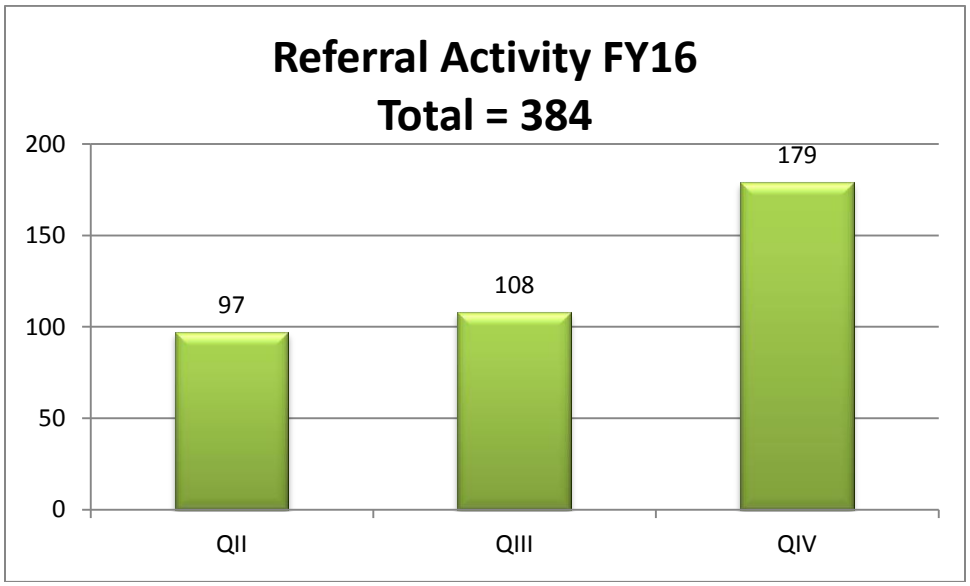
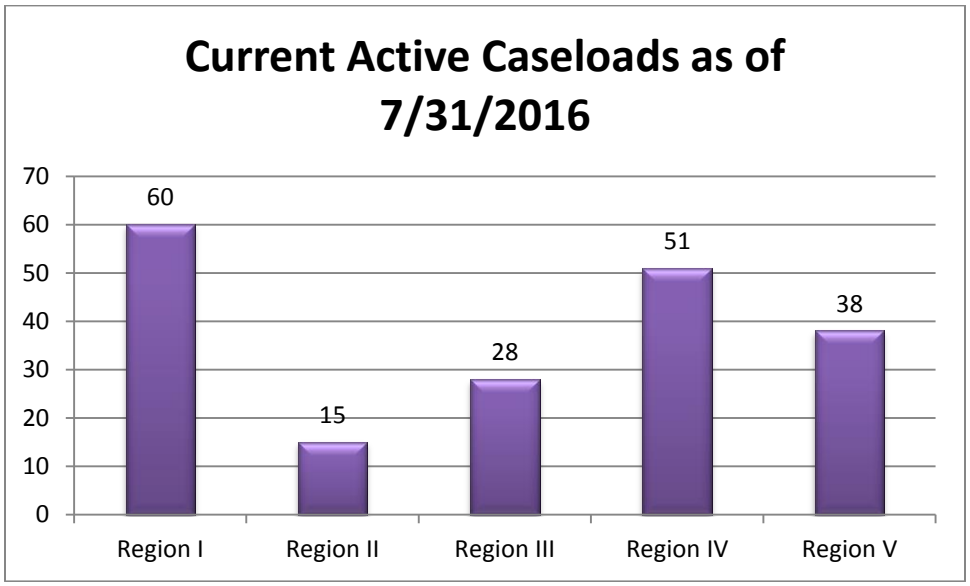
REACH Annual Report: Children's Program
Fiscal Year 2016

