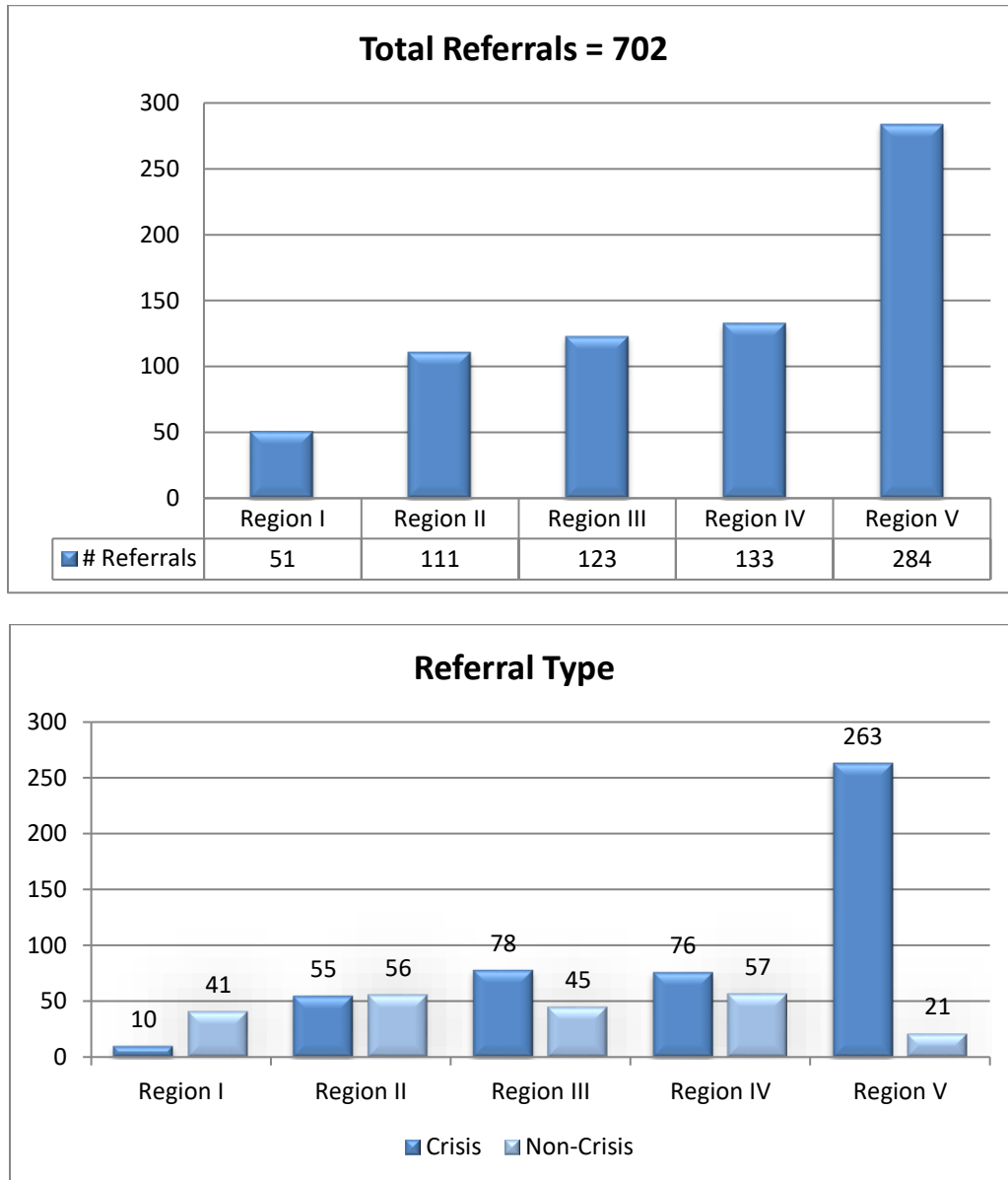


REACH Data Summary Report – Adult: FY26Q1

This report provides data summarizing the referral activity, service provision, and residential outcomes for adults served by the REACH programs during the first quarter of fiscal year 2026.

REACH Referral Activity



For FY26Q1, there was an increase in total referrals as compared to FY25Q4, 627 to 702. The data regarding the breakdown of types of referrals for Regions I and II denote more non-crisis referrals than crisis referrals, whereas Regions III, IV and V received more crisis referrals.

The table below provides a breakdown of referrals by days of the week, ranges of time, and weekends/holidays. Monday through Friday are consistently the prime days for referrals. First shift time frame received the most referrals.

Referral Time	Region I	Region II	Region III	Region IV	Region V	Total
Monday - Friday	50	90	91	109	197	537
Weekends/Holidays	1	21	32	24	87	165
7am - 2:59pm	35	49	49	48	97	278
3pm - 10:59pm	16	54	54	69	159	352
11 pm - 6:59 am	0	8	20	16	28	72

Also, of interest to the Commonwealth is ensuring that the REACH programs serve the DD community in its entirety and effectively. The table below summarizes the breakdown of individuals referred to REACH with an intellectual disability (ID) only, an intellectual and other developmental disability, developmental disability exclusive of ID, and unknown or no developmental 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 were not substantiated. During the first quarter, RII, RIII, and RV supported more individuals with “DD only”, RI and RIV supported more individuals with “ID only”.

Diagnosis	Region I	Region II	Region III	Region IV	Region V	Total
ID only	19	25	44	55	66	209
DD only	16	50	48	54	81	249
ID/DD	16	28	28	20	32	124
Unknown/None	0	8	3	4	105	120
Total	51	111	123	133	284	702

In terms of what type of clinical issues bring individuals to the REACH programs for support; aggression, increase MH symptoms, and suicidal ideation/behavior are noted to be the main reasons for referral during FY26Q1. Previous quarters also note increased MH symptoms, aggressive behavior, and suicidal ideations as the three main reasons for referral. Aggressive behavior includes physical aggression and verbal threats.

Presenting Problems	Region I	Region II	Region III	Region IV	Region V	Total
Aggression	20	36	20	10	45	131
Self-Injury	0	2	8	1	15	26
Family Needs Assistance	6	3	4	8	11	32
Suicidal Ideation/behavior	5	20	35	9	84	153
Increased MH symptoms	9	32	28	95	99	263
Loss of functioning	1	2	1	0	3	7
Property Destruction	0	5	6	0	2	13
Risk of housing loss	2	0	3	4	3	12
Elopement	0	0	1	2	2	5
Hospital stepdown	3	6	2	4	1	16
Other	5	5	15	0	19	44

