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TITLE 214 – DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

CHAPTER 40 – LICENSING

SUBCHAPTER 00 – N/A

PART 6 – MENTAL HEALTH EMERGENCY SERVICE INTERVENTIONS FOR CHILDREN, YOUTH AND FAMILIES REGULATIONS FOR LICENSURE

6.1 GENERAL PROVISIONS

A. Purpose

1. The purpose of these Regulations is to comply with R.I. Gen. Laws § 40.1-5-6, which requires any child who is under the age of eighteen whose health insurance is publicly funded to have an emergency service intervention by a provider licensed by the Department of Children Youth and Families (the Department) as a prerequisite for admission to an inpatient psychiatric facility.

2. In addition, these Regulations implement provisions of R.I. Gen. Laws § 27-18-95 Acute Mental Health Crisis Mobile Response and Stabilization Services which establish the requirement for licensure of Mobile Response and Stabilization Services (MRSS) providers delivering crisis intervention and stabilization services to children.

3. These Regulations further implement 2025-H 5076 Substitute A as amended, by establishing licensure standards for Mobile Response and Stabilization Services (MRSS) providers delivering services within Rhode Island's state-sanctioned crisis system for children's behavioral health, adhering to nationally recognized fidelity standards, for children and youth ages two up to twenty-one. For young adults ages eighteen (18) through twenty-one (21) accessing MRSS services (e.g., via RI Suicide & Crisis Lifeline (Lifeline) or other referrals), MRSS providers shall ensure coordination with BHDDH, BHDDH-licensed Behavioral Healthcare Organizations (BHOs) and Certified Community Behavioral Health Clinics (CCBHCs), and, as clinically appropriate and consistent with applicable law, DCYF-licensed or contracted providers. The Department will oversee MRSS provider compliance through licensure monitoring and quality assurance activities, including but not limited to routine and complaint-based monitoring; review of clinical and care coordination documentation; evaluation of referral

and coordination practices with BHDDH-licensed providers; and review of performance measures and required reporting.

4. Accordingly, these Regulations establish two (2) levels of licensure for entities providing mental health emergency services to children:

   a. Emergency Services (ES) Licensure, authorizing the delivery of immediate crisis intervention; and

   b. Mobile Response and Stabilization Services (MRSS) Licensure, required for the provision of mobile crisis response and short-term stabilization services. MRSS is a distinct service model, separate from Emergency Services (ES), and includes both mobile crisis response and short-term stabilization services. MRSS providers must meet all standards applicable to ES licensure, in addition to satisfying MRSS-specific requirements

B. Legal Basis

1. These Regulations are issued pursuant to:

   a. R.I. Gen. Laws § 42-72-5, Power and Scope of Activities of the Department of Children, Youth and Families

   b. R.I. Gen. Laws §§ 40.1-5-2, 40.1-5-5, 40.1-5-6, and 40.1-5-8 Mental Health Law

   c. R.I. Gen. Laws § 42-72-5.2, Development of a Continuum of Children's Behavioral Health Programs

   d. R.I. Gen. Laws § 27-18-95 Acute Mental Health Crisis Mobile Response and Stabilization Services

   e. R.I. Gen. Laws § 42-72.1, Licensing and Monitoring of Child Care Providers and Child-Placing Agencies f. 2025-H 5076 Substitute A as amended, relating to Mobile Response and Stabilization Services (MRSS) for children and youth ages two up to twenty-one.

   g. R.I. Gen. Laws § 23-4.6-1 (minors' consent to certain health care services)

2. These Regulations include children with Serious Emotional Disturbances (SED) as defined by R.I. Gen. Laws § 42-72-5.

C. Definitions

1. “Adolescent” means an individual ages twelve (12) through seventeen (17), unless otherwise specified.

2. "Behavioral health emergency” means a situation in which a child. adolescent, or young adult, due to a behavioral health condition - including mental health conditions or substance use (such as overdose, intoxication, or withdrawal) - is at imminent risk of harm to themselves or others and requires immediate intervention to prevent that harm. Such an emergency may be identified by the child or adolescent themselves through self-reporting a crisis or requesting immediate help, or it may be recognized by any person based on observable signs, behaviors, statements, or other indications that would lead a reasonable person to conclude that urgent action is needed to protect the child or adolescent or others from harm.

3. "Behavioral health emergency service interventions" constitute steps and actions that are taken by a child-family competent Clinician to address a behavioral health crisis, including telephone contact, crisis evaluation in the community, and follow-up service planning. These interventions take place in a community setting, including (but not limited to) homes, schools, police stations, emergency departments, homeless shelters, child care settings, community mental health providers, or any other community-based setting.

4. “Behavioral healthcare” means the umbrella term that encompasses all mental health and substance use related assessment, treatment, prevention, and support services.

5. Certified Community Behavioral Health Clinic (CCBHC)" means an organization that has been licensed by BHDDH as a Behavioral Healthcare Organization (BHO) and certified by the Executive Office of Health and Human Services (EOHHS) as a CCBHC to provide a comprehensive range of mental health and substance use disorder services. CCBHCs deliver coordinated, accessible, and culturally competent care, including crisis intervention, outpatient treatment, and community-based services, in accordance with federal and state standards for quality, safety, and integration of care.

6. "Child" means an individual under age eighteen (18).

7. "Children and youth," as used in these Regulations, includes individuals aged two (2) through twenty-one (21), except where a different age range is expressly stated.

