

42nd Annual InterCourt Conference



Session 4C: *Innovative Practices*
Licking County Juvenile
Justice Program

How Mobile Crisis
Stabilization Can Reduce
Juvenile Justice Involvement

March 13, 2026
Hilton Columbus at
Easton Town Center
Columbus, OH

FACULTY BIOGRAPHIES

WADE KIRK is a Mentoring Specialist with more than 25 years of experience empowering youth and strengthening communities. Currently serving as Community Mentorship Coordinator for Licking County Probate-Juvenile Court, Wade develops impactful programs that provide guidance and support to at-risk youth while fostering collaboration with community organizations.

His career spans diverse roles, including Family Services Coordinator with NYAP's Juvenile Justice Program, Youth Pastor, and Detention Aftercare Coordinator, where he has championed mentorship, leadership development, and restorative practices. Wade's unique blend of experience in behavioral health, juvenile justice, pharmacy, and pastoral leadership reflects his deep commitment to equipping the next generation with the skills and values needed to thrive.

An ordained pastor and certified Qualified Behavioral Health Specialist, Wade combines professional expertise with a passion for service, helping youth discover their potential and make positive contributions to their communities.

JOEI MCARTOR, LISW-S, brings almost 20 years of experience in behavioral health across a wide range of clinical and leadership settings. Her clinical background includes partial hospitalization, intensive outpatient programming, and both individual and group therapy services. She is a trauma-informed clinician and has trained in Child-Parent Psychotherapy (CPP) and EMDR.

Her work spans school based behavioral health treatment, foster care, outpatient services, and juvenile justice populations. She worked as a Treatment Coordinator and Therapist, and in addition to her clinical work, she has served in multiple leadership roles including Clinical Supervisor and Program Manager. She is currently the Program Manager for NYAP Newark's Behavioral Health Program, and she supervises the Licking County NYAP Behavioral Health Juvenile Justice team. Joei has a strong commitment to strengthening systems, supporting clinicians and staff, and creating meaningful outcomes for youth and families.

CASSIE OLIVER serves as the Director of Clinical Programs at the National Youth Advocate Program. With over 23 years of experience in the mental health field, she brings extensive clinical expertise, leadership, and a deep commitment to serving children, families, and communities.

Cassie has dedicated the past 16 years to NYAP, where she has played a key role in developing and overseeing high-quality clinical services, strengthening program outcomes, and mentoring clinical teams. Her leadership focuses on evidence-based practice, staff development, and ensuring accessible, compassionate care for the individuals and families served.

Throughout her career, Cassie has remained passionate about advancing trauma-informed care, building strong clinical systems, and supporting professionals in delivering ethical, impactful mental health services.

ANTHONY WEDEMEYER is a 2001 Graduate of Newark High School in Newark, Ohio. He graduated with a BA in History from Ohio University in 2005, and eventually earned a Masters Degree in Education from Mount Vernon Nazarene University in 2017. He began working in in the juvenile justice system in 2007 with the Licking County Probate-Juvenile Court. In 2013 after moving to Georgia, Anthony worked with the Department of Juvenile Justice, and upon returning to Ohio in 2015 went to work with the Franklin County Juvenile Court. After teaching one year at Licking Valley High School, Anthony returned to the Licking County Probate-Juvenile Court in 2017 and has been in his current position since 2021. Anthony is an avid reader of history and has coached high school girls soccer for several years.

TIA COKES is a dedicated public servant with nearly 20 years of experience in state government, specializing in programming that supports the health and well-being of underserved populations across the lifespan. She holds a bachelor's degree in Sociology, with a minor in African American Studies, from The Ohio State University and a master's degree in Community Counseling, with a concentration in working with at-risk youth, from The University of Akron.

Tia began her career as a vocational rehabilitation counselor for Opportunities for Ohioans with Disabilities, where she spent seven years empowering individuals to achieve independence and employment goals. She then served for eight years as the Statewide Falls Prevention Coordinator at the Ohio Department of Aging, where she worked on Governor Kasich's Initiative to reduce the risk of falls among older adults. During her time at ODA, she was recognized for her leadership in expanding the "A Matter of Balance" program from 44 counties to statewide coverage, and also for her integral role in establishing Ohio's Falls Prevention Awareness Day and launching the "10 Million Steps to Prevent Falls" campaign, which both continue to be observed annually.