Other: public intoxication, homicidal ideation, lost primary caregiver

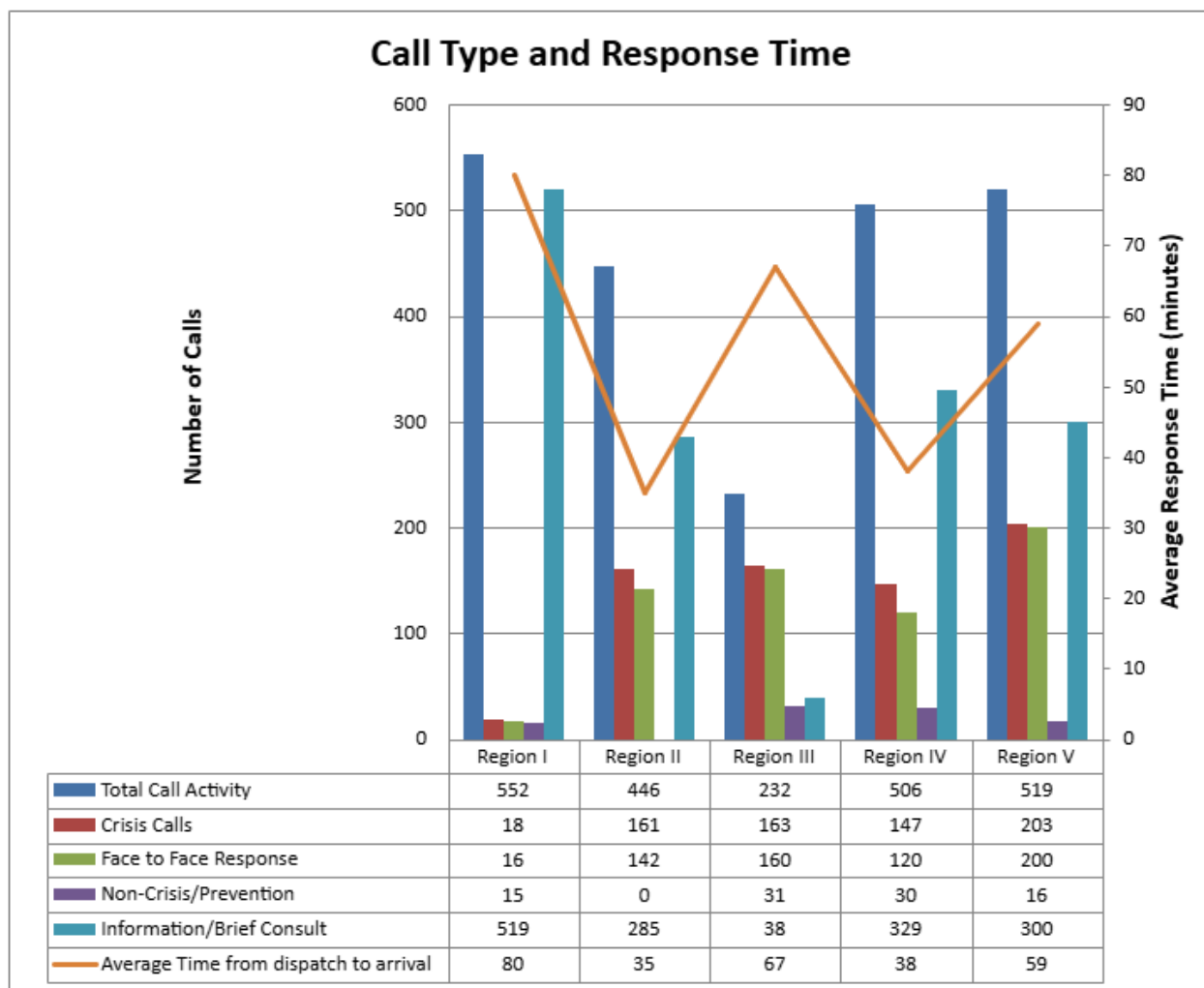
REACH Crisis Response

Each of the five regional REACH programs operates a crisis line 24 hours per day, seven days per week. Arriving calls may be from existing REACH consumers or from systems amid 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. Because the crisis line allows an individual to access a trained clinician 24/7, it is being used more and more frequently by REACH clients and their circles of support to maintain stability or to assist the individual in problem solving through a stressful situation. The “crisis” line is 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
- Non-crisis/Prevention
- Information/brief consult
- In-person assessment/intervention
- Total crisis line activity
- Average response time

A summary of information related to these elements is depicted on 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 clients, 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 before, crisis line activity and referral activity are best understood as separate elements.



In addition to the services outlined in this report and the child report, numerous non-crisis/prevention and informational calls were fielded by regional providers to persons whose age information wasn't obtained during the call. 5, 12, and 5 non-crisis calls were fielded by Regions 3, 4 and 5 respectively. While 362, 80, 75, and 15 informational calls were fielded by Regions 2, 3, 4 and 5 staff respectively.

The average response time in minutes is graphed on a secondary axis represented by the orange line. The number of responses via telehealth varied and face-to-face response for each region also varied, with a decrease in overall use of telehealth this quarter. Overall call activity increased from 1,450 in FY25Q4 to 2,236 in FY26Q1 (for calls identified by age). All five regions met expectations as denoted in the REACH Program Standards regarding average time to

respond to the scene of the crisis event for those responses that were (on-site) face to face. Regions II and IV must have an average response time within one hour as designated as urban setting and Regions I, III, and V within two hours as designated rural setting. Region I provided 11% of their response via telehealth, Region II 12%. Region III 2%, Region IV 18%, and Region V 1%. The table below offers a more detailed picture of response time data by breaking it into 30-minute increments. Traffic congestion/distance, weather, and multiple calls were the reasons given for delays in response. This is consistent with the previous quarter.

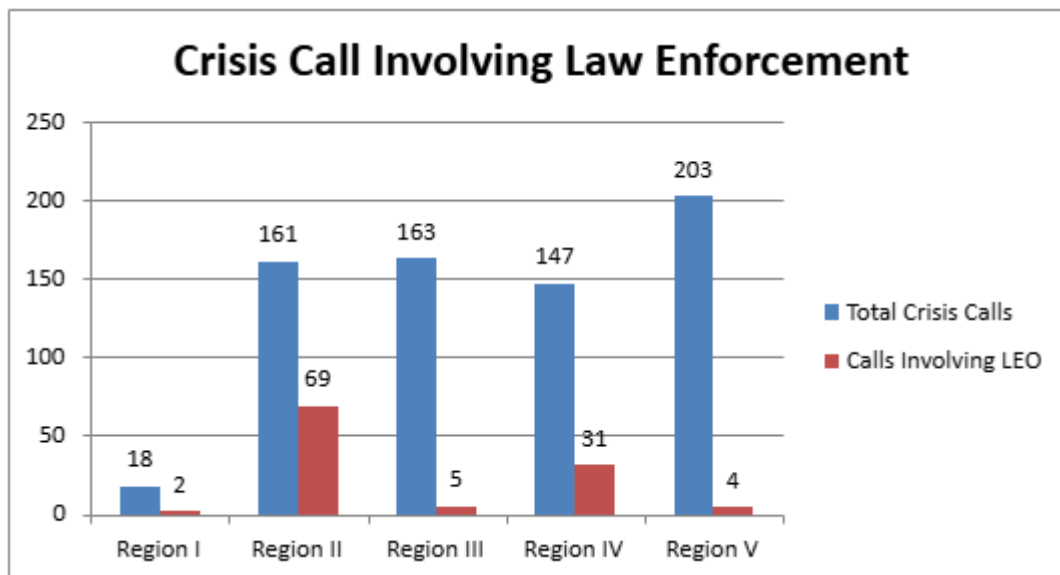
Response Time

	Region I	Region II	Region III	Region IV	Region V	Total Calls
Response Interval: 0 - 30	7	60	20	53	15	155
Response Interval: 31 - 60	2	72	58	56	79	267
Response Interval: 61 - 90	2	8	43	9	62	124
Response Interval: 91 -120	2	0	29	2	21	54
Response Interval: 120+	3	2	10	0	23	38
Total	16	142	160	120	200	638

Location of Crisis Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V	Total
Individual Home/Family Home	1	48	42	25	44	160
Hospital/Emergency Room	9	60	49	71	118	307
Emergency Services/CSB	1	14	46	3	0	64
Residential Provider	3	21	11	22	21	78
Police Station	0	0	0	0	0	0
Day Program	0	1	7	2	2	12
School	0	0	0	0	0	0
Other	4	17	8	24	18	71
Total	18	161	163	147	203	692

When indicated, the REACH programs are expected to arrive at the physical site of the crisis event, regardless of the nature of the setting. The table above provides a summary of the various locations where mobile crisis assessments took place over the course of FY26Q1. The location of assessments listed in the chart includes both those assessments completed by a REACH staff “in-person” and those completed via telehealth. The location denotes where the individual was located when the assessment occurred. The data denotes an increase in law enforcement presence for the first quarter as compared to the previous quarter, 8.31% to 16.04%.



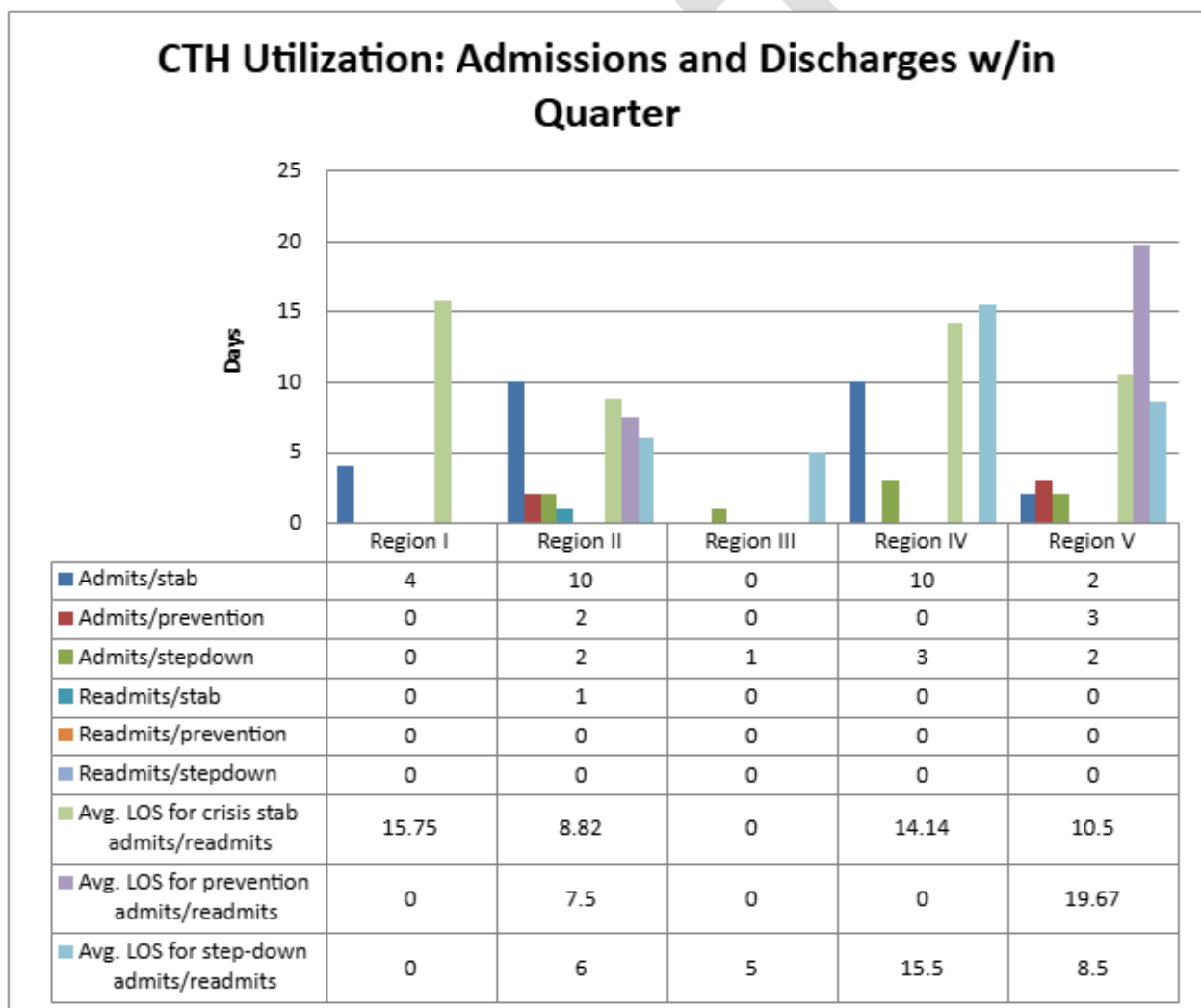
Crisis Therapeutic House

Each of the five REACH programs operates a Crisis Therapeutic Home (CTH) that accepts crisis stabilization admissions, step downs from hospitals and jails, and planned preventive stays. Region specific information such as type of stay, length of stay, readmissions, and waitlists is presented in the graph on the next page. Due to the large variability in average length of stay (LOS) because of individuals being admitted with no disposition, the chart depicting CTH utilization was modified in FY20 to reflect only those individuals who were admitted or readmitted and discharged in the quarter. All other individuals who were admitted in previous quarters and discharged in this quarter will have their LOS data reflected in the narrative and table on page 11. These individuals will also be included in the data on the chart “Dispositions by Service Type” under “CTH”.