8. "Child-family competency" means proficiency in clinical practice skills with children with severe emotional disturbance and their families, knowledge of research on child development, application of the

knowledge in a clinical context and familiarity and experience with community resources that benefit children and families, including knowledge of the cultural beliefs and practices of the diverse communities served.

9. "Child-family competent clinician" (herein referred to as Clinician) includes, but is not limited to: Psychiatrists, Licensed Psychologists, Psychiatric and Mental Health Advanced Practice Registered Nurses (APRNs), Registered Nurses with a Bachelor of Science in Nursing (BSN), Licensed Independent Clinical Social Workers (LICSWs), Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Licensed Mental Health Counselors (LMHCs), Qualified Mental Health Professionals (QMHPs), and associate-level licensees such as Licensed Marriage and Family Therapist Associates (LMFTAs) and Licensed Mental Health Counselor Associates (LMHCAs). including clinicians with substance use disorder expertise, such as Licensed Advanced Alcohol and Drug Counselors (LAADCs) and Licensed Alcohol and Drug Counselor (LADC). The clinician must have at least one year of clinical experience with children and adolescents who have behavioral health problems. The clinician must meet the child-family competency standards outlined in § 6.2(F) of this Part.

    a. Each licensed provider must determine the child-family competency of all staff members providing children's ES or MRSS 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.

10. "Crisis evaluation" means a comprehensive assessment by the Clinician to evaluate the seriousness of the mental health and substance use crisis based on the child's functioning and risk to self and others and the family/caregiver's potential, skill level and capacity, with appropriate supports, to manage the behaviors that put the child at risk. The crisis evaluation includes screening for substance use disorder and, when indicated, an assessment of the appropriate level of care using evidence-informed criteria unless otherwise defined in statute.

11. "Cultural and linguistic competency" means the ongoing ability of a licensed provider organization and its staff to deliver behavioral health services that are respectful of and responsive to the cultural and linguistic needs of the children and families served. This includes understanding that perceptions of behavioral health conditions,

crises, and their causes vary across cultures, which influences help-seeking behaviors and attitudes toward services, providing meaningful access to services for individuals with limited English proficiency; and ensuring effective communication for individuals who are deaf or hard of hearing, including through interpreter services and accessible communication methods.

a. Phone lines and web sites that assure access for people who are deaf or hearing impaired

b. Interpretation services available within the two (2) hour time period for Emergency Services

c. Translated materials/forms for persons who do not speak or read English in the communities served by the Emergency Services or Mobile Response and Stabilization Services program.

12. “Current accreditation from the Joint Commission” means a valid, active accreditation status granted by the Joint Commission, a nationally recognized, independent organization that evaluates and accredits healthcare organizations based on established standards for quality, safety, and performance in the delivery of behavioral health and other healthcare services.

13. “Current certificate from CARF” means a valid, active certification issued by the Commission on Accreditation of Rehabilitation Facilities (CARF), an international, independent organization that accredits behavioral health, human services, and rehabilitation programs based on rigorous standards for service quality, safety, and outcomes.

14. “Current certification from COA” means a valid, active certification granted by the Council on Accreditation (COA), a national, independent organization that accredits organizations providing child welfare, behavioral health, and community-based services, ensuring compliance with standards for quality, safety, and effective service delivery.

15. “Family-Defined Crisis” means a situation identified by the child, parent, or caregiver as constituting a crisis for which a response is needed, regardless of whether the presenting concern appears to meet a traditional clinical definition of acute behavioral health crisis.

16. "Mental health professional" means a psychiatrist, psychologist, or social worker and such other persons, including a psychiatric nurse clinician and licensed advanced practice registered nurse (APRN) as

defined in R.I. Gen. Laws § 40.1-5-2, as may be defined by rules and regulations promulgated by the Director of BHDDH.

17. “Mobile Response and Stabilization Services (MRSS)” means a behavioral health crisis intervention program providing immediate de-escalation, stabilization services, and follow-up care for children or youth experiencing a behavioral health crisis. The primary goal is to ensure the safety and well-being of the child or youth through de-escalation, clinical assessment, stabilization, and connection to ongoing support services

18. Qualified Mental Health Professional (QMHP)" means a mental health professional, as that term is defined in R.I. Gen. Laws § 40.1-5-2 and applicable BHDDH regulations, who is approved by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) and has a minimum of thirty (30) hours of supervised face-to-face emergency services experience as a psychiatric emergency service worker in Rhode Island. Such experience may be gained through employment with: (i) a community mental health center that conducts emergency psychiatric assessments for individuals under consideration for admission to an inpatient mental health facility; or (ii) a licensed hospital that conducts emergency psychiatric assessments for individuals under consideration for admission to an inpatient mental health facility.

19. "System of Care (SOC)" means a coordinated array of easily accessible services that address the behavioral health treatment needs of children and adolescents who have serious emotional disturbances. The SOC operates consistent with core principles and values that are strength-based, child-centered and family-driven. The services are culturally and linguistically competent and emphasize natural and community-based supports that complement behavioral health services provided by professionals in agency and hospital settings. The SOC promotes cross-system collaboration among education, child welfare, juvenile justice, and healthcare systems, and ensures that care is individualized, provided in the least restrictive environment, and guided by measurable outcomes.

20. “Warm handoff” means a seamless transfer of care from one provider or service to another, involving direct, facilitated introduction of the child and family/caregiver through face-to-face, telephonic, or video interaction - to the receiving provider, ensuring continuity of support, reduced risk of disengagement, and immediate access to appropriate ongoing behavioral health or community services.

