

Best Practice Expectations for Mobile Response and Stabilization Services (MRSS) in Rhode Island for **Demonstration Year 1 and Year 2**

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Overview

Purpose of Guidance

The purpose of this guidance is to provide a comprehensive overview of the operational components of Mobile Response and Stabilization Services (MRSS) and to establish clear expectations for Certified Community Behavioral Health Clinics (CCBHCs) and other MRSS providers in Rhode Island.¹ This guidance is informed by [SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care](#), [SAMHSA's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care](#), [SAMHSA's Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services](#), the [2018 National Association of State Mental Health Program Directors \(NASMHPD\) report on Comprehensive Children's Crisis Continuum of Care](#), and the [MRSS Toolkit](#) developed by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Center for Innovative Practices (CIP) at Case Western Reserve University. It also incorporates best and promising practices from MRSS programs in Connecticut, Ohio, New Jersey, Wisconsin, and Maryland. For additional resources, see Appendix A1: MRSS Best Practices (January 2023) and Appendix A2: Best Practice Readiness Companion.

This guidance aligns with federal and state requirements, including the Rhode Island Certified Community Behavioral Health Clinic Certification Standards, R.I. Gen. Laws §§ 40.1-5-5, 40.1-5-6, and 40.1-5-8 (Mental Health Law), R.I. Gen. Laws § 42-72-5 (Powers and Scope of Activities of the Department of Children, Youth and Families), and R.I. Gen. Laws § 42-72-5.2 (Development of a Continuum of Children's Behavioral Health Programs). It incorporates the Emergency Services Regulations as required by R.I. Gen. Laws § 40.1-5-6 for children under 18 with publicly funded health insurance, ensuring compliance with standards for emergency service interventions. Additionally, it adheres to relevant Department of Children, Youth and Families (DCYF) policies, particularly for children with Serious Emotional Disturbances (SED) as defined by R.I. Gen. Laws § 42-72-5.

This guidance covers the goals, operational parameters, service model components, roles and responsibilities, metrics, and resources for MRSS providers in Rhode Island,

¹ These Best Practice Recommendations are compiled for informational purposes only. While portions of this document may reference specific state or federal statutes or regulations, the Best Practice Recommendations themselves do not carry the force or effect of law unless explicitly stated. Providers should carefully assess how these Best Practice Recommendations may apply to their operations and are advised to consult qualified legal counsel with any questions or concerns.

ensuring compliance with state and federal regulations while promoting effective crisis intervention and stabilization services.

Mobile Response and Stabilization Services (MRSS) Model Definition

Mobile Response and Stabilization Services (MRSS) is a crisis intervention model tailored to children and youth and their families, designed to deliver immediate, in-person support to children and youth experiencing a behavioral or emotional crisis. MRSS adopts a family systems approach to address distress in children and youth and their families or caregivers, recognizing the developmental needs of children and youth, including those with developmental disabilities, the critical role of families or caregivers, and the importance of preventing out-of-home placements or the removal of children and youth from their school and community. MRSS collaborates with child-serving systems, including schools, courts, child welfare, juvenile justice, and community supports, that share responsibility for supporting children and youth. As part of a high-quality children's crisis continuum that is culturally and linguistically competent, MRSS works to maintain the safety of children and youth in their homes, communities, and schools whenever possible.

MRSS Goals and Objectives

The MRSS service model is a developmentally appropriate crisis response tailored to children and youth and their families or caregivers. MRSS teams consist of mental health professionals and paraprofessionals trained to support children and youth and their families during crises. This service delivery model aims to prevent: 1) unnecessary reliance on emergency departments or acute care services; 2) out-of-home placements or placement disruptions; and 3) involvement in the juvenile justice system. MRSS seeks to de-escalate and resolve crises before more restrictive and costly interventions are needed, while ensuring connections to essential services and supports.

Parameters of Operation

Population Served

This service is available to Rhode Island children and youth from birth up to age twenty-one (21) who are experiencing a behavioral health crisis.

Family/Caller Defined Crisis

MRSS is defined by allowing the young person, their family, or another referrer to determine what constitutes a crisis. As their definition may differ from a clinical practitioner's, MRSS services should be provided in situations that may not align with a

typical clinical crisis definition. Requests are not screened based on perceived acuity; MRSS adopts a 'just go' approach. Clinical judgment determines whether the response is immediate (within 1 hour) or non-immediate (within 23 hours), and this judgment must be documented for insurance billing audits. Examples of youth- or family-defined crises prompting a call for help include a young person being 'out of control' or destroying property, experiencing trauma from a personal, familial, or community tragedy, being significantly withdrawn/'shut down,' exhibiting psychiatric symptoms such as psychosis or mania, in addition to threats of self-harm or harm to others.