The Commonwealth has been closely monitoring capacity of REACH programs across the Commonwealth. In all instances, the CTH is working with the CSB to ensure the individual is linked to appropriate supports and services. All programs are responsible for working with the Department as well to ensure that the system is working together to ensure an appropriate resolution and placement for the individual being supported. Additionally, the Department is working to address follow-through on services to ensure all parties are working diligently to address the needs of individuals without disposition. The next chart denotes the first quarter admissions/readmissions across all regional programs. During FY26Q1, there were 27 crisis stabilization admissions, 5 prevention admissions, and 7 step-down admissions, reflecting an

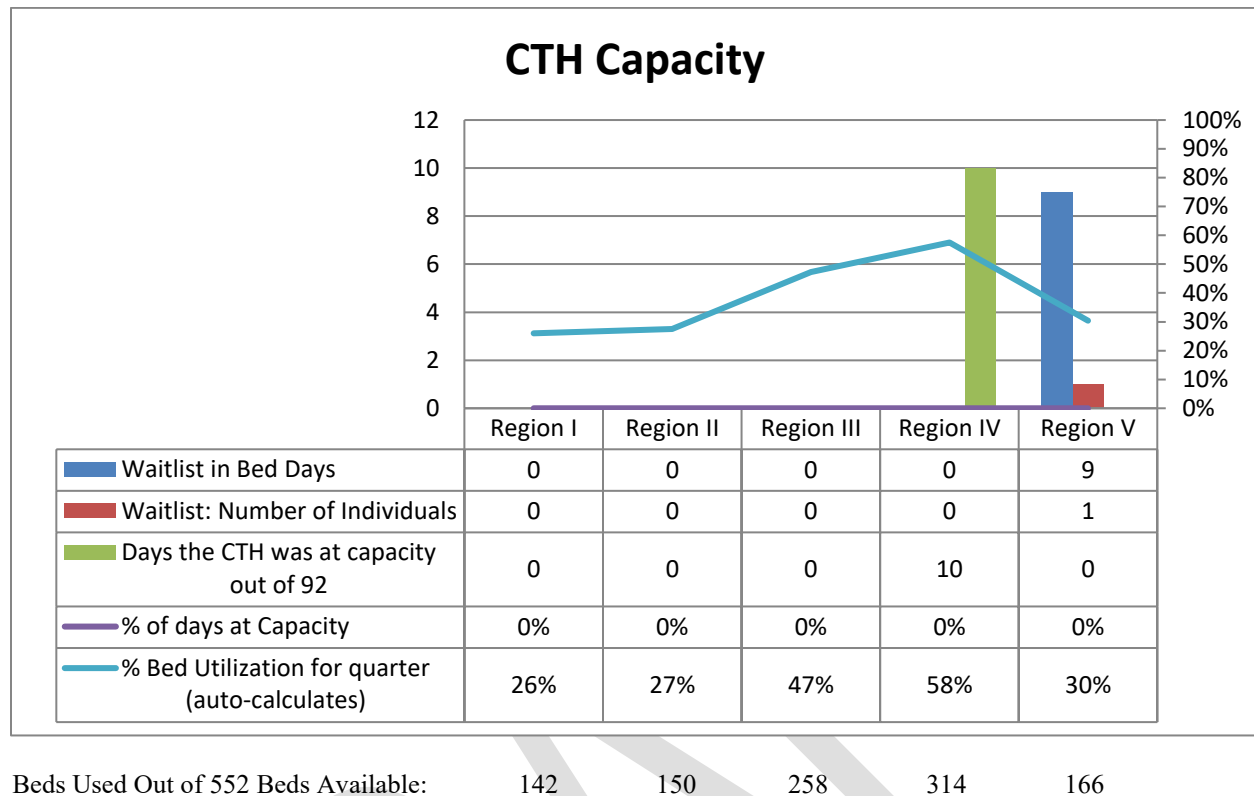
increase of 7 in the number of crisis admissions, an increase of 1 in the number of prevention admissions, and no change in step-down admissions in the first quarter of FY26. Additionally, there was only 1 readmission in the first quarter (crisis stabilization).

Across all regions for those individuals who were admitted in a previous quarter to the CTH and discharged in this quarter, the data is as follows: 3 crisis stabilization admissions with LOS ranging from 34 to 75 days, 7 step-down admissions with LOS ranging from 7 to 98 days, and 1 prevention admission with LOS of 68 days. These discharged individuals are in addition to those individuals admitted and discharged within the quarter. The following table reflects more specific information by person regarding length of stay, region, and type of admission.



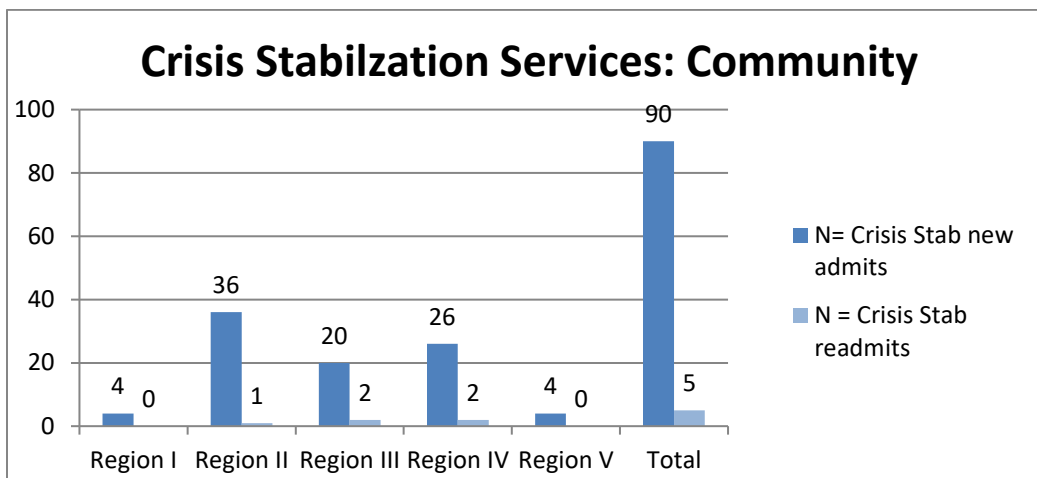
LOS: Individuals Admitted Previously and Discharged w/in Quarter			
<i>Region</i>	<i>Individual</i>	<i>Type of Admission</i>	<i>Total LOS (days)</i>
Region I	Person 1	Stepdown	70
Region II	Person 1	Stepdown	35
Region III	Person 1	Stepdown	98
	Person 2	Crisis Stabilization	47
	Person 3	Stepdown	43
	Person 4	Stepdown	8
	Person 5	Crisis Stabilization	75
Region IV	Person 1	Stepdown	7
	Person 2	Stepdown	18
	Person 3	Crisis Stabilization	34
Region V	Person 1	Prevention	68

The graph on the next page provides information regarding CTH capacity. Please note that waitlist days are ***not*** consecutive. This number reflects the cumulative number of days across the quarter when a bed was not available when requested for an *appropriate* admission to the CTH. The information provided in the graph includes both the number of days when each of the five CTHs was at capacity in the quarter and how many of the beds were utilized. The bed utilization rate for the Crisis Therapeutic Homes ranged from 26% to 58% during the quarter. Occupancy this quarter in Regions I through V for bed utilization was 26%, 27%, 47%, 58%, and 30% respectively.