21. "Young adult" means an individual ages eighteen (18) through twenty-one (21).

22. "Youth" means an individual ages twelve (12) through seventeen (17), unless otherwise specified.

D. Coordination with BHDDH

1. These Regulations govern licensure and standards for children's mental health emergency services and Mobile Response and Stabilization Services (MRSS). DCYF maintains primary responsibility for mental health services for children under eighteen (18), consistent with R.I. Gen. Laws § 42-72-5.2.

2. These Regulations are promulgated in coordination with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), which retains its statutory authority as the State Mental Health Authority and Single State Authority for substance use disorder services. MRSS remains a child, youth, and young adult-focused crisis response service licensed and overseen by DCYF under these Regulations.

3. Authority for the reporting and investigation of abuse, neglect, and exploitation of individuals ages 18 through 21 is shared by DCYF and BHDDH. BHDDH derives its authority from R.I. Gen. Laws §§ 11-5-10.2, 11-5-11, 11-5-12, 23-17.8-2, 23-17.8-3, 40-8.5-2, 40.1-5-3, 40.1-26-10, and 40.1-27-2.

E. Consent for Emergency Service Interventions Involving Minors

1. In Rhode Island, consent requirements for emergency service interventions, including both Emergency Services (ES) and Mobile Response and Stabilization Services (MRSS), depend on age, marital status, and specific circumstances.

2. Minors under 16 generally require parental or legal guardian consent for behavioral health services, including ES and MRSS, unless an exception applies, such as emergencies or imminent risk of serious harm (R.I. Gen. Laws § 23-4.6-1).

3. Minors aged 16 or older, or those who are married, may independently consent to ES and MRSS, and a minor parent can consent for their child (R.I. Gen. Laws § 23-4.6-1).

4. In emergency situations, minors of any age can receive immediate ES and 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).

5. ES and MRSS providers must document consent or the specific exception applied, such as emergency intervention.

6.2 LICENSURE STANDARDS FOR MENTAL HEALTH EMERGENCY SERVICE INTERVENTIONS

A. In order to be licensed for emergency services, the Emergency Service Provider Organization (hereinafter, the Provider) must include a telephone crisis hotline, face-to-face interventions in the community and the means to develop and implement a follow up plan to access community-based and 24-hour services.

B. The Provider meets the standards established under each component.

C. Telephone Contact, Support and Follow up

1. The Provider maintains a telephone system that includes:

   a. A phone line and a number which answered by a live voice twenty-four hours per day, seven days per week, 365 days per year. The answering service or Provider must have the capacity to provide timely language assistance and interpreter services for callers with limited English proficiency and effective communication access for callers who are deaf or hard of hearing, including through accessible communication methods.

   b. The caller has telephone access to the Clinician within fifteen minutes of the initial call to discuss the crisis and to develop a follow up service plan based on the child and their family/caregivers needs and collaboration on next steps.

2. The Provider works with the Department and other applicable state agencies and payers to publicize the service throughout their service delivery area including in languages other than English in diverse communities.

D. The Provider establishes emergency service intervention policies and procedures that meet the following criteria:

1. Families, caregivers, health care professionals and others who are working with a child experiencing a behavioral health crisis have access to a Clinician with back-up from a clinical supervisor/ administrator. The Clinician may consult with additional qualified treatment professionals, including a child- trained psychiatrist licensed to practice medicine in Rhode Island.

a. The Clinician provides face-to-face crisis counseling, evaluation of the current behavioral health emergency and the development of a crisis and safety plan and a follow up service plan for a family/caregiver with a child experiencing a behavioral health crisis.

b. The face-to-face contact takes place within two hours of the child and their family's/caregiver's request regardless of the time of day of the call.

c. The clinical supervisor is available to the Clinician and collateral providers for telephone consultation on the assessment and care planning and returns pages or phone calls within fifteen minutes of the request from the Clinician.

2. The family and the Clinician jointly determine the location for the face-to-face crisis intervention to accommodate family needs and preferences, provide for the timeliest and clinically appropriate setting to gather relevant information, increase the chances of de- escalating the crisis and protect the physical safety of all parties.

3. The Clinician meets with the child and family/caregiver and, as part of the intervention, offers support, completes a crisis evaluation, assesses the child and family for risk to harm self or others and engages the family and collateral providers in the assessment and follow up service planning process.

4. The Provider follows up with families/caregivers to make sure that the plan was implemented.

5. When an overdose or suspected substance use crisis is identified during the intervention, the Clinician shall follow evidence-based overdose response protocols, including administration of naloxone when clinically indicated and permitted under applicable laws and regulations, shall contact emergency services, including 911, when immediate medical intervention is warranted, and shall ensure timely referral to appropriate level of care substance use disorder services, including those specialized for children and adolescents.

E. The Provider establishes policies and procedures to complete the emergency service intervention with follow up service planning including:

1. The Clinician works with the child and family/caregiver to resolve the behavioral health crisis and to promote the health and safety of the child and the family. The Clinician collaborates with the child and family/caregiver to identify services, either existing or new,in the follow up plan that build on the family's strengths, needs, and preferences.

2. The Provider ensures all staff are familiar with the full range of community, residential and hospital-based services that can best match the family's needs, strengths and preferences.

3. The Clinician is also familiar with clinical eligibility criteria and authorization procedures of health insurance coverage.