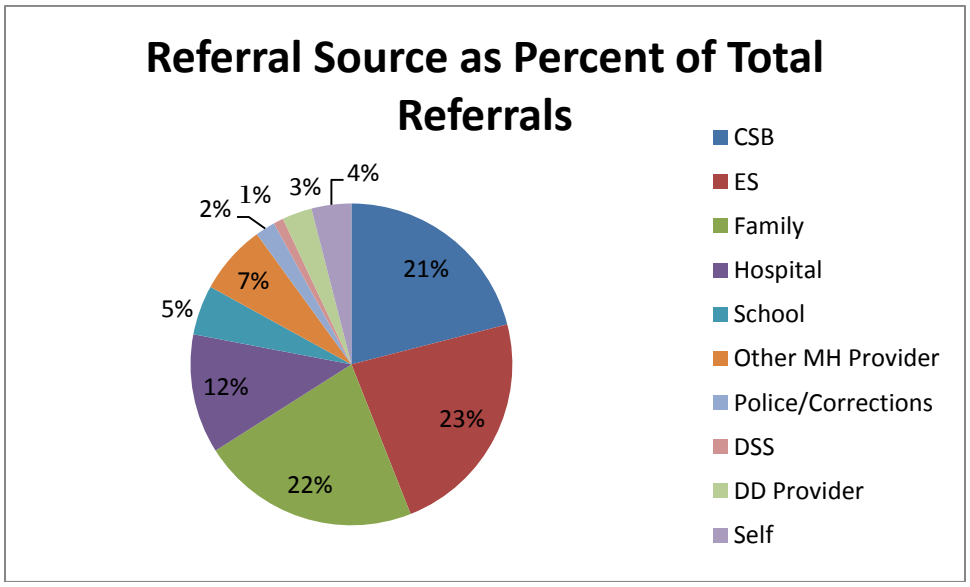
This report will provide a review of the Children's REACH programs over the course of the past fiscal year. The regional programs developed at different rates over the past year and data collection mirrored this process. No complete data set was available for the first quarter of fiscal year 2016. While some regions were able to provide a full report, others were able to provide only partial or limited data. For this reason, this report will not include information from the first reporting period (July-September 2015).

Referral Information

The REACH programs received at total of 384 referrals for service during fiscal Year 2016. Referrals are currently on an increasing trend, which is expected when a new program becomes available. Active cases vary considerably by region, with Region I reporting the most active cases and Region II reporting the fewest at 10% of the total referrals. This was not surprising, as Region II has had the most difficulty establishing a plenary children's crisis service as defined by the Children's REACH standards. The graphs below present information about aspects of referral activity visually.







Referral source data over the course of the past year has been consistent from quarter to quarter. CSB case managers, emergency services personnel, and family members make up the largest cluster of referral parties, and they share this position evenly. Hospitals also add significantly to the pool, but the remaining players contribute in small degrees. Likely, it is positive that law enforcement accounts for only 2 percent of referrals. This low number, combined with the high numbers coming from case management and families, suggest that intervention is being sought before the crisis culminates in the need for law enforcement.

Who is Served by the REACH Program?

General demographic information can be useful as a way to formulate an understanding of the type of individuals seeking REACH services. Gender, age, and level of intellectual disability provide a basic framework for describing the population served by the children's programs during FY16. Given that there do not appear to be any systematic differences between the five regions, all data related to descriptive information will be presented in aggregate.

- Gender: For FY16, the REACH programs served 339 males and 45 females. Converting these figures into percentages indicates that 88% of individuals utilizing REACH programs are male and 12% are female. While the prevalence of behavioral disorders and externalizing mental health conditions is larger among males than their female counterparts, this difference is larger than would be expected. It may point to the need for the programs to target some of their outreach efforts toward girls and the unique issues they experience as they mature into adulthood.

- Age: During FY16, the REACH programs served individuals from the ages of 3 to 17. The chart below provides a view of age distribution as defined by the brackets noted.