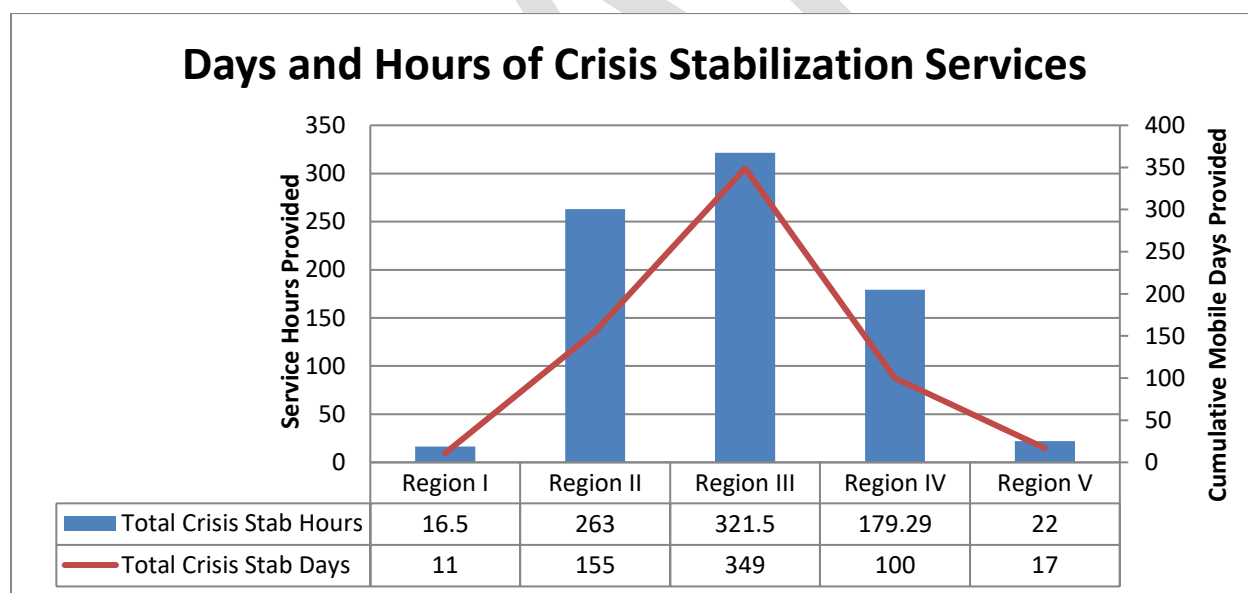


Community Mobile Crisis Stabilization

Community-based, mobile crisis supports are one of the key services that the REACH 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 individual 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 supports provided by the regional programs. The total number of new admissions supported through mobile crisis services increased slightly this quarter from 88 in FY25Q4 to 90 in FY26Q1. The total number of readmissions increased slightly this quarter from 4 in FY25Q4 to 5 in FY26Q1.



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

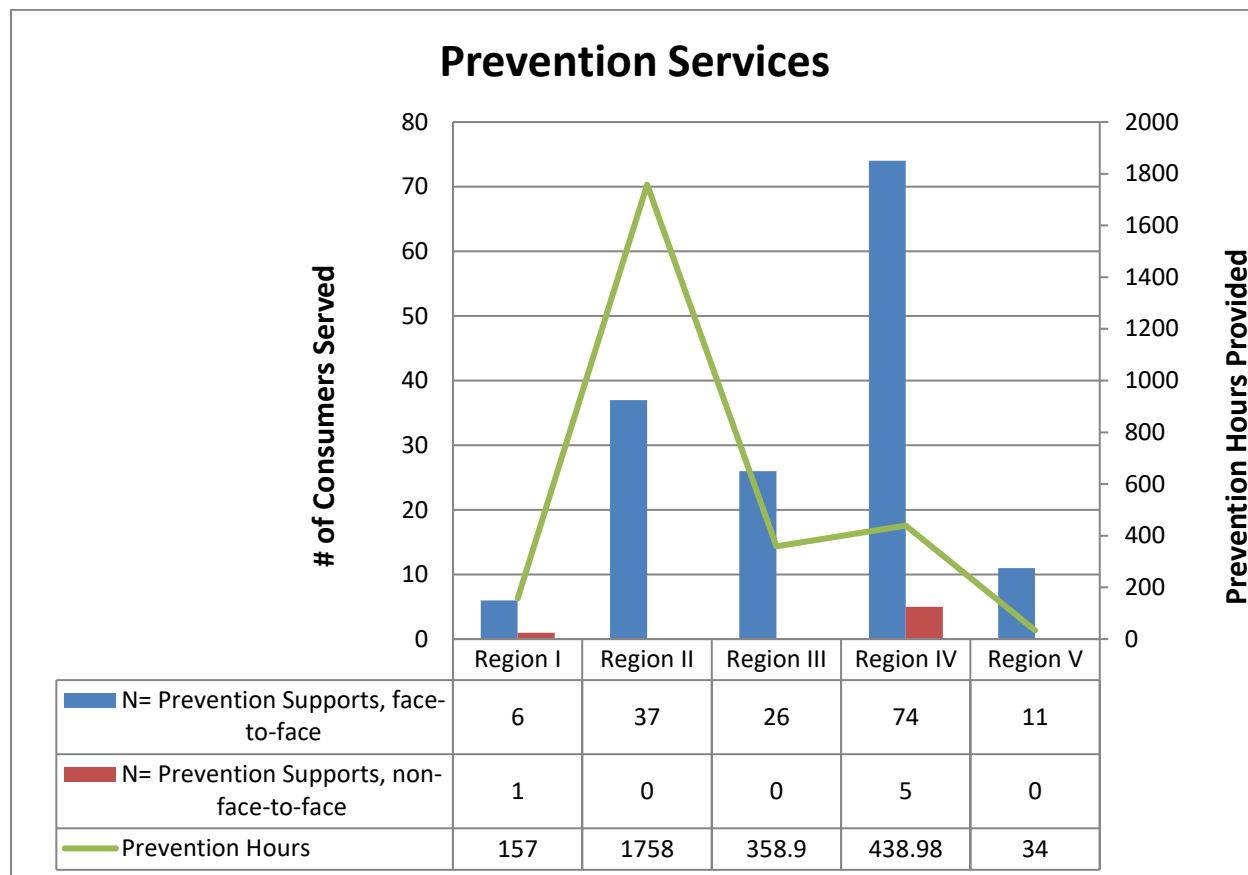


Mobile crisis stabilization services typically involve REACH clinicians going to the homes, day programs, worksite, or recreational site frequented by the individual to work with them on developing and practicing coping skills, and problem-solving situations that arise in the settings where they spend their time. Concurrently, they assist care providers in learning to work successfully with the people they serve. This may involve helping them to effectively coach the

individual using a coping strategy during periods of distress, enhancing their communication skills, or making modifications to the environment or daily routine. Overall, the regional programs provided 802.29 hours of crisis stabilization services across 632 days in FY26Q1. Generally, individuals are provided with crisis service for about 1 to 5 days with a targeted average per day of 2 hours. The fourth quarter data show a range of between 1-15 days of services provided with a range of 0.9 to 1.8 average hours/day. All regions have returned to providing this service on site. Data for the present quarter regarding the range in crisis service days, as well as the average number of days and hours crisis supports were in place, is as follows:

Service Unit	Region I	Region II	Region III	Region IV	Region V
Range of Days	2 - 6	1 - 6	1 - 15	1 - 8	1 - 4
Average Days/Case	2.8	4.2	15.9	3.6	4.3
Average Hours/Day	1.5	1.7	0.9	1.8	1.3
Average Hours/Case	4.1	7.1	14.6	6.4	5.5

REACH also provides ongoing community-based services to the individuals and their support system 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 to 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 stabilized. FY26Q1 prevention services are provided via face to face and telephonic communication. These are included in 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.



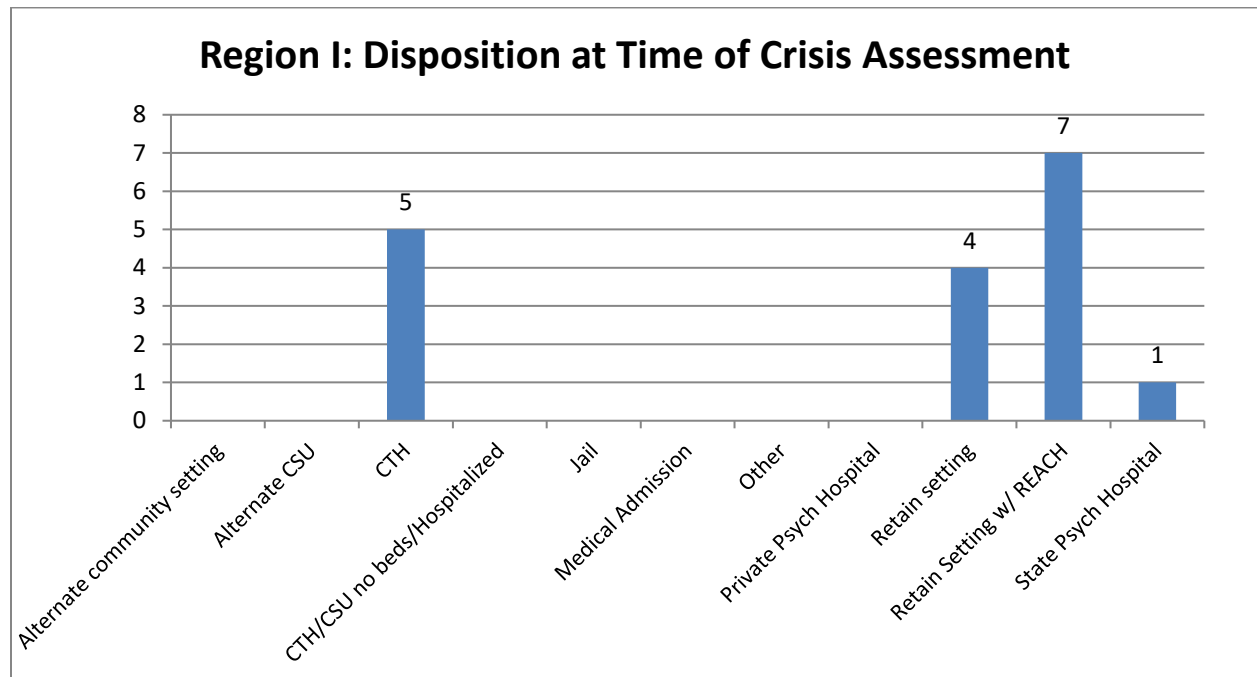
The total number of individuals receiving face-to-face prevention for FY26Q1 was 154. The total number of prevention hours provided by all programs in quarter one was 2,746.88; a decrease from FY25Q4 at 3,577.