4. The Clinician makes an appropriate referral to a program and/or service based on the child-family assessment and mutually identified needs. The Clinician and/or their organization also complete any pre-certification required by the child's health insurance plan.

5. The Provider ensures that the follow up service planning process includes:

    a. The Clinician discusses the follow up that the family prefers and makes arrangements to contact the family and/or the referral source the following day to make sure that the follow up resource was available.

    b. The Provider has a form that notes the legal guardian's signed agreement on the type of follow up in the encounter document or emergency evaluation that is part of the child's medical record.

    c. The Provider is available to the child and family for follow up contact for seventy-two hours after the initial crisis intervention if other community resources are not immediately available.

    d. The Provider establishes a complaint and grievance procedure if the family disagrees with the follow up service plan.

F. Standards for Child - Family Competency

1. To be licensed to provide emergency service interventions, the Provider must establish a policy for the recruitment and/or training of emergency service staff. Staff must possess the following clinical skills:

    a. Knowledge of child development, behavior, and psychopathology: The clinician should have a strong understanding of child development and behavior, including the normal range of emotions and behaviors for children of different ages. This includes knowledge of the normal developmental milestones for children of different ages, as well as the signs and symptoms of common behavioral health disorders in children.

b. Knowledge of family systems: The clinician should 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 identify any factors that may be contributing to the child's crisis.

c. Skills in working with children and families: The clinician should have strong skills in working with children and families. This includes the ability to build rapport with children and families, communicate effectively with children and families and provide support to children and families.

d. Skills in diagnostic assessment: The clinician should be able to formulate accurate and appropriate diagnoses based on the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and apply diagnostic formulations to assess the child's behaviors and presenting conditions.

e. Skills in risk assessment: Child-specific risk and safety assessment skills should 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: The clinician should 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: The clinician should have strong skills in crisis intervention and suicide prevention for children and families. This includes the ability to assess a crisis situation, accurately assess a child's mental health status, de-escalate a crisis in a family setting and provide support to the child and family during a crisis. Clinicians without authority to execute an emergency certificate shall immediately request the in-person attendance of a QMHP, psychiatrist, psychiatric APRN, or physician authorized to do so when emergency certification is clinically indicated.

h. Knowledge of community resources: The clinician should have knowledge of community resources that can be helpful to children and families in a crisis. This includes knowledge of behavioral health services, social services, and other community resources.

i. Ability to work collaboratively with other professionals: The clinician should be able to work collaboratively with other professionals, such as teachers, doctors, first responders, social workers, and other behavioral health professionals. This collaboration is essential for providing comprehensive and coordinated care to children and families in crisis.

j. Cultural competence: The clinician should be culturally competent and aware of and sensitive to the cultural beliefs and practices of the children and families they serve.

k. Other training specific to RI Mental Health Laws, mandatory reporting requirements in cases of child abuse and neglect, Adverse Childhood Experiences (ACEs), trauma and trauma-informed care and social drivers of health, also known as social determinants of health and responding to youth with disabilities.

2. To be licensed to provide emergency service interventions, the ES Provider must establish policies and procedures for maintaining and verifying documentation that demonstrates all clinical staff meet the child-family competency requirements outlined in 6.2.F.1a-k. The documentation must include, at a minimum:

a. Resumes or curriculum vitae verifying education, training, and relevant experience;

b. Professional licensure and certifications as applicable to the staff role;

c. Training records must demonstrate completion of required areas, including but not limited to: knowledge of child development, behavior, and psychopathology; family systems theory and family assessment; skills in working with children and families (including building rapport, effective communication, and providing support); diagnostic assessment skills using the current DSM; risk and safety assessment (including suicide risk, non-suicidal self-injury, violence, abuse/neglect, trauma exposure, and other immediate safety risks); crisis intervention and suicide prevention; knowledge of community resources; ability to

collaborate with other professionals; cultural and linguistic competence; Rhode Island mental health laws and mandatory reporting requirements for child abuse and neglect; trauma-informed care, Adverse Childhood Experiences (ACEs), and social determinants (or drivers) of health; and responding to youth with disabilities.

d. Agency policies and procedures describing recruitment, orientation, supervision, and ongoing training for emergency services staff.

3. To be licensed as a Provider, the organization must provide ongoing training, consultation, support and updated information to staff who provide emergency service interventions. The Provider ensures a minimum of ten hours of training per year on best and promising practices in children's behavioral health and knowledge of community resources including:

a. The types of health insurance coverage and the behavioral health benefit packages

b. The eligibility and/or admission criteria for the children's behavioral health treatment programs.

c. A list of contact names and phone numbers for the community providers of children's behavioral health treatment, advocacy, support and collateral services.

4. The Provider has an identified subject matter expert on the SOC referral process and how to obtain access to social service, housing, employment and other services.

5. The Provider ensures all staff have knowledge of culture-specific services, the linguistic capacity of community services and the ability to work effectively with an interpreter of sign language and/or spoken language.

6. The Provider identifies a clinical subject matter expert who can provide training and consultation to the emergency services staff based on his/her expertise on the current best practice interventions in the field of children's behavioral health.

G. Program Monitoring and Quality Improvement

1. The Provider collects encounter data on emergency service interventions monthly as described herein.

a. Complete and forward mandated forms and reports to the Department.

b. Provides aggregate report to the Department monthly.

2. The standardized report includes aggregate data of emergency service interventions that capture the age, gender, ethnicity, status with the Department, child's living arrangement, insurance coverage, time of day, day of week, location of intervention and type of disposition.

