



# Developmental Disabilities

## Crisis Response System

### “My Life, My Community”

A ROAD MAP TO CREATING A COMMUNITY INFRASTRUCTURE

January 6, 2014

## Executive Summary

The Commonwealth has set a course to transition individuals residing in its five (5) Training Centers to the most integrated settings in the community by 2021. In an effort to reach this goal and remain in good standing with the Settlement Agreement, which states:

*“To prevent unnecessary institutionalization of individuals with IDD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice, the Commonwealth shall develop and provide the community services....” {Section III.A.}.*

*“The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities....”*

- i. Provide timely and accessible support to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;*
- ii. Provide services focused on crisis prevention and proactive planning to avoid potential crises; and*
- iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable” {Section III.6.a.i.ii.iii}.*

The Commonwealth has deemed the most critical of these community supports are crisis interventions, intensive case management and person-centered prevention strategies to address children and adults specific needs to support community living. Also, having a statewide coordinated system allows greater access to services that address individual needs. Based on the Independent Reviewer’s third report, the Commonwealth needs to address specific areas of concern. The Commonwealth responded to the written concerns by October 20, 2013 in a report that describes the progress toward program development.

## Introduction

On July 8, 2013, Dr. Olivia Garland, Deputy Commissioner DBHDS, convened a workgroup of 16 professionals; Emergency Services staff, ID Directors, a RN, LCSW, Licensed Behavioral Analyst, START Director, several DBHDS staff and a facilitator BD Rollins Consulting. Their mission: to evaluate the current capacity of the Commonwealth to meet the needs of children/youth and adults with IDD who experience behavioral and/or psychiatric crises in order to ensure that all individuals remain a part of inclusive communities of caring.

In 2012, the Commonwealth initiated the development of the START model across the five regions of the state as a key component of its crisis system for adults over age 18. The workgroup was charged with the task of identifying key components of a state crisis response system for children and adults; to identify gaps which may not be currently met or may not be met with current resources in the community; and options to improving crisis services—specifically for children and families.

The current array of crisis supports available to individuals through the START programs, were reviewed with the workgroup identifying the following gaps or challenges in the overall system of care:

- 1) Lack of immediate crisis interventions either on-site or in-home for many individuals who exhibit extreme behaviors;
- 2) Lack of Immediate supports for individuals who are NOT known to CSB Emergency Services or START ;
- 3) Lack of crisis intervention services for children/youth with ID/DD and or DD-MI;
- 4) Lack of clear lines of collaborative connections with Emergency Services and the DD system, and;
- 5) Lack of linkages with law enforcement

Subsequent data and reporting from the maturing START models has also determined that some of the initial access challenges from the early onslaught of referrals have diminished. The system has and is developing the capacity to address some of the more intense needs of outliers recognizing that there is a need to develop some acute or specialty units for adults. Also, the Department is moving forward on developing strategies for enhanced case management; to shift the health and dental services of the DD Health Support Networks (former Regional Community Support Centers) from the Training Center to the communities; and to build upon the expertise of current center staff to possibly expand into specialty centers—such as Pathways at Southwestern Virginia Training Center and the newly rebuilt Southeastern Training Center for more intensive treatment, stabilization and longer term care when an immediate community provider has to be identified or developed. START reports that 85% of admissions are of individuals who have aggressive behaviors. One issue for the START model revolves around serving individuals who do not respond to intervention within 30 days resulting in on-going challenging behaviors. The second issue identified is created when a provider discharges an individual once admitted to the crisis center. Both of these can be addressed within a larger crisis system.

With the original workgroup, five (5) sub-groups were formed that included participants from outside DBHDS: VCU, Inner-Vision Education, Virginia Institute Autism School, St. Joseph's Villa, CSB staff, Training Center and State Hospital staff.

The five sub-groups addressed the gaps in the current crisis system while also strategizing actions to be taken in the short-term to ensure the health and safety of individuals with IDD and DD-MI in crisis. Each sub-group reviewed the current system and then proposed enhancements for their assigned area or concern. Each proposal was presented and discussed in the primary group by the group leader. (See Appendix A)

This draft plan was developed to assist the Commonwealth in achieving a comprehensive DD Crisis Response System (DDCRS) in order to increase the array of services and supports in the community for children and adults with ID/DD who are experiencing a behavioral and/or psychiatric crisis.

Subsequently, the draft plan was reviewed by members of the University of New Hampshire START team who provided feedback on the draft as well as a detailed memo of recommendations for a comprehensive IDD/DD crisis system. Other recommendations came from various members of the

Department and proposal team. On December 2, 2013, 20 individuals who included CSB's and START provider staff along with the UNH START team recommended changes.

On December 10<sup>th</sup>, 2013, Dr Garland, Assistant Commissioner Connie Cochran met with Program Administrators for the Center for START Services at UNH to review current progress and challenges with meeting the fidelity of the START model. In order to provide flexibility, build upon the key tenets of the START model in place and enable Virginia to have a statewide coordinated system, it was determined that beginning December 31, 2013, the regions will not operate under the START brand and will be rebranded the Virginia DD Crisis system (subsequently to be branded as REACH). This provides flexibility with each region allowing the programs to continue to operate with services and methods based on the START model.

On December 19<sup>th</sup>, 2013 Connie Cochran, Assistant Commissioner for Developmental Services, Bob Villa and representatives of the 5 Regional START programs formulated recommendations and changes to the DD Crisis Plan based upon the agreed upon changes. Virginia START is to be rebranded as REACH, "Regional, Educational, Assessment, Crisis Response and Habilitation". In addition, the START homes will be renamed "Crisis Therapeutic Homes (CTH)"

## Purpose and Mission

Individuals with intellectual and/or developmental disabilities shall be supported with services that allow the individual to live the most inclusive life possible in his/her community which includes access to appropriate and effective crisis intervention and prevention services including mental health treatment services when indicated.

The commonwealth is building upon the current components of the community crisis system to create the more comprehensive DD Crisis Response System (DDCRS) – a statewide crisis system to meet the crisis support needs of children and adults who have intellectual and /or developmental disabilities.