Exclusionary Criteria

- a) The child or youth is currently in an inpatient hospital, a Psychiatric Residential Treatment Facility (PRTF), an Intermediate Care Facility, or residential care setting.
- b) The child or youth is exhibiting behaviors posing an immediate and significant safety risk (e.g., active violence requiring law enforcement intervention or an active suicide attempt in progress, or severe psychosis or mania) that exceeds MRSS's capacity to manage safely in the community. When exclusionary criteria apply, MRSS will coordinate with emergency services (e.g., 911) as outlined in the 'Emergency' response protocol and resume support, such as de-escalation or stabilization, once the acute crisis is resolved.

Parental Consent

In Rhode Island, consent requirements for Mobile Response and Stabilization Services (MRSS) depend on age, marital status, and specific circumstances. Minors under 16 generally require parental or legal guardian consent for behavioral health services, including MRSS, unless an exception applies, such as emergencies or imminent risk of serious harm (R.I. Gen. Laws § 23-4.6-1). Minors aged 16 or older, or those who are married, may independently consent to MRSS, and a minor parent can consent for their child (R.I. Gen. Laws § 23-4.6-1). In emergency situations, minors of any age can receive immediate MRSS crisis assessments and interventions without parental consent to prevent harm. Additionally, minors posing an imminent risk of serious harm due to a psychiatric disability may be certified for emergency inpatient treatment without parental consent by a physician, advanced practice registered nurse, or Qualified Mental Health Professional (QMHP) (R.I. Gen. Laws § 40.1-5-7). MRSS providers must document consent or the specific exception applied, such as emergency intervention.

Individuals aged 18 or older can independently consent to MRSS crisis services. However, involvement of family members or caregivers, as defined by the individual, is encouraged across all age groups, as they can play a critical role in mitigating crises.

MRSS providers and policies must remain sensitive to diverse family dynamics and strive to include family members or caregivers at the individual's request.

Referrals to MRSS

MRSS accepts referrals from diverse sources, including the 988 Suicide & Crisis Lifeline, 911, law enforcement, first responders, parents, caregivers, youth themselves, schools, hospital emergency departments, Kids' Link, primary care providers, and other behavioral health providers. To ensure timely access, a 24/7 phone service is available, providing immediate triage and crisis response coordination for referral sources, consistent with Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Certification Standards for accessibility.

MRSS Provider Accessibility Requirements

To meet community needs, MRSS providers maintain sufficient staffing capacity and fluency in languages commonly spoken in the service area. Translation and interpretation services are readily available for individuals with limited English proficiency, and TTY or comparable auxiliary aids are provided for those who are deaf or hard of hearing. Clear protocols ensure prompt access to these services, promoting equitable access for all populations, regardless of language, disability, or other barriers, in accordance with Rhode Island CCBHC Certification Standards for access to services.

Service Availability

MRSS providers must have staff available 24 hours a day, 7 days a week, 365 days a year, to ensure timely in-person crisis intervention.

Service Location

MRSS delivers services at the location where children and youth are experiencing a crisis or where their families or caregivers have requested assistance, rather than requiring them to travel to a fixed site like a clinic or hospital. By offering timely and appropriate support in the community, MRSS helps children and youth and their families or caregivers manage crises more effectively, reducing the need for more intensive and restrictive treatments.

Service Response Time

During the telephone triage, conducted by either a call center or MRSS triage staff, the staff will evaluate the behavioral health needs of the child or youth, as well as the risk of harm to themselves or others. They will also assess the family or caregiver's ability to provide support, while considering cultural and linguistic needs. Based on this

evaluation, triage staff will determine the necessary level of MRSS response for the child or youth.