3. Telephone Performance Metrics

The Provider shall track all telephone contacts and shall report the following metrics to the Department monthly, in the format prescribed by the Department:

a. Source of the call (e.g., parent, guardian, child, or collateral party).

b. Percentage of calls in which a clinician was made available to the caller within fifteen (15) minutes of the initial request.

c. Total number of calls received per month.

d. Percentage of calls that resulted in a face-to-face intervention.

e. Time of call and reason for the call.

2. The Provider develops an internal process to review complaints from the family or other parties involved in the intervention.

3. The Provider shall have a process for resolving disagreements with the family/caregiver.

H The Provider has an established training protocol in children's behavioral health that includes an annual plan to address the best practices and current findings related to working with children with serious emotional disturbances and their families in a culturally and linguistically competent manner and from an individual and family systems perspective.

6.3 LICENSURE STANDARDS FOR MOBILE RESPONSE AND STABILIZATION SERVICE (MRSS) INTERVENTIONS

A. General Requirements

1. To be licensed to provide Mobile Response and Stabilization Services (MRSS), a provider must meet the requirements for

Emergency Services (ES) licensure as outlined in § 6.2(A) through (I) of this Part.

2. MRSS providers must meet additional standards to deliver mobile crisis intervention and stabilization services, consistent with R.I. Gen. Laws § 27-18-95.

3. MRSS providers shall deliver services in accordance with System of Care principles. MRSS service delivery, care planning, and coordination shall be family-driven, youth-guided, community-based, culturally and linguistically responsive, and provided in the least restrictive environment appropriate to the needs of the child or youth and family.

4 MRSS providers shall provide services to all children and youth presenting with behavioral health crises, regardless of insurance status, coverage limitations, or ability to pay.

5 MRSS services are available to children and youth ages two to twenty-one, inclusive. Providers shall deliver services in a developmentally appropriate manner.

6. In addition to DCYF requirements as they pertain to reporting of abuse, neglect and/or exploitation, and cooperating with any investigations of such allegations, MRSS providers shall comply with all reporting and investigation requirements pursuant to R.I. Gen. Laws §§ 11-5-10.2, 11-5-11, 11-5-12, 23-17.8-2, 23-17.8-3 40-8.5-2, 40.1-5-3, 40.1-26-10, and 40.1-27-2.

7 MRSS providers must maintain coordination protocols with RI Suicide & Crisis Lifeline (Lifeline).

B. MRSS Service Delivery

1. MRSS providers must deliver services in three phases: screening and triage, mobile crisis response, and stabilization, as follows:

a. Screening and Triage: Providers must maintain a 24/7/365 telephone system that is answered by a live voice, with clinician availability. For purposes of MRSS, a crisis is defined by the child, parent, or caregiver, and the provider shall not deny or screen out a request for response solely because the presenting concern does not appear to meet a traditional clinical definition of acute behavioral health crisis. Providers shall not delay screening, triage, or dispatch of an immediate response while awaiting parental consent when available information indicates that immediate assessment is necessary

for safety. Providers must determine the response type (Immediate, Non-Immediate, or Emergency) as follows:

(1) Immediate: A mobile crisis team responds within 60 minutes to the crisis location, with telephonic support provided until in-person response arrives.

(2) Non-Immediate: A mobile crisis team is deployed within 1 to 23 hours at a time requested by the family/caregiver or referral source, unless a delayed response increases risk to the child. A non-immediate response is used only when requested by the referral source.

(3) Emergency: An emergency necessitating transfer to 911 is defined as a situation where an individual's needs exceed MRSS capabilities. This includes cases requiring urgent medical attention (e.g., overdose, severe self-injury) or involving active violence posing imminent danger. Following a transfer, MRSS will coordinate with emergency services within 24 hours.

b. Mobile Crisis Response: Providers must deploy a two-person mobile crisis team, including a child and family competent clinician and another clinical or paraprofessional staff member. It is strongly encouraged that the clinician serving on the two-person mobile crisis team also be certified as a Qualified Mental Health Professional (QMHP). If a QMHP certified clinician is not part of the responding team, the provider must ensure that the team has timely and ready access to a QMHP for consultation and clinical support. The team must:

(1) Conduct immediate safety and risk assessments, including mental status exams and evaluations for suicide risk, non-suicidal self-injury, violence, abuse/neglect, and other immediate risks.

(2) Provide age-appropriate de-escalation and stabilization, prioritizing crisis resolution before screenings or referrals.

(3) Develop an initial crisis and safety plan in partnership with the child and family/caregiver, outlining triggers, strategies, and resources tailored to their needs.

(4) Avoid law enforcement involvement unless safety necessitates it, with family input and notification, and

remain engaged to support coordination if law enforcement involvement becomes necessary.

(5) Obtain necessary releases and permissions.

(6) Facilitate direct linkages to higher levels of care if the child cannot remain safely in the community, completing pre-certification as required by the health insurance plan.

c. Stabilization: Providers must offer stabilization services for children and youth in crisis, tailored to the needs of the child or youth and their family or caregivers. Stabilization may be provided for a period of up to 30 days, unless the child transitions to appropriate services sooner, or longer if necessary, such as when follow-up services are not yet available. Stabilization includes:

(1) A biopsychosocial assessment and screening tools to inform a follow up service plan.

(2) At least one (1) face-to-face meeting per week with the child and family/caregiver, or more frequent meetings as clinically indicated based on assessment, progress, and family/caregiver preferences.

(3) Telephone support and coordination and consultation with external providers (e.g., schools, community services).

