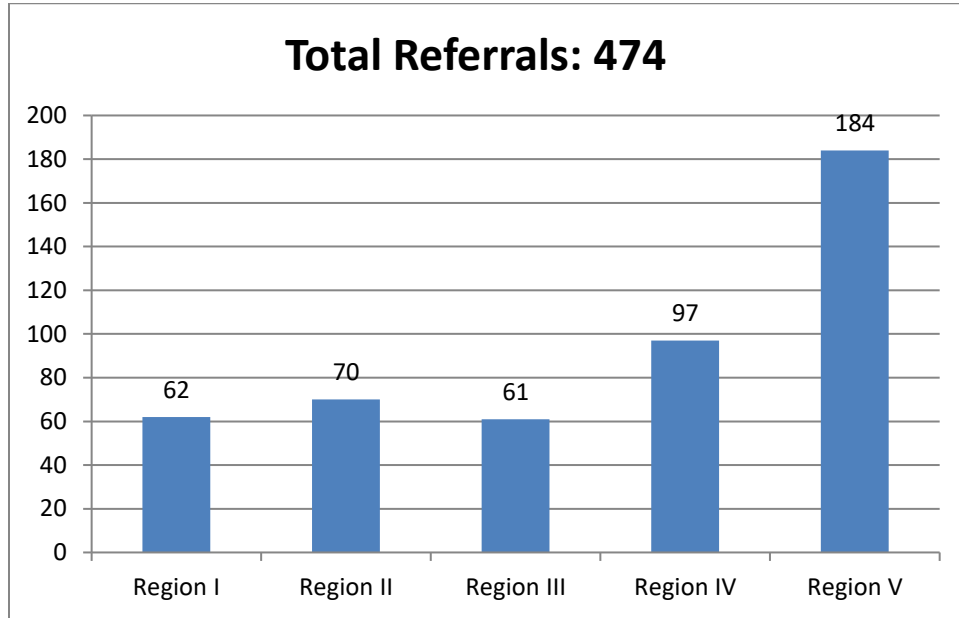


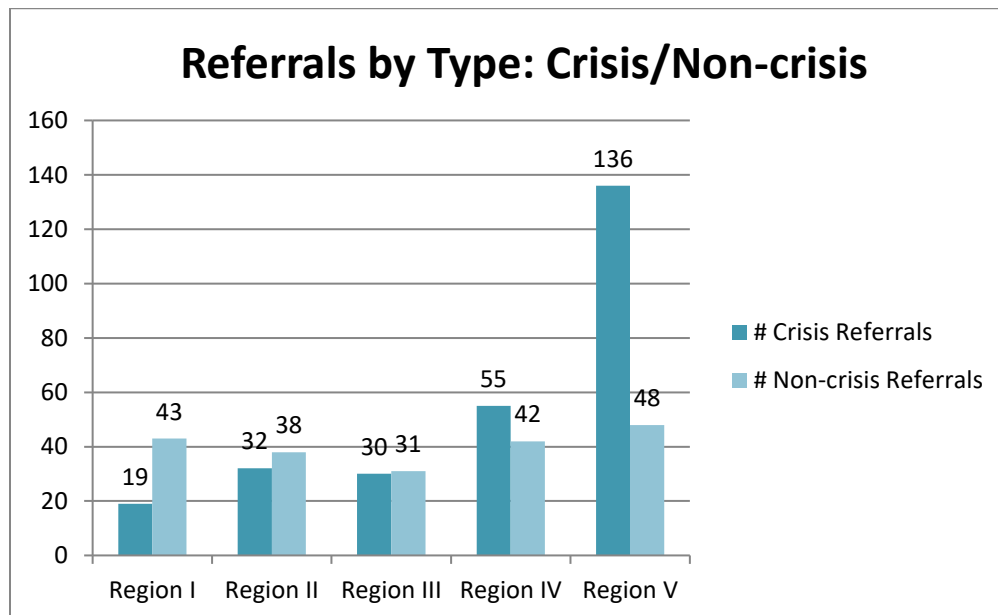
Children's REACH Quarterly Report: II-FY20

This report provides data related to the Children's REACH programs. All data contained in this report corresponds to activity from October 1, 2019 through December 31, 2019.

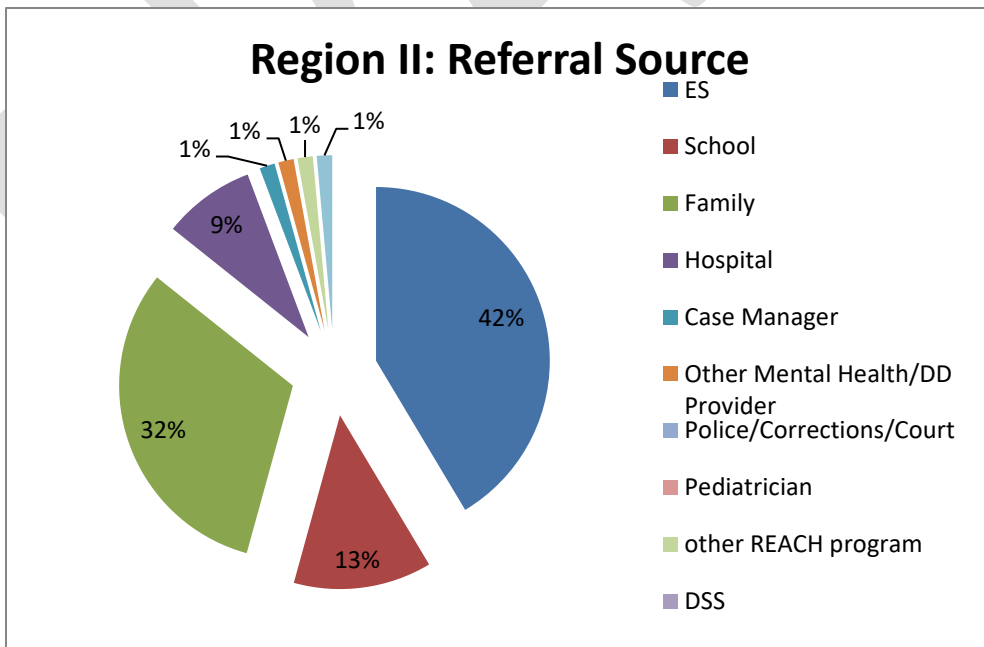
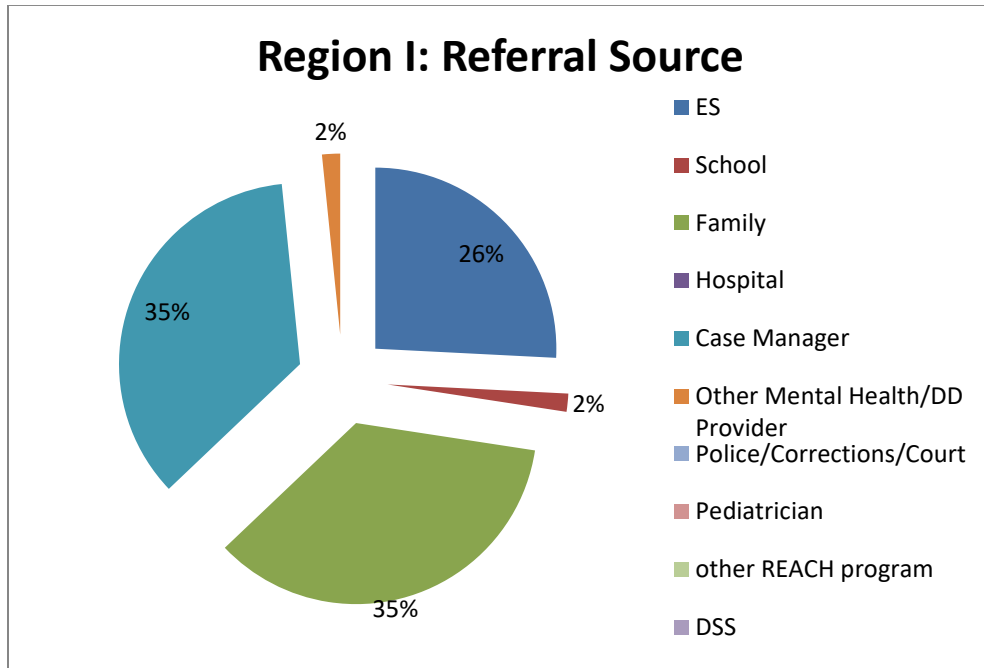
REACH Referral Process