Crisis Service Outcomes/Dispositions

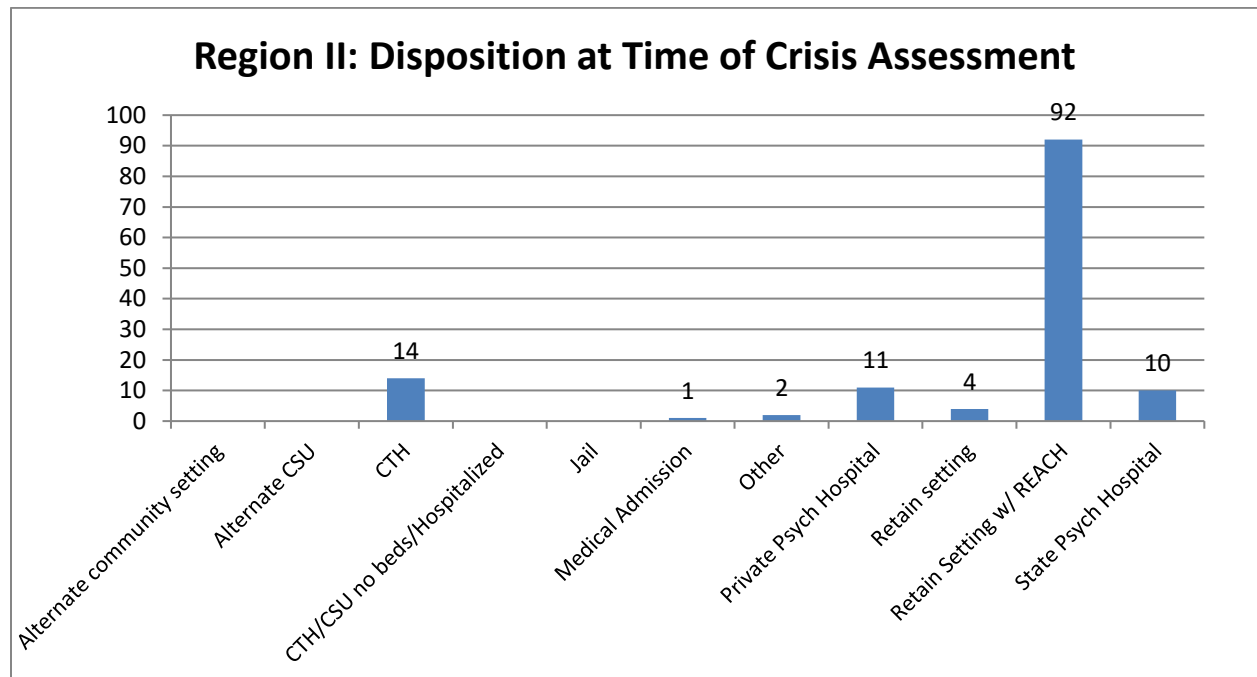
Maintaining residential stability and community integration is one of the primary goals of the REACH programs. Disposition data from three different perspectives are considered in this report. First, what is the outcome when a crisis assessment is needed? Second, what is the outcome when one is admitted to the CTH? Third, what is the outcome when mobile crisis or prevention supports are put in place to stabilize the situation and avoid the need for CTH admission, hospitalization, or some other disposition that involves disrupting the person's residential setting?

For this quarter, 30.8% of the individuals receiving a crisis assessment were able to retain their original residential setting, 33.9% of individuals were able to retain their setting with REACH support, 2.8% were diverted to a CTH, 0.8% of individuals diverted to an alternate community setting, 5.2% to an alternate CSU, and 10.6% were psychiatrically hospitalized in a private

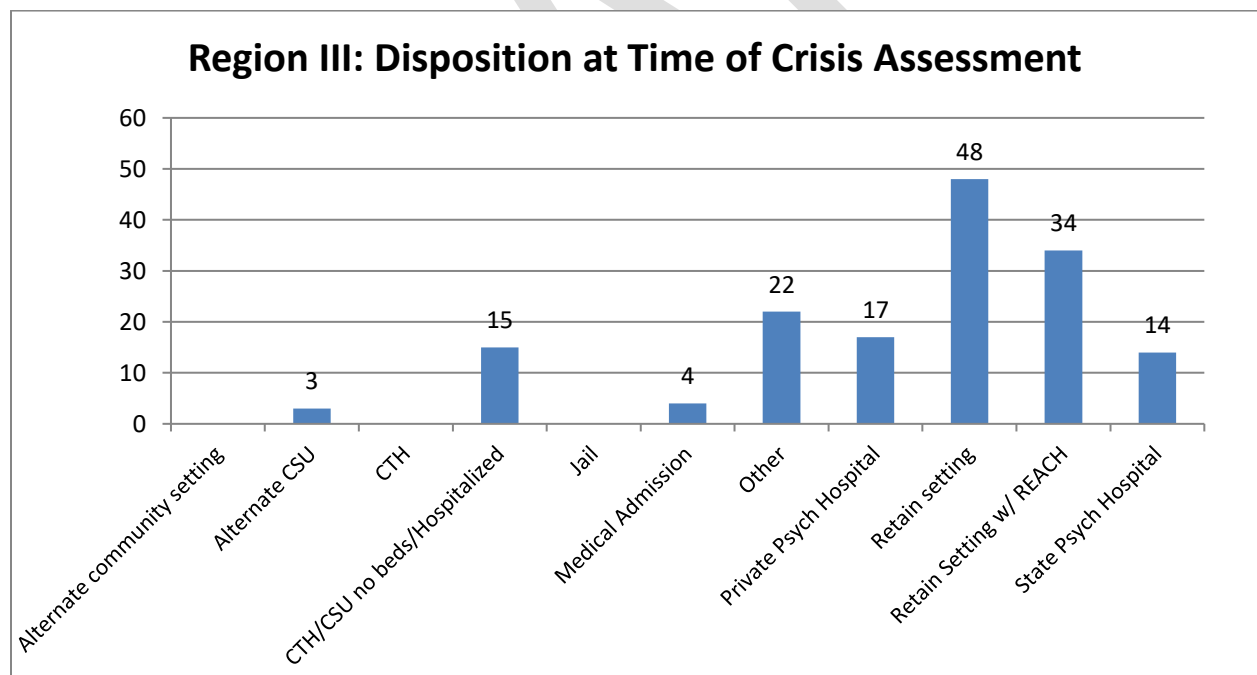
hospital, while 4.9% were hospitalized in a state psychiatric hospital, 1.5% were medically hospitalized, 0.2% went to jail, and 8.8% were listed as “other”. The following graphs display the outcomes of the crisis assessments across each regional program.



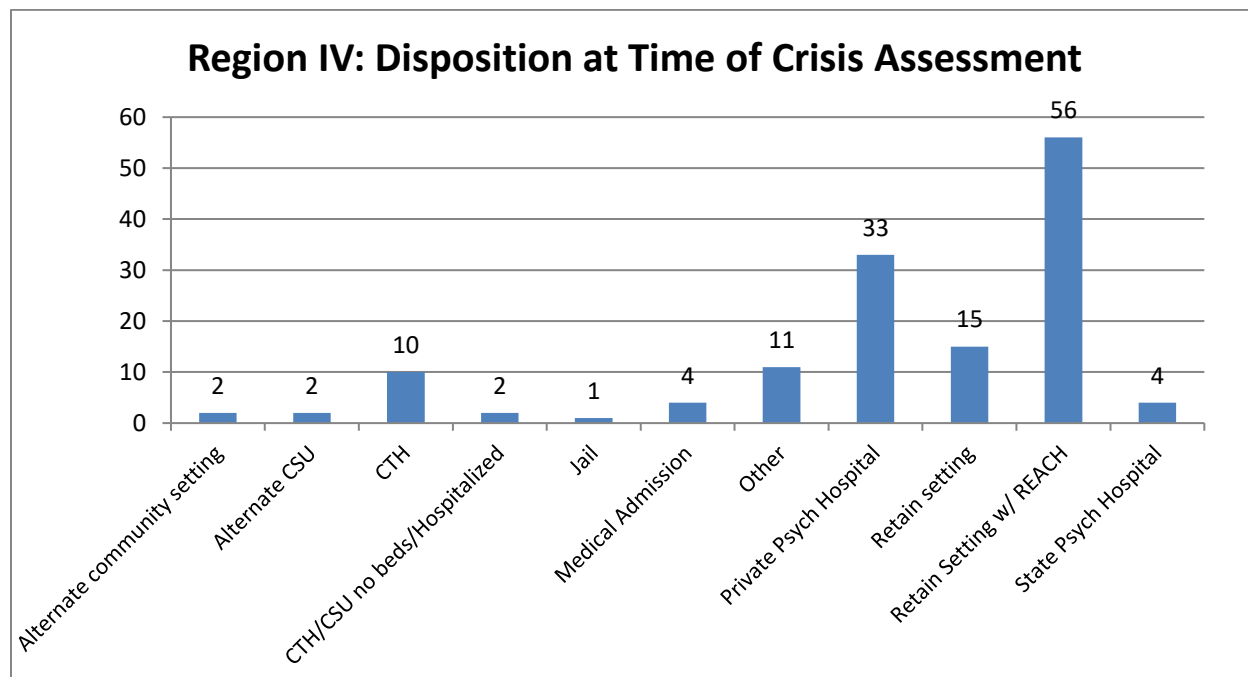
In addition to the above 1 crisis call was ended before the provider could provide an assessment