(4) Collaboration with the child and family to set short-term goals and connect to formal, informal, and natural supports.

(5) Warm handoffs to existing or new service providers for ongoing needs, ensuring continuity of care.

(6) Assessment of immediate basic needs (e.g., food, housing, transportation) and linkage to community resources.

(7) Access to a 24/7/365 on-call system with clinical support throughout the stabilization period.

d. If a child or youth experiencing a crisis is already engaged with an existing behavioral health service provider, and that provider is unable to respond with immediate capacity, the MRSS provider shall deliver the mobile crisis response and

ensure a warm handoff back to the existing provider. In these cases, the MRSS provider may offer stabilization services upon referral, if the existing provider cannot offer timely support, or if the child or youth requires a higher level of care than the existing service can deliver.

e. MRSS providers must collaborate with child-serving systems, including schools, courts, child welfare, juvenile justice, and community supports, to ensure coordinated care and to prioritize maintaining children and youth in their homes, schools, and communities whenever safe and appropriate.

C. Service Areas, Statewide Capacity, and Mutual Aid

1. Scope of Licensure and Designation of Primary Service Areas

a. The Department retains sole and exclusive authority to license, deny, restrict, suspend, or revoke licensure for Emergency Services (ES) and Mobile Response and Stabilization Services (MRSS) providers pursuant to R.I. Gen. Laws §§ 42-72-5, 42-72-5.2, and 27-18-95

b. An MRSS license authorizes a provider to offer MRSS services statewide. Each licensed MRSS provider shall maintain the operational capacity to respond anywhere in the state as needed and to participate fully in the statewide MRSS response network, including through mutual-aid arrangements when activated outside its approved primary service area(s).

c. As part of the licensure application, each MRSS provider shall identify one or more preferred primary service areas in which it will maintain priority responsibility for service availability, accessibility, and timely response.

d. Primary service areas may overlap with the geographic service areas of the state's Certified Community Behavioral Health Clinics (CCBHCs) or may consist of other service areas proposed by the provider and approved by the Department prior to licensure or renewal. In reviewing and approving primary service areas, the Department shall consider the provider's demonstrated operational capacity to ensure service availability, accessibility, and timely response, as well as the overall need to support comprehensive statewide coverage through the mutual-aid system

2. Primary Accountability

a. An MRSS provider is primarily accountable for maintaining adequate staffing, oversight, and operational capacity to meet response time and service requirements within its designated primary service areas.

3. Mutual Aid Requirements

a. All MRSS providers must maintain mutual-aid agreements with all other DCYF-licensed MRSS providers. Mutual-aid agreements must establish clear procedures for requesting and providing backup during periods of exceptional demand, staffing shortages, or other capacity constraints affecting timely response in a provider's primary service area.

b. Mutual aid must incorporate considerations of family preference and clinical appropriateness. When feasible, families shall be informed when a mutual-aid provider will respond and given basic information about that provider.

c. Mutual aid is intended for exceptional circumstances and shall not be used as a routine or ongoing staffing strategy. A provider's license may be subject to review or action if the Department determines that it is relying excessively on mutual aid due to a failure to maintain adequate staffing for its primary service area.

d. In the event of a service area having no designated MRSS provider with primary accountability, some or all licensed MRSS providers shall temporarily assist in covering services in that area via mutual aid until an MRSS provider is designated for the service area.

4. Statewide Response Capacity

a. Because all MRSS providers maintain mutual-aid agreements, each provider is part of the statewide MRSS response network and may be activated to respond outside its primary service areas through the mutual-aid process.

D. Staffing Requirements

1. MRSS providers must meet all ES staffing standards in § 6.2(F) of this Part and ensure the following additional requirements:

a When a QMHP performs functions governed by the Mental Health Law, including emergency certification, such activities shall be conducted in accordance with R.I. Gen. Laws § 40.1-

5-7 and applicable BHDDH regulations, and do not expand DCYF's statutory authority to approve QMHPs.

b Providers must submit staffing schedules as part of their initial application and every six (6) months thereafter, using a Department-approved template. The staffing schedules must specify staff names and credentials, position titles and roles, regularly scheduled hours and shifts, and on-call coverage including rotation schedules, as well as any other information the Department determines necessary to assess staffing capacity. The Department will review and approve all staffing schedules to ensure that providers maintain adequate staffing levels and appropriate coverage to meet service demands.

c Staff must have access to a child and adolescent psychiatrist or an Advanced Practice Registered Nurse (APRN) certified in Psychiatric/Mental Health for 24/7/365 on-call consultation.

d All mobile crisis team staff (clinical and paraprofessional) shall receive routine clinical supervision that includes a minimum of one hour of individual supervision and three hours of group supervision per month for full-time staff (pro-rated for part-time staff), and shall have 24/7/365 access to a qualified clinical supervisor.

e Staff composition should reflect the racial, ethnic, linguistic, and gender diversity of the communities served, whenever possible.

2. MRSS providers must notify the Department within 24 hours when capacity is reached, including current caseload, staffing levels, and estimated duration of constraints. Providers shall establish mutual aid agreements with system partners to manage demand spikes, ensuring continuous availability, accessibility, timeliness, and flexibility.

E. Data Collection and Documentation

1. MRSS providers must comply with ES data collection and documentation standards in § 6.2(G) of this Part.

2. Providers delivering Mobile Response and Stabilization Services (MRSS) shall deliver services in a manner consistent with nationally recognized MRSS fidelity standards and will be required to consistently track and report on a set of fidelity measures designed to assess adherence to the core components of the MRSS model. Providers will be expected to submit this data to DCYF on a regular

basis, following a reporting schedule and format that will be determined by the Department.

