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Welcome to Module 10 of DBHDS Support Coordination/Case Management training entitled Crisis Support and REACH.

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People experiencing a behavioral health crisis may come into contact with parts of Virginia's Emergency Services and the involuntary commitment process. REACH is the statewide crisis system of care for people with developmental disabilities, including intellectual disability. REACH interacts with Emergency Services to provide support and to assist with diverting admission to an inpatient hospital if indicated. Both Emergency Services and REACH want to support people in the community and to help stabilize crises.

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Objectives

- Gain knowledge about the services available for people who are experiencing serious mental health, psychiatric, emotional and behavioral concerns
- Identify how Crisis Support, including REACH, can assist
- Gain comprehension on collaborating with Emergency Services in the provision of crisis intervention
- Develop an understanding of the involuntary commitment process in Virginia and how REACH intersects with this process




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The objectives of Module 10 are to:


- gain knowledge about the services available for people who are experiencing serious mental health, psychiatric, emotional and behavioral concerns;
- identify how Crisis Support, including REACH, can assist;
- gain comprehension on collaborating with Emergency Services in the provision of crisis intervention; and
- develop an understanding of the involuntary commitment process in Virginia and how REACH intersects with this process.

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Emergency Services

- The Involuntary Commitment Process in Virginia is Mandated in the Code of Virginia 37.2-808-814
- CSBs are Responsible for:
 - Operating a Program to Provide Emergency Crisis Intervention
 - Prescreening Admission Evaluations to Anyone Who Presents with a Behavioral Crisis
- May be Provided in Home, Community or Hospital
- Available 24 Hours a Day, 365 Days a Year



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The Involuntary Commitment process in Virginia is mandated in the Code of Virginia (37.2-808-814).

The local CSBs are responsible for operating a program to provide emergency crisis intervention and prescreening admission evaluations to anyone who presents with a behavioral crisis. These services may be provided in an individual's home, community or hospital and are available 24 hours a day, 365 days a year. The location of service provision is based upon local practices, safety and accessibility.

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What Does Emergency Services Provide?

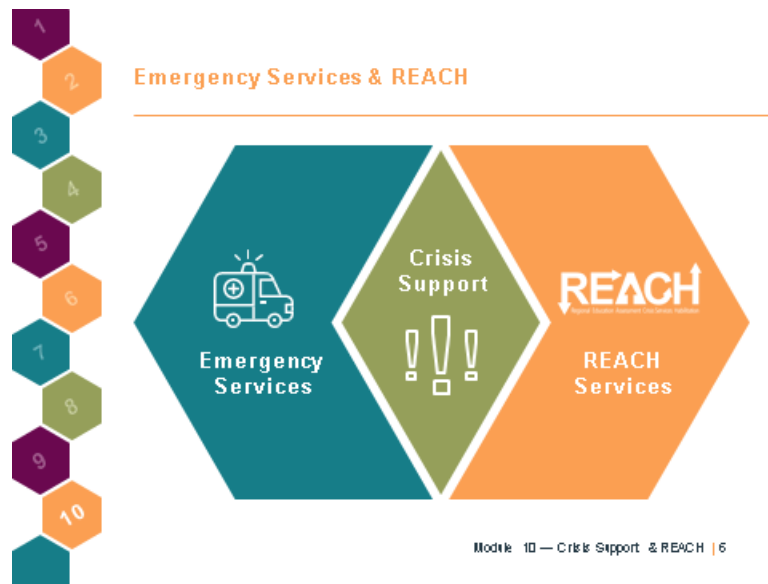
- Comprehensive Preadmission Screening Evaluations
- Crisis Intervention Services



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The Emergency Services program is comprised of clinicians that are certified by DBHDS to provide a comprehensive preadmission screening evaluation to determine if an individual meets the criteria for temporary detention including whether they are unwilling to accept treatment on a voluntary basis or lacks the capacity to determine if treatment is needed. Emergency Services also provide crisis intervention services for anyone experiencing a behavioral health crisis.