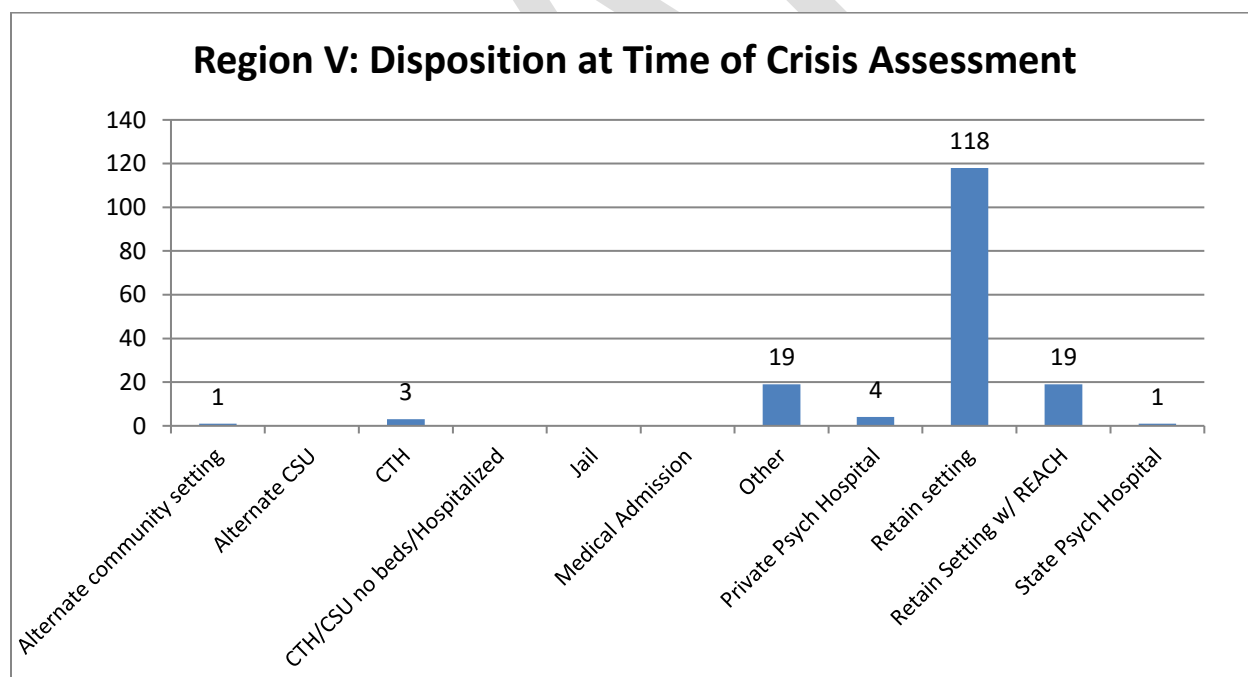
In addition to the above 27 crisis calls were ended before the provider could provide an assessment



In addition to the above 6 crisis calls were ended before the provider could provide an assessment



In addition to the above 7 crisis calls were ended before the provider could provide an assessment



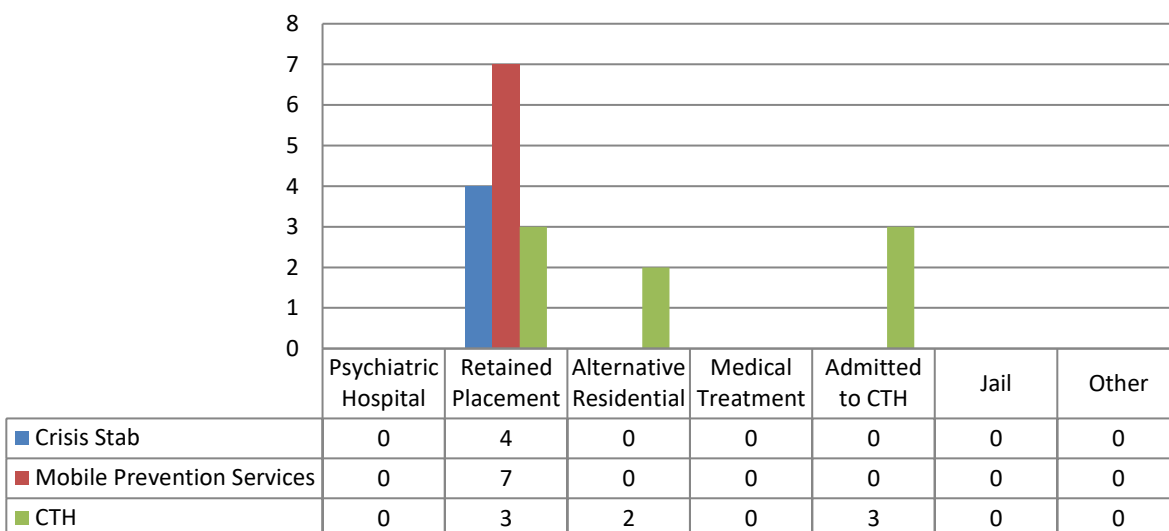
In addition to the above 38 crisis calls were ended before the provider could provide an assessment

Outcomes that are also of interest are those for individuals that have accessed REACH mobile crisis and mobile prevention services during the quarter in addition to the CTH. Similar to the preceding set of graphs, the following graphs provide a summary of outcome status for adults

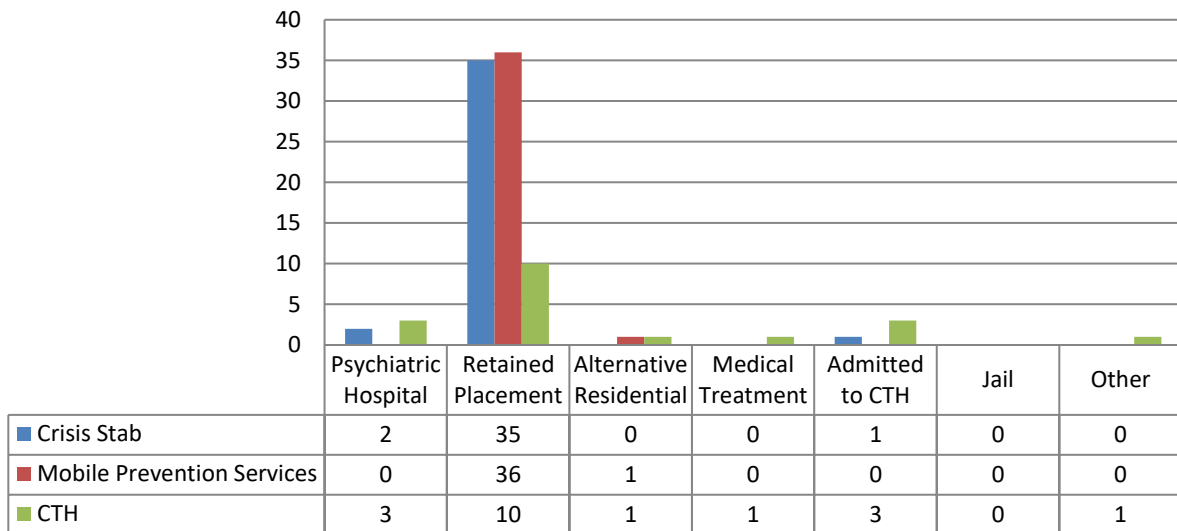
that accessed ongoing REACH services during the FY26 first quarter. Outcomes for individuals admitted to the CTH and discharged this quarter, including those admitted previously and discharged, 46.7% were able to return to their original residence, 8.3% went to alternative residential placement, 11.7% of outcomes for individuals at the CTH resulted in psychiatric hospitalization, and the remaining individuals had other outcomes. For all admissions receiving community crisis stabilization services, 79.7% remained in their residence and 3.8% were psychiatrically hospitalized. Based on reported data on the outcomes of adults in REACH mobile prevention services, 83.8% retained their setting and 0.6% went to an alternative residential community setting, 0% were hospitalized, 0% were admitted to the CTH, and the remainder had other outcomes.

The following graphs display the outcomes of the support services across each regional program. These charts also include outcomes for re-admissions and people carried over and discharged in the quarter.