The intent is that a trauma informed DD Crisis Response System shall:

- Have trained providers that recognize the symptoms of trauma, and engage people with histories of such , and develop trauma-specific plans of care that understand the needs of the individual
- Provide immediate interventions to children and adults who are experiencing crisis due to behavioral and/or psychiatric issues, and supports to their families (including linkage with CSB Emergency Services for acute psychiatric care.)
- Provide in-home and community-based crisis services that are designed to address and resolve immediate crises preventing and/or reducing the risk of removal of individuals from their current living arrangement.
- Provide crisis supports in a Crisis Therapeutic Home (CTH) – a community home for stabilization that shall be used when on-site crisis services or supports are not effective or clinically appropriate. DBHDS has determined that it is best practice to provide supports where the crisis occurs as outlined in the commitment made between the parties of the agreement.

*“Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and if that is not possible, has then attempted to locate another community based placement that could serve as a short-term placement. (section 6.b.iii.B)*

- Collaborate with the treatment team including the individual, case manager, providers, family, guardian, etc. to develop a comprehensive crisis plan providing guidance to the system of care regarding subsequent crisis situations.
- Identify training and support needs for individuals referred that would provide the greatest chance of on-going success to maintain the current placement. Provide planned respite services as indicated to support the individual and system of care until services are available and scheduled through another community provider. Provide or identify resources to meet the training needs of the system of care to increase the capacity to serve the individual.
- Ensure coordination between case management and crisis services to oversee intensive transition supports back to the community acknowledging challenges that may arise in providing on-site services over time.
- Ensure case managers are supported to provide proactive planning and ongoing monitoring to avoid potential crises in the future. Case Managers shall be charged with identifying prevention strategies for individuals including facilitating access as needed to other community based services such as primary care and mental health treatment.

Additional system gaps identified which require increased linkages include:

- Access to mental health in-patient treatment including those recently discharged from training centers
- Need for specialty units dealing with complex issues for persons with IDD-MI

The development of more specialized providers as well as access more professionals across all regions to increase community expertise in dealing with more challenging populations, who may have been served by the Training Centers and building upon the linkages with REACH  
Description

The DDCRS will provide home and community based crisis services that support children and adults with IDD/DD or DD-MI in community settings which provide alternatives to institutional placement, psychiatric hospitalization, emergency room admissions, and/or law-enforcement involvement (including incarceration). These community based crisis services with possible CSH admission will be provided on a time-limited basis to ameliorate the presenting crisis. The DDCRS includes triage, dispatch, referral, crisis intervention services, intensive transition supports and secondary prevention supports.

An essential part of this system is the immediate assessment and application of appropriate interventions intended to deescalate the presenting crisis. Developing agreements with mental health facilities and local community hospitals for individuals requiring stabilization (medical and behaviorally) will be developed.

During a crisis situation, for an adult with ID/DD there is “no wrong door” for accessing services. If the initial contact is made to REACH or the Case Management System, a brief or triage assessment should occur to determine the need to involve CSB Emergency Services. If needed then ES, REACH and case managers will work together to assure appropriate and needed connections are made.

CSB Emergency Services (ES) 24/7 call line is the Single Point of Entry (SPOE) as defined by Virginia Code to initiate crisis services. Emergency Services personnel determine if the presenting circumstance requires interventions by trained crisis counselors which may include the mobile crisis teams. While the current system can provide some supports for children, the-REACH system of evidence informed care is currently designed for adults. This plan includes some initial recommendations of possible programming for persons under the age of 18 based on in part by the program plan developed by the children’s sub-group. As a best practice, services for children are best provided in the family home and this is the preference of parents seeking support for their child. Out-of-home placement will occur only as a last resort. Key elements of a child focused crisis plan are in development stage.

Each region is in the process of identifying key local partners by January 10, 2014 to begin the local cross agencies collaboration. Other critical stakeholders including sister state agencies to help further define the child & family focused DD crisis response system will be convened in January 2014. For each region, a lead staff person with expertise in child and family services will be engaged in the first quarter and coordinate the local development. A team treatment, evidence informed service may be developed to work with youth through mental health and child & family focused agencies, etc. Funding will be dispersed during the January-March quarter to support initial services to families and children within each region.

### Key Components: DDCRS

- Emergency Services (SPOE)
- ES prescreening for inpatient admission as a last resort
- REACH Mobile Crisis Services
  - Intensive Community Crisis Supports
  - Crisis Therapeutic Home (CTH)
  - Intensive Transition Supports (in collaboration with case management)
  - Crisis Prevention Planning
- Quality Assurance & Standards Compliance

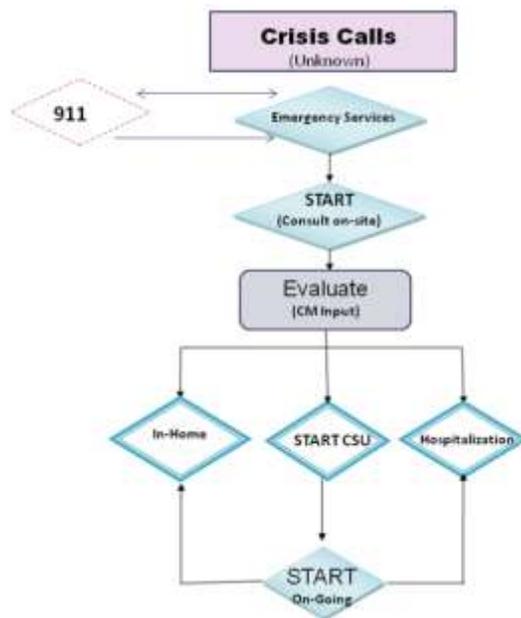
## Components of Emergency Services:

The Community Services Board (Emergency Services) is charged to provide preadmission screening services pursuant to § 37.2-505 or § 37.2-606, § 37.2-805, § 37.2-809 through § 37.2-813, § 37.2-814, and § 16.1-335 et seq. of the Code of Virginia and in accordance with the Continuity of Care Procedures in Appendix A of the CSB Administrative Requirements for any person who is located in the CSB's service area and may need admission for involuntary psychiatric treatment.

### Emergency Services – Single Point of Entry (SPOE)

Community Services Boards (CSB) in each of the 5 HPRs are the SPOE into publicly funded mental health, intellectual disability, and substance abuse services which provides comprehensive services within a continuum of care that includes crisis interventions and supports. Emergency Services by CSB's are considered mandated by the Code of Virginia. The chart below depicts the flow of a crisis call that is received by the ES 24/7 call line.