MRSS Response Types:

- a) **Immediate:** An MRSS team is deployed to the location of the crisis within 60 minutes of the recorded “Dispatch Day & Time,” as defined in the response time tracking section below. If needed, telephonic support is provided by MRSS staff, until the in-person response arrives. The expectation for MRSS is that all calls are coded as immediate unless it is an emergency, or the family, youth or caregiver requests a response at a later time.
- b) **Non-Immediate:** An MRSS team is deployed to the location of the crisis at a time requested by the family or referral source, within 1 to 23 hours of the recorded “Dispatch Day & Time.” This includes situations where the child or youth is experiencing a crisis but is not in immediate danger of harming themselves or others. For example, a family might request a response in a few hours to better accommodate their schedule. Note: A non-immediate response is used only when requested by the referral source, unless a delayed response would increase risk to the child or youth, overriding the parents’ or caregiver’s request.
- c) **Emergency:** When the triage process, conducted by either a call center or the MRSS triage staff, identifies an imminent risk to the health and safety of the child or youth or others due to their behavior or mental health status, and the situation is beyond the MRSS team’s capability to intervene - such as active violence or an overdose in progress or other unmanageable psychiatric symptoms- the call center triage staff or the MRSS triage staff will immediately transfer the call to 911 during triage, before MRSS intervention, sharing relevant information, including known risks and referral reasoning, with emergency department staff. MRSS will follow up with the family or caregiver and emergency department within 24 hours of referral through phone calls or, if requested, in-person contact to monitor the child or youth’s status and assess ongoing needs. If the emergency department discharges the child or youth, MRSS will collaborate with the emergency department, family, or caregiver prior to discharge to prepare for resuming services. After discharge, MRSS will resume de-escalation, stabilization, and development of a crisis and safety plan as needed, in alignment with the family or caregiver’s preferences.

Response Time Tracking:

For data tracking and performance evaluation purposes, the response time clock is initiated when the MRSS provider codes the initial call as immediate or non-

immediate and enters that date and time on the data collection template in the “Dispatch Date & Time” field. If the call is first received by a call center, the response time clock starts once the call is transferred to the MRSS mobile response team and appropriately coded. This approach ensures consistent and structured tracking of response times, enabling a thorough evaluation of the entire process—from the initial call and collection of necessary information to the arrival of the mobile response team at the service location.

Length of Service

MRSS typically involves a three-part process: screening/triage, mobile crisis response, and stabilization. The length of time that MRSS services are provided can vary depending on the needs of the child or youth and their family or caregiver. In general, during the mobile crisis response the team will work with the child or youth and their family or caregivers to stabilize the crisis, develop a safety plan as well as plan for ongoing support. The stabilization phase can last up to 30 days. It may be shorter if the child or youth transitions to an appropriate service or no longer requires stabilization. It can be extended beyond 30 days if follow-up services are not yet available. This is determined in collaboration with the child or youth, their families or caregivers, and any relevant providers.

NOTE: If a child or youth is already involved with a service equipped to meet their ongoing needs, MRSS can provide crisis response as needed. MRSS will not provide stabilization services in these cases. Instead, MRSS will ensure a warm hand-off to the existing service. That service will continue to work with the child or youth.

Intensity of Service

Mobile Response and Stabilization Services (MRSS) are delivered through two distinct phases: crisis response and stabilization services, each with specific delivery methods:

Crisis Response Services: These are provided through immediate, in-person, face-to-face interventions with the child or youth and/or their family or caregiver(s) to address urgent needs and ensure safety.

Stabilization Services: These are provided in the following ways to support ongoing needs and promote long-term stability:

- a) Through face-to-face meetings with the child or youth and/or their family or caregiver(s) at least once a week or more frequently as needed
- b) Through telephone conversations with the child or youth and/or their caregiver(s).

c) Through meetings or phone calls with individuals outside the child or youth's support system, such as service providers, schools, or other community supports

The frequency of face-to-face meetings and phone calls is determined by the current assessment, the needs of the child or youth, and agreement with the child or youth and their family or caregiver(s), if applicable. For young adults aged 18 and older, who may not live with or involve caregiver(s), the frequency is based on their individual preferences and needs. Some children, youth, or young adults may require more frequent contacts, while others may need fewer, depending on their specific situation. The intensity of Mobile Response and Stabilization Services (MRSS) is tailored to the needs of the child, youth, or young adult, with a requirement of at least one face-to-face contact per week to ensure ongoing support and monitoring. The MRSS team collaborates with the child, youth, or young adult (18+), and their family or caregiver(s) when involved, to determine service frequency and intensity.

Youth and Family Voice and Choice

In the MRSS model, the child or youth and their family or caregivers are viewed as active partners in the planning and delivery of their services and their opinions and choices are valued and taken into consideration throughout the process. The services and supports that are recommended are based on the individual needs of the child or youth and their family or caregivers, as well as their preferences and priorities.