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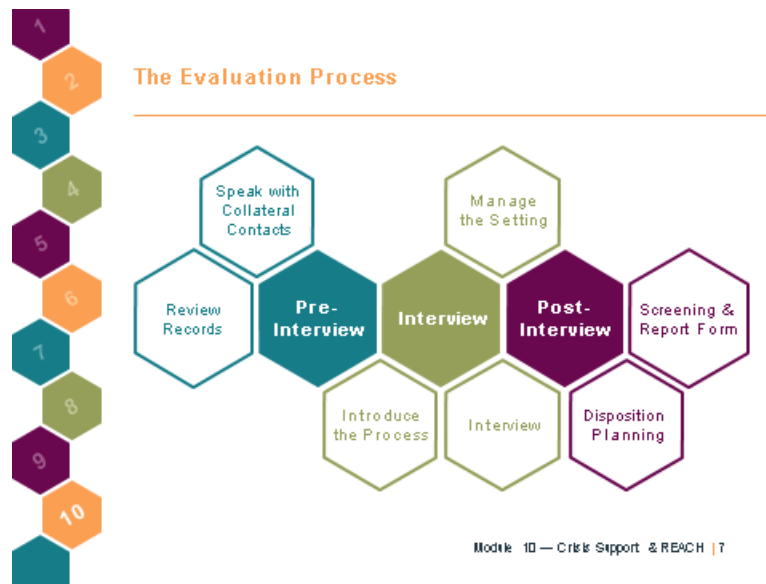


Emergency Services (ES) and REACH work collaboratively to provide crisis supports to individuals with a known or suspected developmental disability experiencing a behavioral health crisis or escalating challenging behavior.

REACH may need to contact ES to assist with providing a preadmission screening assessment for an individual who has been identified as needing support beyond what the community resources can provide.

Emergency Services is to contact REACH every time they are asked to provide a preadmission screening for anyone affiliated with REACH or who has a known or suspected developmental disability.

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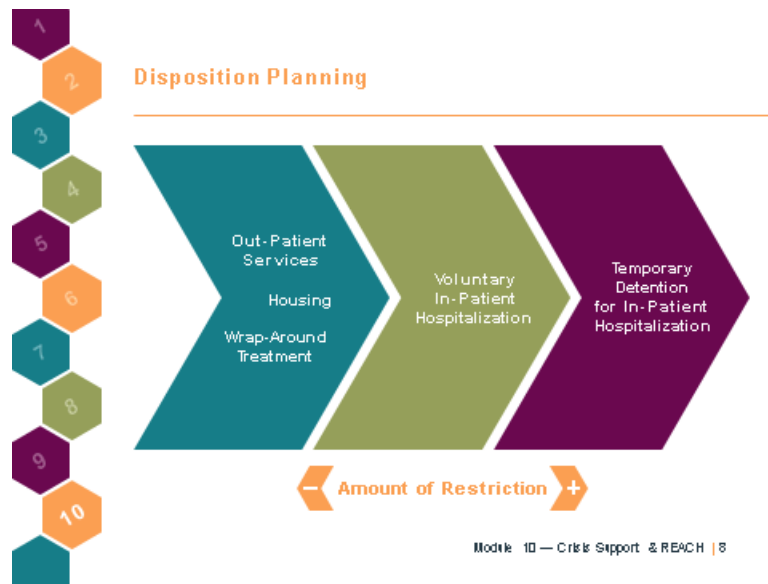
The initial request for Emergency Services may be generated from the person experiencing the behavioral health crisis, their family and sometimes the Support Coordinator/Case Manager. The Support Coordinator/Case Manager should work with emergency services staff during all three stages of the evaluation process.

During the pre-interview stage, the Support Coordinator/Case Manager can assist emergency services staff by providing information from the person's record that might include family history, medical history, and participation in previous services. Communication with collateral contacts such as family members and service providers will ensure that emergency services staff have the information they need to conduct a thorough evaluation.

During the interview stage, emergency services staff will work with the person to manage the current setting. The Support Coordinator/Case Manager can assist by offering help to ensure the person and their family members understand the pre-screening process. Because Support Coordinators/Case Managers have established working relationships with the people they support, they can offer suggestions on preferred methods of communication or can be present during the screening to assist in emotional support to the person experiencing the crisis.

During the post-interview stage, emergency services staff will finalize the pre-admission screening report and begin disposition planning. During this stage, it is important for the Support Coordinator/Case Manager to be aware of the disposition plan in order to develop a new ISP or modify the existing one to address the person's needs related to the behavioral health crisis.

