MOBILE RESPONSE TEAM GUIDELINES

July 30, 2019 Edition

CENTRAL FLORIDA CARES HEALTH SYSTEM
MOBILE RESPONSE TEAM GUIDELINES

PROGRAM GOALS

Mobile Response Teams (MRT) provide on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency departments. Mobile response services are available 24/7 by a team of professionals and paraprofessionals, who are trained in crisis intervention skills to ensure timely access to supports and services. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises. MRT providers are responsible for working with stakeholders to develop a community plan for immediate response and de-escalation, but also crisis and safety planning. Stakeholder collaboration must include law enforcement and school superintendents, but may also include other areas within education, emergency responders, businesses, other health and human service related providers, family advocacy groups, peer organizations, and emergency dispatchers (i.e., 211 and 911 lines).

Services include evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources.

The goals for the MRTs include:

- Provide immediate intervention in attempt to stabilize the individual's condition safely in situations that do not require an immediate public safety response;
- Divert individuals from restrictive care settings such as emergency departments, psychiatric hospitalization or juvenile justice involvement/arrest;
- Increase community awareness of behavioral health needs by providing prevention and treatment-oriented education and outreach to families, schools and communities;
- Increase days in the community by facilitating and encouraging stable living environments.

GUIDING PRINCIPLES

The System of Care values and principles are the foundation of MRTs. These values and principles are the driving force behind systemic change. The core principles include: strengths-based, family-driven and youth-guided, community based with optimal service array, trauma sensitize, culturally and linguistically competent, coordinated and outcome-focused. Section 394.4523(1)(d), F.S., defines the "no-wrong-door" model as the model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system.

MRTs serve in this capacity as they are available at any place where the acute situation or crisis is occurring. MRTs are designed to address a wide variety of situations, including suicidal and homicidal behaviors, individuals displaying hallucinations, family/peer conflicts and disruptive behaviors. The MRT can be the first on the scene or they may be called in by law enforcement or other professionals (school personnel, adult and child protection staff, other medical personnel). MRTs are dispatched to the

location of a crisis with a target response time of one hour from the time of the call. MRTs coordinate in-person services with law enforcement to provide additional safety, when appropriate and necessary.

Further supporting the “no wrong door” model”, the MRT provides warm hand-offs and referrals to other services in the community to meet the ongoing needs of the individual and will follow-up to determine that the appropriate linkage is made. When the situation warrants, they will assist with the individual being admitted to a designated receiving facility or an inpatient detoxification facility, depending on the behaviors displayed by the individual.

Population Served/Eligibility Criteria

The target population for MRT is any individual in the community, under the age of 25, who is in the midst of a psychiatric, behavioral, or emotional crisis for which an immediate response is required and who can be safely served in a community or home setting. Intervention is warranted when a crisis significantly interferes with the ability to function and is severe enough to place the individual at a risk for placement disruption or treatment in higher levels of care.

The clinical threshold for crisis may include aggressive behaviors, suicide attempts/ideation, drug and alcohol overdose or abuse, or disruptive symptoms related to mood and anxiety disorders (e.g., panic, hopelessness, anger, depression) or escalating behavior(s). It may also present as an overt change in functioning, or be prompted by traumatic life events.

Individuals residing in a psychiatric inpatient unit or a residential treatment center are not eligible for MRT intervention.

Staffing Requirements

MRT’s are multi-disciplinary teams of behavioral health professionals and paraprofessionals with specialized crisis intervention and operations training. Staffing must be sufficient to respond within 60 minutes to new requests and to provide continued crisis stabilization and care coordination services. The team should include the following staff:

1. **Licensed Team Leader (1 FTE)**
   The Team Leader must be a full-time employee and possess a Florida license under Chapter 491. The Team Leader must have at least one (1) year of supervisor experience, training in crisis services and experience in initiating Baker Acts. This position coordinates the crisis counseling response at the local level, provides on-site direction and supervision of the team’s intervention services, is responsible for program implementation and team reporting, and conducts team debriefings.