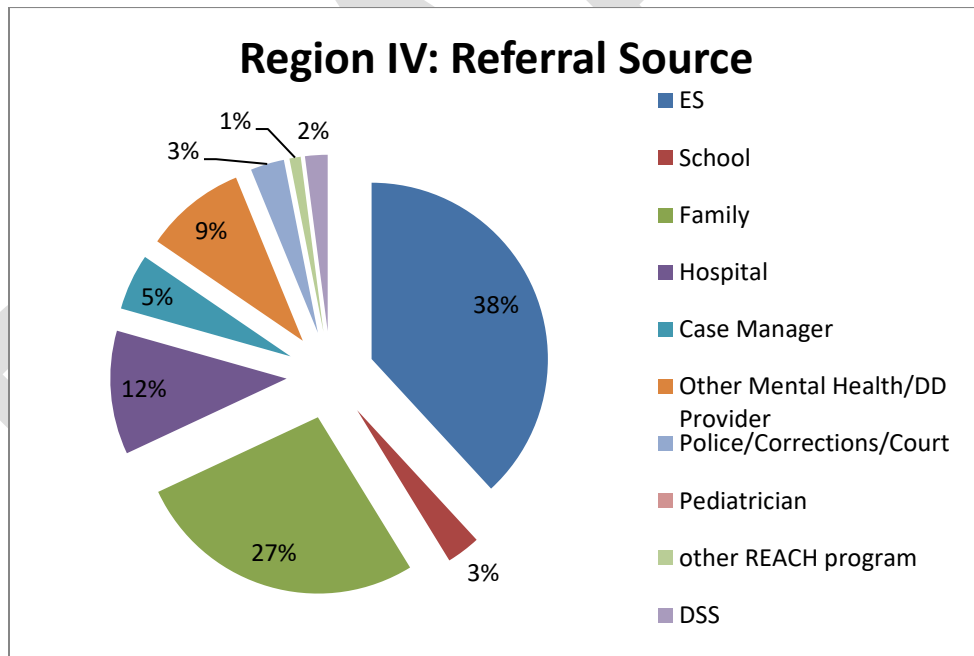
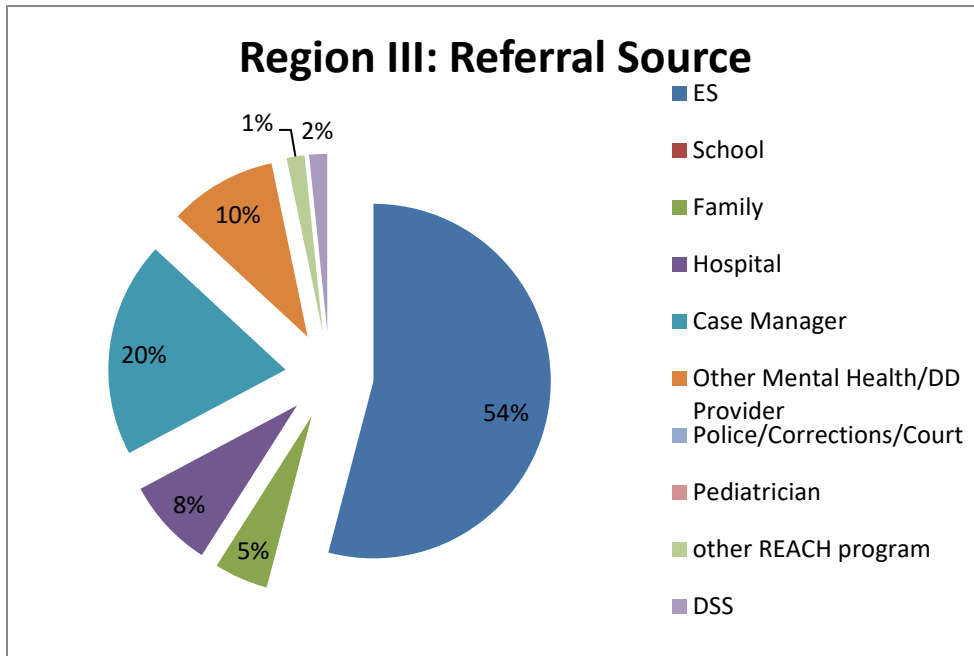


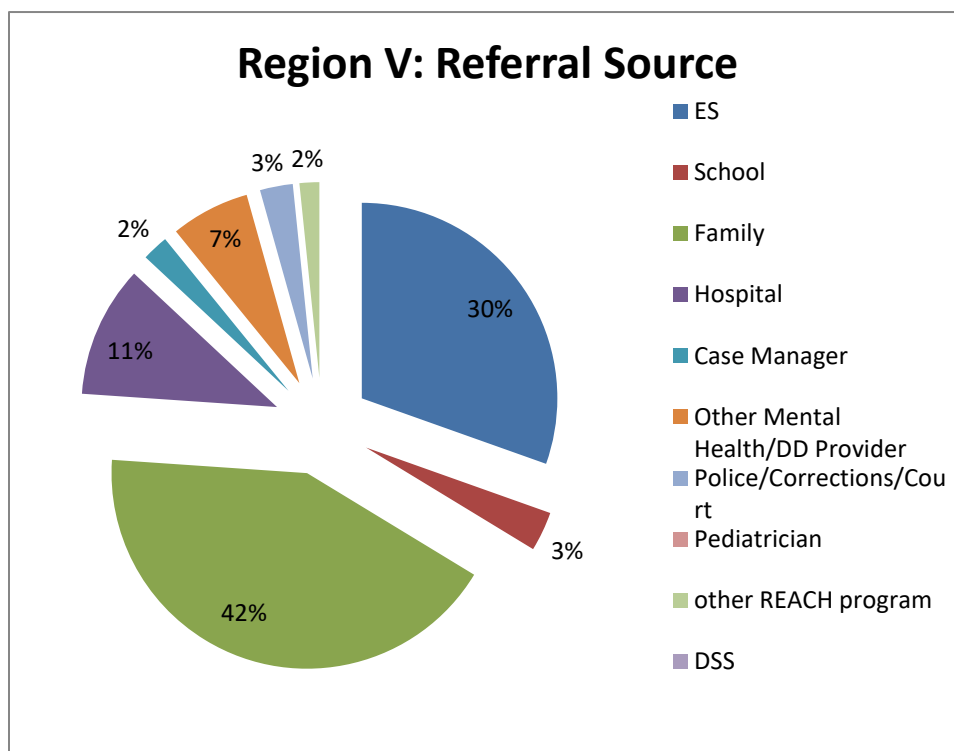
Statewide referrals totaled 474 children and youth for the second quarter of fiscal year 2020 (FY20) for the Children's REACH programs. This is a significant increase in referrals from the previous quarter (343). The table below segments referrals that were crisis in nature (i.e. need to be seen the same day) and those that were non-crisis or of lesser acuity.



The referral sources provide a perspective on how well the programs are establishing themselves within the communities they serve. The five charts below provide a regional breakdown of referral source data. The subsequent tables provide data concerning the day of the week and time of day that referrals are received by the programs.







Referral Time	Region I	Region II	Region III	Region IV	Region V	Totals
Monday-Friday	58	57	50	83	148	396
Weekends/Holidays	4	13	11	14	36	78
7am -2:59pm	36	34	30	53	84	237
3pm - 10:59pm	26	31	27	37	90	211
11pm – 6:59am	0	5	4	7	10	26

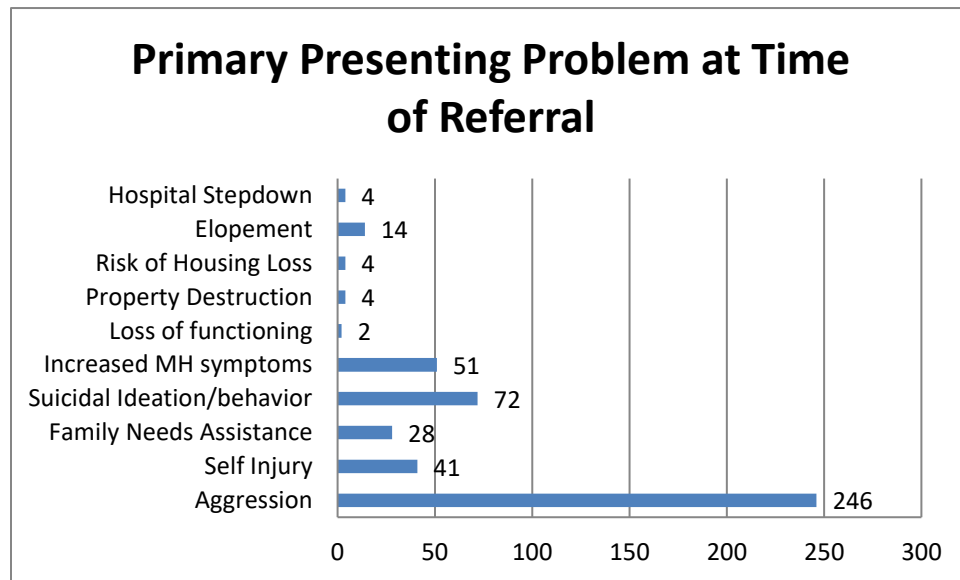
Also of interest to the Commonwealth is ensuring that the REACH programs serve both the ID and the DD communities. The regions are all reporting that they serve more individuals with only a developmental disability as opposed to both a developmental and intellectual disability. “Unknown” refers to individuals who are still in the referral process at the end of the quarter and documentation of disability is being verified, and “None” references individuals for whom a referral was taken but diagnostic criteria was not substantiated.