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In disposition planning, there is a spectrum of support that can be provided to a person experiencing a behavioral health crisis. The spectrum includes services that range from less restrictive to more restrictive.

The less restrictive options might include outpatient services, special housing and wrap around treatment. Virginia currently has 16 Crisis Stabilization Units across the state for adults experiencing a behavioral health crisis and in need of less restrictive options. Support Coordinators/Case Managers can work closely with the person and service providers to research available options.

Voluntary inpatient hospitalization would be the next step after less restrictive options have been explored. In this instance, the person has voluntarily agreed to hospitalization to address their behavioral health crisis.

And finally the more restrictive options would include temporary detention or inpatient hospitalization.

Support Coordinators/Case Managers can assist emergency services staff by advocating for what care placement and treatment intervention options the person and their family have requested. Good collaboration between the person, the family, the Support Coordinator/Case Manager and emergency services staff will ensure the best possible scenario that can lead to successful outcomes.

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More on Disposition Planning...

- What is in the best interest of the individual and the community?
- What care placement and treatment intervention possibilities are suggested by the person or the person's loved ones?
- Discuss your findings with other professionals for additional input.
- Identify the best possible scenario that can lead to successful outcomes.

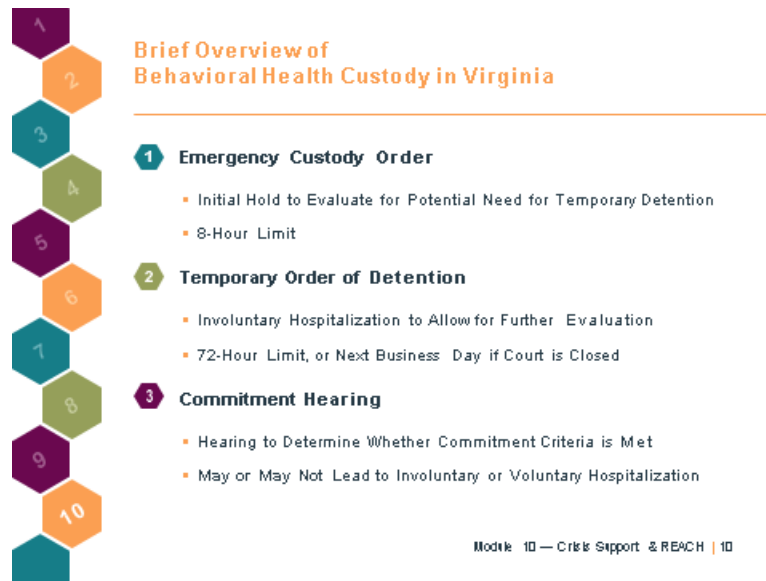


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Some additional points the Support Coordinator/Case Manager in collaboration with emergency services personnel may consider when planning are:

- What is in the best interest of the individual and the community?
- What care placement and treatment intervention possibilities are suggested by the person or the person's loved ones?
- Discuss your findings with other professionals for additional input.
- Identify the best possible scenario that can lead to successful outcomes.


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There are three types of behavioral health custody in Virginia.

- An emergency custody order (ECO), is an order issued by a magistrate authorizing a person to be taken into custody and transported for an evaluation to assess the need for hospitalization or treatment. The maximum amount of time that a person can be in custody during an ECO is 8 hours.
- A temporary detention order (TDO), is an order issued by a magistrate authorizing a person to be taken into custody and transported to a facility designated in the order where further evaluation will be conducted. The maximum amount of time a person can be in custody prior to a hearing is 72 hours.
- A commitment hearing is a court process involving a special justice who hears evidence, and decides whether the person under consideration meets the criteria for involuntary commitment. This may or may not lead to involuntary or voluntary hospitalization of the person.


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Behavioral Health Crisis Stabilization Programs

Virginia Currently Has 16 Crisis Stabilization Units

- Units Range in Size from 6 to 16 Beds
- Some Units Offer Medical Detoxification Services



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Virginia currently has 16 Crisis Stabilization Units across the state for adults experiencing a behavioral health crisis and in need of a less restrictive placement than an inpatient hospital. The units range in size from 6 to 16 beds. Some units offer medical detoxification services. Those persons with a developmental disability are eligible to be admitted as long as they are able to fully participate in the programming and therapeutic milieu.