2. **Crisis Counselors**
   The crisis counselor must possess a master’s degree in a behavioral health field such as social work, counseling or psychology with one (1) year of related work experience. The counselor must also have training and experience in crisis intervention.

With clinical supervision from team leader, this position conducts assessments, provides intervention services, engages individuals and families in the crisis planning process, develops safety plans or individual care plans, facilitates stabilization and care coordination services post-acute intervention, provides supportive crisis counseling, education and development of coping skills and linkage to appropriate resources, while assessing and referring individuals who are in need of more intensive mental health and substance abuse treatment to appropriate community resources.

The crisis counselors who provide assessment and referral services shall be knowledgeable about local resources and work diligently to engage community organizations.

3. **Psychiatrist or Advanced Registered Nurse Practitioner (ARNP)**
   Board-certified or board-eligible psychiatrist or Psychiatric Nurse Practitioner to provide phone consultation to the team and face-to-face appointments with the individual within 48 hours of a request if the individual has no existing behavioral health services provider. With approval from CFCHS, services may be designed to include sub-contracting with a telehealth services company for psychiatric care.

SERVICE COMPONENTS

Mobile response services are **available 24/7 with the ability to respond within 60 minutes** to new requests. MRT staff are expected to triage calls in order to determine the level of severity and prioritize calls that meet the clinical threshold required for an in-person response. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises.

Initial Response

The initial response and assessment phase is intended to support initial crisis stabilization and the gathering of clinical information that will inform the rest of the episode of care. There are a number of activities that take place during this phase, including responding to the first call, conducting the first MRT response, assessing initial acuity level, and beginning to administer clinical measures.

Once a call is received the clinician determines whether to provide the family with an initial response that is either: (1) non-mobile, (2) deferred mobile, or (3) mobile response. Mobile and deferred mobile responses are generally provided by one clinician, but a team of two clinicians is recommended when safety is a significant concern, in which case the MRT should also consider teaming with a police officer to respond to the crisis. Each MRT response option is described below:

a) Non-Mobile Response- A non-mobile (telephonic) response typically occurs only when specifically requested by the caller or the child's family. During the initial non-mobile response, clinicians focus on assessing risk, ensuring safety using a verbal safety plan, and determining appropriate follow-up.
b) Deferred Mobile Initial Response- A deferred mobile response typically occurs only when requested by the caller or the family. Deferred mobile responses occur when the family requests that an MRT clinician respond to the crisis at a later time. MRT clinicians should

provide the deferred mobile responses in less than 4 hours, but no more than 24 hours after receiving the initial crisis call.

c) Mobile Initial Response- A mobile response involves a face to face response to the caller's home, school, an emergency department, or another community location. The MRT clinician should arrive at the scene of the crisis in 60 minutes or less after receiving the call. Mobile responses are preferred among all responses that may be provided to families.

Follow-up Care

Some MRT episodes of care end following an initial call and after receiving resources and linkage to services. There are some instances where individuals and families may receive follow-up care. These services include the provision of direct services and the coordination of follow-up care not to exceed 45 days. In cases where extended follow-up may be required, the MRT must notify the CFCHS SOC Manager regarding the circumstance and reason for an exemption from the follow-up duration.

Services and Supports

During the initial phone contact and throughout the episode of care, the MRT clinician will determine the child's acuity level based on relevant clinical features such as presenting problem, risk of harm to self or others, mental status, diagnosis, risk level, overall level of functioning, and other characteristics. The subsequent delivery of MRT services depends, in part, on the assessed acuity level but also takes into consideration family needs and preferences as well as clinical judgment. The phase of intervention, intensity, and duration of care changes accordingly as youth and families experience changes in acuity level, needs, and preferences. Episodes can be as brief as responding to the initial call or can last for up to 45 days. It is expected that the MRT will develop a crisis plan with all clients and facilitate the transition to ongoing services.

