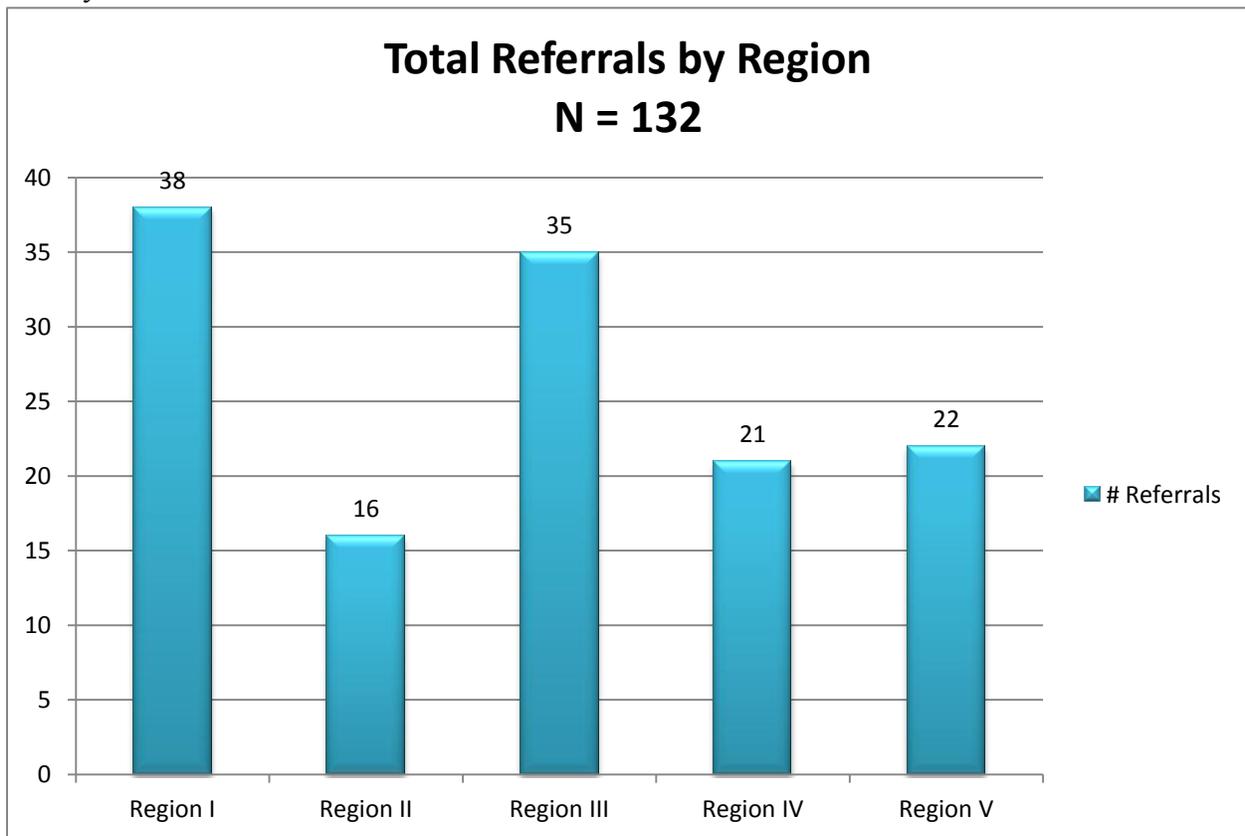


REACH Data Summary Report: Quarter II/FY15

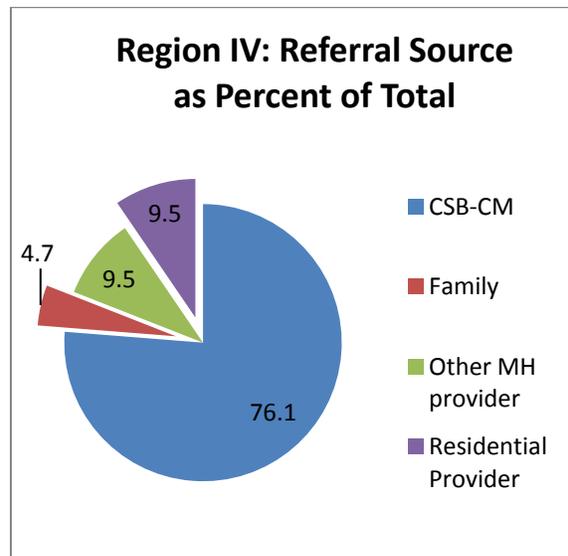
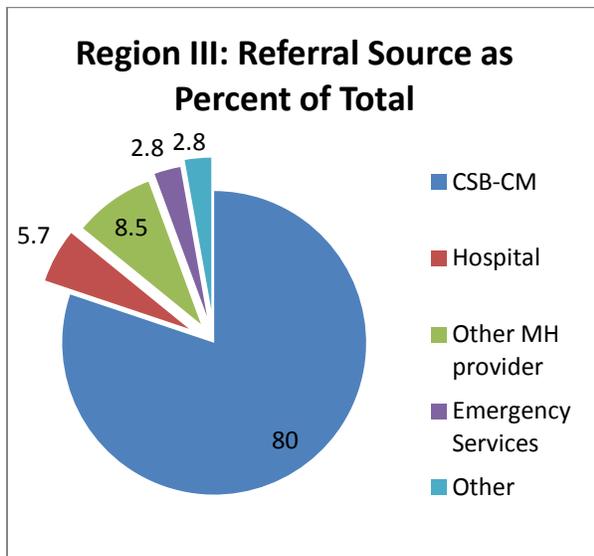
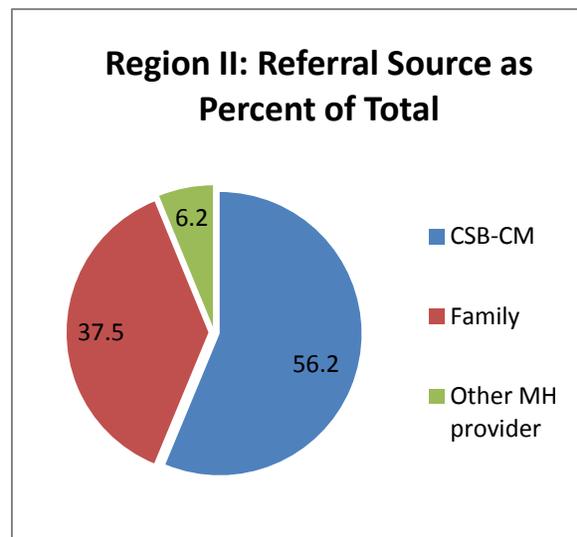
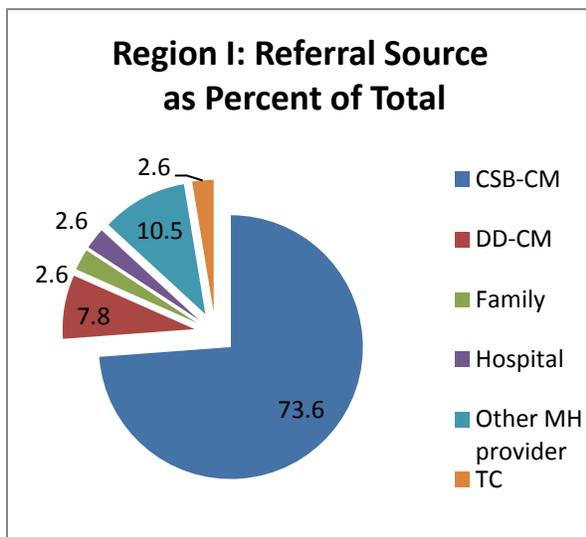
The following report provides a summary of data related to the operation and utilization of the regional REACH programs for adults. It offers a snap shot of the program's status for the second quarter of Fiscal Year 2015. This document is organized to address the referral process to the REACH programs, the operation of the 24/7 crisis lines, the Crisis Therapeutic Home (CTH), the Mobile Crisis Response, and training and outreach efforts.

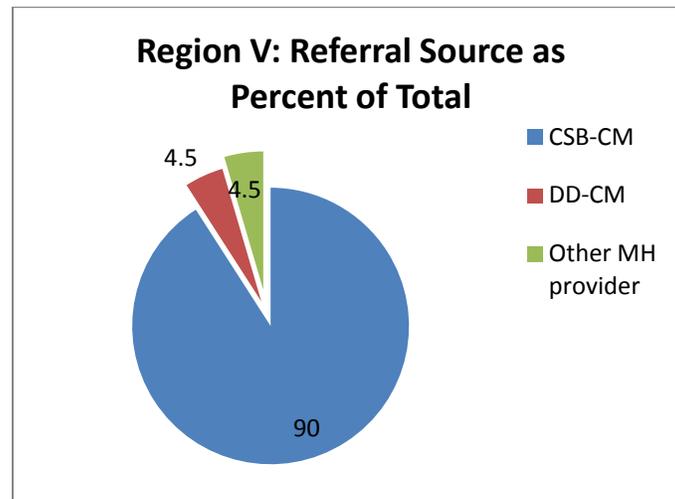
REACH Referral Process

The REACH programs have had an active quarter as they continue to receive referrals to their services on a regular basis. Most referrals are not made due to emergent events, which strongly suggests that the programs are functioning in support of maintaining clinical stability rather than to redress a burgeoning crisis. Across the Commonwealth for the current quarter, a total of 132 new cases have been referred to the program, with the highest number of these coming from Regions I and III. Referrals are fairly evenly divided among the other three regions, suggesting a regular flow of new cases but with reduced volume when compared to Regions I and III. The graph below visually summarizes this information, highlighting regional differences in referral activity.