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Both programs need to have representation at the local, regional and state levels to build understanding and to foster professional relationships to better serve those who interact with both of these critical programs.

Fostering positive relationships between the certified preadmission screening clinicians and REACH directors and coordinators will strengthen the safety net of services for all individuals in Virginia.

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What is REACH?

REACH
Regional | Education | Assessment | Crisis Services | Habilitation

Mission Statement:

People with developmental disabilities shall be supported with services that allow them to live the most inclusive life possible in their community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.



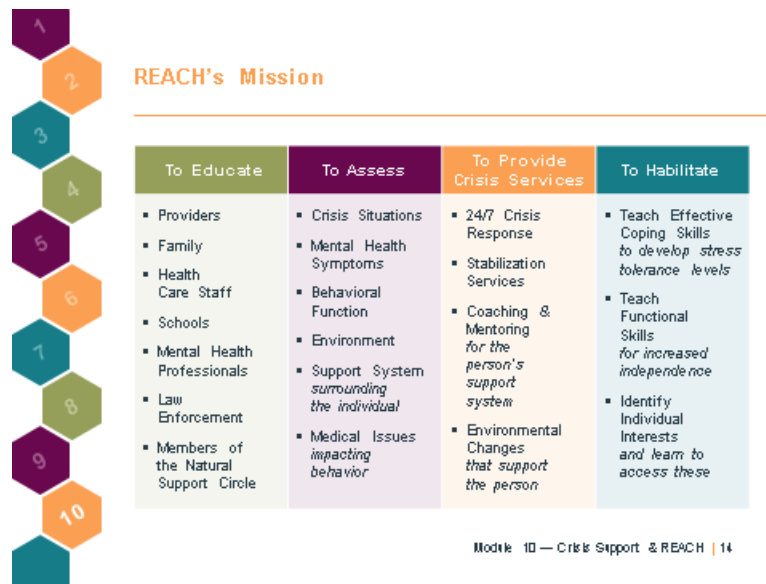
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REACH is an acronym for Regional, Educational, Assessment, Crisis Services, Habilitation.

The mission statement of the REACH program reads as follows:

People with developmental disabilities shall be supported with services that allow them to live the most inclusive life possible in their community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.

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REACH has a variety of responsibilities.

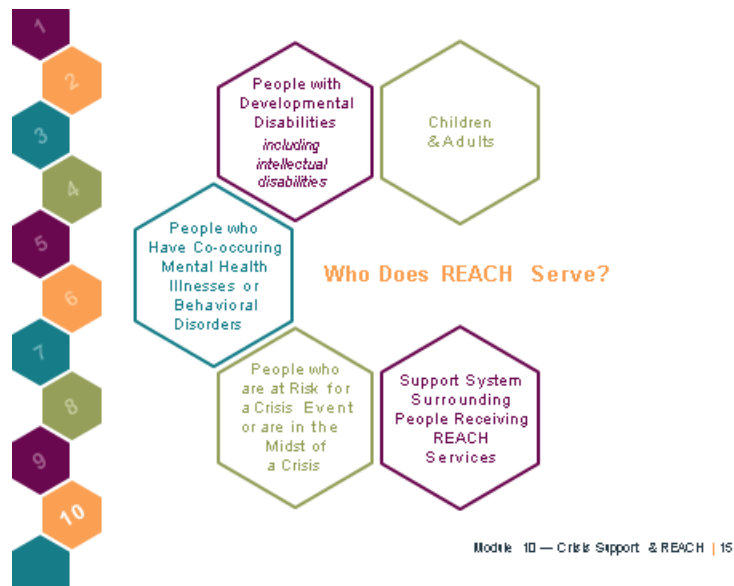
REACH educates those using services, residential providers, family, health care staff, schools, mental health professionals, law enforcement, and members of a person's natural circle of support.

REACH assesses crisis situations, mental health symptoms, behavioral functioning, the environment, the support system surrounding the person and medical issues impacting behavior.

REACH provides crisis services twenty four hours a day including face to face crisis response and stabilization services, coaching and mentoring for the person's system of support, and making environmental changes to support the person experiencing the crisis.