Currently, Tia serves as the Statewide Program Administrator for Mobile Response and Stabilization Services (MRSS) at the Ohio Department of Mental Health and Addiction Services. In this role, she is leading the statewide expansion efforts of MRSS, carrying out the DeWine-Tressel Administration's vision of all Ohio's youth and families having access to high-quality, rapid mobile crisis response services. Tia's professional career continues to be driven by a commitment to improving systems of care, empowering and elevating underserved populations, fostering resilience in Ohio's communities and her overall passion to help Ohioans live well and thrive through every stage of life.

DAWN PUSTER, MSW, LISW-S, is the Deputy Director of OhioRISE with the Ohio Department of Medicaid. She received her B.S. degree in Psychology and M.A. in

Educational Psychology from Tennessee Technological University in 1998. She received her MSW in Social Work from Columbia University in 2000. Dawn has special areas of study during her graduate and undergraduate work that includes social problems, juvenile justice, child and family studies and community programming. During her studies at Columbia her direct practice work focused on residential settings with adolescents and individual and family counseling in a community based mental health setting.

Dawn has worked with children and families in a variety of settings since 1995. During her time in New York City, she worked in the family court system and also did community-based work, all with children and families. She has spent the majority of her work experience with a non-profit provider agency working in intensive-home based treatments, mobile crisis intervention, and program development.

In 2021, Dawn joined the Ohio Department of Medicaid and supported the launch of OhioRISE in July 2022. OhioRISE is a program developed through Medicaid using a shared-governance model with other child-serving systems including, Ohio Department of Mental Health and Addiction Services, Ohio Department of Education and Workforce Development, Department of Youth Services, Department of Children and Youth, and Department of Developmental Disabilities. The program supports youth with complex behavioral health needs. The goal of OhioRISE is to bring systems together to address complex needs through a specialty health care plan (Aetna, Better Health of Ohio) and prevent custody relinquishment. Care Coordination using High Fidelity Wrap Around along with other community-based services are at the heart of this program.

Licking County Juvenile Justice Program

Wade Kirk

*Family Support Coordinator
National Youth Advocate Program*

Joei McArtor

*OPBH Program Manager
National Youth Advocate Program*

Cassie Oliver

*Director of Clinical Programs
National Youth Advocate Program*

Anthony Wedemeyer

*Director of Court Services
Licking County Probate-Juvenile Court*





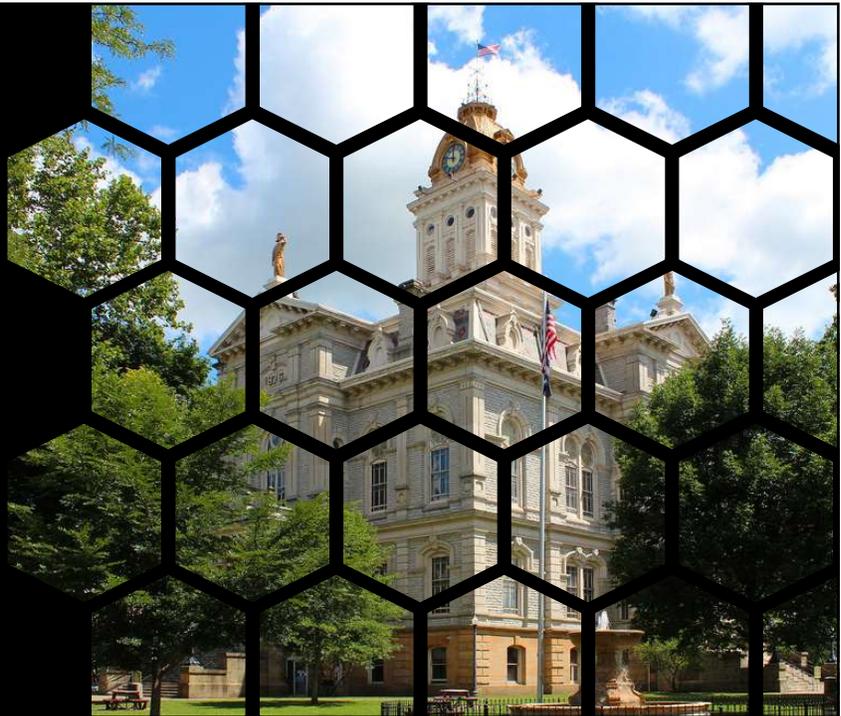
**NATIONAL
YOUTH
ADVOCATE
PROGRAM**

*Caring for People
Connecting Communities
Promoting Peace*

**Behavioral Health Juvenile Justice
partnership with
Licking County Juvenile Court**



**Introduction
to BHJJ**



The Need

- **Historical Context for the shift – Cuff and Stuff to a kinder, gentler approach**
 - **Shift from providing in-house services to engagement with community partners**
- **The Legendary Wade Kirk**
 - **One man's passion for working with Court involved youth**
- **Speed of service – the wait list problem**
 - **Families need services NOW!**
- **Benefits of the BHJJ**
 - **No wait list**