3. Providers must document all interactions and services related to crisis care, including but not limited to triage calls, screening, crisis assessments, biopsychosocial assessments, safety and crisis plans, interventions, stabilization services, and any follow-up or referrals. Documentation must be timely, accurate, comprehensive, clear, accessible to authorized users, and compliant with protected health information (PHI) regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

4. The provider shall establish an internal process to regularly review all MRSS records for completeness, clinical quality, and compliance with documentation standards, and shall develop and implement corrective action plans as needed when deficiencies are identified.

6.4 LICENSURE PROCESS FOR PROVIDERS OF EMERGENCY SERVICE (ES) AND MOBILE RESPONSE AND STABILIZATION (MRSS) INTERVENTIONS

A. Overview

1. The Department of Children, Youth, and Families (the Department) licenses providers of children's mental health emergency services under two distinct levels:

   a. Emergency Services (ES) Providers: Deliver behavioral health crisis interventions, as outlined in § 6.2 of this Part.

   b. Mobile Response and Stabilization Services (MRSS) Providers: Deliver behavioral health crisis interventions and stabilization services for children and youth, as outlined in § 6.3 of this Part, and must meet all ES standards.

2. Organizations applying for licensure as ES or MRSS Providers must submit an application to the Licensing Division at the Department, demonstrating compliance with the standards outlined in § 6.2 of this Part and, for MRSS Providers, additional requirements specified in § 6.3 of this Part.

B. Application Submission

1. Organizations submit applications for ES or MRSS licensure to the DCYF Licensing Division.

2. DCYF reviews applications for completeness within 10 business days. Incomplete applications are returned to the applicant if the applicant does not provide the missing information within 30 calendar days of the date of notification of an incomplete application

3. Organizations may reapply at any time following denial of an initial application. Following revocation of a license or denial of a renewal application, the organization may not reapply for one (1) year from the date of the revocation or denial.

C. Application Requirements for ES Providers

1. Organizations applying to be licensed as ES Providers must submit the following to the Licensing Division:

a. Statement of Assurances: A notarized commitment by the organization to comply with these Regulations; submit monthly activity reports in a format prescribed by the Department; ensure that all staff, volunteers, contractors, and subcontractors who may have direct contact with children successfully complete and maintain current statewide and nationwide criminal record background checks, statewide and national sex offender registry checks, and child abuse and neglect (Child Protective Services) clearances as required by the Department; prohibit any individual with a disqualifying finding from providing services to children under this license; and adhere to all other applicable Department policies and procedures.

b. Organizational Information: Details of the ES program, including name, address, public emergency phone number, and contact information.

c. Documentation of current accreditation by the Council on Accreditation (COA), the Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF).

d. A description of the organization's delivery of children's emergency service interventions, addressing:

(1) Twenty-four (24) hour per day, seven (7) day per week live telephone coverage with language access for non-English speakers and accessibility for deaf/hearing-impaired callers (§ 6.2(C) of this Part).

e. Staffing and Competency:

(1) Documentation of child-family competent clinicians (per § 6.2(F) of this Part) with at least one year of supervised clinical experience with children/adolescents, including credentials (e.g., LICSW, LMHC, RN, MD).

(2) Evidence of a minimum of 10 hours of annual staff training in children's behavioral health best practices.

f. A commitment to reporting to the Department on monthly activity using the Department reporting format, and a commitment to develop internal review mechanisms to monitor compliance with these standards.

g. A statement identifying the geographical areas the organization can reliably serve based on knowledge of and access to local mental health and community-based services and the organization's ability to meet the timelines within these standards.

h. Elements of the organization's quality improvement plan related to children's behavioral health services describing processes for reviewing ES interventions for compliance, handling complaints, and measuring family satisfaction.

D. Additional Application Requirements for MRSS Providers

1. Organizations applying to be licensed as MRSS Providers must meet all ES Provider application requirements listed in § 6.4(B) of this Part and provide the following additional documentation to demonstrate expertise in delivering child-specific mobile response and stabilization services, as required by (R.I. Gen. Laws § 27-18-95 Acute Mental Health Crisis Mobile Response and Stabilization Services

2. Evidence of at least one year of experience providing Mobile Response and Stabilization Services (MRSS); or prior experience delivering mobile crisis and stabilization services for children and youth, combined with participation in recognized MRSS training or technical assistance to ensure consistency with the MRSS model and fidelity to its core principles. Such experience shall be as verified by DCYF through documentation or other relevant information submitted by the provider, including data on crisis response times, stabilization outcomes, and community linkages.

3. Each MRSS applicant shall identify in its application one or more preferred primary service areas and submit documentation demonstrating its operational capacity to maintain service availability, accessibility, and timely response in those areas, and to participate in

statewide coverage through mutual-aid arrangements. Preferred primary service areas may overlap with CCBHC geographic service areas but are not required to do so and shall be subject to Department approval.

4. Policies and procedures for delivering stabilization services post-crisis, including:

    a. Evidence of capacity to provide stabilization services, such as clinical services, care coordination, peer support, and other community-based services to address acute behavioral health crises.

    b. Protocols for collaborating with youth and families/caregivers to develop and implement individualized crisis and safety plans, incorporating formal, informal, and natural supports tailored to the child and family's needs.

    c. A description of a robust data collection and reporting system capable of tracking stabilization outcomes, including client engagement, service utilization, and disposition data, for Department review.