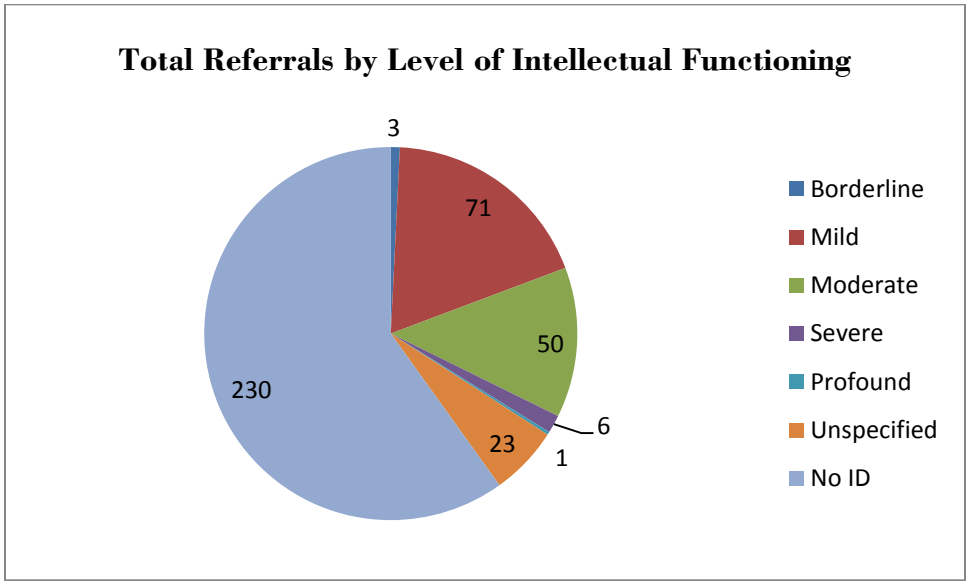
Age Range	Region I	Region II*	Region III	Region IV	Region V	Total
3-5	4	1	4	1	1	11
6-9	21	5	10	13	18	67
10-12	21	12	22	13	21	89
13-15	27	12	15	25	38	117
16-18	26	3	16	29	23	97

*Data missing for two cases

- Level of Intellectual Disability: The Children's REACH programs are charged with serving individuals across the entire spectrum of intellectual functioning. Understanding this element of the customer base is vital both to current treatment approaches and to planning for the future of the program. Clearly, interventions that are efficacious for individuals with no intellectual disability or those who are mildly impaired will be very different from what is provided to a person functioning within the profound range of disability. Different skill sets need to be developed for staff, different activities planned, and different approaches to coping and stress tolerance implemented.

During FY16, the REACH programs served primarily individuals without a diagnosis of intellectual disability. This was surprising, as it differs significantly from the adult data, which has established trends of serving a large number of ID individuals. As the programs continue to grow and develop, it will be interesting to see if these numbers change. Currently, services are heavily weighted toward children with autism spectrum disorders.

For those children with an intellectual disability, most referred to the REACH program function within the mild range of disability, followed by those with moderate intellectual deficits. Those at the lower end of functioning are virtually unrepresented in the referral base, and account for a combined total of only 7 children. This does not necessarily indicate an area of concern for the programs. Referral sources are broad, which suggests that outreach has been sufficient to reach a large array of stakeholders. This would include those working with an ID population. It may be that children with ID as a primary diagnosis experience fewer behavioral and psychiatric challenges than their counterparts with autism.
The chart below summarizes the intellectual functioning of those referred to the REACH programs during FY16. Please note that these are raw referral numbers and include a small number of children who lacked the necessary diagnostic criteria to receive REACH services.



- Psychiatric Diagnosis: The children's REACH program is designed to serve individuals who are challenged with both a developmental disability and a psychiatric/behavioral disorder.

  Information related to diagnostic categories as provided in this document gives the reader only a general impression of the clinical population being served. Diagnostic

information received by the programs at the time of referral can be unclear, confusing, or include diagnoses that are not a part of psychiatric nomenclature. In some cases, this information has been omitted from the data pool to improve the overall accuracy and clinical integrity of the information. Across all regions, frequencies listed below may reflect multiple co-morbid conditions. Additionally, children with an ID or DD diagnosis and no co-morbid psychiatric presentation are not included. Therefore, there is no concordance between the number of referrals received and the reported frequency of psychiatric condition.

Diagnostic Category	Region I*	Region II**	Region III	Region IV	Region V
Externalizing Disorders (i.e. impulse control disorder; ADHD; Bipolar disorder; IED; ODD)	55	13	44	60	96
Anxiety Disorders	4	6	16	16	13
Depression	8	14	3	9	6
Psychotic Disorders	1	1	0	3	18
Unspecified Mood Disorder	6	1	5	9	1
Other	9	3	12	3	1

*Note Region I did not provide this data for QII. **Region II did not provide this data for quarter QIV.