Some individuals and families will receive only a small portion of the clinical services described below whereas others may receive most of these services.

(a) Continued crisis stabilization;
(b) Screening and assessment to determine acuity level;
(c) Development of a Care Plan (ONLY for clients who require follow-up);
(d) Development of Safety Plan or Crisis Plan (see additional requirements below);
(e) Address factors contributing to or maintaining the crisis;
(f) Supportive counseling;
(g) Strengthening of supports;
(h) Address trauma exposure and symptoms of traumatic stress;
(i) Communication and collaboration with referral source and other individuals;
(j) Provide linkage to appropriate resources and supports (including natural, family and kin);
(k) Connecting those individuals who need more intensive mental health and substance abuse services; and
(l) Provide care coordination by facilitating the transition to ongoing services through a *warm hand-off*, including psychiatric evaluation and medication management.

Development of Safety or Crisis Plans

Prior to the end of the initial intervention, a Crisis Plan will be developed with the family and a copy provided to all participants. This initial Crisis Plan should be provided to other key players (e.g. therapist, case manager, school staff) with appropriate consent within one (1) business day of development. The MRT will continually update the Crisis Plan for each family throughout the course of their MRT intervention.

Case Documentation

The case records for participants must be in compliance with the requirements as outlined in this guide and must contain the specific MRT documentation listed below:

1. Client Information Sheet
2. Consent for Services and Treatment
3. Notice of Privacy Practices
4. Client Bill of Rights
5. Release of Information, as needed
6. Suicide Risk Assessment (for responses due to suicidal ideations)
7. Care Plan
8. Safety Plan or Crisis Plan
9. Standardized Assessments, as appropriate
10. Crisis Response Summary

All program services and contacts should be documented and confidentially maintained as part of the client's record. Progress notes content shall include:

(a) Dates of contact with client, and as needed, client's family, friends, and involved service or resource agencies;
(b) Description of client progress, or lack thereof, relative to the Care Plan; and
(c) Description of any modification to the Care Plan resulting from such factors as changes in client's needs, changes in resources and new assessment findings.

Outreach Activities

The MRT will make available posters and other marketing materials to families, behavioral health providers, schools, social, recreational, faith-based and other local establishments to assist in a general community outreach campaign.

Additionally, the MRT will complete a minimum of 24 formal outreach activities annually per Contract Service Area. Priority will be given to schools, law enforcement, and identified high volume referrers to local emergency departments.

Key Partnerships

The success of MRTs depends heavily on community collaborations. The MRT's must ensure that they enter into formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents. Formal partnerships should include Memorandum of Agreements (MOAs) or Memorandum of Understanding (MOUs). Beyond

this requirement, to maximize resources, the MRT's are also responsible for establishing informal partnerships with key stakeholders such as Medicaid managed care plans, Community Based Care lead agencies, 211-United Way, Central Receiving Facilities, Community Health Departments, Department of Education, Department of Health, Department of Juvenile Justice and Florida Department of Law Enforcement.

REPORTING & OUTCOMES

The MRT shall submit the following reports to CFCHS System of Care Manager and CFCHS Contract Manager as indicated below:

1. Monthly Census due by the 10th of each month.
2. Vacancy Position Report due by the 10th of each month.
3. **EXHIBIT C** - MRT Outcomes Report due by the 10th of each month (see below).

Goals	Measures	Outcomes
1. Provide immediate intervention to attempt to stabilize the individual's condition safely in situations that do not require an immediate public safety response;	Respond to a crisis within one hour for at least 80% of mobile episodes.	
2. Divert individuals from hospitalization or arrest;	80% of individuals are able to remain in their living environment as an outcome of mobile crisis episodes	
3. Ensure quality of the MRT response process and client satisfaction;	95% of individuals and families receiving services will report satisfaction with the Mobile Response Team	
4. Provide education and information to the community regarding the benefits and availability of MRT.	Complete a minimum of two (2) formal outreach activities per month for a total of 24 activities per year.	