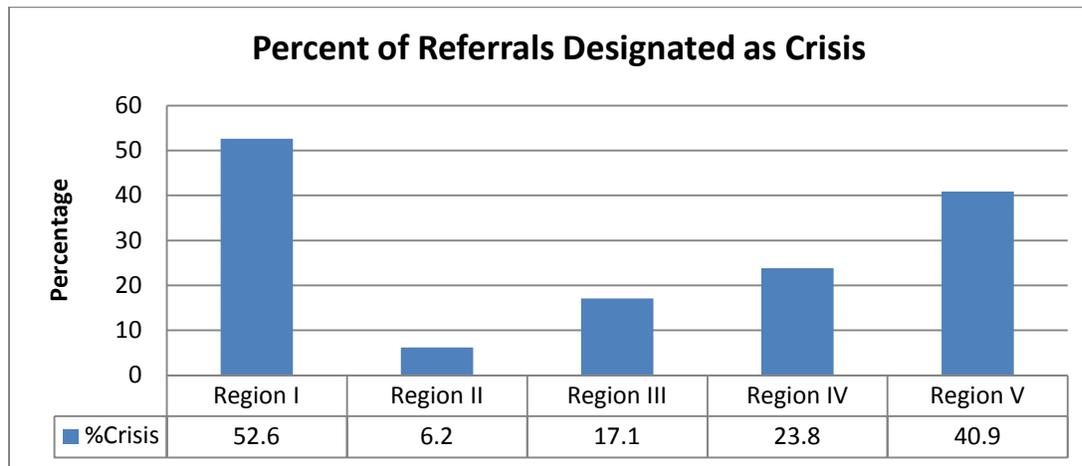


Apart from examining the number of individuals who initiated services during the quarter, referral source information can also be considered in ensuring that the REACH programs are actively embedded in the communities they serve. Consistent with data reported in previous quarters, case managers employed by the local Community Service Boards (CSB's) remain the largest access point for the initiation of REACH services. This is true across all five regions. Beyond this single generality, however, state wide trends disappear and regional differences dominate the picture. More detailed information, presented graphically, can be seen in the charts below. Please note that referrals made to sister REACH programs are incorporated into the numbers for "other MH providers". This quarter, 3 such referrals were made (Regions III, IV, and V).





Referrals to the REACH programs are made primarily Monday through Friday during normal business hours (8:00 am to 5:00 pm). However, services are initiated after hours on some occasions. Across regions, a total of nine calls were made to the crisis lines after 5:00 pm. Six of these were within Region I, one was in Region IV, and two were in Region V. Given that only 31% of overall referrals to the REACH programs are determined to be crises at the time the referral is made, it is not unexpected that most new cases are opened during standard business hours. This trend also suggests that referrals are being made prior to a crisis developing. This is encouraging and in keeping with the prophylactic emphasis of the REACH programs. In terms of how regions differ in the proportion of crisis to non-crisis referrals they receive, there is considerable variability across the regions. The reasons for this are not currently clear, but could be an indicator of how rich the service arrays are in the various locales. It is interesting to note that the two regions with the highest number of crisis referrals both have large rural areas within the regions, suggesting that services may be less available in these areas. The graph and table below offer a more detailed summary of information regarding time and type of referral. Please note that time of day data were not available for all referrals. Regions II, IV, and V had missing data. Totals for these regions as noted on the table below will not match the total number of referrals reported.

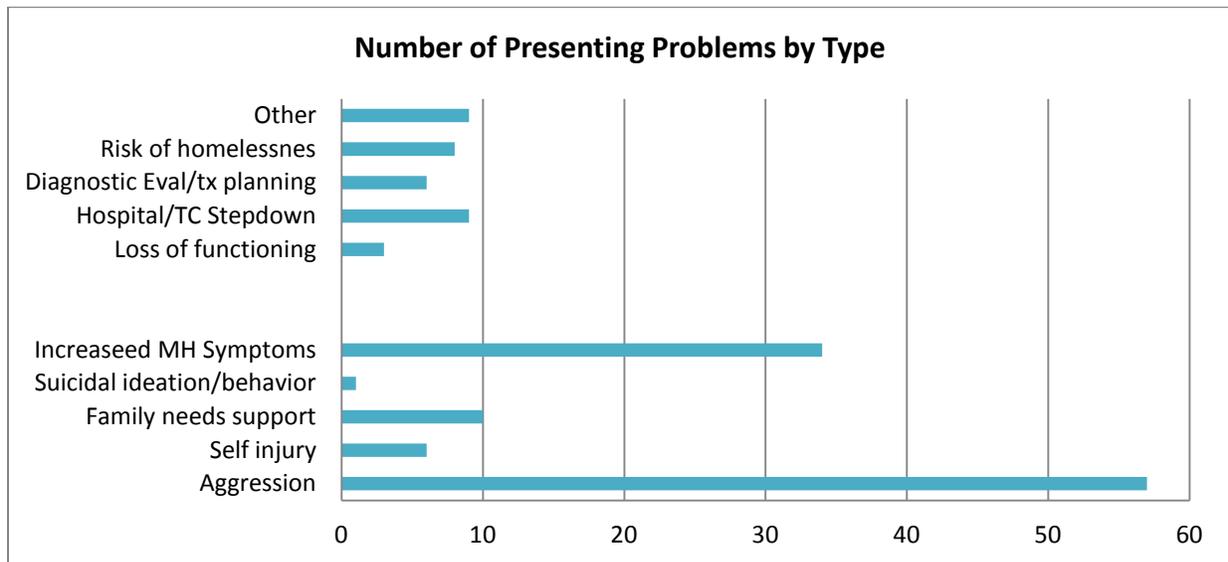


Referral Time	Region I	Region II	Region III	Region IV	Region V
Monday-Friday	37	16	3	20	20
Weekends/Holidays	1	0	2	1	0
8:00 am to 2:00 pm	21	13	20	11	10
3:00 pm to 8:00 pm	14	2	14	3	6
9:00 pm to 2:00 am	1	0	1	0	0
3:00 am to 8:00 am	2	0	0	0	0

In terms of what type of clinical issues bring individuals to the REACH programs for support, aggressive behavior, to include physical aggression, verbal threats, and property destruction, is what most often necessitates a referral, although this is not the case in Regions II and III. The table below provides program specific information on presenting problems. Aggregated data is presented in the graph just below this table.

Presenting Problem	Region I	Region II	Region III	Region IV	Region V
Aggression	18	2	4	13	18
Self Injury	0	0	2	1	1
Family Needs Support	0	0	4	3	1
Suicidal Ideation/Gesture	0	0	0	0	0
Increased Mental Health Symptoms	16	11	3	3	0
Loss of Functioning	0	0	3	0	0
Hospital/TC Step-down	0	0	8	1	0
Diagnostic Eval/Tx Planning	0	1	5	0	0
Risk of Homelessness	4	2	2	0	0
Other	5*	0	4	0	1

*Includes 3 cases where “elopement” was the primary presenting problem.