## Crisis Services Access Flowcharts

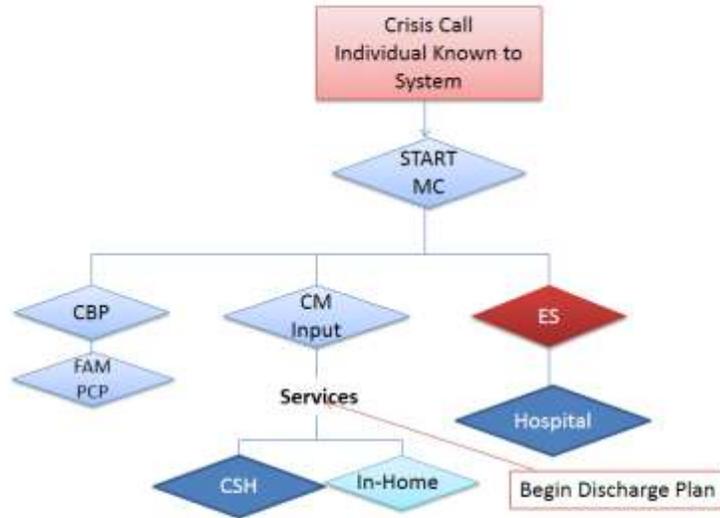


### Emergency Services Role

1. Respond to Crisis Immediately
2. Coordinate with public safety
3. HUB to coordinate crisis response – triage
  - a. Family
  - b. Group Home
  - c. Case Manager
  - d. START to be REACH
4. Remains involved till crisis resolved and coordinate and participate in assessment services

The flowchart above describes the process for triaging individuals who are unknown to the CSB or the REACH system. The chart below illustrates how the process is activated when an individual is known to the system. In this process the call may go directly to the REACH crisis line and supports can be immediately assessed, and if appropriate, mobile crisis service will be dispatched. However, if the situation dictates, ES will be consulted for prescreening for inpatient psychiatric interventions as stated

in the VA Code reference above and should be informed that emergency services were or are being



delivered.

\*CBP- Community Based Provider; MC-Mobile Crisis Services; CM-Case Managers; Fam-Family or Primary Care Provider/Guardian. START to be REACH.

## Current REACH Program Resources and Services

DBHDS contracts with/through the Community Services Boards with one board per region serving as the fiscal agent to operate the REACH programs in each region. These contracted resources (i.e. staff, homes, offices, mobile crisis services, assessments and prevention planning) are a key component of the DD Crisis Response System. It is anticipated that the current programs which are all in full operation will be able to expand their ongoing activities and/or link with mobile crisis counselors to address more “crisis” events with immediate on-site interventions. Secondly, the REACH teams and/or mobile crisis counselors/teams will be providing individualized prevention supports and training of community providers/care takers in order to reduce ongoing demand for mobile crisis services over time. The following describes the expanded direction of service provision that will be undertaken by these regional programs to support persons in crisis.

## REACH Mobile Crisis Services

Team members dispatched are trained and capable of providing appropriate clinical supports to ameliorate the crisis on-site; or determine the need for in-home or other intensive community supports; or arrange transport for the person to the CTH for acute interventions to maintain health and safety of the individual and community. For safety reasons, there may be some circumstances that require law enforcement assistance for transport if the mobile crisis team member, family or community based provider is unable to support due to safety concerns for the individual or self.

Requirements or expectations of on-site mobile crisis:

- Respond to crisis within designated time (1hr Urban, 2hrs Rural) of SPOE dispatch
- Address the crisis to mitigate any risk to health and safety on-site
- Determine disposition of Support Needs (in-home or CTH) including crisis plan or behavioral intervention plan as appropriate from on-site assessment
- Refer the provider or family or individual for follow-up (e.g. community/prevention services, emergency medical, CSB intake, etc.)

## Intensive In-Home Supports

The array of Intensive In-Home Support services may include, but are not limited to the following:

- Implement behavioral intervention strategies recommended by the REACH Mobile Crisis Team and/or Team Member, safety plans, and/or behavioral support plans already established for the individual
- Provide one-to-one support, as necessary, to address the crisis; modeling of interventions with family and/or provider staff; assistance with simple environmental adaptations to maintain safety
- Accompany the individual to appointments related to the crisis response when or if appropriate.
- Enhanced auxiliary staffing patterns up to 24 hours per day, 7 days per week, with the intensity of the Intensive In-Home Support services decreasing or becoming inter-mitten over time.
- Maintain linkages with stakeholder's involvement in order to restore the individual to pre-crisis supports and reduce future risk of crises.
- Provide appropriate training to support crisis stabilization; the return of the individual to pre-crisis services and supports, enhanced stability and reduced risk of repeat crises which may include the possibility of providing transitional supports into a less restrictive environment which includes:
  1. Demonstration and modeling of interventions to the family/caregiver and/or existing IDD/DD service provider (if applicable);
  2. Observation of these interventions by the family/caregiver and/or existing IDD/DD service provider (if applicable) to ensure that appropriate person centered supports will continue post intervention;
  3. When appropriate, securing specialized trauma informed training to develop specific skills and expertise for willing providers for individuals with unique challenges or needs who are at increased risk of more restricted care. To be coordinated initially through the DBHDS Division of Developmental Services

## Intensive Community Supports

Supports to be provided where and when individuals experience crises (day support, work, residential program, school) in their day and/or employment activities. The staffing for all venues where support is needed will be determined by REACH program staff and mobile crisis team members in consultation with the Individual's support team. The support team may include parents, other family members, school staff, private care givers and clinical support team members (nurse, behavior analyst, psychiatrist, case manager, etc.).

## Regional Crisis Therapeutic Home (CTH)

### Requirements for admission to CTH

The mission of the Crisis Therapeutic Home is to provide Crisis Prevention and Stabilization in a residential setting, through the utilization of assessments, close monitoring and a therapeutic milieu. Only Individuals over the age of 18 years may be served in the Crisis Therapeutic Home, accommodating no more than 6 individuals simultaneously.

The existing Crisis Therapeutic Homes are licensed:

- As Group Homes in the community, and
- START MH Crisis Stabilization, START ID Supportive In-Home, MH Outpatient/Crisis Stabilization services
- In process of meeting licensing requirements for IDD/DD Stabilization Services
- And Meetings with Licensure will occur to review the changes needed as the START programs become REACH programs.