REACH staff teach effective coping skills to develop distress tolerance skills, functioning skills for increased independence and help to identify and access individual interests and learn to access these.

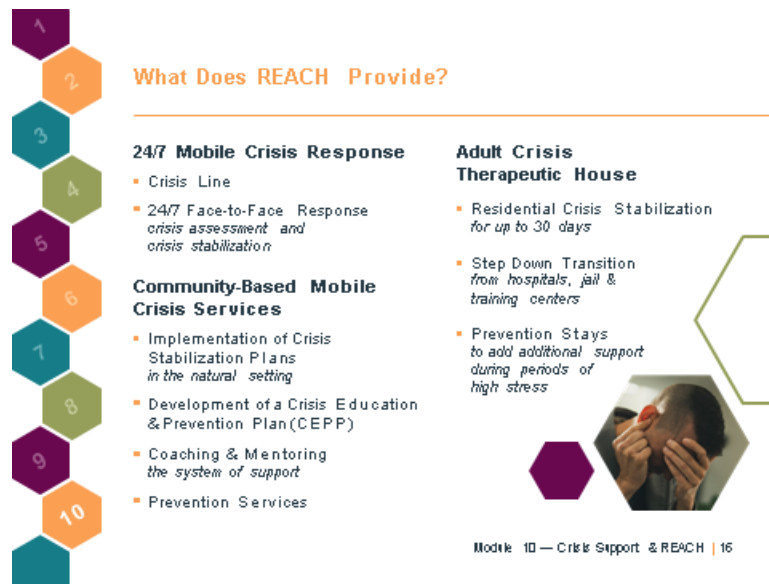
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REACH serves:

- both children and adults;
- persons with a developmental disability, including an intellectual disability;
- those who have a co-occurring mental health illness or behavioral disorder;
- those at risk for a crisis event or are in the midst of a crisis; and
- support systems surrounding those who use crisis services and REACH.

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REACH provides:

- 24/7 mobile crisis response which includes:
 - a crisis line;
 - 24/7 face to face response;
 - community based mobile crisis response which includes:
 - implementation of crisis stabilization plans in the natural setting;
 - development of a crisis education and prevention plan (CEPP);
 - coaching/mentoring the system of support;
 - prevention services;
- adult crisis therapeutic house which includes:
 - residential crisis stabilization for up to 30 days;
 - step down transition from hospitals, jail, training centers; and
 - prevention stays to add additional support during periods of high stress.

More information about each of these services will be provided later in the module.

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REACH coordinators are the primary point of contact for access to the REACH program. They serve as the liaison among the components of the person's system of care. They work to facilitate cooperative communication by bringing all partners to the table to discuss a person's plan of care. The coordinator is also responsible for completing crisis assessments, developing crisis education and prevention plans (CEPPs) and training care providers in how to implement the CEPP. They provide emergency assessments and evaluation during crisis situations but refer to Emergency Services if a preadmission screening is needed. REACH coordinators work to strengthen the system by coordinating the input of the entire team into assessments and interventions, developing plans to teach coping skills, and linking the person to on-going services and supports.

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Crisis Education & Prevention Plans (CEPP)

- Derived from Comprehensive Assessment
- Identifies Interventions that have and have not worked
- Identifies Antecedents to crisis situations
- Suggests Support Strategies to both prevent & stabilize crises
- Offers Strategies to teach coping and replacement behaviors
- Suggests Linkages & Coordination of care as needed
- Living Document that Evolves as new information presents

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The crisis education and prevention plan (CEPP) serves as the foundational document that explains the rationale for the various interventions and describes those interventions operationally so that they can be implemented effectively by the system of care. Every individual who is accepted and utilizes services from REACH will have a CEPP.

REACH program standards indicate that a “provisional” CEPP is to be created within 15 days of admission into the program. The provisional plan offers crisis intervention strategies for those in crisis and their system of support that will be refined over the course of service provision. An “updated” CEPP is to be created within 45 days that provides more robust and comprehensive information to prevent and stabilize crisis situations. The CEPP can be updated subsequent to this as needed as new information comes to light and/or there are significant changes in the person’s life that impact behavior.