BHJJ

- **One-stop shop**
 - **Family Service Coordination**
 - **Individual Therapy**
 - **Home-Based Services**
 - **Groups**
 - **Parent Project**
- **Teamwork**
 - **Court Staff embedded with NYAP (Parent Project)**
 - **Court Officers communicate with FSCs frequently**
 - **Monthly high-level meetings**



- BHJJ services have now extended to Diversion and the Assessment and Resource Center (ARC)

- Services linked more quickly
- Family support
- Linkage through the ARC provides early intervention before Court involvement.



What is BHJJ?

Licking County Juvenile Justice Program

- Partnership between the Licking County Probate-Juvenile Court and NYAP
- Behavioral Health specifically aligning with the needs of court-involved juveniles and families

Why BHJJ?



- No programs existed in LC specific for this population
 - Waitlisting was an issue
 - Huge need for focused care
- Juveniles need for someone to “show up”

Passion & Purpose...

- Individual lives changed and positive community impact through relationship building.

BHJJ Structure

After the referral youth are assigned to staff...

- Therapist, FSC (Family Services Coordinator), Medication Services (CNP)
 - Assessed for intense services (IHBT, FFT)
 - Other agency involvement
- (In most cases, an FSC can still work with the juvenile)

Range of Services Offered

Diagnostic assessments

Psychotherapy

Therapeutic Behavioral Services (TBS)

Psychiatric services

Person-served group therapy

Parent group therapy

Functional Family Therapy (FFT)

Intensive Home-Based Therapy (IHBT)

BHJJ Groups

PARENT PROJECT

- Co-led by BHJJ therapist and PO
- Court ordered or voluntary
- 12 weeks (2 hours per week)



YEP (Youth Empowerment Project)

- Social and Problem Solving Skills
- Self-paced/leader directed
- 12 weeks if motivated
- Primarily Medicaid funded



What do we do?

The FSC is the “secret sauce”

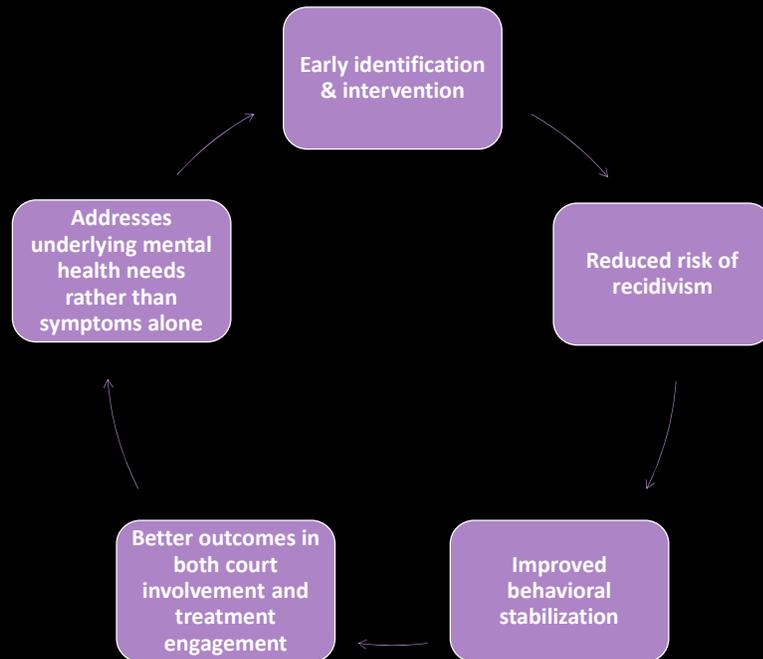
- Behavioral Health, Case Management, Crisis Management, Advocacy, Mentoring, Parent Coaches
 - School (Advocacy, Behavior Support)
 - Probation (Supportive Services)
- Team approach (OhioRise, other services)
 - Medication and Appointments
 - Other community supports

“Holistic” Approach



People are the product of many factors that are all interconnected. Addressing a single area, will not “fix” a kid. We must look at the whole picture.