### Requirement for operation of Crisis Therapeutic Home

The Provider agencies of the DDCSR, will develop by January 30, 2014, revise, utilize and maintain protocols that incorporate person-centered thinking for the services provided in the Crisis Therapeutic Home that include but are not limited to:

- Clear criteria for determining when and if a referral to and admission to a Crisis Therapeutic Home meets necessity;
- Staffing plans that optimally include a Nurse Practitioner, Registered Nurse and/or Licensed Practical Nurse, day, evening and night Direct Support Professionals, a Licensed Behavior Analyst, a Licensed Professional, QMHP, QIDP, and Psychiatric Consultation;
- Expertise to develop crisis treatment plans and implement services/ supports/treatments which enables the individual to step down or return to lower level of services—normally within thirty days for emergency admissions, though flexibility may be granted when intensive training is being provided to the provider who will continue post-discharge services;

- Ongoing adherence and/or review of the Human Rights policies and practices that ensure the health, safety, welfare of the individual is assured—including access to appropriate treatments and/or interventions;
- Transportation plan and/or coordination to accommodate individuals while in the CTH as well as transportation back to the community. Immediate implementation of discharge planning which includes a licensed professional who is qualified by training and experience to assist CSH staff and case managers to ensure that appropriate referrals and/or coordination of services are part of the transition back to the community;

## Crisis Prevention Planning

Crisis Prevention Planning is provided by REACH program with an assessment/evaluation in collaboration with the individual’s case manager, while developing the Cross-Systems Crisis Plan.

Additionally, routine access or authorization of time limited services to connect the individual to the necessary supports to prevent crises should be available. Staff must coordinate with stakeholders to assure development of a discharge plan which includes follow-up to review the effectiveness of the recommended services. This level of planning is provided throughout the continuum of the DDCRS (on-site, in-home, and out of home) and should be terminated after the discharge plan follow-up has been completed and case returned to the assigned case manager.

Increased access to and encouraging some of the 300 plus licensed behavioral analysts to provide services is seen also as critical to increasing the capacity of the community to reduce crises. Reducing or removing barriers to access other training such as at the training centers may be beneficial. More focus on the train the trainer to bring up more skilled professionals is also recommended. Moving up the expertise and skills of community based workers sooner than later will also reduce crises and ultimately cost to the overall system.

## Standards of Compliance in Service Provision

DDCRS providers must comply with the Community Service Standards for Developmental Services Providers found in the Virginia Department of Behavioral Health and Developmental Services Licensing and Human Rights regulations as applicable to crisis supports services.

The following standards are applicable to organizations that provide crisis response services to individuals, family members, care-givers, and/or ID/DD waiver service provider agencies that access the DDCRS.

1. Standard practice is to initiate treatment and stabilize the individual in home or on-site rather than to transfer an individual in crisis to an out-of-home setting Crisis Therapeutic Home by providing additional supports in the home or other community settings.
2. Staff involve the provider agencies of individuals receiving crisis supports to assess and recommend needed changes in services, including offering training to providers willing to develop skills in serving individuals with very challenging behavioral health issues

3. Clinical intervention decisions are made to ensure the least restrictive interventions and placements are utilized as evidenced by assessments that justify the need for any restrictive interventions and/or placements (including intensive in-home supports or intensive out-of-home supports or medications).
4. Plans intended to modify behavior over time (not including crisis plans) are developed after appropriate behavioral assessments are completed, and the personnel who develop the plans are able to provide follow-up activities.
5. Discharge Planning begins at intake and continues throughout utilization of the DDCRS. The discharge planning process includes collaboration with all applicable parties-- family members/care-givers, providers, support coordinators, case managers, waiting list manager, and CSB intake coordinators and REACH staff.
6. Transportation will be provided (as appropriate and available) and/or coordinated by Mobile Crisis Teams, CIT and other law enforcement officers for individuals who need to be transported to the Crisis Therapeutic Homes , emergency facilities, and/or back to the community—when family or providers are unable to assist.

## Community Linkages and Development-Short & Long Term Gap Solutions

In addition to the prevention training and supports provided in the REACH system, the Department will help develop specialized providers to address the needs of a small group of individuals who present with unique needs and requirements. This will be done in collaboration with the REACH system and with the assistance of the various Divisions within DBHDS. Overtime this could potentially include tiered provider network which could serve to test tiered rates for more difficult to support individuals. Incentives can be developed and funds leveraged to accelerate this process—most likely to prioritizing by regions with Training Center closures.

DBHDS will continue the work of enhancing the quality and consistency of the case management system within the 40 CSBs as well as through the DD Case Management System, now administered through DBHDS to ensure adequate understanding of roles and responsibilities of case managers in lessening needs as well as linking and coordinating care pre and post crisis. Essential to that coordination will be building upon the DD Health Support Networks for primary and dental care linked to emergent community health practices which begin transitioning in January 2014 into the community. All REACH programs should develop greater linkages to the medical community. In addition, the DBHDS Division of Developmental Services can adjust its structure and organizational resources to address short-term needs for major outliers who currently are requiring extensive staff resources of CSB case managers and REACH system to accelerate the development of alternative providers of community services; not to become the de-facto case managers of these individuals. The cross department Critical Case Consulting group is being formed and will be operational by January 20, 2014 to work with REACH, case managers, training centers, CSB's and others as appropriate per case.

## Quality Assurance Measures through data collection and Reporting

### Quality Assurance Data Management

In conjunction with DBHDS, the REACH programs and other providers of DDCRS supports will develop performance indicators and outcome measures for each stage of operating the system. Providers must participate in data collection and generate quality assurance reports for submission to DBHDS. Every effort is being made to align data systems and identify what key data elements should be used—reducing redundancy and reducing administrative costs. The data should drive evidence informed care for individuals within the system including improving crisis prevention training, activities and screenings for the IDD/DD and DD-MI population.

Once sufficient baseline data has been collected, DBHDS will develop specific performance indicators that will be subject to ongoing refinement. Measureable goals for the system with short-term and long-term outcomes will be formulated that are evidence driven. These indicators or dashboards tied to achieving specific outcomes will allow DBHDS to monitor the DDCRS. With key stakeholders and with ongoing vigorous analysis, quality improvement decisions will routinely occur to strengthen the overall system and improve outcomes for the individuals who receive services. The intent is to also collect post discharge data to determine who best benefits from the crisis services and remains stabilized with lower level of services over time. The Division Developmental Disability Services will work with University of New Hampshire Center for START Services over the next six months to identify those key elements with the intent of BETA testing a regional evaluation tool July to September 2014 and implementing system wide by October 1, 2014.

DBHDS is committed to using current and emerging evidence based or informed treatment and support models and to building linkages to best practices.