These services and supports can range from traditional to non-traditional options, including informal and natural supports. For example, a family or caregiver may choose to work with a traditional mental health provider, or they may prefer to receive support from a community-based organization that specializes in youth development. They may also choose to rely on informal supports, such as extended family members or close friends.

Ultimately, the goal of MRSS is to provide young people and their families with the support they need to navigate a crisis and access the resources that will help them achieve their goals. By partnering with families and valuing their opinions and choices, MRSS is able to provide a more individualized and effective approach to crisis intervention and stabilization.

Trauma-Informed Service Delivery

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a set of guiding principles for trauma-informed care in 2014. The guiding principles in the Concept of Trauma and Guidance for a Trauma-Informed Approach emphasize the importance of creating a trauma-informed care environment that is supportive,

empowering, and culturally responsive. By implementing these principles, service providers can help individuals feel safe and supported, while promoting their overall well-being and recovery. MRSS providers must ensure that the following principles are integrated into service delivery.

These principles include:

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

MRSS Staffing

MRSS Staff Composition

Services are provided by a team of professionals and paraprofessionals with expertise in behavioral health care. At a minimum, the team includes at least one behavioral health care professional who is licensed under Rhode Island law to conduct clinical assessments within their scope of practice. This includes, but is not limited to: Psychiatrists, Licensed Psychologists, Registered Nurses licensed under Rhode Island law, Licensed Independent Clinical Social Workers (LICSWs), Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Licensed Mental Health Counselors (LMHCs), and associate-level licensees such as LMFTAs and LMHCAs. All licenses must be current and recognized by the Rhode Island Department of Health (RIDOH).

Mobile crisis teams shall include a Qualified Mental Health Professional (QMHP) on every two-person team when responding to a child or youth in crisis, as required by the Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Certification Standards for crisis services.

Team composition:

- One behavioral health clinician
- One paraprofessional

In addition:

- MRSS staff must have access to routine clinical supervision to support professional development and ensure high-quality service delivery. Routine

supervision should occur on a predictable schedule, with a minimum of one (1) session per month. For full-time clinicians, supervision should include at least four (4) hours per month, with a minimum of one (1) hour of individual supervision and the remaining three (3) hours optionally in a group setting, pro-rated for part-time clinicians. Additionally, MRSS staff must have access to a qualified clinical supervisor 24 hours a day, 7 days a week, to address emergent clinical needs and ensure continuous support.

- Access to a psychiatrist or an Advanced Practice Registered Nurse (APRN) certified in Psychiatric/Mental Health for consultation available on-call 24 hours a day, 7 days a week.

Whenever possible, hire staff whose racial, ethnic, linguistic, and sexual orientation or gender identities are representative of the communities served.

Supervisor Description

- a) Independently licensed behavioral health practitioner (LICSW, LMHC, LMFT, PhD, etc.).
- b) Two years of clinical and supervisory experience.
- c) Demonstrates expertise and experience in child and adolescent behavioral health and family systems.

Clinical Staff Description

- a) Has specialized training or experience in child and adolescent behavioral health and family systems (see Clinical Staff Child/Family Competency below).
- b) Has two years of clinical experience with children and adolescents who have behavioral health problems.
- c) A QMHP must be part of every two-person mobile crisis team, as required by Rhode Island CCBHC Certification Standards, to ensure readiness for potential hospitalization.

Paraprofessionals in Crisis Services

Paraprofessionals are non-licensed staff who provide supportive services under the direct supervision of a licensed clinical supervisor. These staff are limited to Certified Peer Recovery Specialists, Family Partners, Youth Partners, Case Managers, and Community Psychiatric Support and Treatment (CPST) providers. All paraprofessionals must meet CCBHC standards for crisis services, ensuring appropriate training and competencies to support children, youth, and families in crisis. Under the direction of a licensed clinical supervisor, paraprofessionals assist with non-clinical tasks, including accompanying licensed clinical practitioners during mobile crisis responses, supporting

the development of safety plans, providing emotional support to individuals and families during and after a crisis, and facilitating connections to identified community resources and services. Paraprofessionals may not independently conduct clinical assessments, diagnostic evaluations, or therapeutic interventions, and all activities must comply with CCBHC certification standards and applicable Medicaid regulations.