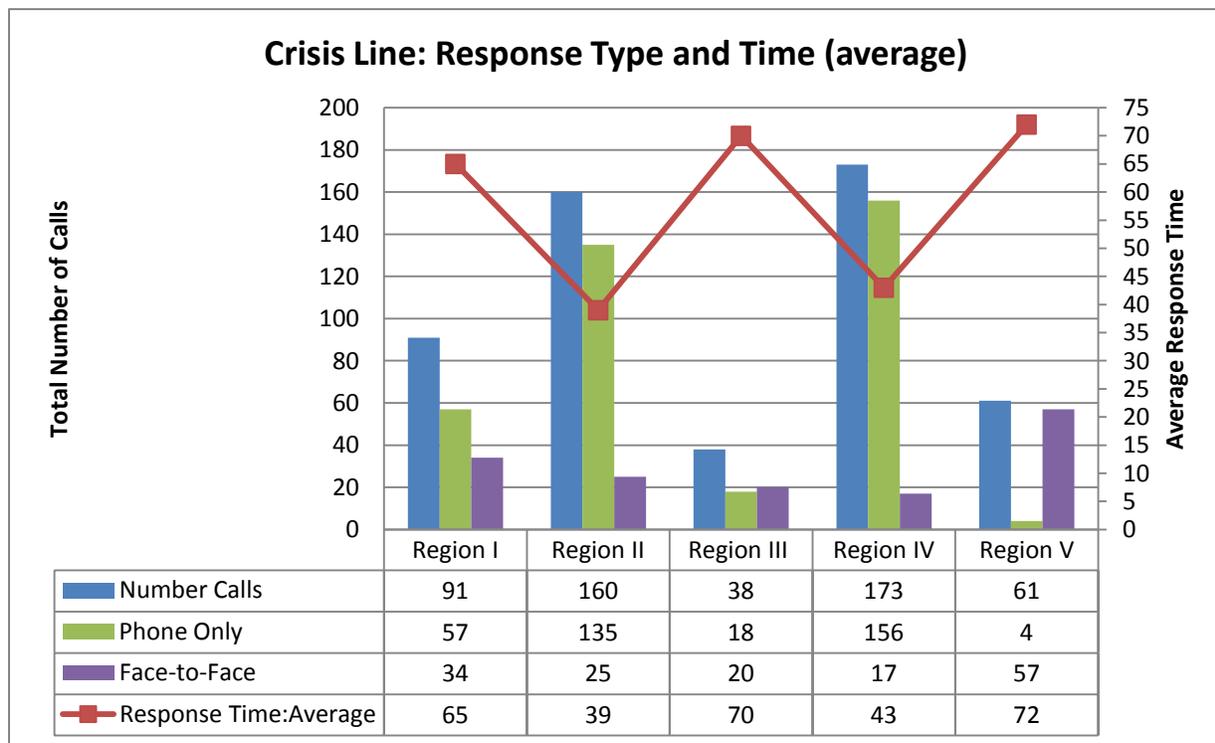


In examining these data as a whole, two impressions emerge. First, the programs are predominantly being used to treat behavioral challenges and increased psychiatric acuity. The degree to which changes in the frequency of aggressive responding might be explained by an exacerbated mental illness cannot be determined from the data available. However, psychiatric instability likely does contribute to aggression, suggesting that these two primary presenting problems might be closer in their numbers than the above graph suggests. In any case, it does appear that the REACH programs are being utilized to address the specific clinical challenges that they are designed to address: psychiatric illness and behavioral disorders. Other presenting problems vary considerably from region to region, with no discernible trends developing at this time. It is hoped that data from future quarterly reviews will allow the Department to understand and analyze this information in a meaningful way.

REACH Crisis Response

Each of the five regional REACH programs is expected to operate a crisis line 24-hours per day, seven days per week. Calls coming into the crisis lines may be from existing REACH clients or from systems 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. Domains of interest related to crisis response include the type of response, the response time to the site of the incident, the location where an on-site assessment and intervention took place, and the outcome of the mobile crisis response. In general across the regions, only a minority of crisis calls required an on-site response. Most calls were handled effectively through phone consultation or intervention with the individual. This is very positive as it suggests that the programs are developing effective clinical relationships with the individuals they serve such that

REACH coordinators are seen as a valuable support to bring into a situation before a crisis becomes too critical. It also suggests that the crisis lines may be serving a preventive function by allowing providers and individuals to reach a clinician to resolve an issue before it develops into an emergency. This prophylactic function is wholly in keeping with the REACH model that emphasizes skill building and crisis prevention. A summary of information about crisis calls and responses is depicted in the graph below. Please note that this graph encompasses all crisis calls received during the review cycle. Therefore, it includes on-site responses to existing REACH clients, repeat calls from individuals, and new referrals. Because most referrals for this quarter were not crisis in nature, the total number of crisis calls will exceed the total number of referrals for any given quarter.



In terms of response times to the site of a critical event, all five regions are currently meeting the expected standard for their regions when response times are averaged within region. Regions II and IV are expected to respond to the site of a crisis call within 60 minutes. Average response times for these regions are 39, and 43 minutes, respectively. Regions I, III and V, designated as rural regions, are allowed a two hour response time, which they were well below (Region II: 65; III: 70; Region V: 72). When individual response times are examined, it is apparent that most call responses are in line with the standards set by the Settlement Agreement. When reviewing individual crisis call logs per region, it can be seen that responding outside of the standard designated in the Settlement Agreement is at very low rates. Regions II and III had no response times exceeding their assigned standard. However, Region I and IV had two, and Region V had

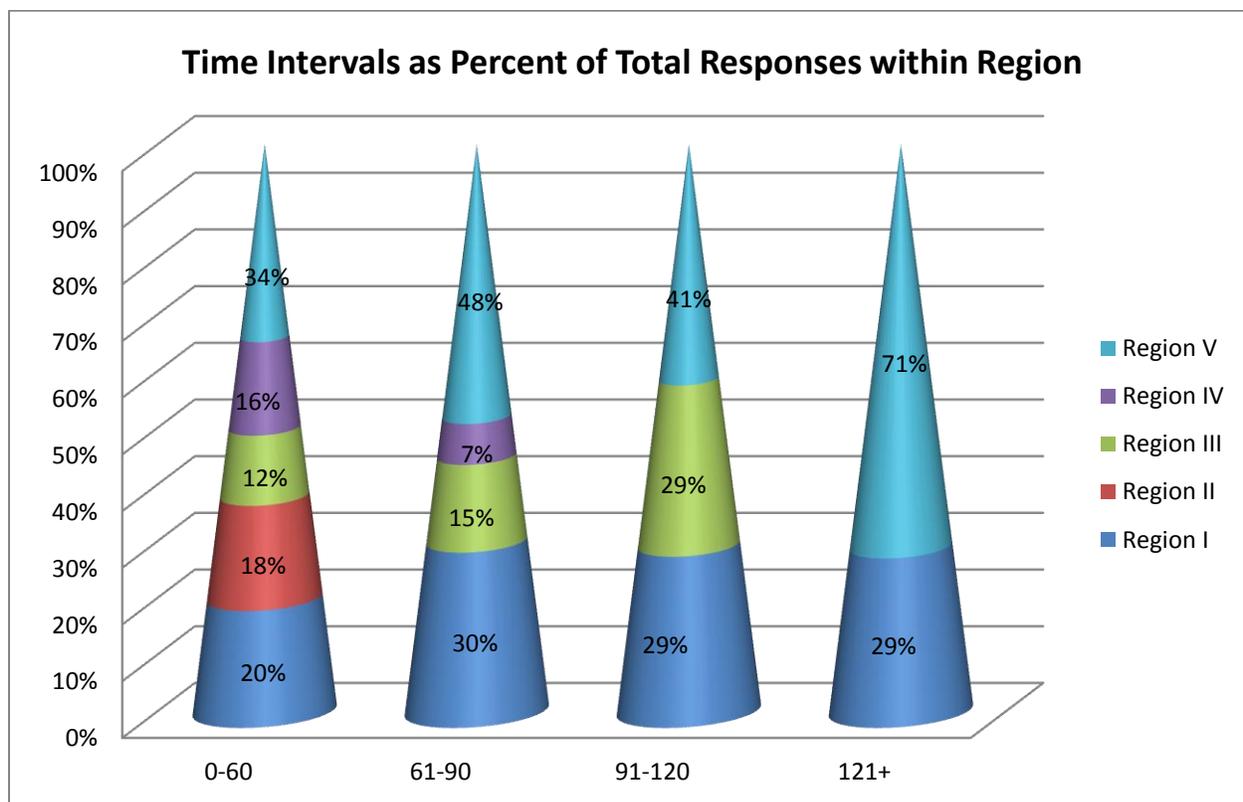
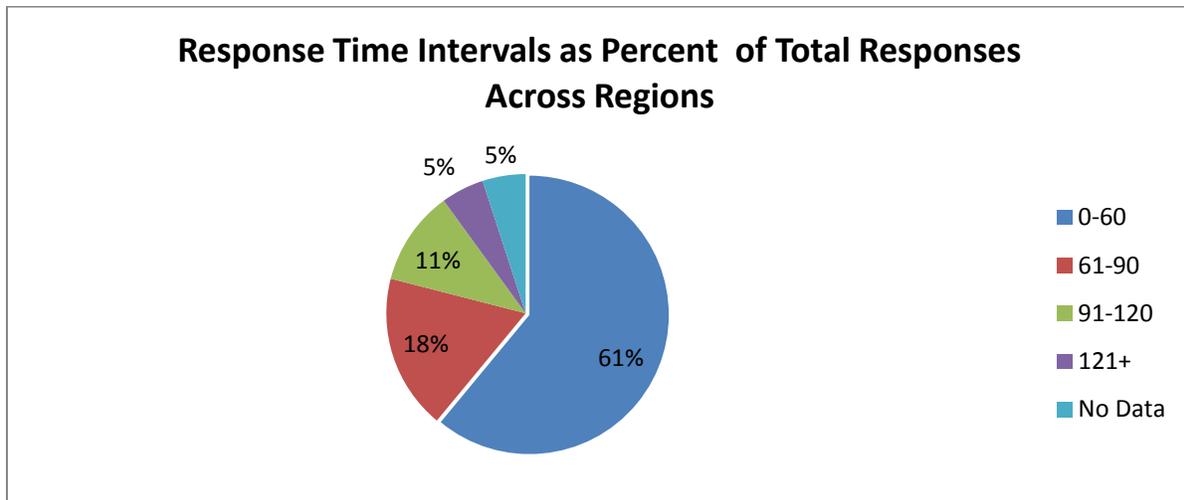
five. Reasons given for the extended response times included traffic, coordinators responding to other crises, and coordinator being in a city far away from the site of the crisis call, among others. Given the geographic particulars of Region V, it is not surprising that this Region has missed the criterion more than the others. Region V covers a very large area that contains both urban and rural sections. Due to the presence of several very large military bases in the area (4 plus) combined with the use of tunnels routing traffic underneath the Chesapeake Bay, this area presents a unique logistical challenge. Accidents occurring in the tunnels or on the highways can cause extensive and unpredictable delays, particularly if they occur in the late afternoon as personnel from the military bases embark on their travels home. Indeed, traffic problems did explain at least one delayed response in Region V. Going forward, data are being collected on all response times that exceed standards in an effort to ameliorate any patterns that exist. The table below provides a summary of response times broken out by time intervals. The table presents both regional and aggregate data in a single table. On-site responses reflect responses to new referrals, existing Reach clients, and multiple responses to the same client over the quarter.

