child can delay the provision of crisis services.[xxv] New Jersey has streamlined the process of obtaining consent by requiring the parent or caregiver to be on the initial call requesting services. The parent/caregiver gives verbal consent, and consent is documented in the electronic health record. As with MRSS requested from any other setting, intensive services are available during the 72 hours following the initial call, with a focus on de-escalation, and can be extended for up to eight weeks of stabilization services.[xxvi]
Community-based mobile crisis intervention services are available 24 hours a day, 365 days a year	Round-the-clock availability and the ability to respond quickly to a child/family's crisis is an important component of MRSS. **A mobile response team is always dispatched.**
Community-based mobile crisis intervention services programs maintain the privacy and confidentiality of beneficiary information consistent with federal and state requirements	MRSS requires consent throughout the entire process; consent for any particular component of treatment or participation in services altogether can be withdrawn at any time (assuming there is no court order requiring treatment). For example, MRSS workers/teams might seek verbal or written consent at any of the following points in an intervention: ➢ Dispatching an MRSS worker/team ➢ Coordinating with health care providers and other service providers ➢ Making a referral to other services such as In-Home Therapy or Intensive Care Coordination

- Sharing copies of treatment documentation with appropriate providers
- Continuing communication with care providers and other members of the treatment team after the initial crisis call

For children under the age of 18, the consent of a parent or guardian is commonly required to initiate and continue services.[xxvii] For this reason, it is critical that caregivers are actively engaged in the process. If MRSS team members neglect to make the parent/s an active participant in the response, "parents may feel 'double-teamed' or as if they are being 'talked into' something. This may lead to resistance about a recommended decision or it may compromise parent/caregiver trust in the recommendations."[xxviii] In some cases, MRSS providers can deliver limited MRSS services to a minor without the consent of a parent or guardian. For example, in Massachusetts, if a young person experiences a crisis in school but the parent or guardian cannot be immediately reached, MRSS can assess immediate risk and stabilize the situation prior to receiving parental consent. However, a parent or guardian must provide consent before the MRSS responders can complete a full assessment or begin planning for any additional services.[xxix]

Lessons in Seeking Consent from the Massachusetts Mobile Crisis Intervention

MRSS is designed to allow youth and their families to drive the decisions behind their care. The ideas below may support systems in designing their MRSS services to ensure consent is central in the process.

- "MCI should note services that are offered and declined, but avoid using language such as 'family refused,' which can be misconstrued as a sign of neglect or non-compliance instead of a youth or parent/guardian choice."
- "Listening to, exploring the reasons behind, and respecting the wishes of youth and parents in the current episode makes it more likely they will choose to come back if needed in the future. At that point, they may be more open to exploring treatment options."
- "That a youth meets criteria for a particular level of care does not compel his/her participation in it. Nor is it inherently neglectful of a parent to decline a treatment service."

If a youth and/or guardian declines consent for services, this decision usually is recorded in the young person's behavioral health record. One such scenario is when a third party such as a school or an outpatient program contacts the MRSS service directly, either in an attempt to circumvent the parents' wishes or due to an unfamiliarity with the process. Some common reasons families decline to consent are past poor experiences with mental health providers, a desire to pursue alternatives, a need for more information about mental health services, disagreement between co-parents, cultural perceptions of mental health, and negative experiences of the mental health system by different cultural, racial and ethnic groups.[xxx]

	Transition age youth 18 years and older are able to consent to crisis services. However family members are still engaged given their importance to mitigating the crisis. Families can still be a valuable resource in building a safety plan and identifying and/or providing natural supports available to the young person. Some young adults who have a history of "forced" treatment may be reluctant to involve others in their treatment planning, while young adults who experienced removal from their home as a child may be eager to reconnect with and involve their families. MRSS providers and policies must be sensitive to the wide range of family dynamics at play and should strive to incorporate family members based on the wishes of the young adult.[xxxi] Relatedly, MRSS providers deal with questions surrounding when and how a child's personal health information can be shared with family members and/or other service providers in serious situations without disregarding privacy protections. In general, the Health Insurance Portability and Accountability Act (HIPAA) permits providers to disclose protected health information when the health or safety of an individual or the public is at imminent risk *and* the information is being shared with someone who can reduce or eliminate that risk.[xxxii] Notably, this type of disclosure is not *required* by HIPAA, but is simply permitted by it in these limited circumstances. State laws may also impose additional privacy protections on sharing this type of information.[xxxiii]

NJ

NEW JERSEY Requirements for Initial MRSS Certification

*Crisis Response Protocol

*Setting Yourself Up for Safety: Practical Tools for Outreach Workers

*DSM5

*Infusing Practice with Cultural Competence

*Developmental Tasks of Childhood & Adolescence

*Engagement & Motivation Skills

*Family Dynamics

*Child Traumatic Stress

*Risk Assessment & Mental Health

*Understanding Child Abuse & Mandatory Reporting Laws

*Crisis Assessment Tool (CAT)