Psychiatric Consultation

Ready access to a board-certified child and adolescent psychiatrist, a psychiatrist with demonstrated experience working with children and adolescents, or an Advanced Practice Registered Nurse (APRN) certified in Psychiatric/Mental Health is available for consultation when needed. A qualified psychiatrist or APRN is available on-call 24 hours a day, 7 days a week.

Staffing Levels

All MRSS providers must ensure that they have enough qualified staff to meet client needs at all times. This includes having staff available 24 hours a day, 7 days a week, and 365 days a year. The provider must also have a staffing plan in place that documents the qualifications of all staff, including their training, clinical experience, and education.

There is a low team to child/family ratio to allow for a deliberative, thoughtful crisis response that is able to develop a truly individualized plan of care and sustain ongoing stabilization services.

If an MRSS provider reaches capacity and cannot accept additional clients, the provider must notify the Department of Children, Youth, and Families (DCYF) within 24 hours via a designated contact point. This notification should include the provider's current caseload, staffing levels, and estimated duration of the capacity constraint.

In addition, the provider must notify other applicable state agencies and partners, including the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the Executive Office of Health and Human Services (EOHHS), and, if applicable, their Certified Community Behavioral Health Clinic (CCBHC) if functioning as a Designated Collaborating Organization (DCO).

Staff Child/Family Competency

The following section outlines the core competencies expected of staff delivering MRSS services, including both clinical and paraprofessional team members. These competencies are informed by Rhode Island's existing regulations (214-RICR-40-00-6) and have been updated to reflect current best practices in the field.

Clinical staff are expected to meet all of the clinical competencies listed below and must have the training and licensure necessary to conduct assessments, make diagnoses, and lead intervention planning.

Paraprofessional staff are not expected to meet clinical competencies, but they must demonstrate skills and knowledge relevant to their specific roles—such as supporting engagement, assisting with stabilization efforts, facilitating follow-up care, and helping families navigate services.

These competencies are developed through a combination of formal education, supervised clinical experience, and ongoing professional development. Provider agencies are responsible for verifying and documenting that staff meet these requirements through personnel files, training records, and supervision logs. DCYF reviews provider policies and documentation as part of the certification and monitoring process.

a) **Knowledge of child development, behavior, and psychopathology (Clinical Staff Only):** Clinicians must understand child development, behavior, and the typical range of emotions and behaviors across age groups. This includes knowledge of the normal developmental milestones for children of different ages, as well as the signs and symptoms of common mental health and substance use disorders in children.

b) **Knowledge of family systems (Clinical Staff Only):** The clinician must have knowledge of family systems theory and how it applies to child and adolescent behavioral health. This includes understanding the concepts of family structure, roles, boundaries, communication patterns, and coping strategies. The clinician should also be able to assess the family's strengths and weaknesses, and to identify any factors that may be contributing to the child's crisis.

c) **Skills in working with children and families (All Staff):** All MRSS staff must have strong skills in working with children and families. This includes the ability to build rapport with children and families, to communicate effectively with children and families, and to provide support to children and families.

d) **Skills in diagnostic assessment (Clinical Staff Only):** The clinician must be able to formulate accurate and appropriate diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and apply diagnostic formulation to determine the child's behavior as a Serious Emotional Disturbance.

e) **Skills in risk assessment (Clinical Staff Only):** Skills in conducting risk and safety assessments for children and youth must include the ability to assess suicide risk, non-suicidal self-injury, violence risk, abuse and neglect, exposure to violence and/or

other types of traumas, human trafficking risk, fire setting, substance use, risk of runaway, and other clinical presentations that pose an immediate risk or safety issue.

f) **Skills in family assessment (Clinical Staff Only):** The clinician must be able to assess the family's structure, roles, boundaries, communication patterns, coping strategies, strengths, needs, and goals. A clinician needs to be able to identify and address any family issues or conflicts that may contribute to or exacerbate the child's crisis, such as domestic violence, substance abuse, mental illness, trauma, or neglect.

g) **Skills in crisis intervention (All Staff):** All MRSS staff must have strong skills in crisis intervention. This includes the ability to assess a crisis situation, accurately assess a child's mental health status, de-escalate a crisis, and provide support to the child and family during a crisis.

h) **Knowledge of community resources (All Staff):** All MRSS staff must have knowledge of community resources that can be helpful to children and families in crisis. This includes knowledge of behavioral health services, social services, and other community resources.

i) **Ability to work collaboratively with other professionals (All Staff):** All MRSS staff must be able to work collaboratively with other professionals, such as teachers, doctors, social workers, and other mental health professionals. This collaboration is essential for providing comprehensive and coordinated care to children and families in crisis.

j) **Cultural and linguistic competence (All Staff):** All MRSS staff should be culturally competent, aware of, and sensitive to the cultural, historical, and linguistic beliefs and practices of the children or youth and their families or caregivers, delivering services in alignment with National Standards for Culturally and Linguistically Appropriate Services (CLAS).