Region	Total On-site Responses	0-60 Minutes	61-90 Minutes	91-120 Minutes	121+
Combined	153	94	27	17	7
I	34	19	8	5	2
II*	25	17	0	0	0
III	20	11	4	5	0
IV	17	15	2	0	0
V	57	32	13	7	5

* Note: Region II has missing data. Eight on-site responses did not include response times. This amounts to approximately 5% of the data. The above table is based upon information available. Per the clinical director for Region II, failure to enter this data has been addressed as a staffing issue. Currently, a new data tracking system has been put into place so that monitoring can be on-going.

Meaningful information can also be gleaned by considering the percentage of responses that fall into the “hit rate”, meaning those that meet established targets. This can be looked at in aggregate or within each region. The aggregate data offer the broadest view, but do not allow for an understanding of regional differences. By looking at each region and considering the contribution each time intervals makes to that region’s overall response rate, the region is compared only to itself. This is helpful given the high variability between regions in the number of face to face responses provided. The two charts below offer these different perspectives in graphic form, affording the reader additional clarity on the relationships within and among regions. The overall hit rate across all regions is 94.1%, indicating that only about 6 percent of responses did not meet their target. Note that this figure assumes 100% on time responding by Region II, although they provided data for only 17 out of 25 on-site. When removing these 8

responses from the total number of responses, the overall hit rate remains remarkably the same: 93.7%



Regions I, IV and V had response times outside of their windows. These regions are quite different and no immediate traits are shared that might explain delayed responding. Two regions are designated as rural areas, although Region V does contain some urban areas within its boundaries. In Region I's case, response times exceeded standards by only about 15 minutes.

The reasons for this are not known. In Region IV, one response time exceeded the standard by only five minutes. This appears to be an understandable degree of variability. The other extended response occurred due to an operational flaw, with the REACH staff answering the crisis line but passing the call to another coordinator instead of addressing the situation at hand. This is a staff training issue that can be resolved in consultation with the Region IV REACH Director.

The chart on the previous page (*Response Time Intervals as Percent of Total Responses Across Regions*) offers a slightly different interpretation on response time by making finer distinctions in the time intervals considered. Regardless of regional designations, well over 50 percent of crisis calls resulted in the on-site presence of REACH staff within 60 minutes. In 79% of cases, on-site assistance was achieved within 90 minutes. These response times take into account the day-to-day practicalities of providing mobile supports across the state, where traffic patterns are inconsistent, distances traveled vary greatly, and the infrastructure itself is relatively new and developing.

The chart on the preceding page illustrates each region's contribution to the response intervals noted on the x-axis of the chart. Within each time interval, the cones represent the percent each region added to cumulative total (i.e. 100%) of the responses within that time interval. By looking at this pattern, we can see that Region V had the longest response times of any region, while Region II had the shortest. Region I has very little inconsistency among the response times, which suggests that the two hour response time generally "matches" the demographics and geography of the region.

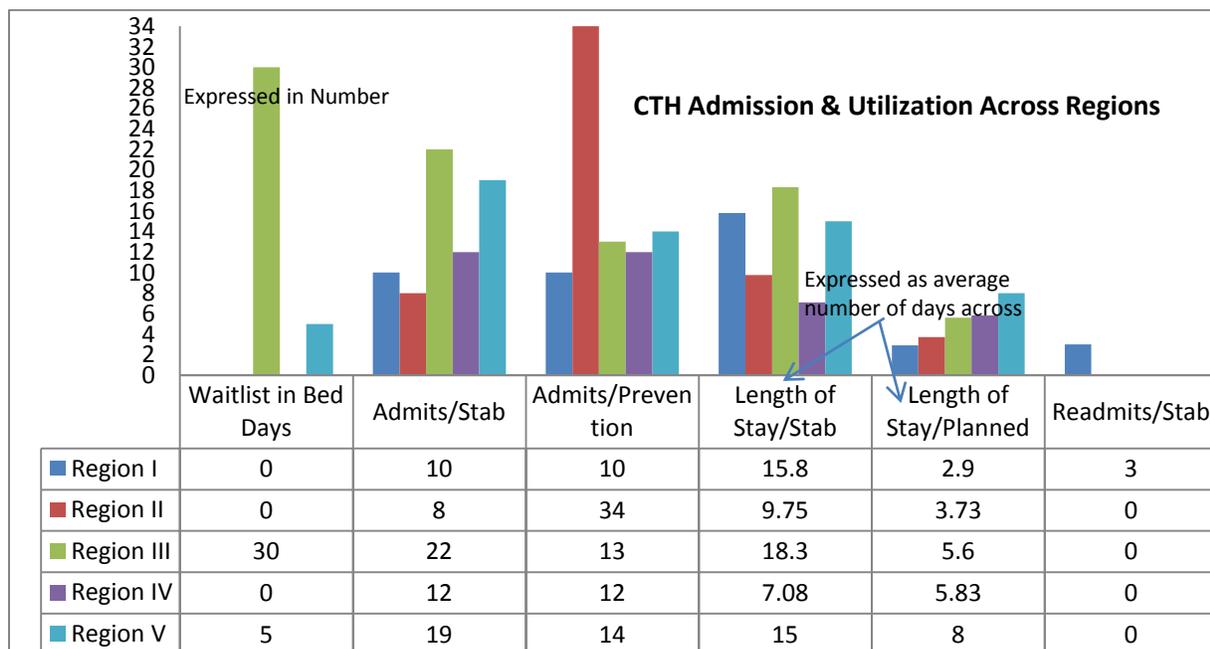
Arriving at the crisis on time is one way to examine the mobility of a service. Where services are rendered provides a complimentary perspective. When responding to a crisis in person, REACH clinicians conduct assessment and initial intervention in a variety of settings. The table below provides information about where mobile responses occur throughout the five regions. These data suggest that mobile crisis teams are active and fluid in responding to the scene of a crisis in the natural setting.

Location of Mobile Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V
Family Home	10	6	3	2	45
Hospital/Emergency Room	16	8	8	1	10
Residential Provider	0	4	7	12	0
Day Program	1	1	0	0	3
CTH	1	1	0	0	0
Emergency Services/CSB	1	5	1	2	0
School	0	0	0	0	1
Police Station	0	0	1	0	0