Not surprisingly, those disorders that result in overt behavior that is extreme or very destabilizing to the social environment are the most frequently noted. Region V serves a much higher number of children with symptoms of psychosis. This may be because they serve more kids in the 13-18 year age range when symptoms of a major mental illness tend to manifest for the first time. No region reported diagnoses related to substance use or abuse, which was surprising especially in light of the high number of children presenting with normal intellectual functioning.

- Presenting Problems: The table below provides a summary of the presenting problems that initiated Children's REACH referrals over fiscal year 2016. The reader is reminded that there is no concordance between the total number of presenting problems and the number of individuals served as some individuals present with multiple serious challenges at the time of referral while others have only a single need.

Presenting Problem	Totals	Region I*	Region II	Region III	Region IV	Region V
Aggression	216	45	20	40	57	54
Risk of Placement Loss	2	0	2	0	0	0
Decline in Daily Functioning	7	5	0	0	0	2
Family Needs Assistance	44	0	0	8	8	28
Increased Mental Health Symptoms	32	10	16	2	3	1

Self-injury	12	1	0	2	4	5
Suicidal Ideation/Behavior	60	20	11	10	8	11
Step Down/Transition Assistance	3	0	0	3	0	0
Unsafe Community Behavior	7	7	0	0	0	0

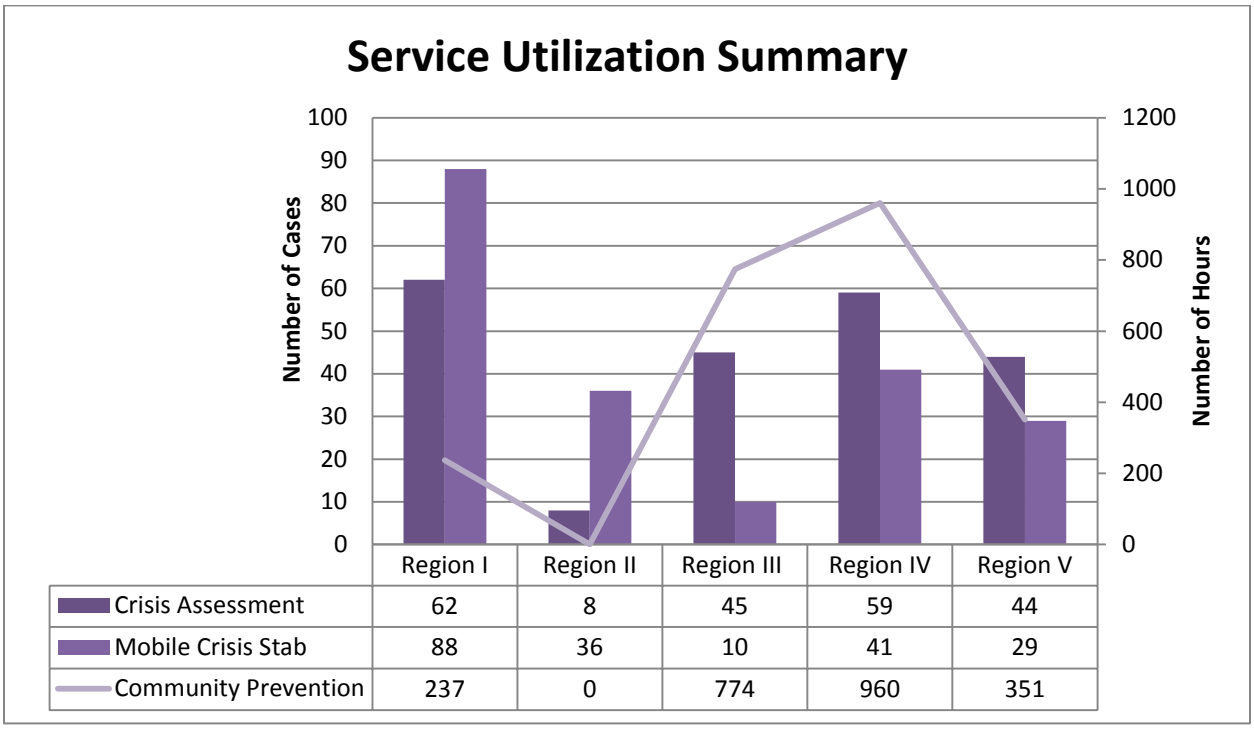
*Region I did not provide this data for QII.