MRSS Service Delivery

MRSS Stage One: Screening and Triage

a) When a call for MRSS is received by a call center or the MRSS provider, staff follow risk and decision-making protocols to assess the acuity of needs, prioritizing the safety of responders, youth, and families.

b) During phone screening/triage, staff evaluate the child or youth's behavioral health needs, risk of harm to themselves or others, and the family or caregiver's ability to provide support, while considering cultural and linguistic needs. Based on

this evaluation, staff determine the appropriate MRSS response type (Immediate, Non-Immediate, or Emergency), as detailed in the **Service Response Time** section above.

MRSS Stage Two: Mobile Response

- a) For an Immediate response type, MRSS responds within one (1) hour in person (24/7/365)
- b) A 2-person mobile crisis team consists of a clinical staff and another clinical or paraprofessional staff. One of the responding team members must be a QMHP.
- c) MRSS responds without law enforcement unless safety concerns necessitate their involvement as a last resort. Must include child or youth and family or caregiver's input in the decision to involve law enforcement when possible and ensure child or youth/family or caregiver is aware of the use of law enforcement prior to arrival.
- d) Conducts the following essential operational functions:
 - Immediate review of safety concerns and assessment of risk and protective factors. The initial focus needs to be on the assessment of risk, rather than on a specific diagnosable condition or disorder. Risk and safety assessment should include a mental status exam, suicide risk, non-suicidal self-injury, violence risk, abuse and neglect, exposure to violence and/or other types of trauma, human trafficking risk, fire setting, substance use, risk of runaway, and other clinical presentations that pose an immediate risk or safety issue
 - Age-appropriate de-escalation and stabilization of the behavioral health 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 partnership with the child or youth and family or caregiver, develops and implements an initial crisis and safety plan. To create a crisis plan, the mobile response team collaborates with the child or youth and family or caregiver to identify and document their definition of a crisis, as well as potential risks and triggers that could lead to one. The plan includes several key components, such as communication strengths and challenges, concrete strategies to reduce the likelihood or severity of a crisis, available resources, and the functional strengths of the child or youth and family or caregiver in a crisis situation. Additionally, the plan

outlines multiple specific strategies for responding to crisis situations based on triggers identified by the child or youth and family or caregiver, which are tailored to address the needs of both the child or youth and family or caregiver.

- Obtain necessary releases and permissions.
- If it is safe for the child or youth and their family or caregiver, every effort should be made to help them remain in their current living environment or another least restrictive community setting, such as the home of a trusted person, with family or other natural supporters actively participating in the child or youth's care and stabilization. Any informal resource should be provided with the child or youth's safety plan with permission of a custodial parent or legal guardian. For children or youth in the custody of the Department of Children, Youth, and Families (DCYF), placement with an informal resource may only occur if the individual has been approved by DCYF in accordance with applicable regulations. If the child or youth is unable to remain safely in the community and needs a higher level of care, direct linkages are made. The clinical staff and/or their organization also complete any pre-certification required by the child or youth's health insurer.
- In cases of imminent risk where a minor requires emergency inpatient treatment and parental consent is not obtainable, a QMHP, physician, or APRN may certify the treatment per Rhode Island Mental Health Law.

MRSS Stage Three: Stabilization

- a) The stabilization phase typically lasts up to 30 days but may be shorter if the child or youth transitions to an appropriate service or no longer requires stabilization, or can be extended beyond 30 days if follow-up services are not yet available, as determined in collaboration with the child or youth and their families or caregivers and other relevant providers.
- b) As the presenting crisis begins to stabilize, the clinician will complete a brief Biopsychosocial Assessment and utilize screening and assessment tools required by Rhode Island CCBHC Certification Standards to gather additional information for developing and implementing a plan of care.
- c) The MRSS team works collectively with the child or youth and their families or caregivers to set and achieve short-term goals and develop resources, including formal, informal, and natural supports to assist the family after the MRSS episode of care is complete.