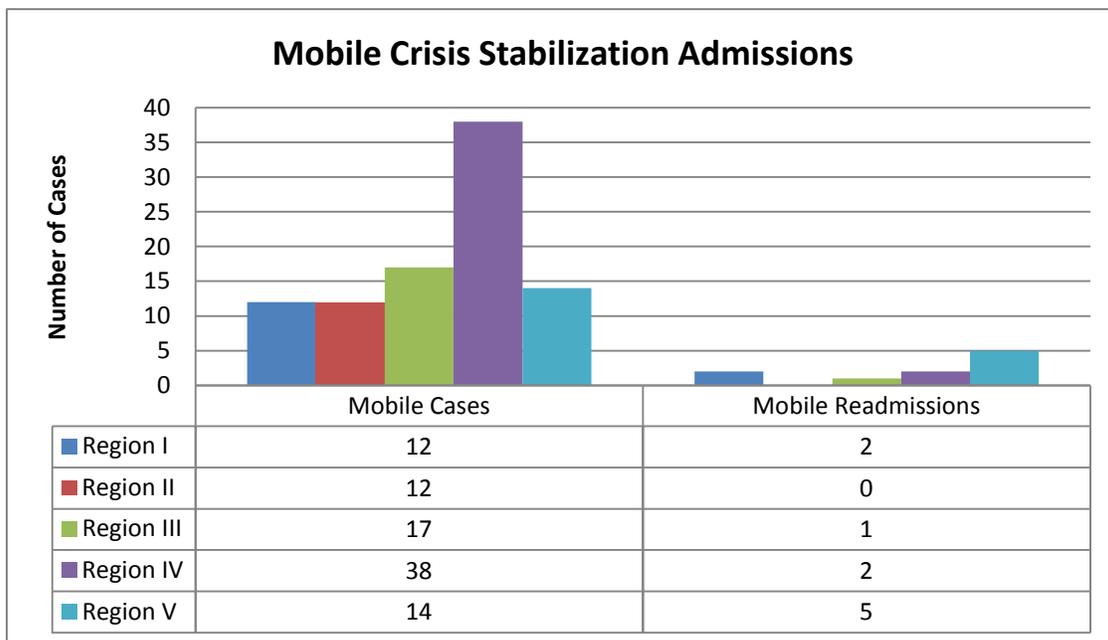
Crisis Therapeutic House

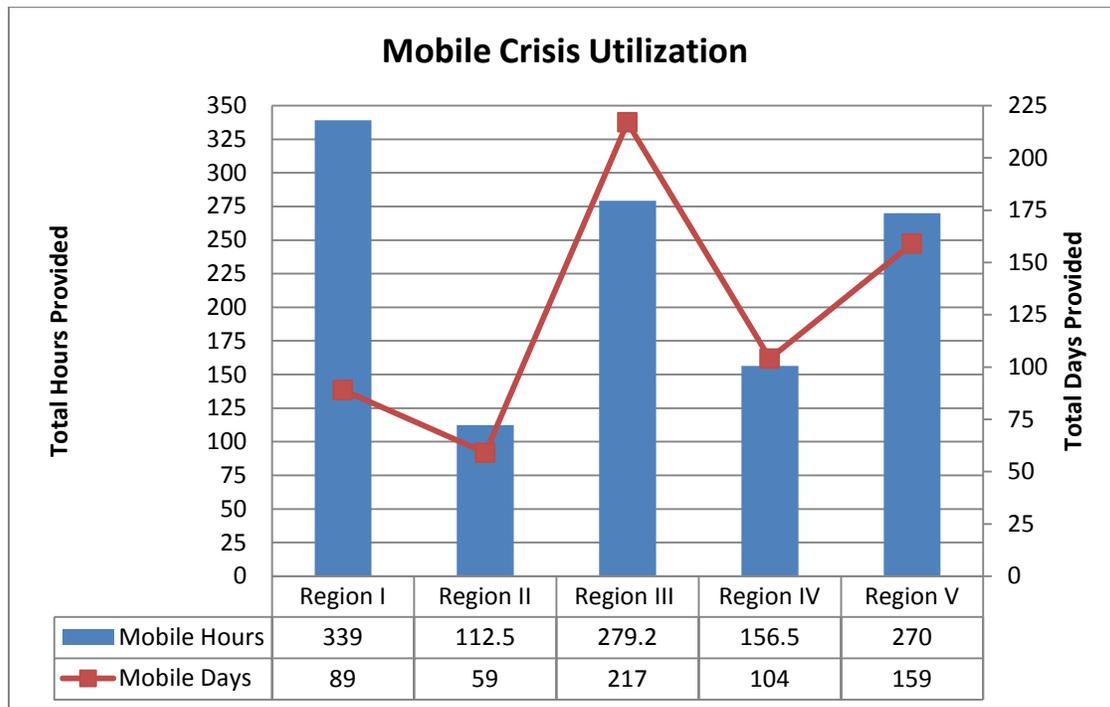
Each of the five REACH programs operates a CTH that accepts both crisis stabilization admissions as well as planned, preventive stays. Region IV, whose CTH is currently located on the campus of a facility serving children, is in the process of purchasing an indented piece of property that they will use to build a new CTH. The Region is actively proceeding with plans to design a home suited to the purposes of the CTH. All other regions continue to operate their existing homes. Regional differences exist in types of admissions to each of the five programs, with Region III being utilized more frequently for crisis stabilization services while Region II provides more planned/preventative services at the CTH. Denials to the CTH are very low across all regions, with only two regions reporting any service denials for the quarter. In one case, a diagnosis of an intellectual or developmental disability could not be substantiated. In the other case, the individual was found not to be in need of REACH services at the time the referral was made. Information related to waitlists, length of stay, readmissions, etc. are presented in the graph below. 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. Only two regions utilized a waiting list. In cases where admission to the CTH had to be delayed, mobile supports were put in place to sustain the individual in his/her setting until more comprehensive stabilization services could be provided through the CTH. While using a sister REACH program to avoid the need for a waiting list, it is often not desirable as doing so removes the person from their existing natural supports. Natural supports are often the kingpin to any plan of support, particularly during times of stress. Therefore, it is generally clinically beneficial to stabilize the individual within their own community unless doing so places them at greater risk.



Mobile Crisis Stabilization

In addition to the Crisis Therapeutic Home, the REACH programs offer mobile, community based crisis intervention and stabilization plans. This service is preferable to the use of the CTH because it allows the situation to resolve within the individual’s natural social environment. A review of the utilization of mobile crisis supports suggests that this service is being routinely used across all five regions. In understanding the relevance of this, it is perhaps more important to reflect upon the overall number of days and hours that these supports were implemented. Each region is providing a high rate of community based crisis supports. This may indicate that intervention is occurring earlier in the escalation cycle, with a less restrictive intervention strategy being prescribed. The graphs on the following page summarize basic information about the use of the Mobile Crisis Stabilization service.





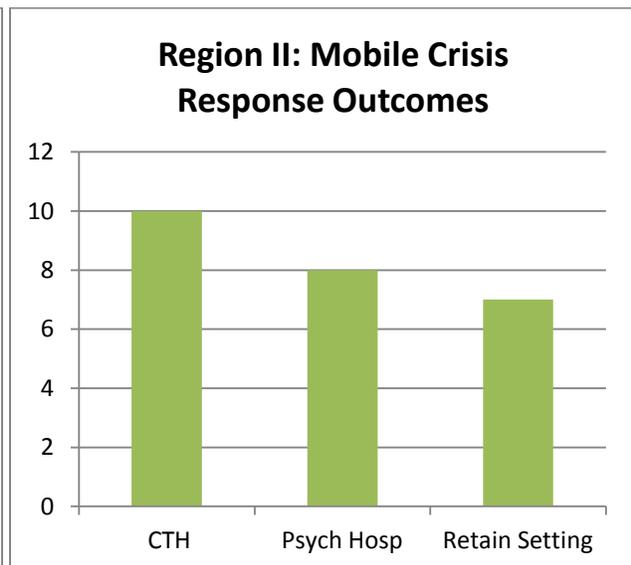
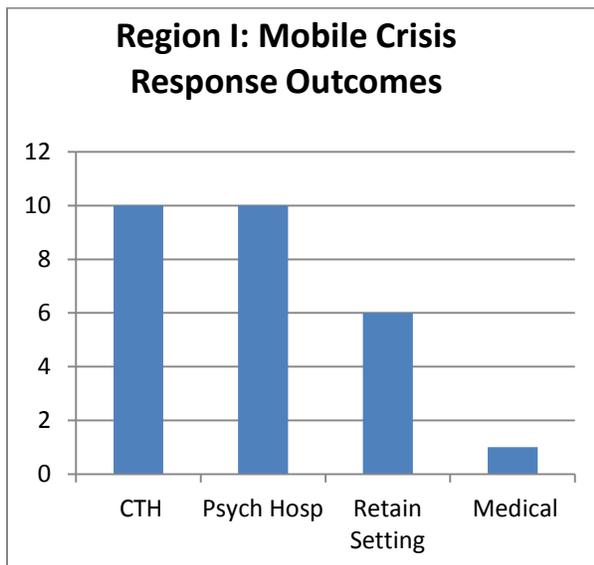
Almost across the board, the average number of days that mobile supports are in place following a crisis exceeds the three days noted in the settlement agreement (“Mobile crisis teams shall provide local and timely in-home crisis supports for up to three days...”). However, the range among the number of days provided is large across all regions with the exception of Regions II and IV. Because of this, looking at the mean number of days is likely not meaningful and the mode might be a better measure of central tendency in the future. For the present quarter the range in the number of mobile crisis supports across regions is as follows:

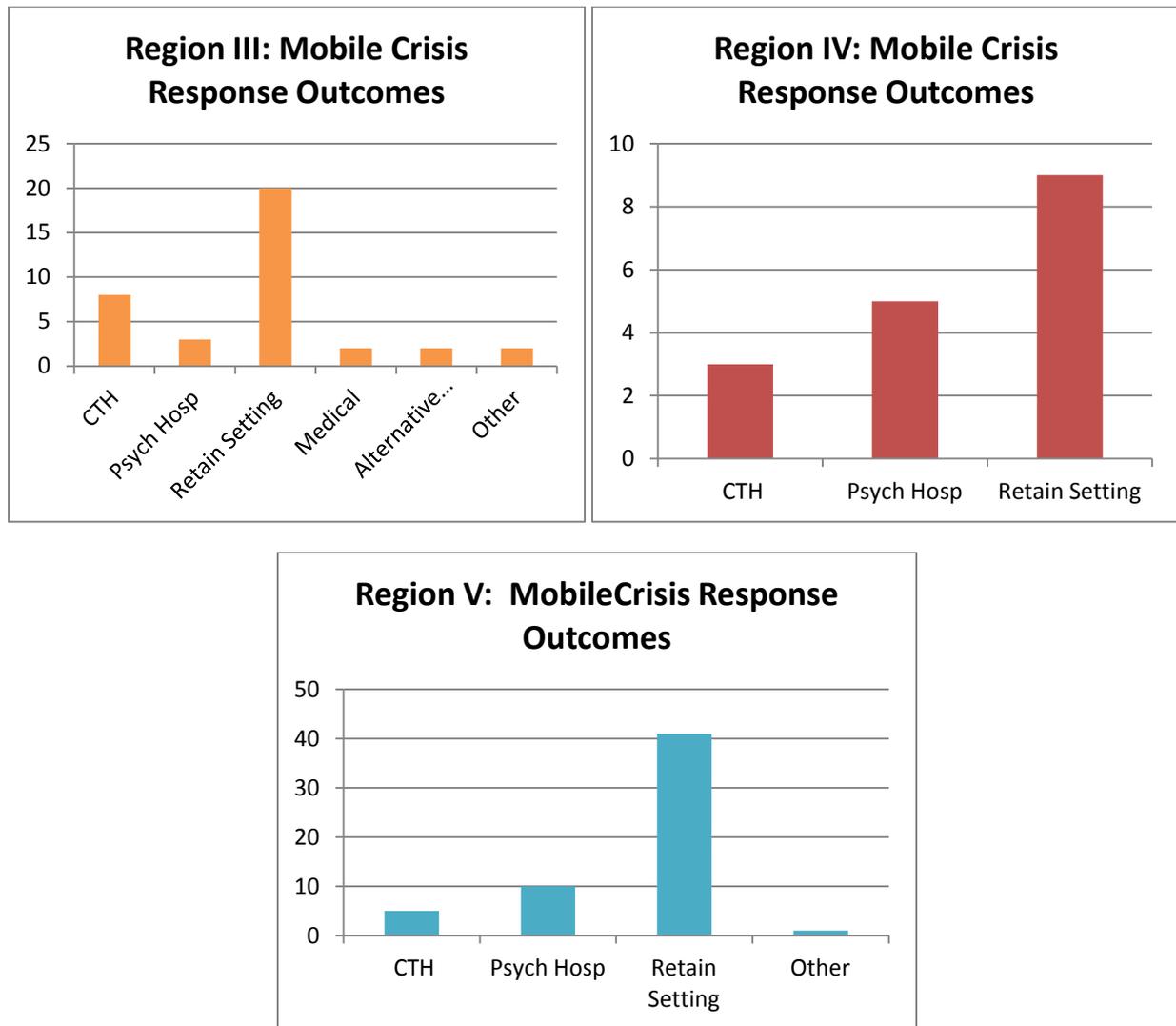
- Region I: 1 to 58 days
- Region II: 2 to 9
- Region III: 2 to 30
- Region IV: 1 to 7
- Region V: 1 to 24

It is interesting to note that there is significant variability between the regions in terms of the maximum number of days of mobile crisis support provided. The reasons for this are not clear and will be examined in future reports. It is encouraging, however, that the regions appear to be well able to accommodate the needs of individuals who require more intensive, longer term supports. This suggests that the regions remain flexible in meeting the needs of the communities they support, which is integral to the success of any mental health endeavor. Additionally, outcomes are strong for these services, indicating an effective use of resources.

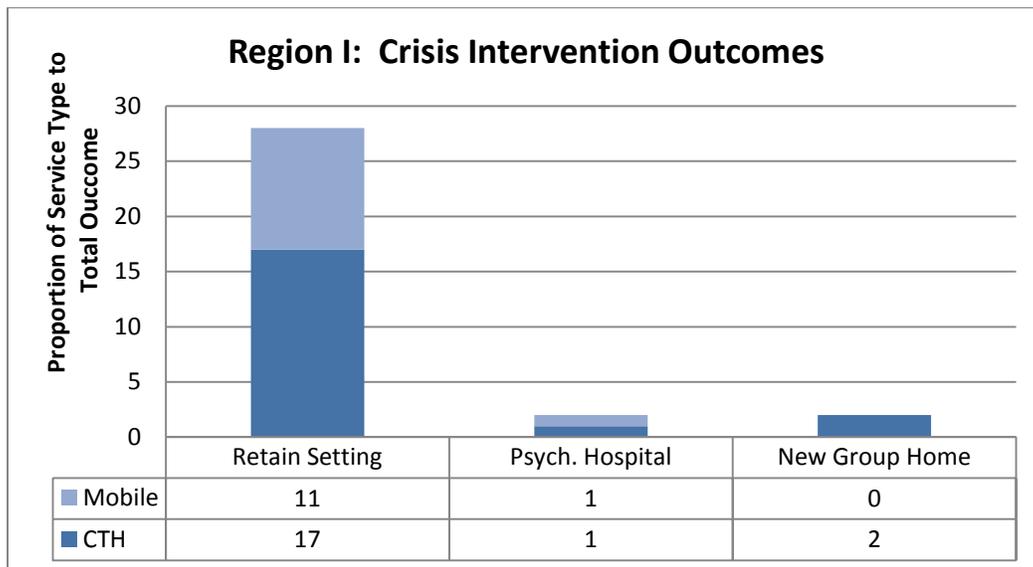
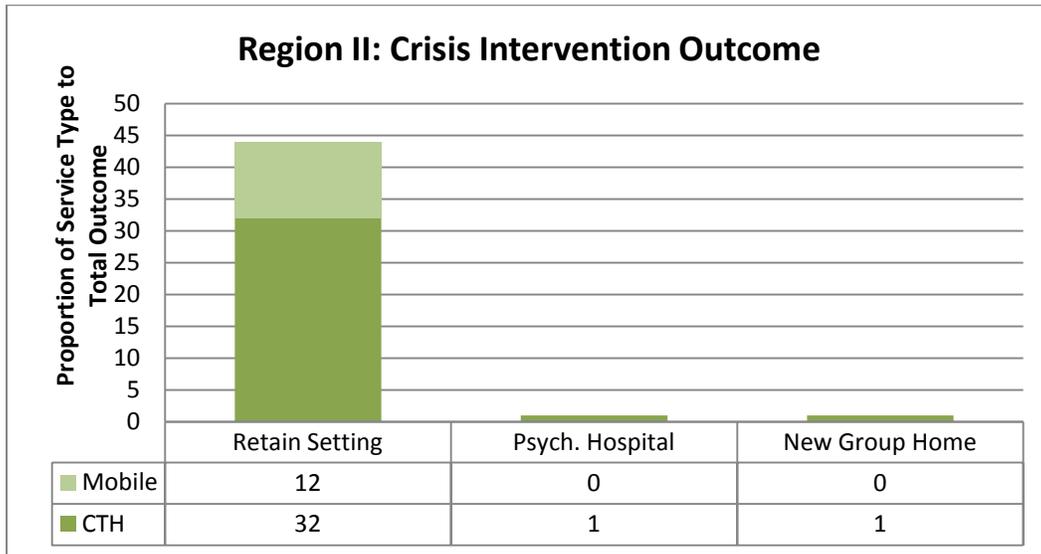
Crisis Service Outcomes/Dispositions