REACH programs and other providers of DDCRS must develop internal systems of quality and will generate reports to include, but not limited to the following:

- a. Reason for crisis call
- b. Site of crisis (including DBHDS Region)
- c. Demographic information of the individual in crisis (including Medicaid status)
- d. Provider currently providing supports/services (include a category of none)
- e. Family Involvement and other key persons in the child or adult's life
- f. Resolution and/or final outcome of crisis incident
- g. Dispatch team response time and barriers that may have delayed response
- h. Services received (include a category of none, behavioral health services)

- i. Identification of waiver status or wait list status
- j. Name of support coordinator or case manager along with name of agency or if referred to CSB for assignment of a case manager
- k. Incidences of mobile crisis team dispatch to emergency rooms and resolution
- l. Incidences of intensive community supports (in-home, out-of-home or other community environments)
- m. Number of days of supports—scheduled or emergency
- n. Recidivism of individuals and providers in relation to utilization of DDCRS past discharge from active involvement and reason identified
- o. Referrals by crisis service providers to Child Protection Services and Adult Protection Services

*NOTE: Recommend that only useful data elements should be collected and the requirement for data collection should not be duplicative. And where ever possible every effort will be made to streamline and link data bases. DBHDS has started the development of a data warehouse that should address the concerns regarding the amount of duplication of data entry into different data systems.*

## Mobile Crisis Staffing & Credentials

The Mobile Crisis Team should dispatch licensed/certified clinical staff to a reported crisis. Clinical staff responding to crisis call shall be sufficient to attend to the crisis and/or provide safe transport of the person if needed. One of the staff present shall be a QIDP/QMHP. Mobile Crisis Team configuration remains flexible as recruitment and the geography of the region may play a critical role in the success in building the team. The list of team members detailed is intended to also identify critical skill sets or expertise that ideally should be available across a region. Potential access to expertise with other community based providers may be developed or utilized on teams. It is not anticipated that teams will or can be developed which includes all possible combinations of specialized, licensed professionals. Some or much of the access to the expertise may be found with linking IDD/DD mobile crisis teams with certified START programs and or through MOA's with mental health treatment/crisis facilities.

### Recommended Team Members Who Should or May Have Needed Expertise

- Qualified Intellectual/Developmental Disability Professional (QIDP) including those who have received START Coordinator certification through the Center for START Services
- Qualified Mental Health Professional (QMHP)
- VA Nurse Practitioner
- VA Registered Nurse
- VA Licensed Practical Nurse
- VA Licensed Physician/Psychiatrist

- VA Licensed Psychologist
- Positive Behavioral Supports Professional
- VA Licensed Behavior Analyst
- Behavior Technician (Direct Support Professional)
- Children Crisis Supports Navigators (intensive support staff for children and youth)
- Social Worker or other VA Licensed Professional with related experience in discharge planning—particularly with dual diagnosed individuals

The above are the estimated staffing needs (skills, expertise—not necessarily FTE’s) to operate the mobile crisis team and the CSH to be successful. To ensure health and safety of everyone involved in the crisis, individuals will need staff with the highest level of expertise to provide interventions.

It is also recommended that there be linkages/collaborations with different community partners to ensure alternative expertise would be available for ensuring knowledge transference, technical assistance and/or direct supports.

Developing the expertise across the regions will require different strategies and configurations based upon available resources and current resources within specific communities.

Note: See Attachment B, it contains complete job-descriptions for each position.

## Training

Training records are to be maintained, with documentation that all REACH programs and other DDCRS staff have participated in training as appropriate as well as documentation demonstrating their competence in all crisis protocols and relevant applicable trainings. Wherever possible, prior training and experiences may be provided that demonstrate that the staff members’ previous trainings, licenses or board certifications or other certifications has the required competencies. DBHDS will make every attempt to cross walk similar trainings and certifications from other sources. Mobile team members and intensive support staff shall demonstrate competencies in the following areas;

- I. Assessing the crisis
- II. Ability to function within the home or facility
- III. Ability to complete and routinely make critical referral decisions
- IV. Routinely incorporates and facilitates person center solutions. Evidence that the staff member has received appropriate training through Person Centered Thinking Required crisis Physical intervention curriculum (at least one of the following) [HTTP://WWW.VCU.EDU/PARTNERSHIP/PCT/](http://www.vcu.edu/partnership/pct/)
  - Crisis Prevention Institute (CPI) [WWW.CRISISPREVENTION.COM](http://www.crisisprevention.com)
  - Handle with Care Behavior Management System, Inc. [WWW.HANDLEWITHCARE.COM](http://www.handlewithcare.com)

- Mindset [WWW.MINDSETCONSULTING.NET](http://WWW.MINDSETCONSULTING.NET)
  - Safe Crisis Management [WWW.JKMTRAINING.COM](http://WWW.JKMTRAINING.COM)
  - Human Empowerment Leadership Principles (HELP) [WWW.CAPSCANHELP.COM](http://WWW.CAPSCANHELP.COM)
  - Professional Crisis Management (PCM) [WWW.PCMA.COM](http://WWW.PCMA.COM)
  - Safety- Care (QBS, Inc.) [WWW.QBSCOMPANIES.COM](http://WWW.QBSCOMPANIES.COM)
  - Therapeutic Options of Virginia (TOVA) [WWW.THEROPS.COM/NODE/12](http://WWW.THEROPS.COM/NODE/12)
- v. Cardiopulmonary Resuscitation (CPR), AED use as required by Licensing.
  - vi. First aid as required by Licensing.
  - vii. Documentation of utilization of required standards and/or rules
  - viii. Should be able to demonstrate, understand and routinely utilize behavioral principles, analysis and intervention techniques
  - ix. START and/or REACH training curriculum—START certification where indicated

## Recruitment

Staff recruitment and retention in crisis focused programs create challenges. Start-up of programs is often hindered by the inability to demonstrate exactly the population who will be served. Not surprisingly this was problematic to the START/REACH program implementation. An extended process of ensuring that staff skills and understanding of their roles and environment by determining a candidates affinity for specific types of programs and if the candidate demonstrates key competencies.

Region III REACH program has improved retention of staff by utilizing shadowing, role playing to determine ability to adjust and respond with appropriate interventions, and a written test that uses a vignette whereby the interviewer must provide an assessment with short goals/interventions for an individual. This will help the interview panel to assess the person's ability to write goals with measurable outcomes.