- d) For children or youth already involved with a program or intensive home-based service that addresses their ongoing needs, the MRSS team will respond to de-escalate the immediate crisis. After de-escalation, the MRSS team will ensure a smooth transition to the existing service provider to maintain uninterrupted care. Stabilization services will not be provided by the MRSS team unless the existing service is unable to offer a timely appointment or lacks the capacity to stabilize the child or youth. When the child or youth needs a brief stabilization period before returning to their existing service, such as general outpatient therapy, the MRSS team will provide short-term stabilization support. If more intensive or prolonged services are required, the MRSS team will arrange a transition to a suitable alternative service.
- e) The MRSS team connects children or youth with ongoing intensive needs and their families or caregivers to the full array of home- and community-based providers, including those available through a CCBHC or other providers of intensive care coordination, intensive in-home services, and youth and family peer support. The MRSS team provides a warm handoff to identified supports and services.
- f) The MRSS team assesses immediate basic needs the child or youth and their family or caregivers may have such as food, finances, stable housing, utilities, transportation, medical care, and access to community services.
- g) Children and families will have access to a 24/7/365 on call system with clinical support for the duration of their time receiving MRSS.

Administration

Provider Licensing and Certification

- a) Must meet all the standards established in the Department of Children, Youth, and Families (DCYF) Regulations for Certification for Mental Health Emergency Service Interventions for Children, Youth and Families.
- b) Must meet all the licensing standards established for a Behavioral Health Organization (BHO) through the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) if providing services via a CCBHC or any regulations promulgated by the Department under R.I. Gen. Laws § 42-72.1 thereto.
- c) MRSS providers must have a Qualified Mental Health Professional (QMHP) on their team. QMHPs are individuals who have met specific education and training

requirements and are authorized to certify for involuntary hospitalizations. QMHPs are certified through the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

MRSS providers must comply with applicable certification and licensing standards. Providers must either be Certified Community Behavioral Health Clinics (CCBHCs) or operate as Designated Collaborating Organizations (DCOs) under a CCBHC, as defined by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). All individual practitioners delivering MRSS services must hold valid licenses from the Rhode Island Department of Health (RIDOH), as required for their clinical discipline. If MRSS providers contract with staff to deliver specialized behavioral health services, those staff must also hold relevant credentials or certifications, as required by the Rhode Island Certification Board (RICB) for specific provider types.

Data Collection and Documentation

a) **Data Collection:** CCBHCs must submit a monthly Mobile Crisis Report to EOHHS using the EOHHS-developed template for CCBHC monthly Mobile Crisis Report data collection. The report, covering mobile crisis events outside the CCBHC office, includes data from all prior months and services by both CCBHCs and Designated Collaborating Organizations (DCOs). Key data elements include provider/client details, crisis event timing and location, referral sources, interventions, and outcomes (e.g., diversion from hospitalization, linkage to care).

b) **Documentation:** Crisis Assessments, biopsychosocial assessments, safety plans, treatment plans, and progress notes detailing services and contacts must be documented in a Medicaid-compliant electronic health record (EHR) format that ensures clarity and accessibility for authorized users. Records should be securely maintained and accessible to authorized personnel for licensing, certification, audits, or oversight purposes through secure channels, in compliance with protected health information (PHI) regulations. Active and terminated records must be regularly reviewed for completeness, quality, and adherence to documentation deadlines, with a corrective action or quality improvement plan implemented as needed.

Appendix A: MRSS Resources and Training

A.1 MRSS Best Practices (January 2023)

The MRSS Best Practices document, published in January 2023 by the University of Connecticut's Innovations in Social Work, offers a comprehensive overview of evidence-based and promising practices for mobile crisis response and stabilization services. This resource draws from national models and state-specific programs to provide actionable guidance for MRSS providers. It is recommended as a reference for Rhode Island MRSS providers to enhance service delivery and ensure alignment with national standards.

Access: Available at [Mobile Response Best Practices](#), January 2023.

A.2 Best Practice Readiness Companion

The Best Practice Readiness Companion Document complements the MRSS Best Practices resource by providing a framework for assessing organizational readiness to implement MRSS. This tool helps providers evaluate their capacity, staffing, and operational systems to deliver effective crisis services. It is recommended for Rhode Island MRSS providers to use as a self-assessment tool during program development and ongoing quality improvement.

Access: Available at [Best Practice Readiness Companion](#), 2024.