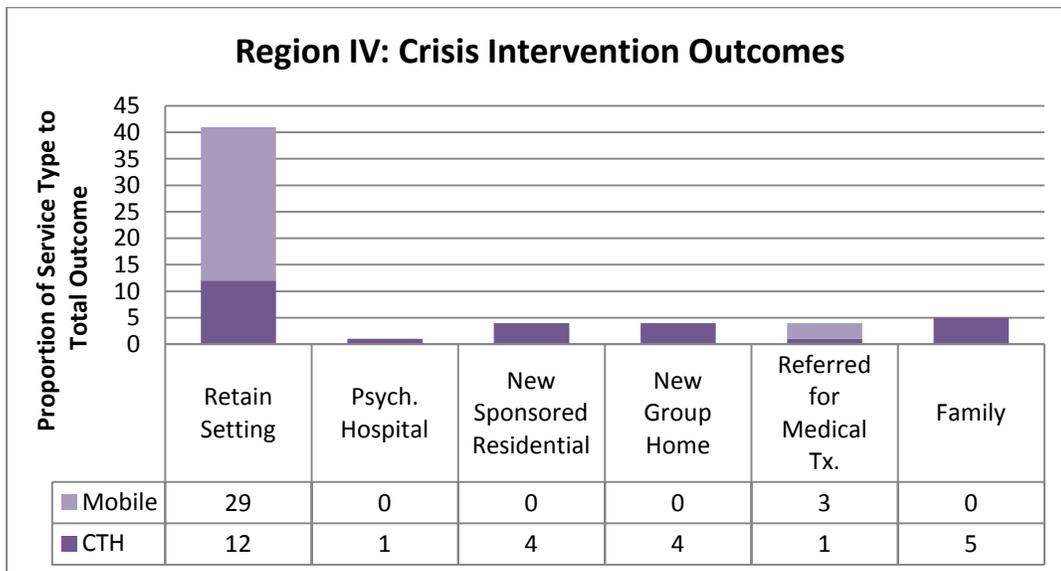
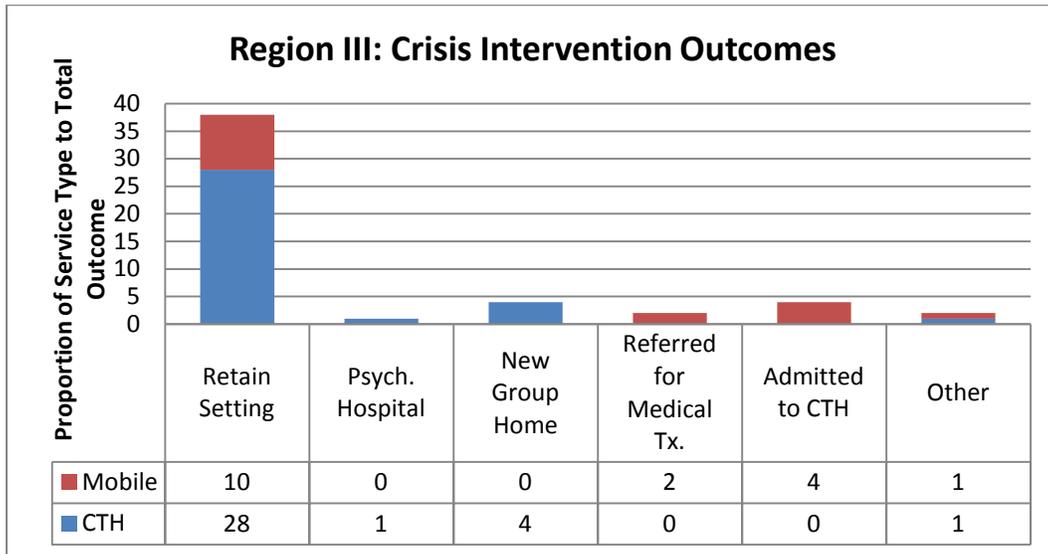
An aerial view of the REACH data suggests that the programs are becoming increasingly imbedded into the communities they serve. Community based supports are generally being used more often than center based interventions, and a substantial number of referrals continue to come from CSB case managers, which clearly indicates that these key players are setting up services prior to an emergent crisis and that they see the programs as a viable additional service for the individuals with whom they work. In understanding and supporting these impressions, the disposition of individuals served through crisis services, both mobile and through the CTH, can serve as a gross proxy for the success of the programs. When looking at the outcomes of on-site crisis responses, three out of five of regions (III, IV, V) overwhelmingly resolve these situations *and* retain the individual’s residential setting. These individuals and their care providers are able to weather the challenges that acute crises present with success. Furthermore, readmission rates to both the CTH and community crisis supports are very low, suggesting that the system has made sufficient changes to support the individual without the need for additional crisis services. In Regions I and II, this remaining in the placement is not the primary outcome, with admissions to the CTH and psychiatric settings being about equal and assuming rank of the most frequent outcome. More detailed information is presented in the graphs below. The reason for this regional difference is not currently known. It may reflect local interpretations of TDO laws and commitment criteria or other demographic factors such as availability of psychiatric bed space. It may also indicate a higher acuity level of individuals in these regions for some reason. Conducting a case study of those admitted into inpatient settings would likely be the best method for understanding differential rates of hospitalization. The relatively small numbers would make such a study feasible. The reader is reminded that this information applies only to the initial crisis resolution and does not imply that a placement remained unavailable once treatment was received in an alternative setting.

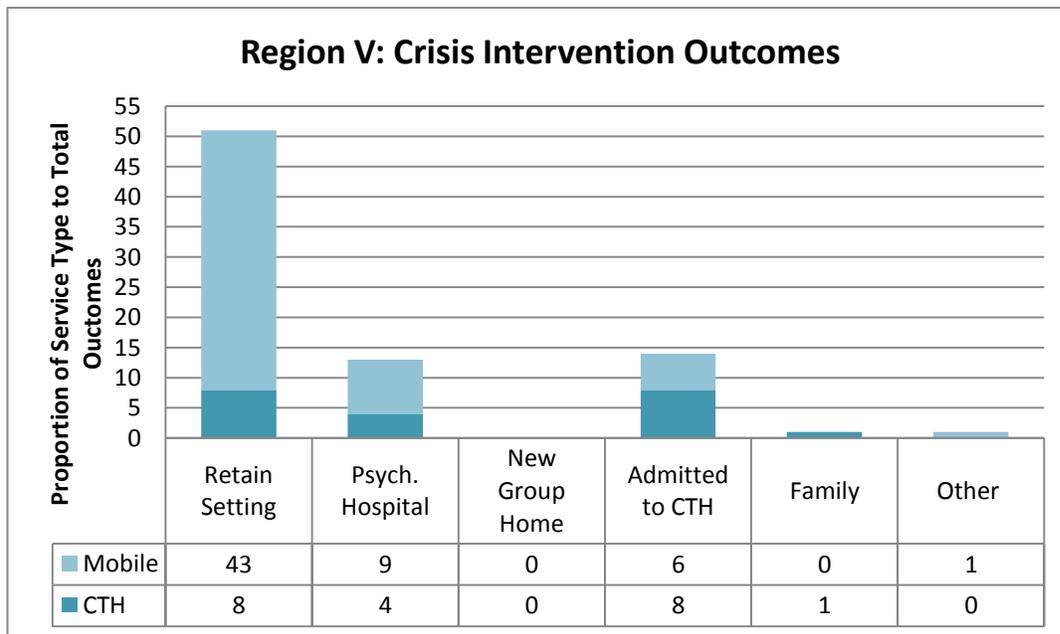




Another way to look at the effectiveness of crisis services is to examine the outcome of individuals who have received the service and are discharging from it. Overwhelmingly, regardless of service type (mobile or CTH), individuals successfully retain the residential setting that they had prior to REACH intervention. This is a meaningful outcome, as residential stability is correlated with positive outcomes for individuals receiving mental health or behavioral supports. The graphs below provide a synopsis of this outcome data. For each outcome noted, the graphs depict the relationship of service type to the total number of individuals falling into the various placement categories. This provides a better point of comparison across regions given that the number of relevant outcome categories differs from one region to another.







Service Elements

Each of the five regional REACH programs provides an array of services to their ID/DD communities. The table below provides a summary of service utilization for the quarter under review. Please note that figures are broken out by type of service (CTH or Mobile) as well as by region.

Service Type Provided in CTH					
Service Type	Region I	Region II	Region III	Region IV	Region V
Crisis Prevention	20	42	35	12	33
Crisis Intervention/Prevention Planning	20	42	35	5	32
Crisis Stabilization	13	42	22	24	33
Medication Evaluation	20	18	35	24	6
Therapeutic Treatment Planning	20	42	35	24	9
Follow Up	20	42	35	24	23

Service Type Provided with Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Crisis Prevention	12	12	17	38	12
Crisis Intervention/Prevention Planning	12	--	17	8	12
Crisis Stabilization	12	--	17	38	2
Medication Evaluation	12	--	17	19	2
Therapeutic Treatment Planning/Consult	12	12	17	38	2
Follow Up	12	--	17	--	2

A review of these data suggests that individuals receiving services in the CTH generally receive the entire service array with only 1 or two exceptions per region (note that Region V is an exception to this pattern). For example, in Region I all services were provided with equal frequency with the exception of crisis stabilization services, which was provided in a total of 13 cases. Across regions, these “outlier” services differ. Although a precise explanation cannot be provided to explain this pattern, it may be that it indicates a degree of clinical tailoring of service provision. That is, each individual’s service package is customized to meet the unique needs of the person being served. This would be in keeping with the principles of Person Centered Planning, where the “over treatment” of individuals is discouraged and the emphasis is on designing a plan that is the best-fit for the individual. Region V is the exception

A review of Mobile Support services does not appear to show patterns across regions. Overall, specific elements within the service array are used with reduced frequency when mobile supports are being provided. Given that services are being provided within the natural environment where some pre-existing supports remain in place and must be acknowledged, it makes sense that an a la carte approach to selecting services among a larger array would be used. This may also reflect the reduced acuity in this subpopulation, where interventions can be more precisely targeted.