Diagnosis	Region I	Region II	Region III	Region IV	Region V	Totals
ID Only	3	8	4	16	3	34
DD Only	41	50	43	76	162	372
ID/DD	14	8	9	3	15	49
None/Unknown	4	4	5	2	4	19
Totals	62	70	61	97	184	474

Aggression continues to be the most common reason for a referral to the REACH program. Aggressive behavior includes physical aggression and verbal threats. Suicidal ideation/behavior remains the second most frequent presenting problem. The following table summarizes primary presenting problems by region.

<i>Presenting Problems</i>	Region I	Region II	Region III	Region IV	Region V	Totals
Aggression	35	33	21	34	123	246
Self-injury	4	7	4	16	10	41
Family Needs Assistance	0	6	7	11	4	28
Suicidal Ideation/behavior	5	14	16	13	24	72
Increased MH symptoms	13	9	10	6	13	51
Loss of functioning	0	0	0	0	2	2
Property Destruction	0	0	1	3	0	4
Risk of Housing Loss	2	1	0	1	0	4
Elopement	3	0	0	9	2	14
Hospital Stepdown	0	0	0	4	0	4
Other	0	0	2*	0	6*	8
Total	62	70	61	97	184	474

*=*homicidal ideation*

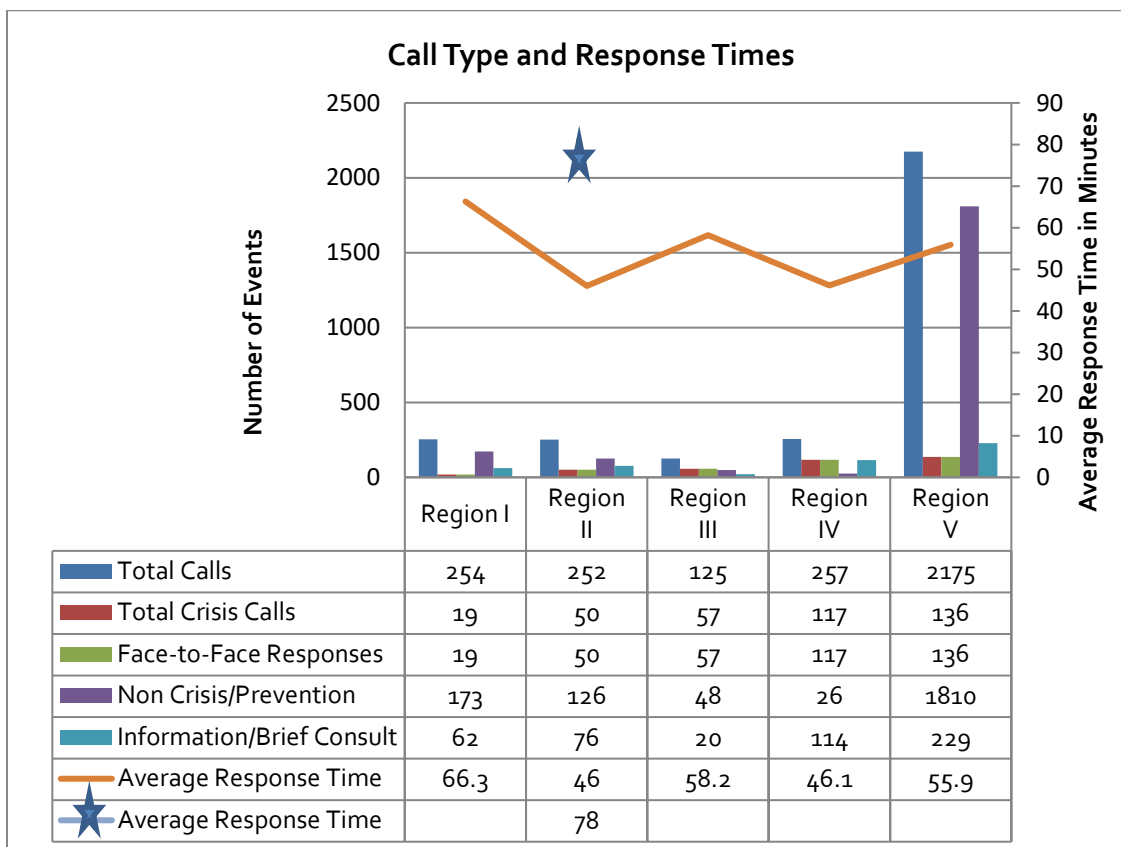


REACH Crisis Response

Each of the five regional REACH programs operates a crisis line 24-hours per day, seven days per week. Calls coming into the crisis lines may be from existing REACH families or from families or care providers in the midst of an escalating situation. Calls are responded to in one of two ways: either by telephone consultation or through an on-site, face-to-face assessment and intervention. As the crisis line allows an individual to access a trained clinician 24/7, it is being used more and more frequently by REACH consumers and their circles of support to maintain stability or to assist the individual in problem solving through a stressful situation. The crisis line is becoming a primary tool of prevention for some of the programs. REACH clinicians are expected to respond in-person to situations that meet the acuity level of a crisis, and this includes partnering with emergency services prescreening staff when a Temporary Detention Order is being considered. Non-crisis calls that are received by the programs are understood to serve a preventive role and may be a prescribed element within a written Crisis Education and Prevention Plan (CEPP). Domains of interest related to crisis line activity include the following:

- Crisis calls
- In-person assessment/intervention
- Telephone intervention
- Prevention
- Total crisis line activity
- Average response time

A summary of information related to crisis calls and responses is depicted in the graph below. Please note that this graph encompasses all calls received on the crisis line during the review cycle. It includes on-site responses to existing REACH consumers, repeat calls from individuals, as well as new referrals who may be contacting REACH for the first time. Therefore, call totals when combined across categories will exceed the total number of referrals for the quarter. As has been noted in previous reports, crisis line activity and referral activity are best understood as separate elements.



The graph above details calls activity for the programs over the second quarter of FY20. Average response time is graphed on the secondary y-axis as an orange line, both to emphasize it and to allow any variability to be clearly seen. The table on the following page offers the reader a more comprehensive view of response time data by breaking it into 30-minute increments. All response times are within expectations defined in the Settlement Agreement. As in previous reports, data for Region II have been parceled to present face to face response times in both rural and urban areas, with the rural response data represented with a blue star, which corresponds to the secondary y-axis (average response time in minutes).

Region	Region I Rural	Region II Urban	Region II Rural	Region III Rural	Region IV Urban	Region V Rural	Totals
0-30 Minutes	3	13	1	21	19	17	74
31-60 Minutes	6	18	0	17	86	69	196
61-90 Minutes	5	6	7	10	6	37	71
91-120 Minutes	5	2	3	5	5	11	31
121+ Minutes	0	0	0	4	1	2	7
Totals	19	39	11	57	117	136	379