A plan is derived from a comprehensive assessment which includes:

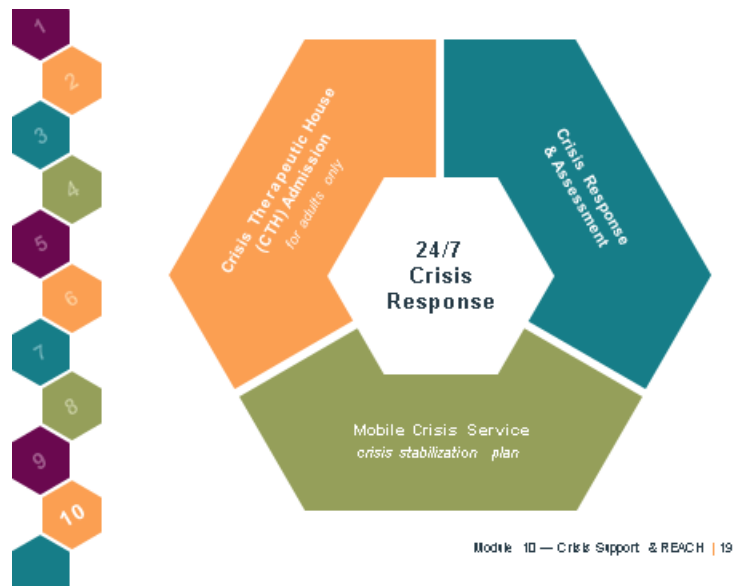
- personal background, history, and preferences;
- mental health symptomatology;
- behavioral function;
- environment;
- medical issues impacting behavior; and
- support system surrounding the individual.

A plan :

- identifies interventions that have worked and those that have not;
- identifies antecedents to crisis situations;
- suggests support strategies to both prevent and stabilize crises;
- offers strategies to teach coping and replacement behaviors;
- suggests linkages and coordination of care as needed; and
- is a living document that evolves as new information presents.
-

Appropriate training with the person using services and their system of support should also be part of the plan.

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When REACH receives a crisis call, they dispatch a clinician to the location of the event. While REACH clinicians are not first responders in the sense that they will physically manage situations where the risk of harm to self or other is imminent or immediate, they will assist those who are designated to ensure that a trauma informed approach is used to the degree possible. They will also remain with the individual to support them through the event and to ensure that accurate communication takes place among all parties involved.

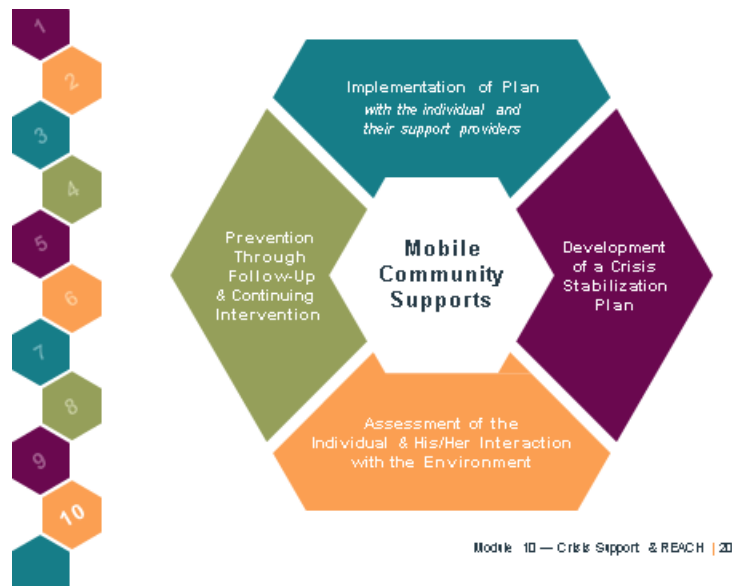
The vast majority of crisis calls do not require the presence of “first responders”. After initial intervention to attempt to stabilize the immediate situation, the clinician completes a crisis assessment and makes recommendations.