Required for 2nd year Certification

*NJ Wraparound Values & Principles

*Crisis Intervention for Youth with Intellectual and Developmental Disabilities

*Domestic Violence (1 of the following):

-DomesticViolenceFundamentals

-Domestic Violence, Child Abuse, and the NJ Prevention of DV Act

*Foundations of Developmental Disabilities

*Substance Use Training

*The Nurtured Heart Approach

*Positive Behavior Support (1 of the following):

-Positive Behavior Support: Understanding Behavior through PBS & Assessment Templates o Managing Frustration, Anxiety, and Teaching Social Skills

-Positive Behavior Support for Youth with IDD and Challenging Behaviors

*Effective Collaboration for Resource Development

*Working with a Trauma Lens in Crisis Intervention

Source: https://www.nj.gov/dcf/providers/csc/training/CSOC-Training.Course.Catalog.pdf

CT

Connecticut MRSS Required Training

Mobile Crisis Performance Improvement Center provides ongoing workforce development and training for mobile crisis clinicians. The following are summaries of currently required trainings:

*21st Century Culturally Responsive Mental Health Care

*Assessing Violence Risk in Children and Adolescence

*Adolescent-Screening, Brief Intervention, Referral and Treatment (A-SBIRT)

*Autism Spectrum Disorder

*Columbia-Suicide Severity Rating Scale (C-SSRS)

*Disaster Behavioral Health Response Network (DBHRN) Introduction

*Mobile Crisis Assessment, Planning and Intervention

*Mobile Crisis Emergency Certificate Training

*Overview of Intellectual Developmental Disabilities and Positive Behavioral Supports

Source: https://www.empsct.org/training/

[i] New Jersey Department of Children and Families. (2016). Children's System of Care, Crisis Assessment Tool. Retrieved from: https://www.nj.gov/dcf/about/divisions/dcsc/Crisis.Assessment.Tool.pdf
[ii] District of Columbia. (undated). Children, Youth, and Family Services. Retrieved from: https://dbh.dc.gov/service/children-youth-and-family-services
[iii] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (2012, April). Mobile Crisis Intervention, Performance Specifications. Retrieved from: https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf
[iv] Georgia Department of Behavioral Health & Developmental Disabilities. (2019, July 1). Provider Manual for Community Behavioral Health Providers, FY2020. Retrieved from: http://dbhdd.org/files/Provider-Manual-BH.pdf
[v] Nevada Department of Health & Human Services, Division of Child & Family Services. (undated). Children's Mental Health. Retrieved from: http://dcfs.nv.gov/Programs/CMH/
[vi] Oklahoma Department of Mental Health and Substance Abuse Services. (undated). Enhanced Children's Mobile Crisis. Retrieved from: https://www.ok.gov/odmhsas/Mental_Health/Enhanced_Childrens_Mobile_Crisis.html
[vii] Georgia Department of Behavioral Health & Developmental Disabilities. (2019, July 1). Provider Manual for Community Behavioral Health Providers, FY2020. Retrieved from: http://dbhdd.org/files/Provider-Manual-BH.pdf
[viii] Kentucky Department for Behavioral Health, Developmental, and Intellectual Disabilities. (2016, March 24). Kentucky BHDID Service Standards. Retrieved from: https://dbhdid.ky.gov/kdbhdid/documents/standards/stabilization.pdf?t=14045306122019
[ix] Office of Children and Family Services, New York Department of Health. (2019, Jan. 9). Updated Children and Family Treatment and Support Services (CFTSS) Manual. Retrieved from: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf
[x] Virginia Department of Behavioral Health & Developmental Services. (2017, Dec. 29). Peer Support Services and Family Support Partners, Supplement to Provider Manual. Retrieved from: http://www.dbhds.virginia.gov/assets/doc/recovery/provider-manual-supplement.pdf#page=7
[xi] https://www.nctsn.org/trauma-informed-care/secondary-traumatic-stress
[xii] Manley, E., Schober, M., Simons, D., & Zabel, M. (2018) Making The Case for a Comprehensive Children's Crisis Continuum of Care. NASMHPD. Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
[xiii] Oklahoma Department of Mental Health and Substance Abuse. (2018). Services Manual. Retrieved from http://www.odmhsas.org/picis/Documents/Manuals/FY2018_ODMHSAS_Services_Manual.pdf
[xiv] Cf. Balfour, M.E., Winsky, J.M., & Isely, J.M. (2017). The Tucson Mental Health Investigative Support Team (MHIST) Model: A Preventive Approach to Crisis and Public Safety. Psychiatric Services 68(2), 211-212. Retrieved from https://doi.org/10.1176/appi.ps.68203
[xv] Manley, E., Schober, M., Simons, D., & Zabel, M. (2018) Making The Case for a Comprehensive Children's Crisis Continuum of Care. NASMHPD. Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
[xvi] Manley, E., Schober, M., Simons, D., & Zabel, M. (2018) Making The Case for a Comprehensive Children's Crisis Continuum of Care. NASMHPD. Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
[xvii] Fendrich, M., Kurz, B., Ives, M., & Becker, J. (2018). Evaluation of Connecticut's Mobile Crisis Intervention Services: Impact on Behavioral Health Emergency Department Use and Provider Perspectives on Strengths and Challenges. Farmington, CT: Child Health and Development Institute of Connecticut, Inc. Retrieved from: https://www.chdi.org/index.php/download_file/view/1646/1171/
[xviii] Manley, E., Schober, M., Simons, D., & Zabel, M. (2018) Making The Case for a Comprehensive Children's Crisis Continuum of Care. NASMHPD. Retrieved from https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
[xix] National Center for Mental Health and Juvenile Justice. (2012). Law Enforcement-Based Diversion. Strategic Innovations from the Mental Health/Juvenile Justice Action Network: Retrieved from https://www.ncmhjj.com/wp-content/uploads/2013/07/CIT-Y-Brief-2012.pdf
[xx] Green, J. G., Keenan, J. K., Guzmán, J., Vinnes, S., Holt, M., & Comer, J. S. (2017). Teacher perspectives on indicators of adolescent social and emotional problems. *Evidence-based practice in child and adolescent mental health*, *2*(2), 96–110. doi:10.1080/23794925.2017.1313099
[xxi] National Association for College Admission Counseling and American School Counselor Association. (2015). State-by-State Student-to-Counselor Ratio Report, 10-Year Trends. Retrieved from: https://www.schoolcounselor.org/asca/media/asca/Publications/ratioreport.pdf