Benefits for Youth & Families



Keys to Success

- Early intervention
- Regular check-ins (text, calls)
- - Consistency showing up
- Getting the match correct
- Intentional relationship building (Court, probation, OhioRise, Resource agencies)
- Manageable caseloads
- Boundaries to prevent burnout

BHJJ Program Significance

Serves a specialized, high-need population

Reaches youth who may not engage in traditional outpatient services

Supports system-involved youth with complex needs

Enhances program stability and sustainability

Case Study



“Tank”

BHJJ Referral Process

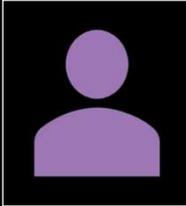
- **Court-Based Referral**
 - Person served is referred by court staff via JotForm
 - JotForm is sent to the Program Manager
 - Program Manager assigns case for opening and services

- Person served completes referral:
- Consents are sent to the family
- Person served is placed on waitlist
- Services scheduled when an opening becomes available

Traditional Referral Process



Value to the Court & Stakeholders



Positions NYAP as a trusted behavioral health expert



Strengthens collaboration with:
Judges
Probation officers
Court staff



Improves compliance with court expectations



Streamlines case coordination



NATIONAL
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ADVOCATE
PROGRAM

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How Mobile Crisis Stabilization Can Reduce Juvenile Justice Involvement

Tia L. Cokes, MA

*MRSS Statewide Program Administrator
Bureau of Crisis Services
Ohio Department of Behavioral Health*

Dawn Puster, MSW, LISW-S

*Deputy Director
OhioRISE Program*



Mobile Response and Stabilization Services: How MRSS Can Support the Juvenile Justice System

Tia Cokes

Ohio Department of Behavioral Health

Dawn Puster

Ohio Department of Medicaid



MRSS

Mobile Response &
Stabilization Services

“One of the biggest complaints I hear in my travels around Ohio is from families who don’t know where to turn for help when their child is in a mental health crisis. And so, we are increasing the availability of immediate behavioral health care in the right place at the right time through the expansion of what we call “Mobile Response Stabilization Services.”

...I intend to take this model to all 88 counties, so no matter where you live, if your child is in crisis, that child will get immediate care.”

Governor Mike DeWine
State of the State Address
April 10, 2024



What is MRSS?

What is MRSS?

MRSS stands for **Mobile Response and Stabilization Services**.

Mobile Response and Stabilization Services (MRSS) is a community-based intervention that provides immediate support to young people, aged 20 and under, who are experiencing mental, emotional or behavioral distress or any other traumatic circumstances that has impacted their ability to function within their family, school, or community.



What is MRSS?

- **It's mobile, so youth and parent or caregiver don't have** to go anywhere. Trained professionals come directly to the home or to another agreed upon safe location, such as a school, within 60 minutes of contacting MRSS.
- **With MRSS, the family/caller defines the crisis** - if it's a crisis to the youth and/or their family, MRSS will be there to respond. Some common issues that MRSS teams can help with include, but are not limited to:

TOP 5 Primary Reasons for Referral

- Suicidality (43%)
- Family Conflict/Stress (27%)
- Aggression/Physical Outburst (20%)
- Depression (18%)
- Self-Injury/Harm (16%)

Goals of MRSS

- 1**
Establish individual and family safety
- 2**
Maintain youth in the least restrictive setting
- 3**
Divert children from hospital emergency rooms and inpatient hospitalization
- 4**
Decrease the number of unnecessary arrests in school or in the community
- 5**
Assist youth and families in learning new skills

MRSS Team Composition

- Independently licensed supervisor(s) always available to staff
- Licensed or license-eligible clinician(s) who can either independently or under supervision diagnose behavioral health disorders **and**
- Qualified behavioral health specialist(s) (QBHS) **and/or**
- Parent and/or youth peer supporter(s) **and**
- Access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation

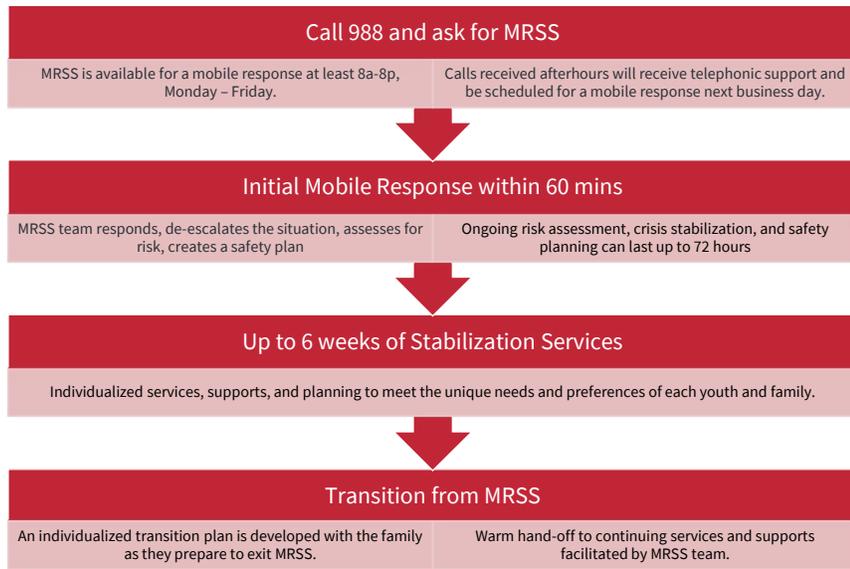


How Is MRSS Different?

MRSS stands out from traditional crisis services because the model also incorporates:

- **Immediate and flexible** - "just go" mentality coupled with location flexibility (at home, school, etc.)
- **Focus on continuity of care** - coordination of services/supports; integrated approach (facilitating, joining, and/or collaborating with interdisciplinary treatment team)
- **Integration of Peer Supporters** with specific and relevant experience to improve youth/family engagement and investment
- **Caller/Family defines the crisis** – there is no level of acuity required for a response; if it's a crisis to the caller, MRSS will respond

MRSS Process



Ohio's MRSS Journey

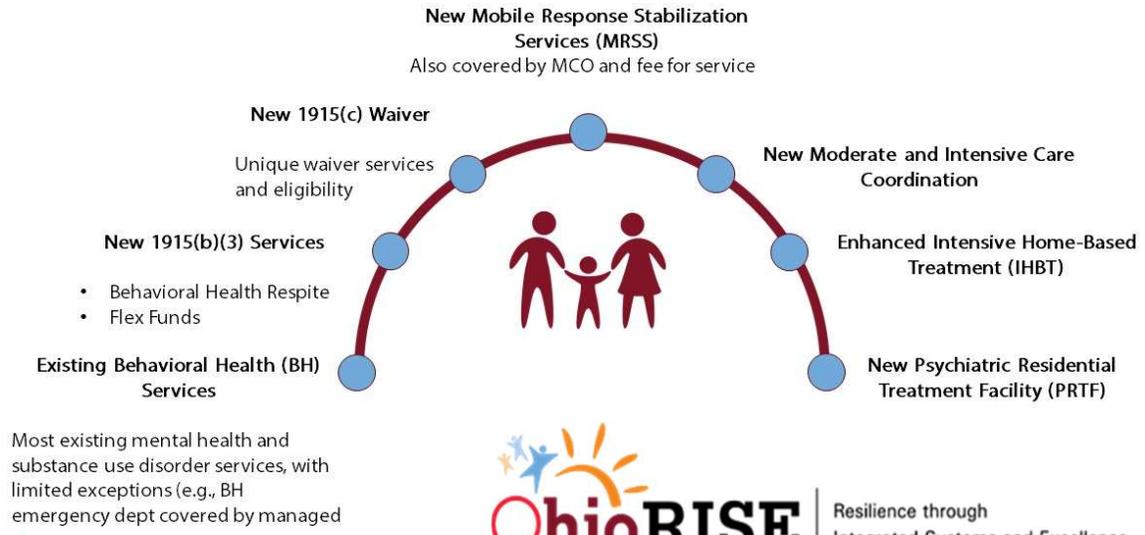
Journey of MRSS in Ohio

From grant funded pilot to Medicaid billable service

- 2017** • DBH awarded federal SAMHSA SOC Expansion grant, ENGAGE 2.0
- 2018** • MRSS pilots begin with 7 organizations providing MRSS in 13 counties
- 2022** • OhioRISE, DBH and ODM MRSS Rule, Statewide Call Center, and Data Management System launch
- 2023** • 20 organizations providing MRSS in 47 counties, 9 providers operate 24/7
- 2024** • Gov. DeWine commits to ensuring MRSS is available to all Ohio youth and families by the end of his administration



OhioRISE New and Enhanced Services



MRSS Statewide Expansion

Commitment to ensure MRSS is available for all Ohio families

- After the commitment from Governor DeWine, DBH and ODM partnered to begin working on plans to expand MRSS statewide.
- To achieve this Governor's priority, the following areas needed to be addressed:
 - Expansion of coverage area and availability of MRSS statewide
 - Benefit coverage for all youth (Medicaid and non-Medicaid)
 - 24/7 in-person response
 - Workforce shortages
 - Streamlined infrastructure