If the situation is sufficiently stable, they will make a safety plan for the remainder of the day/evening and schedule follow up which includes a full intake and assessment for a crisis education and prevention plan; or

The clinician may recommend in-home support services with the implementation of a crisis stabilization plan often beginning the next day; or

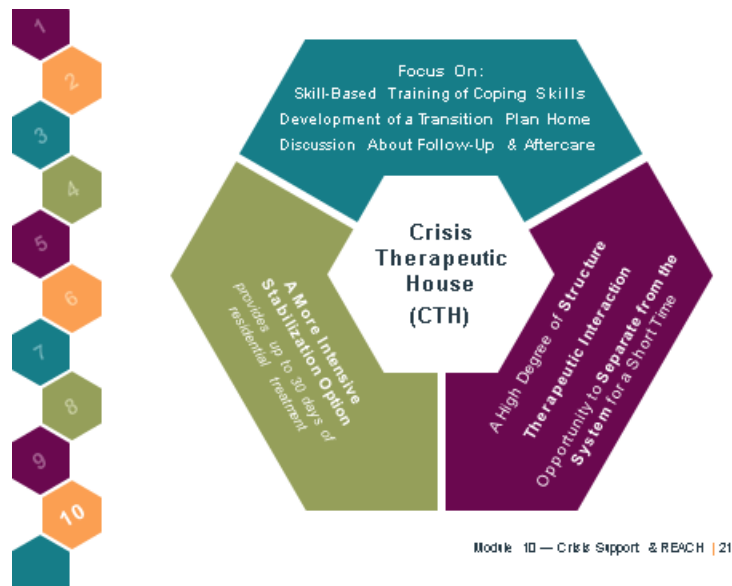
The clinician may recommend admission to the Crisis Therapeutic House for the implementation of crisis stabilization services.

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Mobile community supports are *generally* offered in the form of a crisis stabilization plan whose length is dependent on the needs of the person being supported. These plans work with the person in crisis to identify and develop coping skills to manage those stressors that seem to trigger a crisis cycle. The plans also include recommendations for the care provider regarding interaction style, environmental adjustments that might be beneficial, and training on specific behavioral techniques to be used (if appropriate), mental health topics as they relate to the individual, medical issues that affect behavior, and any other information that will help the system support the person through stressors without a full crisis developing. Mobile community supports are the preferred intervention and are considered less intrusive than other options because the residential setting is preserved and the trauma of removing someone from their home environment is avoided.

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The Crisis Therapeutic House (CTH) programs are 6 bed homes that have increased staff to guest ratios and offer a daily schedule that provides between 6 and 8 small group sessions per day, an activity in the community, and opportunities for individual supportive counseling. The homes have each been designed to meet the specific needs of individuals with DD who are in crisis. The homes are safe (locked sharps, no curtain rods, safe light fixtures, etc.), comfortable (décor is emphasized in each home—colors are soft, art work with encouraging affirmations is used liberally, rooms are individualized), and have dedicated treatment spaces, including a sensory room.

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Prevention & Step Down CTH Stays

Additional Types of CTH stays:

- Prevention Stay
- Step-Down Stay

Admissions criteria and policies are the same for planned and emergency admissions.



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In addition to crisis stabilization, the CTH also provides prevention and step down stays, which can divert an emergent crisis, assist individuals in coping with a stressful situation, or serve as a therapeutic and structured way to reintegrate into the community.

The other two types of stays that could occur at a REACH CTH are as follows:

A prevention stay may be helpful for a person with a cyclical pattern of crisis behavior, or possibly for an individual that is coping with a significant life change, such as the death of a close family member. This type of stay can offer proactive support to that person and his/her natural system of supports.

A step-down stay from a hospital, jail, or training center may be appropriate in some instances such that an individual can integrate back into their community in as therapeutic and structured of a way as possible.

Medical clearance, to include a TB test is required for admission to the CTH, as are labs and a medical review by a physician. For those entering the CTH and who are known to REACH, the physical and TB screen can be up to a year old and still be valid. For crisis admissions, labs, medical review and TB screen must be done just prior to admission. This is done to ensure that no obvious and untreated medical issues are causing the crisis behavior, as well as to protect others in the home from becoming ill. Each REACH program has a full-time registered nurse who can act as a guide through the process of medical clearance.

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REACH's role is twofold:

- they provide crisis stabilization services and follow up; and
- they work with the system to establish integrated service linkages.