Location of Crisis Assessments

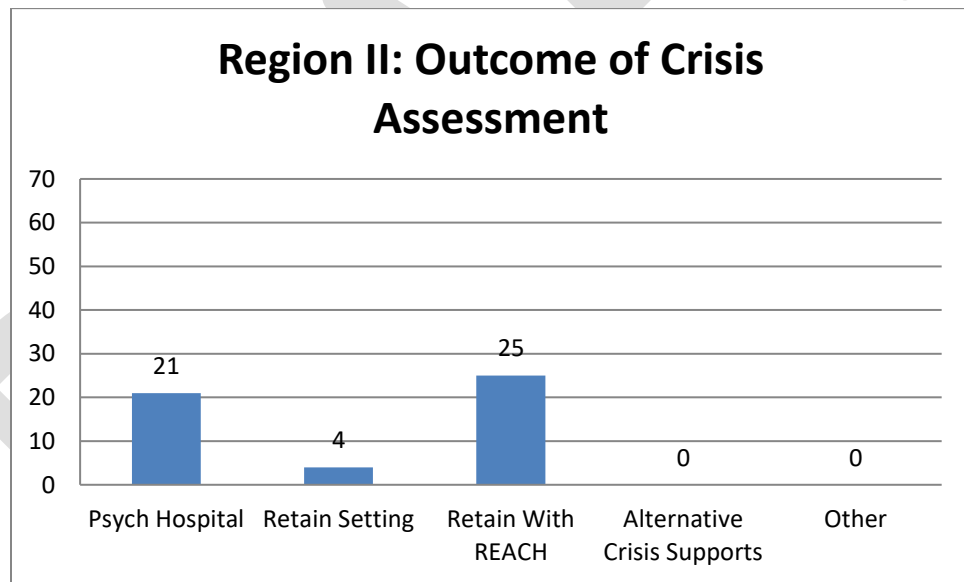
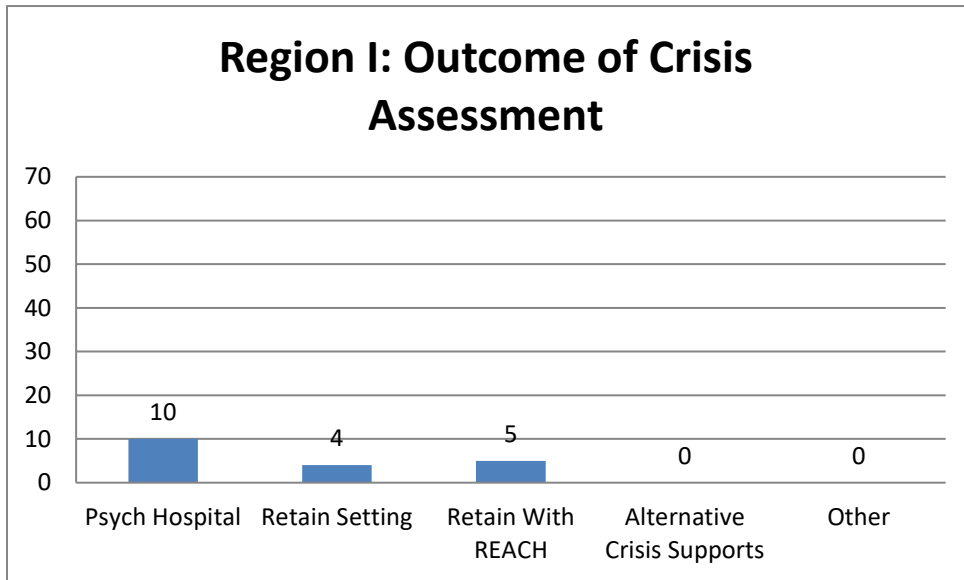
Assessment Location	Region I	Region II	Region III	Region IV	Region V	Totals
Family Home	0	7	12	42	58	119
Hospital/Emergency Room	9	28	37	50	50	174
Emergency Services/CSB	10	11	4	3	11	39
School	0	4	3	8	6	21
Residential Provider	0	0	0	1	3	4
Other	0	0	1*	13	7**	21
Totals	19	50	57	117	135	378

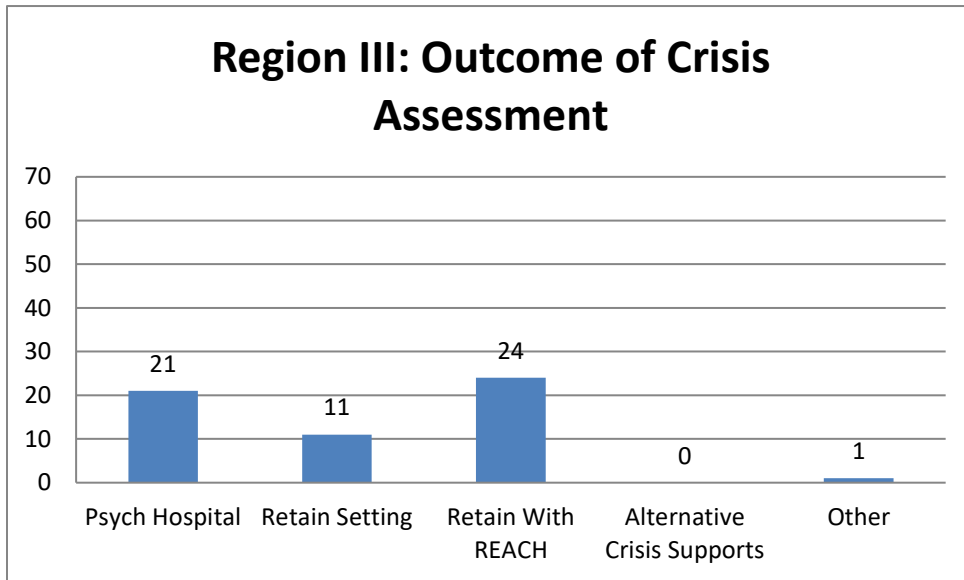
*=police station, **= CSU, CIT office, hotels, behavioral health center, day program

Region V: one less crisis assessment than crisis call/response as family and youth left scene of crisis prior to REACH arrival

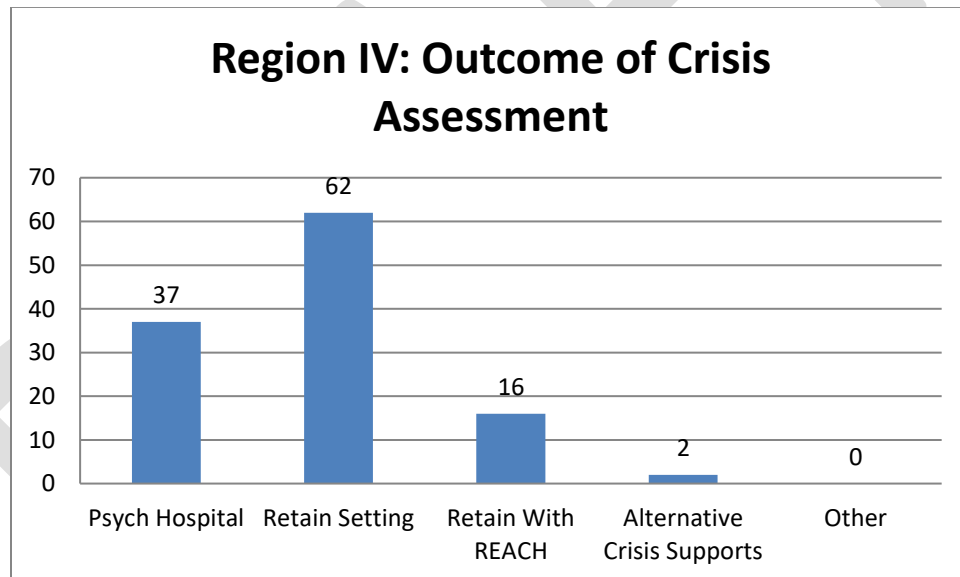
REACH program staff members are expected to travel to the physical site of the crisis event, when deemed clinically appropriate, regardless of the nature of the setting. If they are informed that inpatient care is being considered, they are expected to be present whenever a child is being prescreened for hospitalization. The table above is a summary of the various locations where mobile crisis assessments took place over the course of the second quarter of FY20.

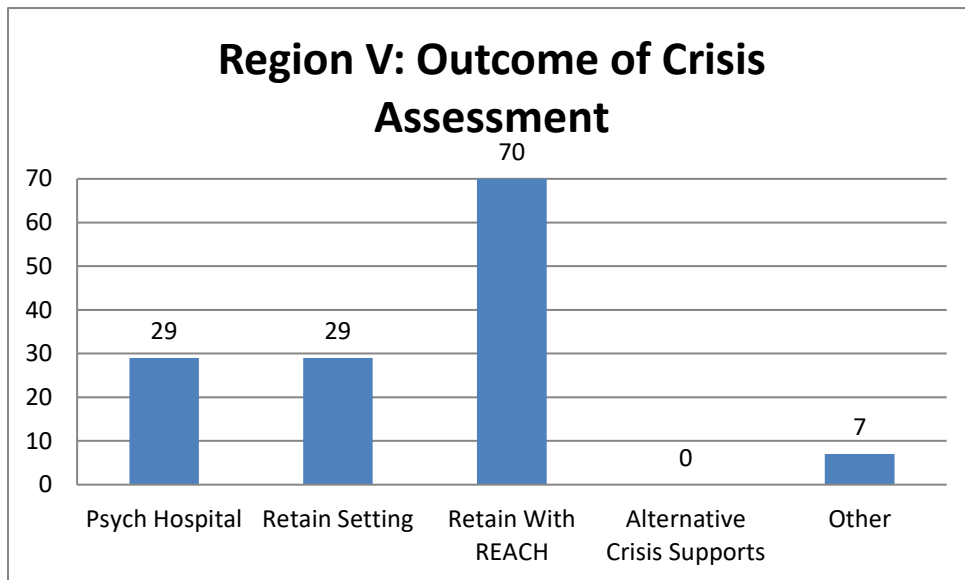
Ideally, when a crisis response occurs, it is hoped that the resulting outcome will be that the child will remain in his/her home with family. While this is not always possible, the REACH programs are very often able to intervene in the moment to prevent out-of-home placement. They can do this by providing immediate in-home support to the family, problem solving a safety plan to stabilize the crisis situation until additional help can be accessed, and by following up with community-based crisis stabilization plans. The charts on the following pages offer a picture of the initial outcome after an in-person crisis response has been dispatched by region. In these charts, “Retain with REACH” means an individual retained their setting while receiving community-based REACH services.