Over time the Crisis System may wish to employ other screening tools that are used to determine if an applicant is most likely to or not to be successful in this stressful environment.

## Leveraging the Current REACH Programs, Mental Health Hospitals and Training Centers—Case Example

Region III in Southwestern Virginia has demonstrated the ability to build upon the evidence informed REACH system. While detailed data has yet to be collected and analyzed, initial review indicates that there are possible means to 'innovate' on regional structures to develop a flexible, cost effective initial DD crisis system - building the plane as it flies.

Region III has been able to link mobile crisis teams-coordinators with the REACH services to address particular needs of residential providers and families across a wide and very rural portion of the state.

The expanded activities function as a crisis intervention/stabilization program with critical enhancements linked to REACH. DBHDS has determined that Region III operations with adaptations can serve as a blue print or model for other REACH programs with the goal of creating consistency in program operations, training, protocols and policies statewide. Specifically, Region III has been able to secure resources to build the mobile crisis teams, which appears to be reducing crisis calls. Region III has been able to generate additional resources by maximizing its allowable Medicaid billing and utilizing these funds to staff the teams.

In addition, Region III has been able to access the Pathways program on SWVTC for additional scheduled respite. Most importantly, the program has developed an excellent partnership with the state mental health hospital in Marion. As a result, Region III is able to secure critical mental health services and provide step-down services back into the REACH Crisis Therapeutic Home routinely and effectively.

### Region III- Enhanced Crisis Services

The following operational enhancements have proven successful in providing immediate crisis interventions to individuals in Region III by the REACH program. The Start Director restructured the staff creating two “sub-teams” that enabled greater coverage of the Region.

A parallel track was established to provide crisis services. While the Community Crisis Clinicians are providing immediate intensive interventions, the REACH Coordinators are working to identify community resources to support the individual and connecting him/her and/or their families to the supports.

The addition of a fulltime nurse practitioner allows for the immediate assessment of medical issues that may be a contributing factor to the behavior.

Crisis plans that are currently used as part of State Plan Option Medicaid (SPO) stabilization and intervention services may be used as a format to immediately assess and address an individual already in crisis in order to determine immediate stabilization needs.

Each individual is assessed; the assessment is reviewed by the Director or other licensed professional. A determination is made whether they meet criteria. Plans generally last 3-5 days but can last up to 15 or more days in acute situations. REACH services continue while crisis stabilization services are being provided.

Staff participate in daily team meetings to discuss each case. This brings together all team members including the Mobile Crisis Clinicians and the REACH Coordinators to provide updates. Staff have been trained through START as well as trained within the current crisis stabilization services to assess and provide services. This is not the emergency services program.

## Children's Crisis Supports

Children's crisis services are needed to ensure supports to children and families preferably in their home. These services will be provided by staff who have experience and who are capable of providing appropriate clinical supports to ameliorate the crisis on-site; and determine the need for in-home or other community supports. Such services by necessity cross multiple systems of care requiring extensive collaboration and coordination.

### Children's Crisis Services: Best Practices

A review was conducted of four evidence informed programs in other states providing crisis services to children with ID/DD who are experiencing a behavioral and/or psychiatric crisis. In addition, Horizon's Behavioral Health has developed an innovative program. The workgroup acknowledges that a more comprehensive review of evidence informed program within and outside of the state should occur. The following programs were identified for review:

1. San Francisco, CA - Comprehensive Child Crisis Services
2. Fresno County, CA - Children's Crisis Assessment Intervention Resolution Center
3. Seattle, WA - Children's Crisis Outreach Response System
4. Minneapolis MN - Community Support Services, Metro Crisis Coordination Program
5. Horizon's Behavioral Health Child Crisis Program in Lynchburg, Virginia

Some of the key components of the above programs include:

- Services available 24 hours a day, 7 days a week
- Multidisciplinary staff consisting of clinicians, nurses, case manager and psychiatrist
- Mobile Teams trained to assess the crisis, prescribe an appropriate intervention and implement the course of treatment within the family's home
- Post crisis time limited supports and services to the individual and/or family
- Access to hospitalization for stabilization and mental health treatment including health assessments when the child is presenting symptoms indicating that he/she is a danger to self and/or other. In-patient services may be required to stabilize and begin the treatment process when in-home options are exhausted with the goal that the child is returned as soon as possible to the home environment as a standard of best practice.
- Access to out of home placement in a therapeutic foster home when the crisis cannot be deescalated in the current environment and placement is required for a period of time outside of the natural home--always as a last option. In addition, placement into a hospital, if needed, should be as short as possible with possible step-down into a professional therapeutic foster home as an option.

Again, the workgroup noted the need to involve all elements of the public system that provides children services before launching a specific evidence- informed model/program to include at a minimum the

Departments of Social Services, Education, Juvenile Justice, Comprehensive Services Act Office, CSBs and DBHDS, Office of Children's Services. The plan anticipates beginning the process with the funding of key positions within the five regions.

### Crisis Services for Children Diagnosed with Intellectual or Development Disabilities

Extensive work must occur with mental health providers, DSS, other child focused agencies and CSB's to determine how to develop a crisis response system for children and families. In reality, the numbers of referrals may be low and also will include not only children who have an ID/DD, but of children with mental health challenges. Each of the five CSB regions will identify and relay to the Department by January 17<sup>th</sup> recommendations of potential partners, including providers who demonstrate expertise in working with children & families as well as children with mental illness and developmental disabilities. Each region will be provided funds to hire or contract for a lead position. This "Navigator" position will have proven clinical skills as well as demonstrated ability to collaborate with an array of stakeholders. The intent then is to begin with 18 month period to focus upon a core group for each region to begin to develop a system that has to be imbedded with multiple other systems of care. Additional funds will be allocated per region to allow each region to engage professionals to provide needed expertise to family and adults to provide child crisis services during this development stage. Work will continue on reviewing the evidenced informed models as well as developing team approach to services (See detailed list below of skills/expertise that should be available within each region.).

These services will be provided by staff who have experience in providing appropriate clinical supports to ameliorate the crisis on-site and determine the need for continuous in-home or other community supports. Initially, one position will be established per region. In addition, regions may move to hire two additional positions as indicated to create a team and or retain limited hours from multiple professionals to create dispersed network of providers.

Licensed Regional Children's Team Leader

QMHP C/QIDP-Child Coordinator (Master's Level preferred)

QMHP C/QIDP –Child Community Crisis Professional (Master's Level preferred)

And Or: Utilize funding to provide contracted professionals across the regions to provide more immediate access by families with critical needs rather than hiring dedicated QPs.