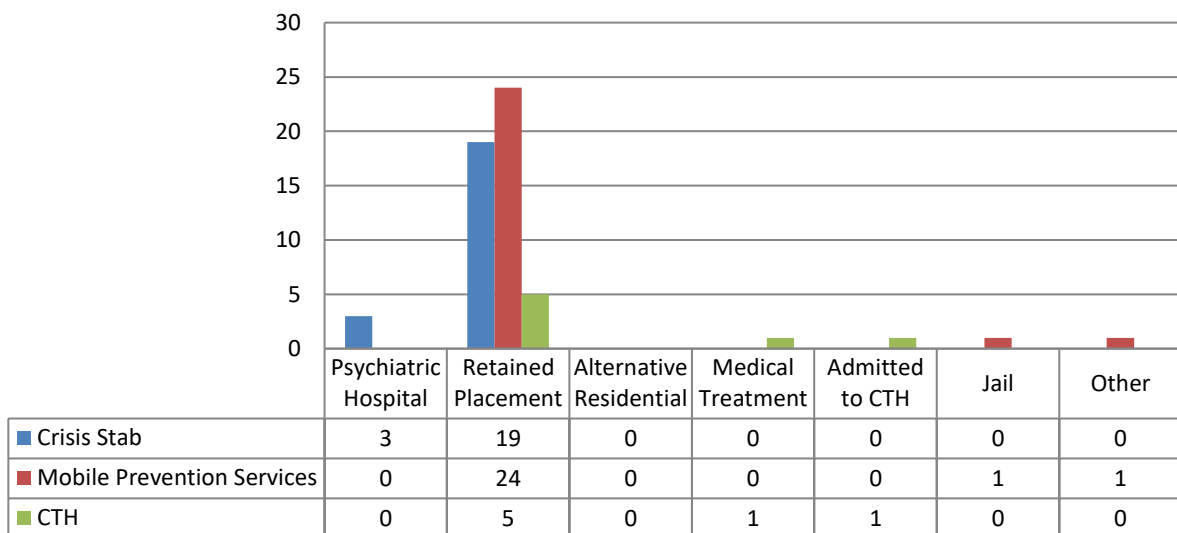
Region I: Discharge Disposition by Service Type



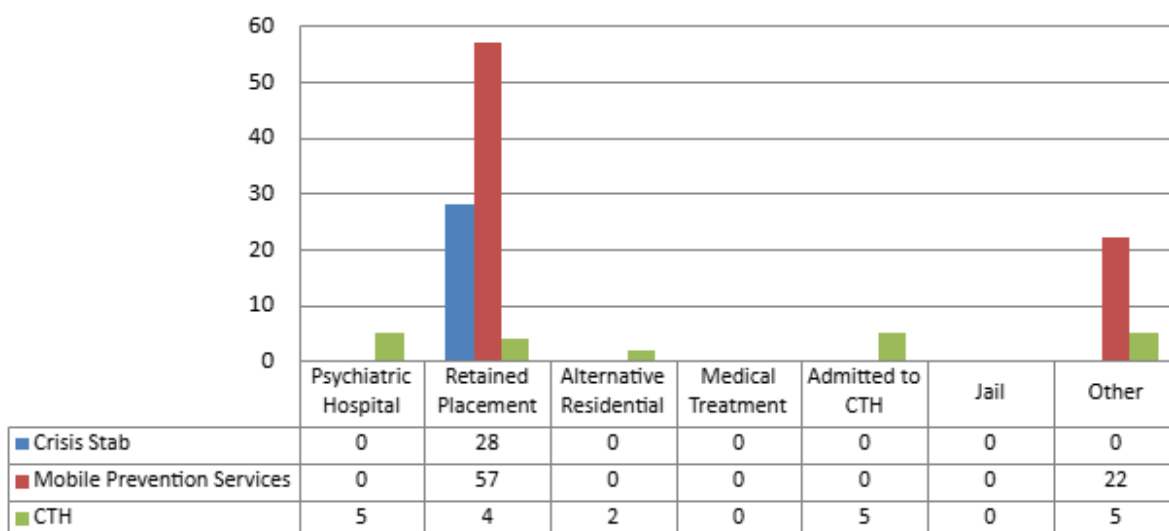
Region II: Discharge Disposition by Service Type



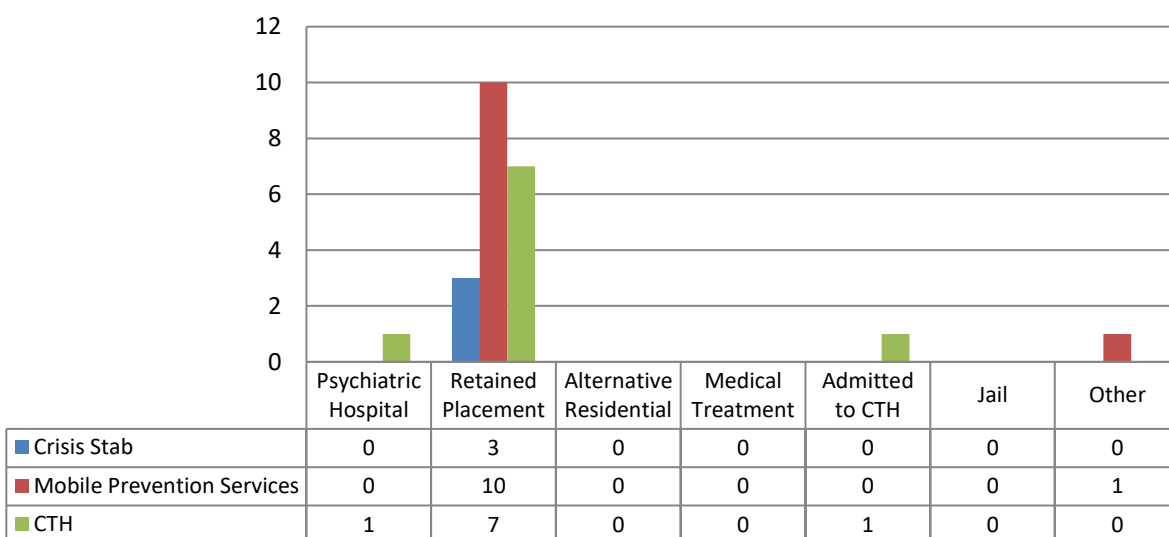
Region III: Discharge Disposition by Service Type



Region IV: Discharge Disposition by Service Type



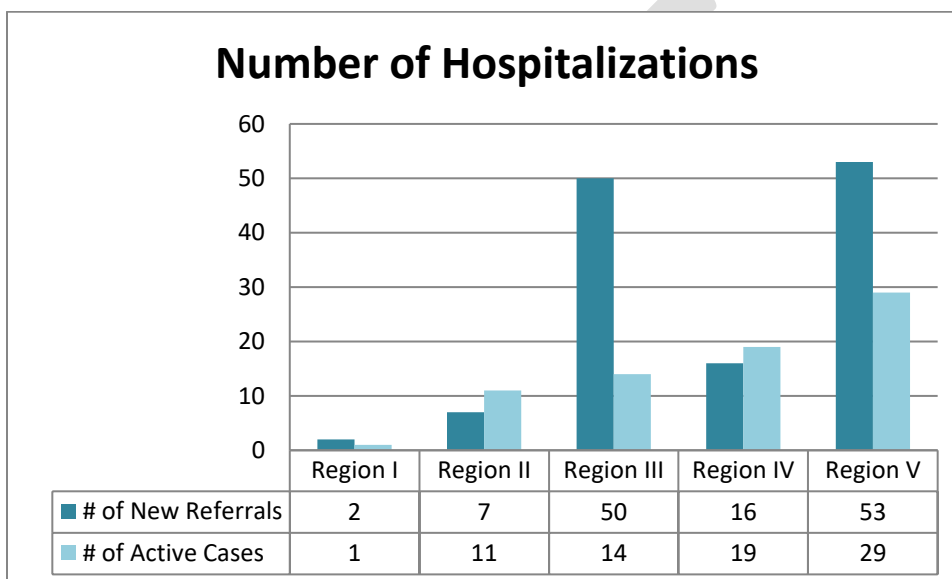
Region V: Discharge Disposition by Service Type



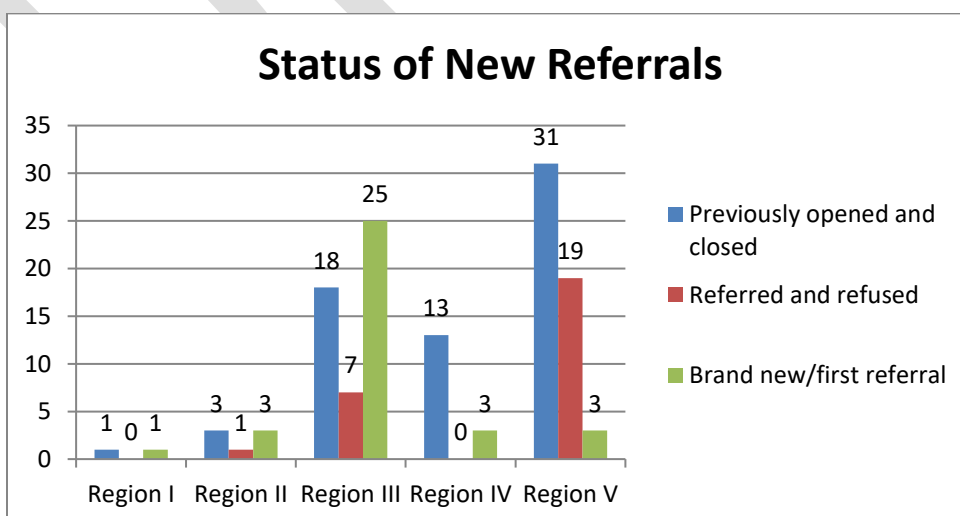
Hospitalizations

The next graphs provided are intended to supplement the information contained in the larger quarterly report. While the REACH programs remain actively involved with all hospitalized cases *when they are aware of this disposition*, they may not always be apprised that a REACH consumer