Consistent with the data presented on psychiatric diagnoses which indicate that externalizing disorders are the most commonly reported diagnosis among consumers of REACH services, aggression is also the most frequent presenting problem. As defined here, aggression includes verbal aggression, physical aggression, and property destruction. Suicidal ideation and behavior assumes the second position in the rank, which is unique to the children's data but may reflect the high rates of suicide attempts and completions in the adolescent population.

Service Utilization

The REACH programs are charged with providing crisis intervention and prevention services to children with developmental disabilities and co-occurring mental health and or behavioral needs. In service of this mandate, they provide crisis assessments, home-based crisis intervention and stabilization, and prevention through training, active monitoring, and individualized supportive interventions. The chart below summarizes service utilization by type across the five regions. Please note that Region II and III did not provide information on prevention or number of crisis assessments for the second quarter of the fiscal year. Both programs were still evolving an essential service model and, unfortunately, data collection efforts were still lacking during the second quarter of service. Additionally, Region II provided no prevention services for the fiscal year. Again, this was due to challenges the region faced in developing a fully-functioning REACH program. They have since established a plenary service and will provide all components of the REACH service going forward.

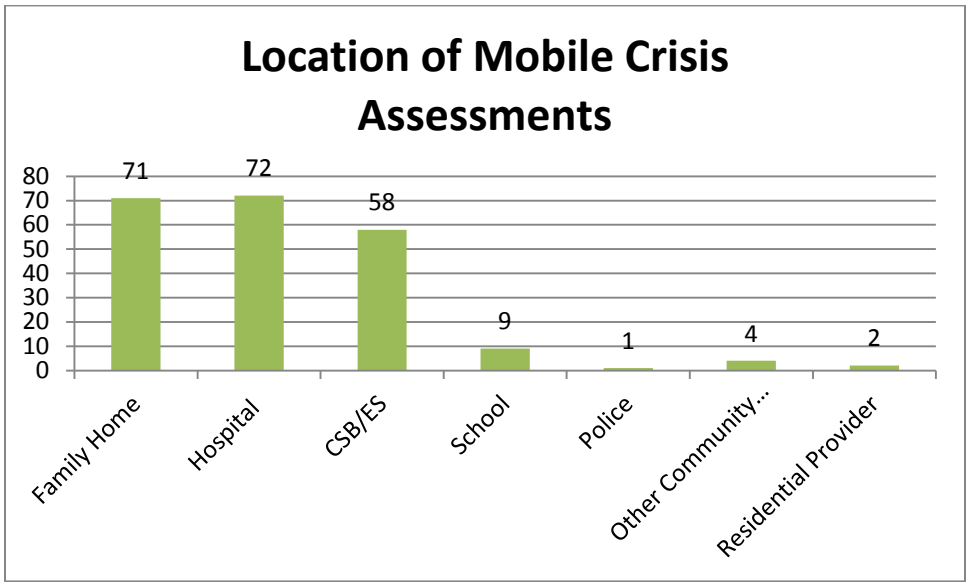
Data on the number of prevention hours provided is graphed on the secondary Y axis, as this data element is collected in a different metric (hours versus cases).



	Region I	Region II	Region III	Region IV	Region V
Crisis Assessment	62	8	45	59	44
Mobile Crisis Stab	88	36	10	41	29
Community Prevention	237	0	774	960	351

In addition to examining the volume of services that are being provided, it is also important to consider if the services are fully embedded in the communities that they serve. REACH is first and foremost a crisis intervention and prevention program; it must be able to demonstrate flexibility in where and how it provides services. One proxy for this data element is location of crisis assessment. The REACH guidelines make clear that crisis responders should, unless specifically contraindicated, report to the scene of the crisis event to complete their assessment. This is important for several reasons. First, an on-site response allows for a therapeutic response to be provided by a clinically trained professional, potentially calming the situation *in vivo* and resulting in the person maintaining placement. Secondly, the on-site response and initial intervention provides valuable information, resulting in a more accurate assessment of the crisis event. Additionally, face-to-face contact creates an opportunity for REACH staff to offer immediate support to child and family, even when a TDO cannot be avoided. The goal is for REACH staff to be seen as an integral part of the initial crisis response, available as a resource *for* the community and *in* the community.