Individuals can and should be referred to REACH if they have a history of behavioral crisis. Refer them even if they are stable and doing well. This gives REACH a chance to get to know them and see them at their best, information that is extremely useful when a crisis does arise.

REACH cases may become “inactive” or “closed” if service goals are reached or if the person is otherwise determined not to be in need of continuing support from REACH. Reinitiating services is as simple as contacting the REACH coordinator to change a person's status or to initiate a new referral. Please note that when a new referral is made for an inactive participant, it may not be necessary to complete a new referral packet. Contact the REACH coordinator and provide any updates to the information they previously received.

REACH does not replace any current emergency services providers, rather, it provides clinical consultation and support for emergency service workers, clinicians, and other members of a person's support system.

REACH emphasizes crisis prevention through early identification of persons at high risk. REACH is most effective when intervention begins when things are going well.

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Working Well with REACH

For Providers & Families	For Emergency Services	For Law Enforcement
<ul style="list-style-type: none">▪ needs to be contacted as soon as behavior begins to escalate▪ does not replace staff/family▪ supports individuals in crisis by assisting with de-escalation strategies▪ supports staff in managing crisis situations through coaching and mentoring	<ul style="list-style-type: none">▪ needs to be contacted as soon as a request for prescreening is made▪ does not make decisions regarding TPO criteria; however, their input is valuable!▪ has successfully diverted people from TDO's▪ When unavoidable, can support the person through the TDO process	<ul style="list-style-type: none">▪ provides training as part of CIT or separate from CIT on REACH and supporting people with developmental disabilities▪ can help with de-escalation and support in crisis situations▪ Encouraging involvement of REACH can help the prevention of future crises

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The information on the slide provides some reminders about REACH for providers, families, emergency services and law enforcement. A copy of this chart may be found in the material section of this module.

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Know the Resources

- Research Local & Regional Resources
- Learn About ES at the Local CSB
- Share Emergency Services Contact Information



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To effectively help a person in need of REACH services it is important for the Support Coordinator/Case Manager to become familiar with both local and regional resources. It is important for the Support Coordinator/Case Manager to learn about the Emergency Services System available through the local CSB. This may require discussions with the Support Coordinator's/Case Manager's Supervisor and emergency service staff. Support Coordinators/Case Managers need to be resourceful and learn about crisis and related supports within their community and region.

The Support Coordinator/Case Manager should ensure that families and people who may be in need of REACH services know who to contact.

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REACH Contact Information

Region I (Western)
Adult REACH Hotline: (855) 917-8278
Children's REACH Hotline: (888) 908-0486

Region II (Northern)
REACH Hotline: (855) 897-8278

Region III (Southwest)
REACH Hotline: (855) 887-8278

Region IV (Central)
REACH Hotline: (855) 282-1006

Region V (Eastern)
REACH Hotline: (888)255-2989



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If you are interested in learning more about REACH, you can contact the local REACH program for your region.

Region I (Western):

Adult REACH Hotline: (855) 917-8278

Children's REACH Hotline: (888) 908-0486

Region II (Northern):

REACH Hotline: (855) 897-8278

Region III (Southwest):

REACH Hotline: (855) 887-8278

Region IV (Central):


REACH Hotline: (855) 282-1006

Region V (Eastern):

REACH Hotline: (888)255-2989

Contact information is included in the material section of this module.

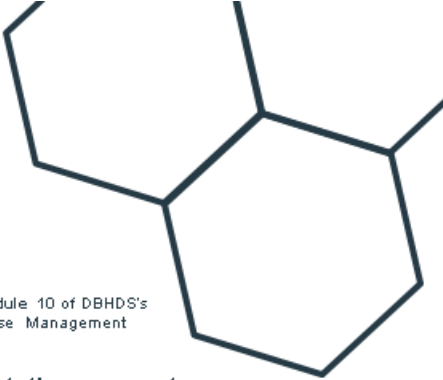
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Congratulations!

You have completed Module 10 of DBHDS's Support Coordination/Case Management online training.

Click here to complete the assessment.



Congratulations!

You have completed Module 10 of DBHDS Support Coordination/Case Management online training. Please note that all of the web links provided in this Module are contained in the accompanying training materials. Please complete the assessment for Module 10 before proceeding to Module 11.

Thank you for your participation!