A challenge for the system is that the issues and skills needed to deal with a wide array of child and family issues can quickly overwhelm whatever is initially placed upon the ground. Focusing first on the local development in conjunction with state efforts engaging other key players will allow Virginia to develop a crisis response system without duplicating existing programs, or services.

a) Services will include crisis resolution provided by a Community Crisis Professional, the use of individuals skilled in the treatment and supports of children including comprehensive case management to assist families in navigating service systems that support children and youth after the crisis has been resolved.

b) Demonstration and training of interventions to the family/caregiver and/or IDD service provider (if applicable) that are effective and sustainable, and

c) Observation of these evidence informed interventions by the family/caregiver and/or existing IDD service provider (if applicable) that the Commonwealth may be able to implement through multiple methods (for example ABA, positive behavior supports, etc.)

**Phase One** will be to determine priorities of how best to reach those families and youth. For example developing an expanded REACH system that works with youth ages 14/15 to 18 may be feasible and deal with specific family needs. Each REACH program will examine means of expanding current activities by May 2014, with implementation of appropriate options by July 2014. This includes projecting the resources that can be generated through the current Medicaid benefits plan. Other options include looking at programs such as the emergent Child First program for the treatment and intervention for families with children birth to six (a dyad treatment model).

**Phase Two Requirements:**

- a) Respond to crisis within designated time (1hr Urban, 2hrs Rural) of SPOE dispatch
- b) Address the crisis to mitigate any risk to health and safety on-site linked to child protective services
- c) Determine disposition of Support Needs (in-home or out of home services) and
- d) Make non-crisis appropriate referrals for follow-up (e.g. community/prevention services, emergency medical, CSB intake, DSS, etc.)

**Mission:**

To assist Families and their support systems in developing and maintaining a stable and happy home for children who have been identified as having an intellectual or developmental disability.

**Target Population:**

Children and families with children under 18 years of age who have experienced a crisis event that their family and support system needed assistance to resolve.

**Crisis Supports and Services**

A Full array of family support and training services that teach ALL members of the extended family system the skills needed to promote wellness and independence. With additional specific skills in how to help with crisis events and how to help children learn new skills.

- 1) Recognition of early warning signs of impending crisis events and steps to take to avert the crisis as well as teach self-management skills
- 2) Phone support
- 3) In home coaching

- 4) **Direct services to child/family/support system:**
- I. Crisis de-escalation
  - II. Development and implementation of a short term crisis support plan designed to maintain stability while the support systems are activated and strengthened
  - III. Medical screening and referral for evaluation and treatment of medical conditions
  - IV. Family and support system assessment to include development of a comprehensive support plan and teaching how to effectively implement that plan
  - V. Behavior assessment and/or Functional Analysis to include direct intervention provided by the crisis staff as well as the development of a Behavior Support Plan
  - VI. Parent training
  - VII. Intensive in home respite services
  - VIII. Services and supports linkages
  - IX. Alternative placement in a therapeutic foster home A professional parent home or treatment foster care home could be used with wraparound support where short-term out of home stabilization is needed without getting into an inpatient or residential setting.
  - X. Referral to inpatient services as a last resort when needed to assure the safety of the individual, family and/or system of support

*Full program description is included in Attachment C*

### Establishing Children's Crisis Operations

The following is a timeline of the processes to be completed In order to establish initial supports for children in the existing programs or within the emerging regional approach to DD crisis services. Funding and positions will not necessarily be attached to the five existing REACH programs as other partners or CSB's may currently possess the expertise and experiences to quickly bring forth a wider array of services. Either way, the services will be developed as part of the larger emergency crisis response system.

#### **Phase I: up to 3 months from funding notification**

1 FTE Licensed Regional Children's Team Lead—Program Developer

#### **Phase II: within 3-6 months from funding notification**

1 FTE QMHP C/QIDP-Child Coordinator (Master's Level preferred)

1 FTE QMHP C/QIDP –Child Community Crisis Professional (Master's Level preferred)

And/Or Allocation of Funding to allow for contracting for professional services periodically across a wide geographic area as the local infrastructure is developed and reviews continue on currently evidence based models from throughout the country.

DBHDS will further explore where these positions or other potential positions fit as part of the professional team, integrated into the larger mobile crisis team or the larger crisis system itself to maximize additional support and expertise and to avoid creating a separate silo for children's' crisis

services. The need for additional staffing will be analyzed as service provision begins and data is reviewed to ensure any services launched by July 2014 will be sustainable and effective

**To establish crisis services for children within the existing REACH programs will require licensing under the following categories via DBHDS**

07	006	Outpatient Srv /Crisis Stabilization #3	A mental health non-residential crisis stabilization service for adults/children/adolescents
03	013	ID Supportive In-Home Srv	A REACH intellectual disability supportive in-home service for children, adolescents and adults
07	010	Outpatient Srv-ABA	A mental health outpatient community-based applied behavioral analysis service
02	010	DD Day Support Srv #5	An developmental disability day support service for (population served)
02	009	ID Day Support Srv #4	An intellectual disability non center-based day support service for children and adolescents.
16	006	Intensive Care Coordination Service	An intensive care coordination service for children and adolescents

The program should also be licensed by VA DSS as a Child Placing Agency certified to Provide Treatment Foster Care Case Management Services to allow for direct out of home placement of children when needed. (See reference materials at [HTTP://WWW.DSS.VIRGINIA.GOV/FAULTY/LCPA.CGI](http://www.dss.virginia.gov/faculty/lcpa.cgi))

**Phase III: expansion based on needs identified in first 6 month of operations**

- A. With careful review by DBHDS and REACH programs, determination will be made about expansion and cross training existing REACH Clinical staff in providing and/or developing supports for children and adolescents to enhance the comprehensive system.

**Phase IV: 2-3 Years**

Expansion will be based on documented need for crisis services.

## DDCRS Development Timeline

It will be important for a workgroup including DSS, CSA, DOE and REACH to be developed to more fully establish a work plan and timeline considering the elements that have been proposed in this report.