Other Reflections and Lessons Learned

In addition to expanding statewide, there were additional areas that needed to be incorporated into planning efforts

- **MRSS Rule:** There was no minimum requirement for hours of operations
- **Funding Model:** Funding MRSS as reimbursement for services only was not sustainable long-term
- **Mobile Response Staffing Requirements:** With continued workforce challenges, providers continue to report difficulties expanding due to an inability to find licensed clinicians.
- **Crisis Continuum Alignment:** While the state is fully invested in 988 as Ohio's statewide crisis support line, we were also operating a separate statewide call line for MRSS.



MRSS Regional Model

OHIO'S REGIONAL MRSS MODEL

AN EFFICIENT AND SUSTAINABLE APPROACH to achieve the vision of statewide access to MRSS for all youth in Ohio.



Developing a regional MRSS approach to enhance access and service capacity, designated MRSS regions and expanded dollars to support a "firehouse"* rate model.



Creating MRSS model flexibility by updating OhioMHAS' MRSS certification rule and Practice Standards.



MRSS Model Vision Goals:



18 Regions in all 88 counties.



One MRSS Provider for each region.

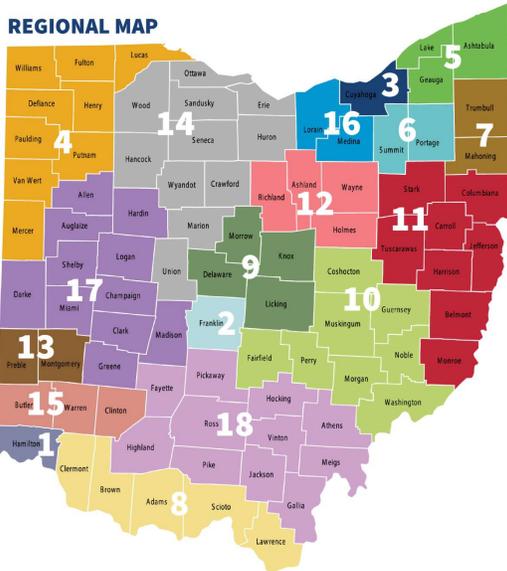


Firehouse Model and Braided Funding structure.

Ohio's Regional MRSS Model Counties and Providers

Map of MRSS providers by region and county.

REGIONAL MAP



12 PROVIDERS BY REGION

-  **Allwell Behavioral Health**
region 10
-  **Alta Care Group**
region 7
-  **Applewood Centers**
region 16
-  **Coleman Health Services**
regions 6, 14, 17, 18
-  **The Counseling Center of Wayne and Holmes**
region 12
-  **Nationwide Children's Hospital**
region 2
-  **Butler Behavioral Health**
regions 1,15
-  **Child Focus**
region 8
-  **Choices Coordinated Care Solutions**
region 13
-  **Ohio Guidestone**
regions 3, 9, 11
-  **Ravenwood**
region 5
-  **Unison Health**
region 4

Role of Regional MRSS Providers (RMPs)



Capacity Building, Quality Monitoring, and Improvement:

- Provide mobile responses for crisis response, de-escalation, and stabilization, to the entire coverage region for all calls during the minimum mobile response operating hours, 8 a.m.- 8 p.m. Monday-Friday.
- Work towards establishing regional operational hours of 24/7 mobile response coverage by April 1, 2028.
- Engage in regional quality monitoring and oversight
- Implement performance improvement measures for MRSS.



Community Partnerships & Collaboration:

- Maintain and build strong partnership with:
 - Alcohol, Drug Addiction, and Mental Health (ADAMH) boards
 - Child-serving agencies
 - Child Welfare
 - Other providers within the region
- Promote access to and use of MRSS through these partnerships.
- Collaborate with contiguous regions to confirm efficient service delivery.



MRSS integrated into 988

- **988 is the access point for MRSS**
- 988 serves as the crisis control center for all things crisis in Ohio, connecting the community to whatever crisis support they need – whether it’s **someone to talk to, someone to respond, or a safe place to go.**



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988's Role in MRSS



988 staff have completed two trainings in preparation for the integration of MRSS and 988.



988 staff have an understanding MRSS, the screening/triage process, use of the DMS, and the process for warm transferring callers to the appropriate RMP.