Reach Training Activities

One of the most important functions of the REACH team is to build resource capacity for ID/DD individuals within the communities they call home. The REACH programs actively train police officers, case managers, residential providers, and others who interact with this population on a regular basis. Regional differences in the frequency and types of training do exist. To address this, DBHDS has developed a training presentation for all case management staff, including CSB emergency services personnel. This presentation was offered on January 29th, 2015. A total of 65 professionals created the audience for this talk, which was embedded within a day-long training covering a variety of topics related to working in the community with DD individuals. Additionally, policy changes are in process and will require all new CSB emergency service workers and case managers to complete the REACH training on-line as part of their overall

orientation process. This will be extremely important in ensuring that REACH services continue to be seen as an integral part of community supports for individuals with ID/DD.

During the past quarter, each region has completed trainings in their communities. The table below summarizes these activities. While there is significant variability across regions, most regions are active in disseminating information about the REACH program and how to serve the population of individuals with disabilities of a cognitive or other developmental nature. Region IV had some unique challenges for the quarter due to staff shortages. They are aware of their responsibility to train law enforcement and CSB personnel and they maintain an active presence in the CIT training provided by Richmond Behavioral Health Authority (RBHA). In reviewing Region V's training activities, it appears that they continued to train regularly within their region. Training was scheduled with Portsmouth CSB to train emergency service personnel, but this training was cancelled by the CSB. Region V was also without a clinical director and a CTH house manager for the majority of the quarter, which lessened the availability of other staff to provide training.

Community Training Provided					
Training Activity	Region I	Region II	Region III	Region IV	Region V
CIT/Police: #Trained	15	20	50	0	46
CSB Employees: # Trained	92	5	75	0	7
Emergency Service Workers: #Trained	8	20	15	0	0
Other Community Partners: #Trained	35	15	101	10	34

Summary

This report provides an interpretive summary of the Regional REACH programs based upon data for referrals received from October 1, 2014 until December 31, 2014. The data appear to support the conclusion that, in a general sense, the REACH programs are contributing to the continuum of care for individuals with ID and DD as they find a place within their own communities. The programs are successful in helping individuals keep their homes, which is a vital component of life stability for us all. Residential stability is the highest overall outcome for individuals receiving a REACH intervention. Additionally, the programs are providing a resource to the State Hospital System by providing on-going consultation while the individual is in the hospital and step down services as they discharge. Admissions to state hospitals continue, which, while not ideal, may be necessary in many clinical situations where severe mental illness presents co-morbidly with ID/DD. It is suggested that future reviews look at the length of inpatient stay for individuals psychiatrically hospitalized rather than the rate of admission. Often

times, treatment in an inpatient setting is the appropriate course of action, and what is concerning is how long these admissions last. Potentially, the REACH programs can play a role in reducing the duration of admissions in some cases, both through active consultation and training of the system and through step down services when indicated.

A review of the data also indicates that services are being provided across the spectrum and appear to be addressing the specific needs of the individual, avoiding the cookie cutter approach that can describe some intervention programs. Rates of utilization are good across service type (CTH or mobile, prevention), and this trend will likely continue as the State continues to close its Training Centers. The flexibility of the programs in designing service delivery procedures will hopefully assist in growing the services seamlessly.

Identified areas of growth for the programs must be part of any review. Certainly, it remains true that the overwhelming majority of referrals received for the quarter are for intellectually disabled persons. Indeed, across regions only 16.8% of service referrals were for individuals with a primary DD diagnosis. In only one region (Region II), did the number of DD individuals referred surpass those with an intellectual disability (10 DD; 6 ID). Across the other four regions, referrals of individuals with a primary diagnosis of developmental disability were as follows: Region I-3; Region III-1; Region IV-0; Region V-5. As funding streams differ for these individuals, it is possible that they are receiving services from other programs, which may or may not meet their unique clinical needs. REACH needs to continue to work within their communities to ensure that individuals with DD have equal access to their supports.

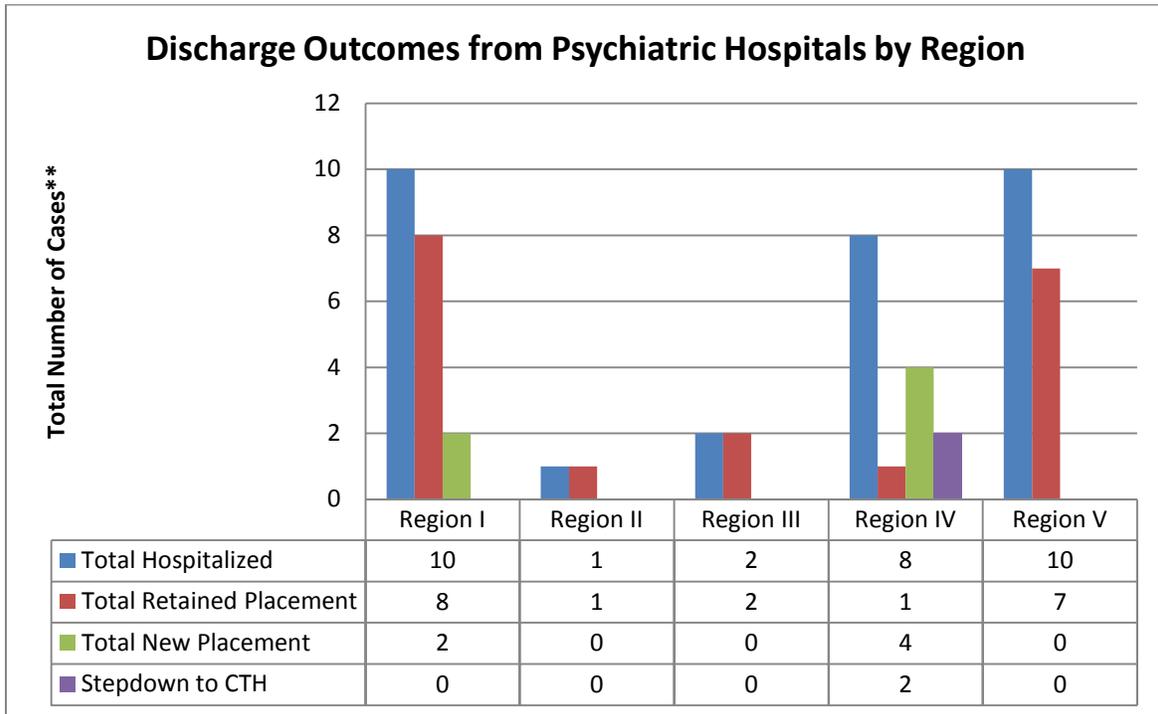
For those three regions that have not elected to continue their relationship with the START program for training purposes, the training and mentoring of newly hired coordinators is a concern. However, Regions III, IV, and V have developed a training program for new staff. The program has been modeled after the START certification process, and the State is in the process of developing an official certification process for new REACH coordinators. The program of training for new REACH staff will need to be monitored to ensure a high level of skill and professionalism for REACH coordinators across the state. Another area of concern in training matters is the independent reviewer's expectation that *all* law enforcement personnel receive training about the REACH program and ways to intervene with those who are intellectually or developmentally disabled. DBHDS can move toward this goal, but cannot mandate it for other agencies. DBHDS has developed a plan for increasing the awareness of law enforcement across all police departments related to the REACH programs, which will be very beneficial. This will take the form of a public education, with police officers being the public in this case. It is hoped that this initial endeavor will grow into a more comprehensive outreach approach.

Finally, ensuring that all crisis calls are responded to within the time frames established by the Department of Justice is an area that DBHDS continues to monitor closely. While we acknowledge that the State may struggle to achieve and maintain 100% compliance with the

designated response times due to idiosyncratic obstacles that are out of the control of the programs, we likewise understand that there is room for improvement in this area for Regions IV and V. Data is being collected on the reasons for response times that miss targets, and it is anticipated that this information will enable DBHDS to make adjustments to the programs as needed.

The REACH programs have been in operation for approximately three years and it seems apparent from a review of the available documentation that they are moving from being a nascent conceptual structure into a valued component of the care the State provides to individuals with intellectual and developmental disabilities. As this process continues, it may be more prudent to consider data from two distinct perspectives: does the referral information suggest that the programs are embedded in the community and known to all key players *and* are services appropriate and timely? These two points of interest will rely on separate data sets that may not often cross paths. Going forward, it may be helpful to reconsider how data is reported to ensure that the most accurate picture is provided.

ADDENDUM



**Totals may not account for all hospitalizations. Some individuals remain hospitalized. Disposition information is not available for all cases. Please note that these figures do not coincide with disposition data as presented in the graphs on pages 15, 16, and 17. These figures combine outcomes for psychiatric hospitalizations supported by the REACH programs, other agencies, and referrals to the REACH programs for step down services.