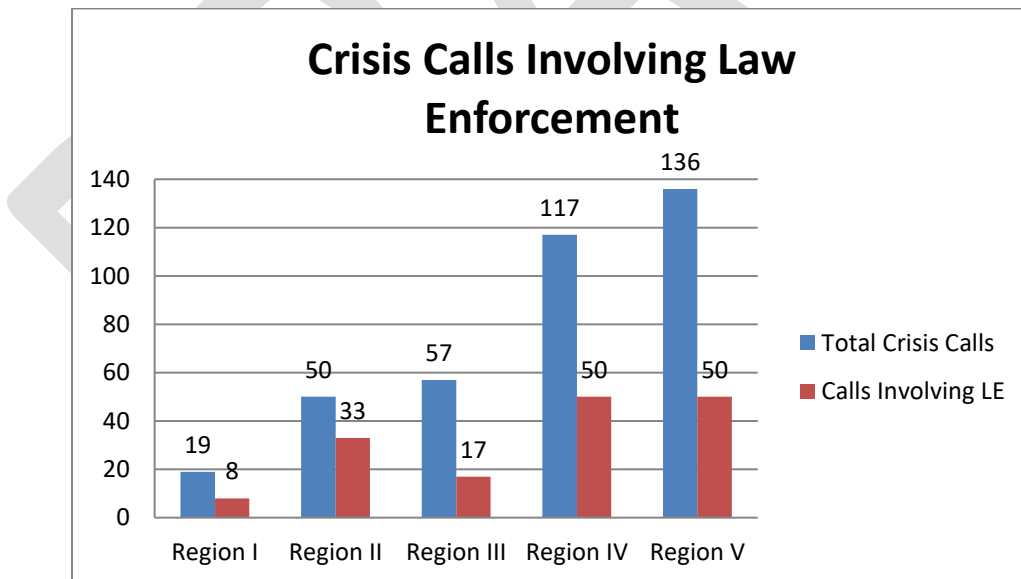
Other=alternate community setting



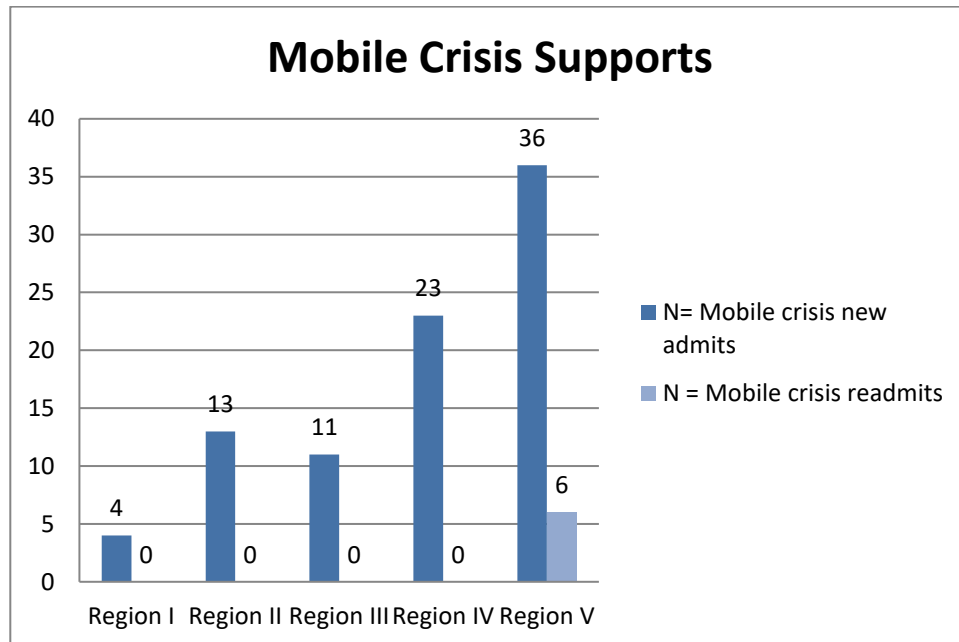


Other=refused REACH (4), ineligible (2), alternate community setting (1)

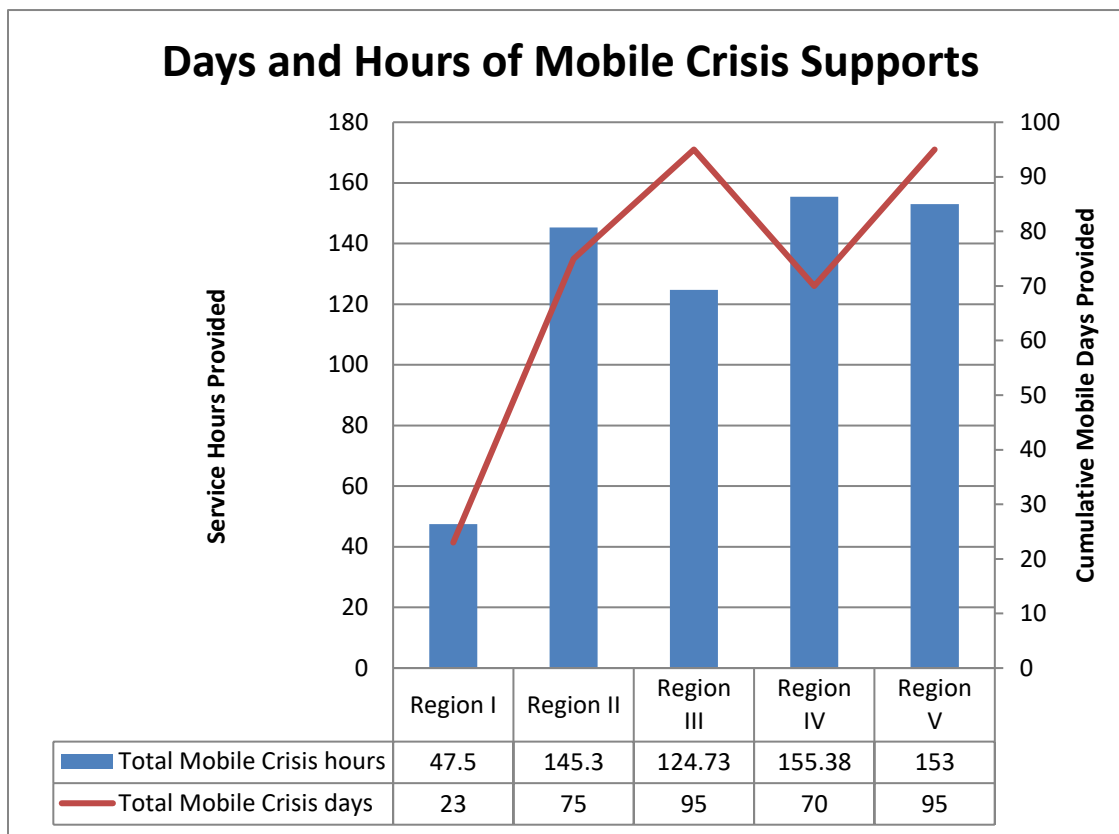
The table below provides a contrast of the total number of crisis calls to total number of crisis calls which involved law enforcement. Forty-two percent of overall crisis calls received involved law enforcement, which is a decrease from the previous quarter (45%).



Community-based, mobile crisis supports are one of the key services that the children’s programs provide. These services are provided in the home or community setting as an immediate result of a crisis event. It is especially important to the REACH model because it impacts and benefits not only the child but their immediate support system as well. Generally, these supports are successful in stabilizing the situation and being part of the solution for obviating out-of-home placement. The chart below depicts admissions activity for the community mobile crisis support program.



In addition to collecting information related to the number of admissions into the mobile crisis supports program, data related to service provision is also tabulated. The chart on the following page summarizes both the number of days and hours of crisis intervention and/or stabilization services offered by each region. On the secondary axis, the cumulative number of mobile days provided for families across the quarter is shown.