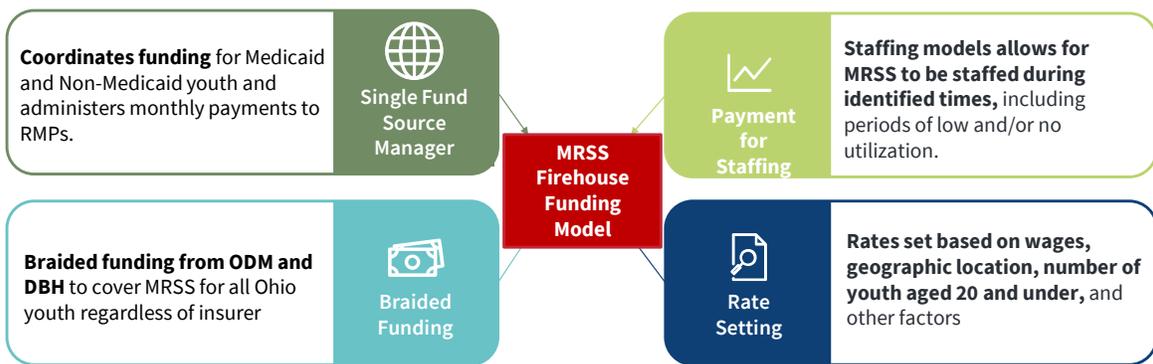
MRSS may be initiated through **988 or direct connection with the RMP.**



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Financing

MRSS Firehouse Model



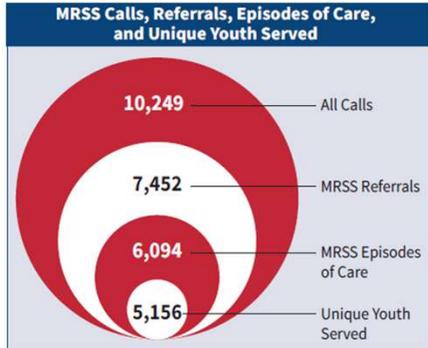
Ohio developed a "firehouse" model funding approach for MRSS providers to create a more predictable funding stream that supports efficiency, availability, and access to services.

Firehouse Model Rate Setting Approach

MRSS RATE MODELS	
Previous Rate Model	Updated Rate Model
FEE SCHEDULE MODELS	FIREHOUSE MODEL
<ul style="list-style-type: none"> Crisis mobile response – per episode rate 	<ul style="list-style-type: none"> Determined by modeling the overall funding needed to support an MRSS team on a weekly basis The hours staff are available to provide MRSS on a weekly basis have a significant impact on the per week rate Multiple models included in RFP developed to address major differences in costs across providers (e.g., team staffing and hours of service differences) Not “cost-based”, but modeled rates based on provider-specific staffing
<ul style="list-style-type: none"> Crisis mobile response follow-up – per hour rate 	
<ul style="list-style-type: none"> Crisis stabilization – 15-minute rate 	

MRSS Data

MRSS Data & Outcomes – FY25



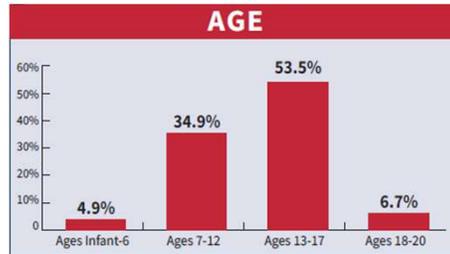
*Not all Calls were seeking MRSS service or Mobile Response within 48 Hours. To be counted as an MRSS Episode of Care, referrals had to be served within 48 hours of the first call. In addition, 938 youth re-engaged in Service within SFY 2025, so we also provided the Unique Youth Served Count.

26% MRSS Youth RE-ENGAGED in MRSS Services



TOP 5 Referral Sources

	#	%
Parent/Caregiver	3,896	52.3%
School Staff	1,466	19.7%
Emergency Department	419	5.6%
Mental Health or Substance Use Provider	274	3.7%
Law Enforcement	224	3.0%



INSURANCE

66% Medicaid Managed Care, OhioRISE, Fee for Service

21% Private or Commercial Insurance

MRSS Data & Outcomes – FY25

73% of referrals were triaged as **IMMEDIATE**

with **82%** responded to in 60 minutes or Less

42% of youth only received a mobile response (did not receive stabilization services)

2,542 Youth served

58% of youth received stabilization services after their initial mobile response

3,554 Youth served

TOP 3 MRSS Location of 1st Visit

- Home (59%)
- School (21%)
- MRSS Office (7%)