E. Applicant Eligibility

1. Any organization that provides behavioral health services to children and meets the criteria below may apply to become a licensed ES and/or MRSS provider.

    a. The organization is licensed as a Behavioral Health Organization by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) or under regulations promulgated by the Department per R.I. Gen. Laws § 42-72.1.

F. Approval Process

1. Review:

    a. DCYF reviews Emergency Services (ES) and Mobile Response and Stabilization Services (MRSS) applications within 60 days.

    b. At its discretion, DCYF shall request any additional documentation or clarification within fifteen (15) business days of receiving the application or any subsequent submission.

2. Determination:

a. DCYF issues:

(1) Full licensure as an ES Provider, indicating compliance with all ES standards.

(2) Full licensure as an MRSS Provider, indicating compliance with both ES and MRSS standards, subject to Department approval based on state-wide service needs and demonstrated expertise in child-specific mobile response and stabilization services.

(3) Denial: A written explanation shall be provided, along with notice of the applicant's right to request an administrative hearing pursuant to 210-RICR-10-05-2 (Appeals Process and Procedures for EOHHS Agencies and Programs).

6.5 LICENSING ACTIONS

A. The Department may deny, suspend or revoke a license for an Emergency Services (ES) or Mobile Response and Stabilization Services (MRSS) provider, or curtail specific activities, if the conditions specified in this Section are met.

1. The provider fails to comply with these Regulations or applicable state or federal laws.

2. The provider submits false or misleading information during the licensing process.

3. The provider's operations pose a health or safety risk to children or clients served.

4. The provider fails to address identified deficiencies within the timeframe specified by the Department.

B. The Department follows the procedure specified in this Section for licensing actions.

1. The Department's Licensing Administrator or designee sends written notice to the provider's chief executive, detailing the violation, complaint, or circumstances warranting action and providing a deadline for response.

2. The notice offers the provider an opportunity to meet with the Licensing Administrator to demonstrate why the action should not be taken.

3. If violations persist after the meeting, the Department issues written notification of the licensing action within ten (10) business days, specifying:

   a. Requirements for a corrective action plan.

   b. Information about the provider's appeal rights.

4. The provider submits a corrective action plan within the timeframe specified by the Department, addressing the violation and providing:

   a. Evidence of compliance, or

   b. A plan to achieve compliance.

5. If the provider fails to comply with the corrective action plan or meet the deadline, the Department may:

   a. Suspend the license; or

   b. Revoke the license.

C. The Department may take emergency actions as specified in this Section.

1. If the Director or designee determines that public health, safety, or welfare requires immediate action, the Department may summarily suspend a license or curtail activities, pending further proceedings, in accordance with R.I. Gen. Laws § 42-35-14(c).

2. Written notice of the emergency action and appeal rights is provided to the provider.

D. The Department may revoke or refuse to renew a license if the conditions specified in this Section are met.

1. The provider remains non-compliant with these Regulations.

2. The provider fails to submit required documentation.

3. Continued operation poses an imminent danger to the health, safety, or welfare of clients.

4. The provider fails to correct deficiencies within the timeframe specified in the notice of non-compliance.

E. Providers must comply with requirements for voluntary surrender or closure as specified in this Section.

1. Providers must notify the Department at least ninety (90) days before closing or changing ownership.

2. Upon closure, the license must be returned to the Department.

3. Providers ensure continuity of services for clients for up to:

    a. Ninety (90) days, or

    b. Until alternative arrangements are made.

4. Providers shall inform the Department of any intention to discontinue participation as a licensed ES or MRSS provider. This includes planned agency closure or discontinuation of ES or MRSS services.

5. Upon providing notice to the Department of the decision to close or discontinue providing ES or MRSS services (referred to as the "Notice of Service Termination"), the provider shall continue to provide such services for up to ninety (90) days or until the Department approves an earlier transition date, whichever is sooner. This ensures continuity of care for clients.

6. In the case of a planned agency closure or service discontinuation, within forty-five (45) days of the Notice of Service Termination, the provider shall develop and submit a written transition plan to the Department.

7. The transition plan must ensure the orderly transfer of all clients receiving services. This includes coordination with other providers, warm handoffs, and linkage to appropriate ongoing behavioral health or community supports.

8. The Department shall review and approve the transition plan prior to its implementation.

9. Clients and their families or guardians shall receive written notice of the provider's termination of services. This notice must include details of the approved transition plan. The notice shall be provided no later than thirty (30) days prior to the approved transition date.

F. Providers may appeal licensing actions as specified in this Section.

1. Providers may appeal any licensing action in accordance with R.I. Gen. Laws Chapter 42-35 and the Executive Office of Health and Human Services (EOHHS) Rules and Regulations for Appeal Process and Procedures (210-RICR-10-05-2).

G. The Department coordinates with other state licensing agencies as specified in this Section.

1. The Department coordinates with other state licensing agencies regarding licensing actions, as required by state regulations or law.

6.6 LICENSE DURATION AND RENEWAL

A. The continued validity and renewal of licenses are contingent upon adherence to these Regulations.

1. Licenses are issued for a two-year period.

2. Renewal applications, including all required updated documentation, must be submitted to the Licensing Division no later than 90 days prior to expiration.

3. A license remains in effect during the review of a timely renewal application unless it is revoked or voluntarily surrendered.