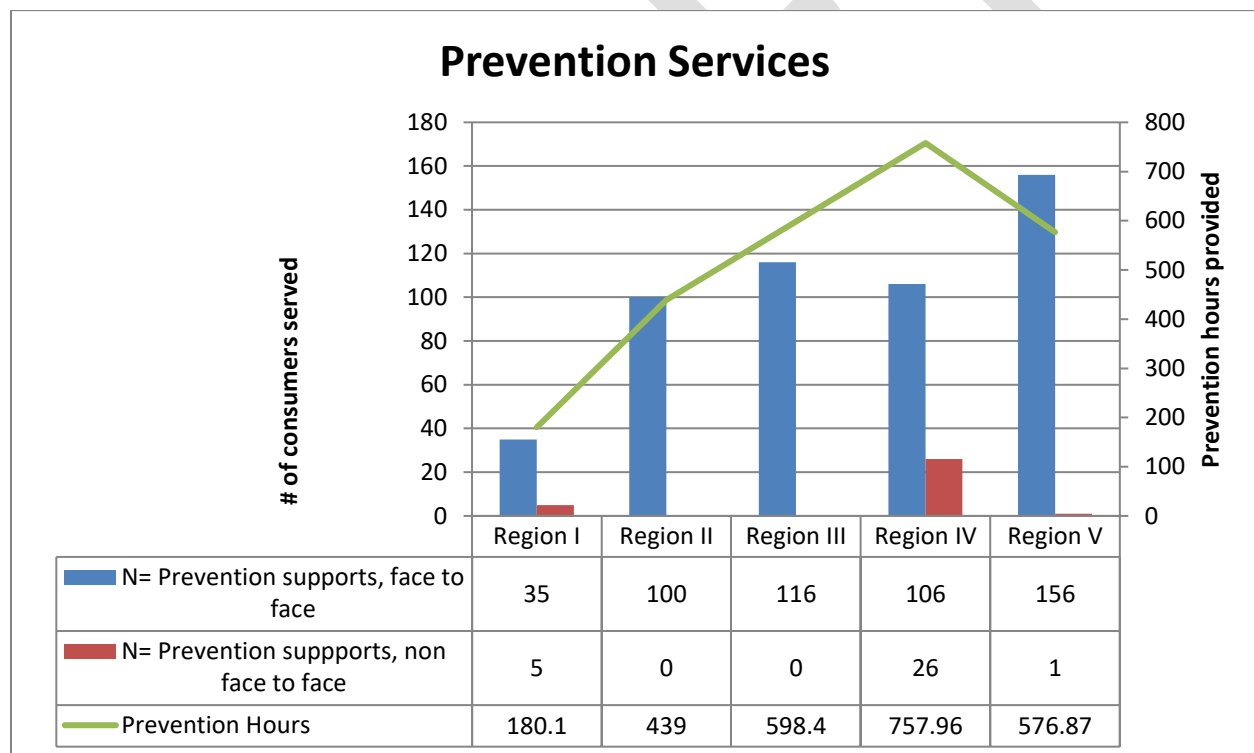


REACH sends clinicians to the homes and schools of individuals to work with them on developing and practicing coping skills. The table below provides information on the range of days across individuals served that mobile crisis supports were in place, the average number of days an individual received mobile crisis supports, and the average number of hours that each individual received per crisis event.

Service Unit	Region I	Region II	Region III	Region IV	Region V
Range of Days	2-9	2-6	4-15	1-5	1-7
Average Days/ Case	5.7	5.8	8.6	3.0	2.3
Average Hours/Day	2.1	1.9	1.3	2.2	1.6
Average Hours/Case	11.9	11.2	11.3	6.8	3.6

REACH also provides ongoing community based services to children and their families that is more “preventative” in nature. Mobile prevention services consist of face to face, community based services that target deterring future crisis situations via ongoing education and practice on emerging skills, training on individualized strategies with the support system, and continued

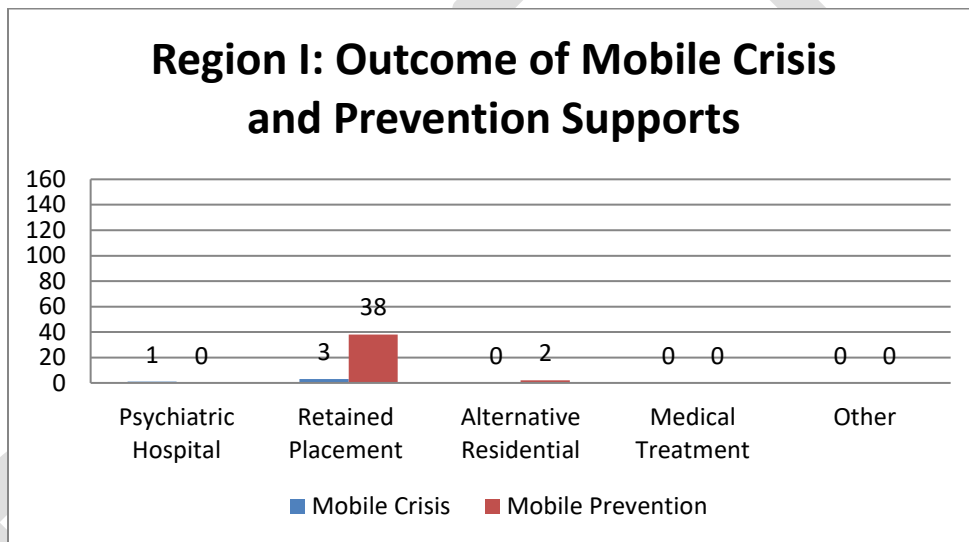
linkages and coordination with other necessary services as needed. In comparison to mobile crisis supports, mobile prevention services are provided at a titrated frequency and do not occur as the immediate result of a crisis situation. More specifically, individuals included in mobile prevention services may be those who stepped down from mobile crisis support or those that were referred to the program in a non-crisis situation. At times, prevention services may include individuals who are offered mobile crisis support immediately following a REACH crisis response but do not elect to access REACH services until sometime after the crisis was stabilized. The graph below depicts the following: 1) the number of youth that accessed face to face mobile prevention services; 2) those that were matriculating out of the REACH program based on ongoing stability and may have received brief non face to face prevention services (e.g. telephonic communication); and 3) the total number of prevention hours provided, across each program. These metrics are displayed via the blue column, red column, and green line, respectively, with the green line corresponding to the secondary y-axis. It should be noted that in previous reports, only total prevention hours by program have been displayed.

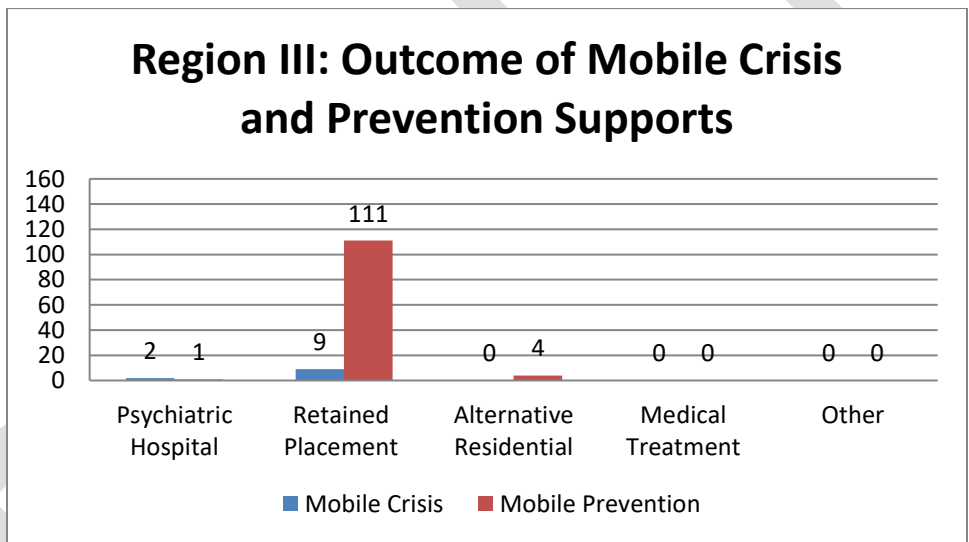
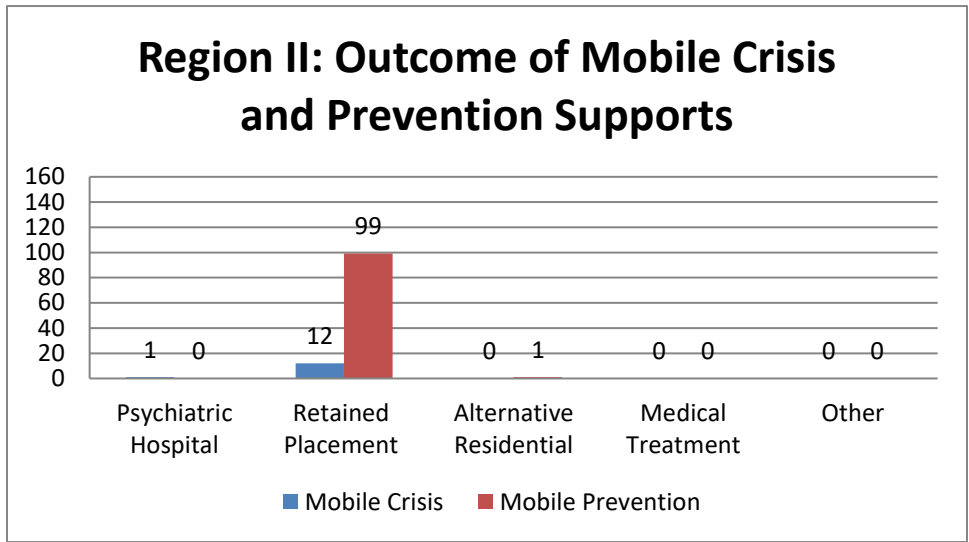