17 AVERAGE DAYS OF SERVICES FOR MRSS YOUTH AND FAMILIES

TOP 5 Primary Reasons for Referral

- Suicidality (41%)
- Family Conflict/Stress (27%)
- Aggression/Physical Outburst (19%)
- Depression (19%)
- Self-Injury/Harm (17%)



MRSS Data & Outcomes – FY25

Comparison of Outcomes for MRSS Youth in the Past 30 Days vs During MRSS Stabilization

52%	REDUCTION	in New Admissions to Emergency Department (BH/SUD)
34%	REDUCTION	in New Admissions to Inpatient Hospital (BH/SUD)
21%	REDUCTION	in New Admissions to Residential Treatment Centers
48%	REDUCTION	in New Admissions to Crisis Stabilization Unit
56%	REDUCTION	in New Admissions to Detention (Jail/Detention Center)
37%	REDUCTION	in New Arrests/Probation Violations/Status Offenses
53%	REDUCTION	in Non-Arrest Calls from Caregivers or Schools
25%	REDUCTION	in School Suspensions/Expulsions



MRSS and the System of Care

Ohio's Crisis Continuum of Care

MRSS is only one part of the larger system of care in Ohio.



MRSS within Ohio's System of Care

MRSS SOC Collaborators and Partners

- Shared responsibility across systems
- Developing collaborative partnerships to assure that services, supports, planning and linkages are coordinated
- Consultation and coordination with schools, existing providers/services, and care coordination programs during mobile response and stabilization phases
- Facilitated youth and family planning meetings
- Transition to community-based services and supports



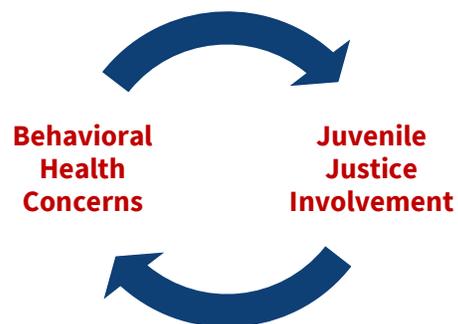
MRSS and Law Enforcement

- One of the primary goals of MRSS is to reduce unnecessary engagement with law enforcement.
- MRSS can assist with preventing escalation of behaviors, to the point of law enforcement involvement.
 - Law enforcement officers are trained and specialize in addressing life threatening situations, crimes in progress, or other public safety emergencies, but not necessarily behavioral health crises.
 - MRSS teams are trained and specialize in assisting with behavioral health crises and do not respond with law enforcement, unless absolutely necessary.



MRSS and the Juvenile Justice System

- When compared to youth with no juvenile justice system involvement, youth involved in the juvenile justice system have disproportionately higher rates of behavioral health disorders.
- Most youth with juvenile justice system involvement reside in the community, so ensuring youth are connected to community based behavioral health support is essential to help prevent continued or increased juvenile justice involvement.



(Sichel, C. E., Galbraith, K., & Elkington, K. S. (2025). Breaking the cycle: connecting youth under community supervision to effective behavioral health services)



MRSS and the Juvenile Justice System

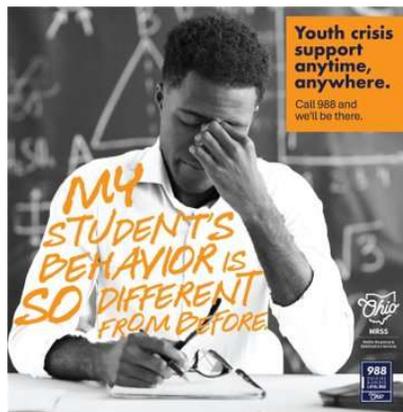
How MRSS can support the juvenile justice system:

- MRSS can serve as a resource for the juvenile justice system to support youth in crisis instead of engaging law enforcement for emotional or behavioral health concerns.
 - juvenile courts
 - law enforcement/911 dispatch centers
 - probation officers
 - schools resource officers
- MRSS can be engaged at the time of discharge from JDCs or other residential facilities to assist with transition back to the community if needed.



MRSS Resources

Resources including flyers, posters, and rack cards are available for community partners to post and share.



QUESTIONS?



MRSS

Mobile Response &
Stabilization Services

MRSS.ohio.gov



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MORE INFORMATION

dbh.ohio.gov

Join the DBH listserv for all
the latest updates.

OhioMRSS@dbh.ohio.gov