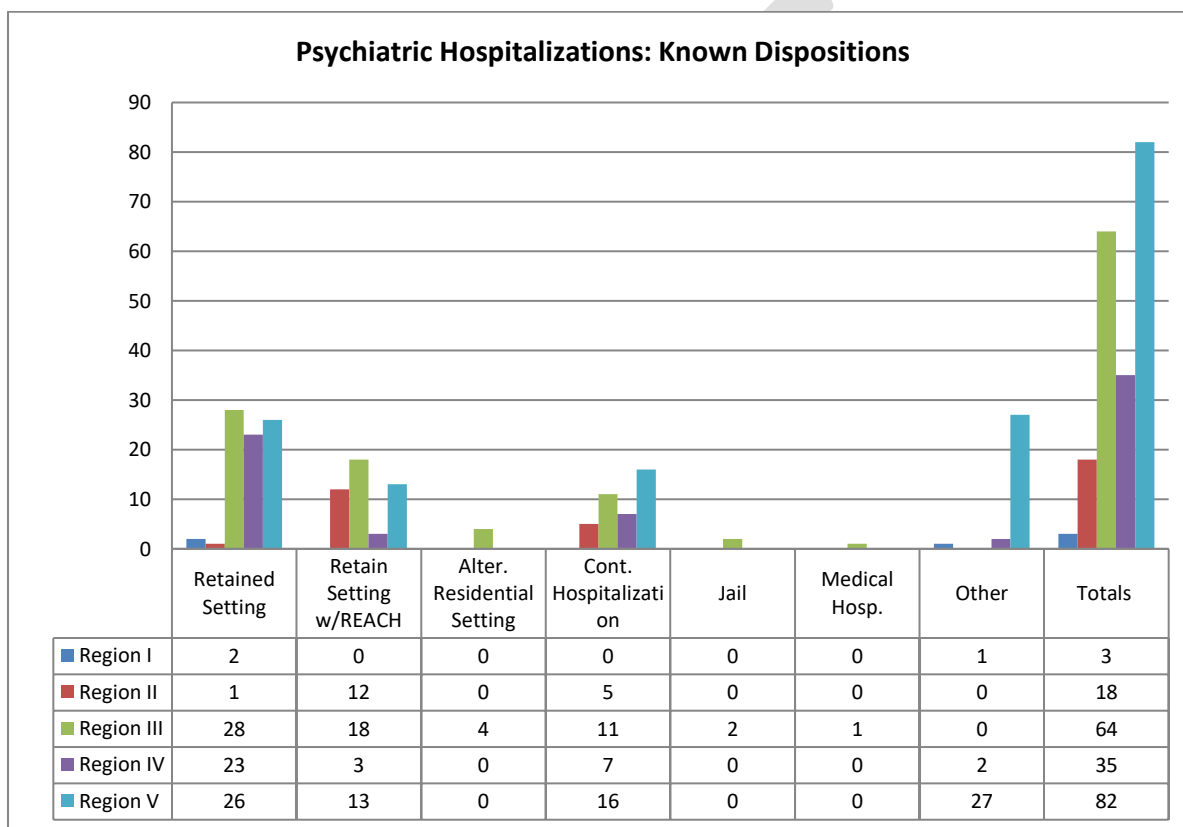
has been hospitalized or that an individual with DD has entered inpatient treatment as evidenced by the difference in the number of assessments as compared to the number of admissions. While the process of notifying the REACH teams when prescreening is needed has improved tremendously over the past few years, it remains the case that individuals are sometimes hospitalized without REACH being aware. REACH is active throughout all known psychiatric admissions, including attending commitment hearings, attending treatment team meetings, providing supportive visits, and consultation to the treatment team.



The programs are tracking new referrals according to whether individuals previously received supports through REACH and were closed, were referred but refused follow up services, or were first time referrals.



Of all hospitalizations, 63.37% were “new referrals” to the REACH program. Of the new referrals to REACH that were hospitalized, 27.34% of the individuals were new to the program, 21.09% were referred to REACH but refused services, and 51.56% had been previously discharged (inactive) from REACH services. Of the known dispositions of the people hospitalized and discharged, 39.60% retained their original community home, 22.77% retained setting with REACH, 1.98% went to an alternative community setting, and the remaining had other outcomes. Refer to the chart below for a more detailed breakdown of outcomes.



SERVICE ELEMENTS

Each of the five regional REACH programs provides an array of services to individuals enrolled. These services include prevention and education services, assessment services, and consultation services. The REACH staff also provide training to providers/families on the Crisis Education Prevention Plan (CEPP) developed during the guest’s stay at the CTH or when receiving community-based crisis stabilization services. In some instance the CEPP may not be updated as the plan may be clinically accurate as it may have been recently updated, such as in the case of a readmission into service or a transfer of service (mobile to CTH admission) within the quarter. A compliance indicator target has been set related to community-based crisis stabilization services

of 86% of families and providers will receive training in implementing CEPPs. Excluding the CEPPs that did not require an update and subsequent training, the combined REACH programs trained providers/families on 67% of the community-based crisis stabilization CEPPs this quarter. The data for community-based crisis stabilization services is as follows: Each region makes continuous attempts to schedule training and follow up into the next quarter for those who carry over due to continued admission or admitting late in the quarter. Respectively, Regions I through V completed the following percentages of the required training for mobile supports: 50%, 90%, 53%, 45%, and 75%. The tables below summarize the services provided in each of the REACH program components. In accordance with recent updates to the licensing regulations for Community-Based Crisis Stabilization Services and Crisis Stabilization Units, providers are now required to complete a crisis assessment as part of the service delivery process. As a result of this change, the "Comprehensive Evaluation and Consultation" components have been removed from the service elements chart in this report, as they are now addressed through the required crisis assessment.

Service Type: Crisis Stabilization (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Crisis Education Prevention Plan	3	4	0	6	2
Family/Provider Training	3	4	0	6	2

R1 CEPP and Training: 1 previously completed; R2 CEPP and training: 1 previously completed, 2 left service, 4 hospitalized; R4 CEPPs and Training: 2 left service and 2 completed previously

Service Type Provided: Planned Prevention (CTH)					
Service Type Delivered Per Case	Region I	Region II	Region III	Region IV	Region V
Crisis Education Prevention Plan	0	1	0	0	2
Provider Training	0	1	0	0	2

R2: CEPP and Training: 1 left service; R5 CEPP and Training – 1 previously completed

Service Type: Crisis Stepdown (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Crisis Education Prevention Plan	0	1	1	2	1
Provider Training	0	1	1	2	1

R2: CEPP and Training: 1 hospitalized; R4 – CEPP and Training – 1 previously completed; R5 CEPP and Training – 1 previously completed

Service Type Provided: Mobile Crisis Support					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Crisis Education Prevention Plan	2	28	8	10	3
Provider Training	2	28	8	10	3

R1: CEPP and Training: 2 left service; R2 CEPP and Training: 2 hospitalized, 3 left service, 4 still in service; R3 CEPP and Training: 2 hospitalized, 2 left service, 5 done previously, 5 REACH error; R4 CEPP and Training: 10 Left service, 5 completed previously, 1 hospitalized, 1 refused, 1 REACH Error; R5 CEPP and Training – 1 REACH error.

REACH Training Activities

In addition to the training REACH programs provide to their staff, REACH continues to expand its role as a training resource for the community of support for those individuals with DD. The REACH programs offered numerous training programs this quarter which enabled 1276 community partners to receive this training.

The table below provides a summary of attendance numbers for various trainings completed by the REACH programs. These trainings target the information needed by professionals in various work settings and are generally tailored to the specific needs of the audience. The training numbers listed in the table are in addition to the training provided to individuals and their respective support system.

Community Training Provided						
Training Activity	*Region I	*Region II	*Region III	*Region IV	*Region V	Totals
CIT/Police: #Trained	78	32	2	5	56	173
Case Managers/Support Coordinators	0	38	8	8	113	167
Emergency Service Workers: #Trained	0	0	3	15	0	18
Family Members: #Trained	0	0	0	0	32	32
Hospital Staff: #Trained	0	0	0	0	6	6
DD Provider: #Trained	0	76	50	7	112	245
Other Community Partner: #Trained	0	26	408	46	155	635
Totals	78	172	471	81	474	1276

*Duplicate counts with Children for training in all regions.

Summary

This report provides a summary of data for the regional adult REACH programs for the first quarter of fiscal year 2026. In keeping with the DBHDS' vision, all five of the programs continue to focus on mobile crisis and prevention work with adults and outreach with the systems that support these individuals. The Department continues to review the consistency of clinical practice, training requirements, and documentation across all the REACH Programs. During FY26Q1 the REACH regional programs continued to experience the impact of the national staffing shortage inclusive of both recruiting and retention of qualified staff. Most programs are actively recruiting qualified DSP, QMHP, LMHP types and nurses. The programs continue to work to retain those qualified and veteran staff within the programs. The Department remains committed to fulfilling its mission to have a continuum of qualified care for adults with developmental disabilities and their families across the Commonwealth.