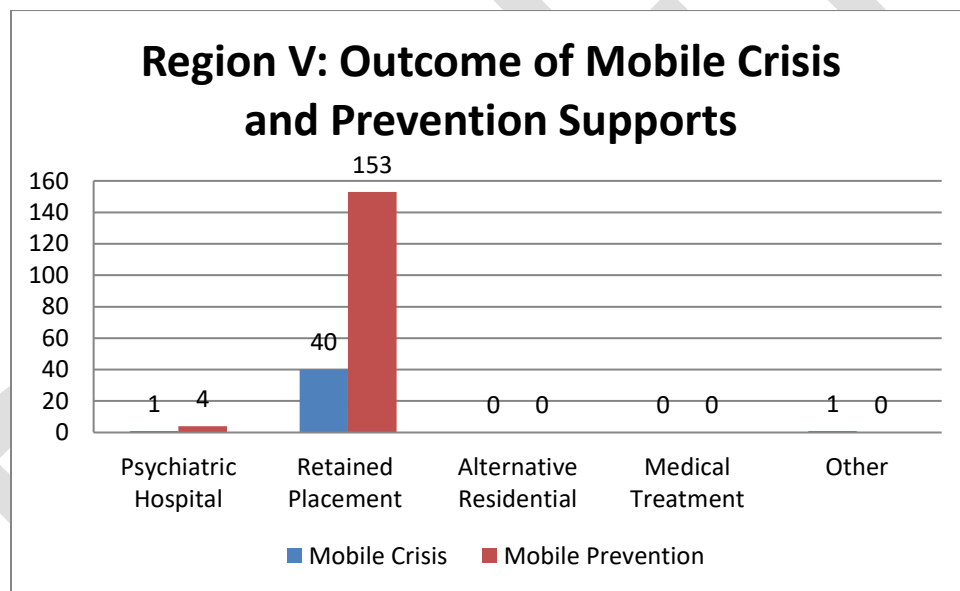
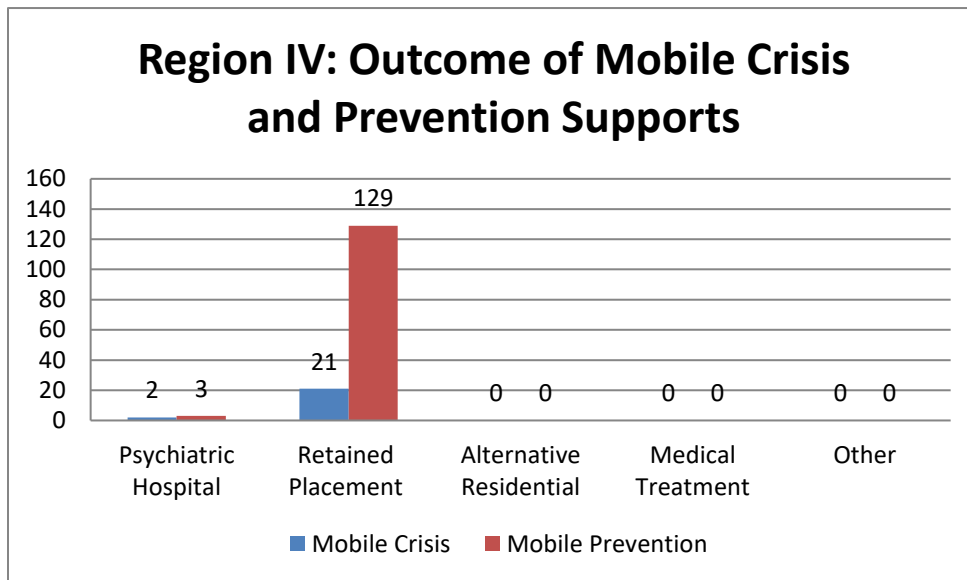
Crisis Service Outcomes/Dispositions

Maintaining residential stability and community integration is one of the primary goals of the REACH programs. The graphs on the following pages provide a summary of outcome data for community mobile crisis and prevention support services. Based upon reported data of the mobile crisis support outcomes for children, 92% of children were able to avoid hospitalization with the provision of mobile crisis supports. Based upon reported data of mobile prevention supports, 98% were also able to avoid hospitalization. These data suggest that community based REACH supports are effective in helping families and their children through times of crisis and in maintaining stabilization post-crisis such that placement in the community can be maintained.

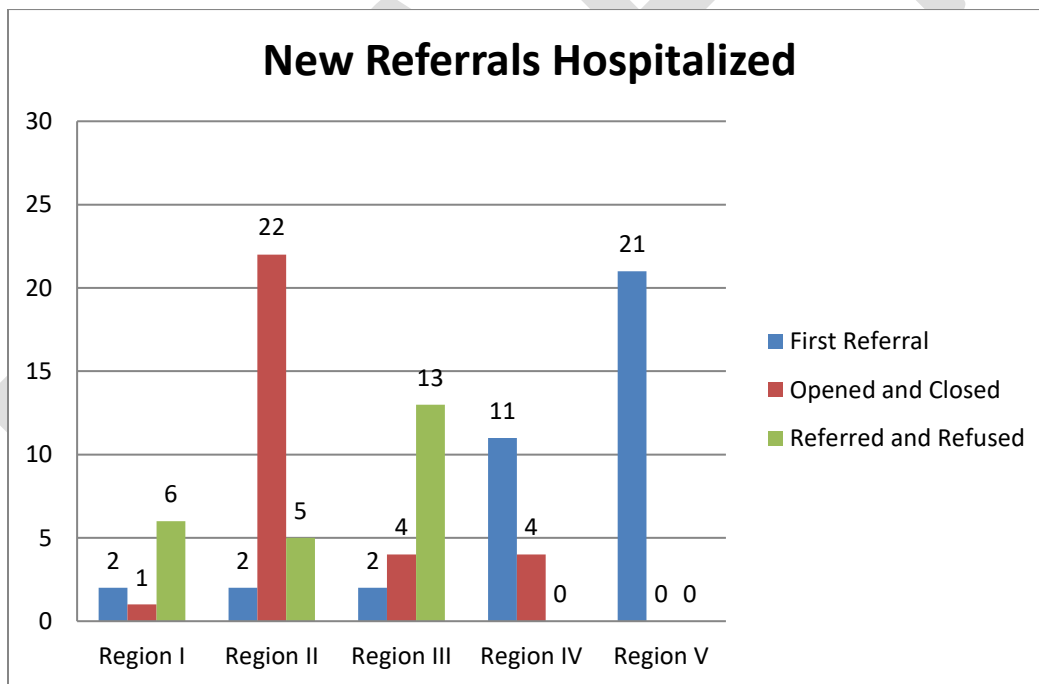
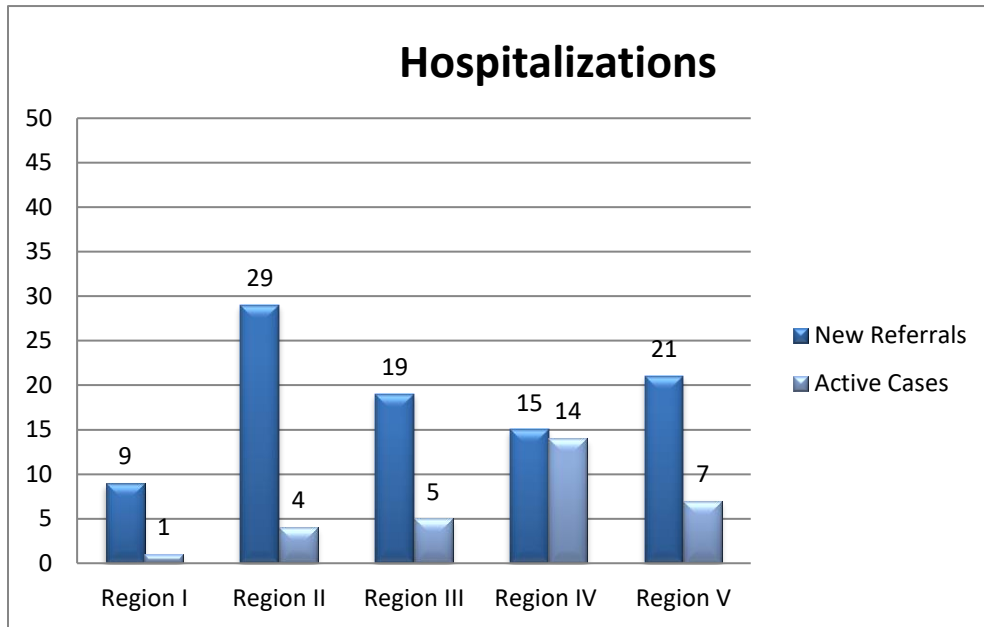
The graphs below display the outcomes of both mobile crisis and mobile prevention services across each REACH program.