A review of data for fiscal year 2016 indicates that the majority of assessments take place either in the child's home or within a hospital setting. CSB emergency services departments are also fairly common, although this is primarily due to Region I's model, where children present at their local crisis service office for assessment by REACH staff. This model will be changing in fiscal year 2016, so this number may well be lower at the time of next year's annual report.

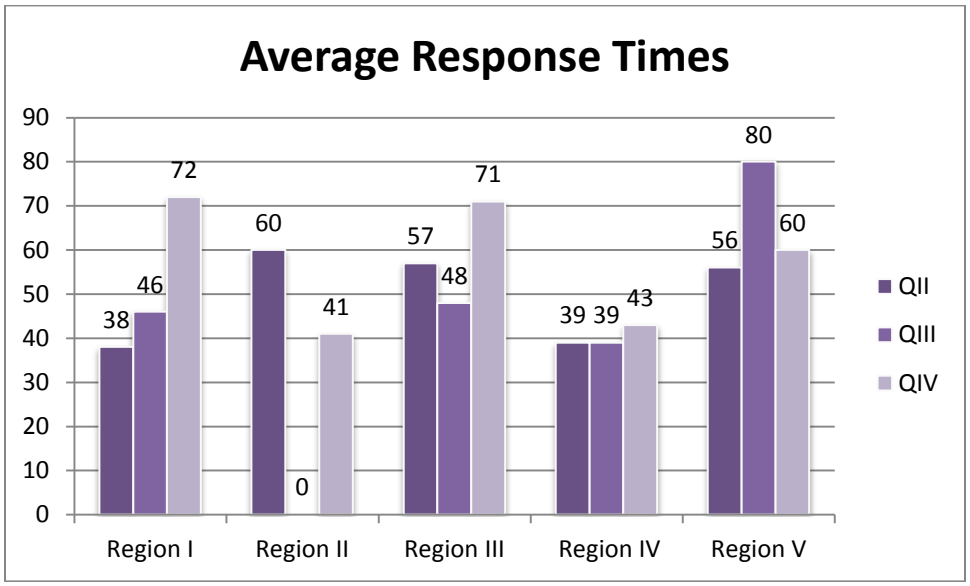


Crisis Response Time

Currently, the REACH programs are well within the bounds of the standards established by DBHDS when response times are averaged within Region. There continues to be a small number of individual events that exceed established expectations. It is a small number, however, such that average response time likely represents "true", actual response time.

Average response time data is presented region by region rather than being aggregated across the five programs. This provides for a more accurate review of the data for two reasons. Firstly, the regions have different response time standards, depending upon their status as either rural or urban. Secondly, the physical geography, staffing resources, and organizational structure of the programs differ significantly from area to area. Aggregating the data is only appropriate when the differences between the categories being studied are minimal. This is not the case with the REACH programs. Please note that response time data was not provided by Region II for the third quarter of the fiscal year.

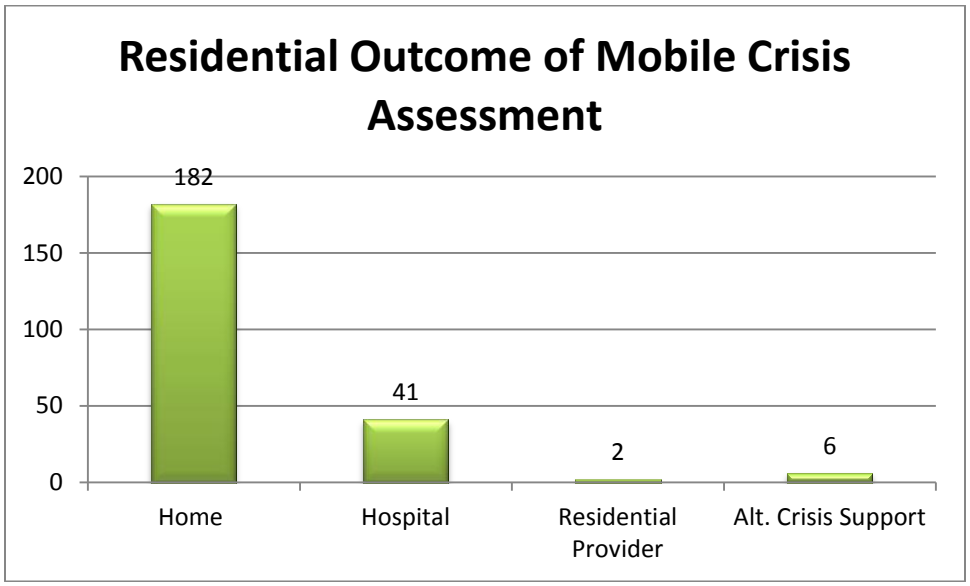
As the chart below depicts, response time patterns differ region by region, but not in a way that points to any meaningful trends. The regions are performing within expectations in this area of performance. In fact, only eight individual responses exceeded one or two hours, although data was missing for Region I, II, and V on individual response times during the second quarter of the fiscal year. All data was available for the final two quarters and will continue to be available in future quarters.