[xxii] Osher, D., Dwyer, K. P., Jimerson S. R., Brown, J. A. (2012). Developing safe, supportive, and effective schools: facilitating student success to reduce school violence, in Handbook of School Violence and School Safety, eds. Furlong M., Jimerson S., Nickerson A. B., Mayer M. J., editors. (Mahwah, NJ: Lawrence Erlbaum Associates. Retrieved from: https://www.routledgehandbooks.com/doi/10.4324/9780203841372.ch3

[xxiii] Florida Department of Children and Families, Office of Substance Abuse and Mental Health. (2018). Mobile Response Teams Framework. Retrieved from: https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf

[xxiv] Williams, S. & Polakowski, A. (2018, Dec. 11). Mobile Response & Stabilization Services Peer Curriculum: Day 1. National Technical Assistance Network for Children's Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201500007C. Retrieved from: https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/samhsa-sponsored-meetings/Day-1-Combined-MRSS-December-2018.pdf

[xxv] Hussey, D., Riske-Morris, M., Coen Flynn, K., Fulton, S., (2018, Aug.). Cuyahoga County Crisis Response Services Needs Assessment. The Begun Center for Violence Prevention, Research and Education, Jack, Joseph and Morton Mandel School of Applied Social Sciences, Case Western Reserve University. Retrieved from: http://adamhscc.org/pdf_adamhscc/en-US/Cuyahoga%20County%20Crisis%20Response%20Needs%20Assessment-%20Final%20Report%20-%20August%202018.pdf

[xxvi] Casey Family Programs. (2018, May 31). What is New Jersey's Mobile Response and Stabilization Services intervention? Retrieved from: https://www.casey.org/nj-mobile-response-stabilization-services/

[xxvii] Some states permit minors to consent for mental health and substance use services. Cf. Kerwin, M. E., Kirby, K. C., Speziali, D., Duggan, M., Mellitz, C., Versek, B., & McNamara, A. (2015). What Can Parents Do? A Review of State Laws Regarding Decision Making for Adolescent Drug Abuse and Mental Health Treatment. *Journal of child & adolescent substance abuse*, *24*(3), 166–176. doi:10.1080/1067828X.2013.777380

[xxviii] Children's Behavioral Health Initiative. (2014). *Emergency services program mobile crisis intervention practice guidelines*. Retrieved from http://www.rosied.org/resources/Documents/MCI%20Practice%20Guidelines.final.pdf

[xxix] Ibid, 11.

[xxx] Fendrich, M., Kurz, B., Ives, M., & Becker, J. (2018). *Evaluation of Connecticut's mobile crisis intervention services: Impact on behavioral health emergency department use and provider perspectives on strengths and challenges*. Farmington, CT: Child Health and Development Institute of Connecticut, Inc.

[xxxi] Ibid, 21.

[xxxii] Draper, J., Murphy, G., Vega, E., Covington, D.W., & McKeon, R. (2015). Helping callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide: The importance of active engagement, active rescue, and collaboration between crisis and emergency services. *Suicide and Life-Threatening Behavior 45*(3), 261-70. Retrieved from https://doi.org/10.1111/sltb.12128

[xxxiii] Ibid.