A.3 Proposed Training Curriculum

The following training curriculum is proposed to support MRSS staff in delivering high-quality crisis intervention and stabilization services. While this curriculum reflects current best practices and aligns with Rhode Island CCBHC Certification Standards, it is subject to further refinement and stakeholder consensus to ensure it meets the diverse needs of MRSS providers, children, youth, and families in Rhode Island. Providers are encouraged to adapt and expand this curriculum based on emerging evidence, community needs, and ongoing feedback.

Trainings for Clinical Staff Only (Licensed Clinicians or Qualified Mental Health Professionals [QMHPs])

The following trainings are recommended for clinical staff to ensure competency in conducting assessments, interventions, and crisis planning:

- Suicide and Risk Assessment: Skills for assessing suicide risk and other safety concerns.
- Violence Assessment and Intervention: Strategies for managing and de-escalating violent behaviors.
- Cognitive Behavioral Therapy (CBT) or Trauma-Focused CBT (TF-CBT): Evidence-based therapeutic approaches (recommended for some clinicians).
- Dialectical Behavioral Therapy (DBT): Skills for managing intense emotions and behaviors (recommended for some clinicians).
- Screening, Brief Intervention, and Referral to Treatment (SBIRT): Tools for identifying and addressing substance use issues (recommended for some clinicians).

Trainings for Paraprofessionals Only

The following trainings are suggested for paraprofessionals to support their role in assisting clinical staff and engaging with families:

- Safety Assessments (Support Role): Assisting clinicians in evaluating safety concerns.
- Family Psychoeducation (FPE): Providing education and support to families (recommended for some paraprofessionals).

Trainings for All Staff (Clinical and Paraprofessionals)

The following trainings are proposed for all MRSS staff to ensure a consistent, trauma-informed, and culturally competent approach:

- MRSS Practice and Protocols: Understanding MRSS operational guidelines and procedures to ensure consistent service delivery across all team members.
- Crisis Assessment and Intervention: Techniques for evaluating and addressing behavioral health crises, tailored to the roles of clinical and paraprofessional staff.
- Crisis Planning (Proactive and Reactive): Developing proactive and reactive crisis and safety plans in collaboration with children, youth, and families.
- Motivational Interviewing (MI): Techniques to engage and motivate clients.
- Trauma-Informed Care: Principles for delivering trauma-sensitive services.

- Cultural Competency and Humility: Skills for providing culturally and linguistically appropriate services, aligned with National Standards for Culturally and Linguistically Appropriate Services (CLAS).
- Military and Veterans' Culture Training: Understanding the unique needs of military-connected families.
- Community First Responder Naloxone Training: Training on overdose prevention and response.
- De-escalation Training: Strategies for managing crisis situations safely.
- Policy and Procedure for Continuity of Operations/Disasters: Preparing for service continuity during emergencies.
- Person/Family Centered/Recovery-Oriented Care: Focusing on individual and family strengths and recovery goals.
- Recovery-Oriented Treatment Planning: Developing client-centered treatment plans.
- Care for Co-Occurring Mental Health and Substance Use Disorders: Addressing dual diagnoses.
- Policy and Procedure for Integration with Primary Care: Coordinating with primary care providers.
- Suicide and Overdose Prevention and Response: Comprehensive strategies for prevention and intervention.
- Roles of Family and Peer: Leveraging family and peer support in crisis services.
- Zero Suicide (ZS): Framework for suicide prevention in healthcare settings.
- Crisis Intervention for Diverse Populations: Tailoring interventions to diverse communities.
- Legal and Ethical Requirements for Behavioral Health Emergency Services: Understanding legal and ethical obligations.
- Child Abuse/Neglect and Mandated Reporting Laws: Compliance with reporting requirements.
- Clinical Eligibility and Insurance Authorization Procedures: Navigating insurance and eligibility processes.
- Rhode Island Mental Health Law: Knowledge of state-specific mental health regulations.
- Engagement Skills with Children and Families: Building rapport and trust with clients.

Training Notes:

- Trainings marked as applicable to "All" staff in their respective categories (clinical, paraprofessional, or both) are recommended for inclusion in initial orientation and annual refreshers to ensure consistent service delivery.
- Trainings marked as applicable to "Some" staff (e.g., CBT, DBT, FPE) should be assigned based on the provider's capacity and the specific needs of the populations served, with documentation maintained for compliance.
- All trainings should align with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to promote health equity and reduce disparities.