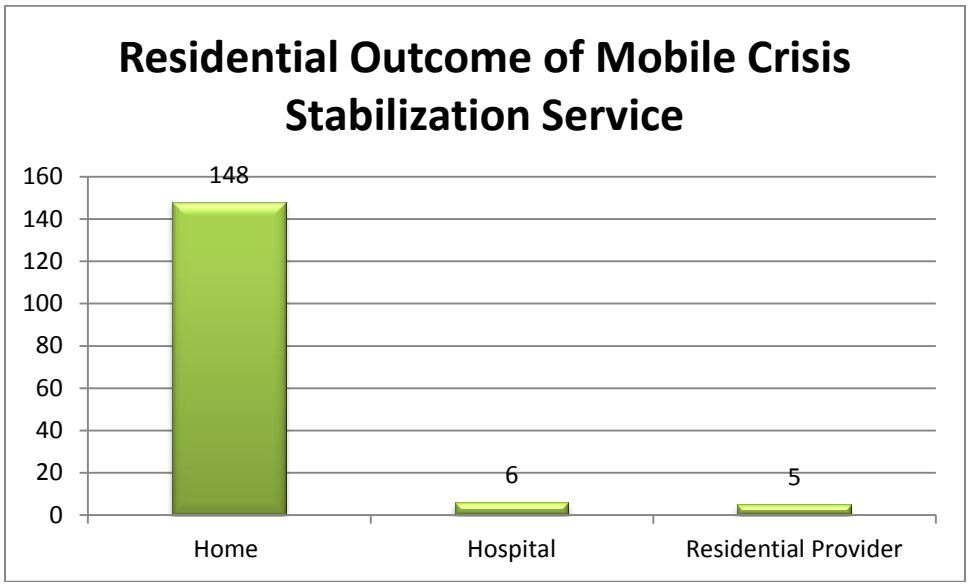


Note: Regions I, III, and V are designated rural and have up to 120 minutes to respond as measured by the average annual response time. Regions II and IV have urban designations, allowing them a 60 minute response time as measured by the average annual response time.

Service Disposition

The REACH programs have been very successful in fostering the residential stability of the children they serve. The charts below illustrate the outcomes of the REACH program as defined by placement disposition. Two perspectives are presented: disposition from crisis response and disposition at the close of community-based mobile support services. Please note that Region I did not provide information for Quarter II and III, and for Quarter III, they reported completing no crisis assessments.





Conclusions & Recommendations

This report has summarized the work of the REACH children's programs over the past fiscal year. As the children's programs have developed they have benefitted tremendously from what the adult programs learned as they built a new service system for adults with developmental disabilities. The growth trajectory has not been equal across the Commonwealth. Regions I and II have struggled to find their place as an alternative crisis stabilization and prevention program. This is evident in the challenges that they have had in providing complete and accurate data, providing the full array of services expected, and becoming integrated into the communities they serve. These two programs will be undergoing significant changes in the coming year, with good results expected. Region I will be redesigning its program in order to adhere more closely to the models being used by the rest of the state. Region II will focus on expanding its core service to include prevention, outreach, and better data collection.

The Commonwealth is pleased with the direction in which the REACH programs are moving. There continues to be much work ahead to ensure that consistent, accessible, and high quality services are being delivered. With the finalized Program Standards, the Data Store, and the quarterly regional review schedule, the foundation is in place to ensure a quality crisis service system within the DD community for children and adolescents.