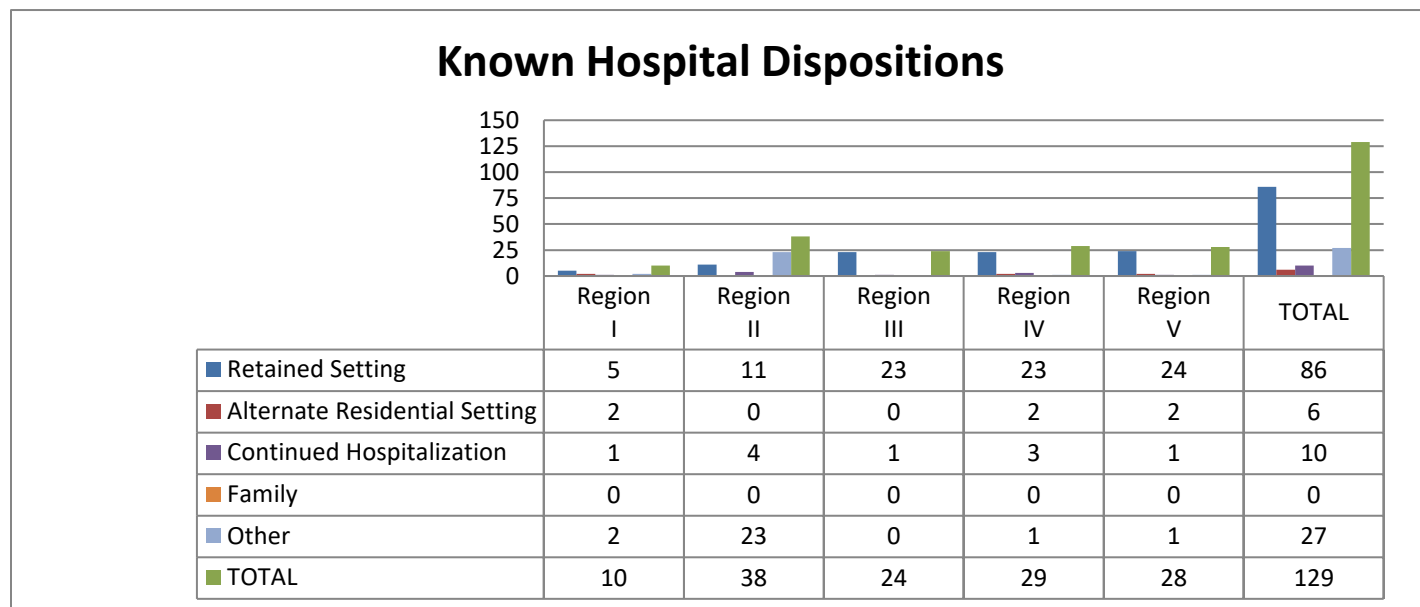






The three graphs that follow display hospitalizations for new referrals and active cases, hospitalizations for new referrals, and known hospitalization dispositions, respectively. While the REACH programs remain actively involved with all hospitalized cases *when they are aware of this disposition and have parental consent to provide service*, they may not always be apprised that a REACH client has been hospitalized or that an individual with DD has entered inpatient treatment. While the Commonwealth Center for Children and Adolescents educates families about the children’s REACH programs, many families elect not to access this service.





Region 1 Other=psychiatric residential facility (2); Region 2: five children hospitalized twice; Region 4 Other=CSU; Region 5 Other=unknown, person ineligible for services

SERVICE ELEMENTS

Each of the five regional REACH programs provides an array of services to children and families enrolled. These services include prevention and education services, assessment services, and consultation services. The tables that follow summarize the services provided.

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	4	14	11	22	42
Consultation	4	14	11	22	42
Crisis Education Prevention Plan	4	14	11	22	18
Family/Provider Training	4	10	10	22	23

REACH Training Activities

The Children’s REACH programs are working to expand their role as a training resource for the community of support for children and families impacted by developmental disability. The REACH programs, both child and adult, continue to train law enforcement officers about REACH and the I/DD population. In addition to ongoing training offered by the REACH programs for law enforcement offices, DBHDS has participated in a partnership with the Department of Criminal

Justice Services (DCJS), the Virginia Board for People with Disabilities, and Niagara University surrounding comprehensive training targeting disability awareness for law enforcement in Virginia. Since October 2017, trainings on “Disability Awareness for Law Enforcement Overview” have been provided to different law enforcement agencies utilizing a “train the trainer” model such that law enforcement personnel are able to deliver this training ongoing to their colleagues. Several pinpointed training topics have been provided beyond the broad “Disability Awareness for Law Enforcement Overview”, including training specific to the I/DD population, mental health disorders, and acquired brain injury. This contract was fulfilled at the end of quarter one in FY20. The REACH program will continue to partner with law enforcement to offer training through the CIT trainings and other avenues to continue the efforts to act as a community training resource in supporting individuals with developmental disabilities and their support partners.

The table on the next page provides a summary of attendance numbers for various trainings completed by the Children’s REACH programs. These trainings target the information needed by professionals in various work settings to work effectively with individuals with DD.

Training Activity	Region I	Region II	Region III	Region IV	Region V	Totals
CIT/Police: #Trained	35	62	0	52	112	261
Case Manager/Support Coordinator: # Trained	24	119	56	39	80	318
Emergency Service Workers: #Trained	3	12	4	4	25	48
Family: # Trained	29	66	22	77	15	209
Hospital Staff: # Trained	2	15	5	0	30	52
DD Provider: # Trained	12	117	104	17	56	306
Other Community Partners: #Trained	58*	0	136**	7***	27****	228
Totals	163	391	327	196	345	1422

=school personnel, other community members; **=MH providers; *= MH provider, behaviorist, teachers, DBHDS staff; ****=various therapy providers, special education providers*

Summary

The statewide Children’s REACH program has now been operational for over three full fiscal years. The programs are functioning well and are actively serving children and families in crisis. There are regional differences, however, and these are being minimized through ongoing standardization of documentation and processes, as well as via quarterly and annual reviews of the programs to bring the programs into closer alignment with one another. DBHDS and the Children’s REACH program have continued to work together towards the goal of offering out of home crisis stabilization services such as those offered by the Adult REACH program’s crisis therapeutic homes (CTH). The REACH programs have been working towards opening two child CTHs, one of which will be located in Culpeper to serve the Northern and Western DD regions,

and the other of which will be located in Chester to serve the Southwest, Central, and Eastern regions. At the time of this report, the home in Chester is open and has accepted its first admissions. The home that is located in Culpeper is expecting to be licensed contingent upon the full training of several recently hired staff members and should be accepting children in Q3. In the upcoming report, data that is parallel to the data reported out on service for the adult CTHs will be included.

DBHDS and the Children's REACH programs are working in concert to establish out of home prevention services to provide an extra layer of support for children and their families in the Commonwealth. This service would be separate from the Children's CTH homes that were previously described. DBHDS completed a request for information during FY19 for planning and informational purposes in which several providers from different areas of the state responded. A request for proposal (RFP) is currently active, with a closing date in January 2020; subsequently, proposals will be reviewed with hopes that contracts can be negotiated and awarded by spring 2020.

Overall, the program continues to move forward in support of the mission for a full spectrum of crisis, prevention, and habilitation services to be offered to children in Virginia with a developmental disability. Much has been accomplished within the area of children's crisis services, and the path ahead appears to be clear in terms of defining next steps. The Department remains committed to fulfilling its mission to have a continuum of qualified care for children with developmental disabilities and their families.