### Schedule of Activities

Proposed items to be included in the time line

Project	Task to be completed	Begin	Complete
1	Plan Approval	10/20/2013	1/16/2014
2	Review & Revise Plan with START Directors and Others	11/1/2013	1/15/2014
3	Establish Implementation/ Millstones	12/15/2013	1/31/2014
4	Hire/Train Children's Staff /Contract QPs	1/15/2014	3/31/2014
5	Develop Communications Strategy	12/5/2013	3/5/2014
6	Home Modifications (if needed)	12/1/2013	2/31/2014
<b>7</b>	<b>Quarterly Updates</b>	<b>10/20/2013</b>	<b>8/31/2014</b>
	Region I		5/31/2014
	Region II		5/31/2014
	Region III		4/30/2014*
	Region IV		7/1/2014
	Region V		7/1/2014
<b>8</b>	<b>Full Implementation Statewide</b>		<b>8/31/2014</b>

## Collaborative Partners

### Enhancing a Coordinated Systems Approach

Throughout the Commonwealth there are agencies public, private for-profit and non-profit that people with disabilities utilize for support needs or have involvement in various personal ways. The agencies listed below are considered partners in the public service system supporting people with IDD. However, this list is not exhaustive and will be expanded as program changes occur.

- DD Health Services Networks (RCSCs)
- Community Services Boards
- REACH & Public Agencies (i.e. DARS, DMAS, DSS)
- Private Service Providers (Medicaid Enrolled)
- Courts and Law Enforcement
- Schools Systems
- Advocacy Groups
- Private Hospitals
- Office of Comprehensive Services (CSA)
- Others

## Recommendation: Develop Additional Community Resources

### Therapeutic Respite

This plan also addresses community therapeutic respite supports for children as an option that should be made available for families if needed.

### Planned/Maintenance Respite Supports

For families who are caregivers.

### Emergency Respite

For individuals who would otherwise be at risk of homelessness

**Note: This section will be further developed with REACH, state & local partners as well community stakeholders.**

## Communications Strategy and Plan

The communications plan will be developed with the aid of all parties involved with implementing the DDCRS.

- Individuals
- Education of Families
- School Systems
- Law Enforcement
- Regional staff –REACH, case managers, emergency services workers, etc.
- Relevant Agencies
- Community at-large

## Budget: Projected Costs and Funding Sources

To be determined.

## Attachment A

### DD Crisis Response System Workgroup and Sub-group Members

Olivia Garland, Deputy Commissioner DBHDS	Debbie Burcham, Executive Director Chesterfield CSB
Kathy Drumwright, Assistant Commissioner QI	Lynnie McCrobie, ID Director MNCSB
Heidi Dix, SA Executive Advisor	Nicky Morley, LCSW, VA Beach CSB
Bob Villa, ID/DD Crisis Manager	Pam Nicholls, RN HNN CSB
Gail Rheinheimer, Provider Service Development Manager	Robert Tucker, ES Valley CSB
Andrea Coleman, Community Resource Consultant	Denise Hall, START Director Region III
Mary Begor, Crisis Intervention Community Specialist	Lee Price, Senior Policy Analyst
Keven Schock, Associate Director of Licensing, Licensed Behavioral Analyst	Sandy Bryant, Horizon BH
Carol M. Schall, Ph.D., Director, Virginia Autism Resource Center VCU	Lyanne Trumbull, Regional Projects Manager Region II
Linda Saltonstall, St. Joseph's Vila	Katharine Hunter, DBHDS, Child and Family Services
Gail Paysour, Regional Projects Manager, Region I	Damon Peterson, Inner-Vision Education
Cindy Gwinn, DBHDS/DDS	Ethan Long, VA Institute of Autism
Tara Portee, Assistant Clinic Manager, District 19 CSB	Ruth Ann Bates, Social Work Director, Central State Hospital
	BD Rollins Consulting - DOJ Consultant

## Attachment B

### Job Descriptions for Crisis Staff

#### **VA Licensed Clinical Social Worker**

Qualifications of Professional Social Worker (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Clinical social work licensure (LCSW) issued by the State of Virginia that is current and unrestricted AND
- Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
- Knowledge of federal, state, and local programs that have been developed for people with Intellectual/Developmental Disabilities including eligibility criteria and how to access these services AND
- Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities Act (ADA) and their legal mandates as they relate to special education programs and the rights of people with disabilities.

Serves as team leader and coordinates all internal and external activities of the Crisis Team.

#### **VA Licensed Nurse Practitioner**

Qualifications of the Licensed Nurse Practitioner (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Must be a Licensed Nurse Practitioner Registered Nurse with a specialty education category that allows them to practice with the person being served.
- Have experience in caring for individuals with Developmental Services who are in crisis.

The Licensed Nurse Practitioner will be directly involved in all aspect of crisis intervention and will take the lead in assessing and recommending appropriate actions related to potential and actual medical issues.

### **VA Licensed Physician/Psychiatrist**

Qualifications of **Physician** (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Graduate of medical or osteopathic college; AND
- Licensed by the Virginia Board of Medicine
- The physician will operate as part of the team to provide any required medical assessment, diagnosis and prescription of medication.

Qualifications of **Psychiatrist** (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Meet all the qualifications as a physician
- Certified in Psychiatry by the American Board of Medical Specialties (AMBS)
- Specialized training in providing psychiatric services to individuals with intellectual disabilities
- The Psychiatrist will operate as part of the team to provide any required psychiatric assessment, diagnosis and prescription of psychiatric medication.

### **VA Licensed Clinical Psychologist**

Qualifications of Licensed Clinical Psychologist (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Clinical Psychologist license issued by the State of Virginia that is current and unrestricted AND
- Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care
- At least 2 years providing services to people diagnosed with intellectual and/or developmental disabilities

### **VA Licensed Behavior Analyst**

Qualifications of Licensed Behavior Analyst (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Licensed by the Virginia board of medicine as a Behavior Analyst AND

- Have at least two years experience in behavioral assessment, developing, implementing and monitoring behavior intervention/support plans and services for people with ID/DD
- Shall provide an assessment of the function of socially significant targeted behaviors and design short and long term interventions. These interventions will assist the person to avoid the negative effects of the behavior associated with the crisis event and learn alternative behaviors
- Shall be the expert and take the lead in demonstrating the interventions that can be applied successfully. Will also provide training on the implementation of the interventions to the individuals that support the person with IDD who is experiencing a crisis event
- Shall collect and analyze meaningful data that allows for objective analysis of the effectiveness of the crisis intervention and determination of when the individual has met the criteria to transition out of crisis services

### **Behavioral Technician (Direct Support Professional)**

Qualifications of Behavioral Technician (Direct Support Professional) (as defined for the purposes of the Virginia Crisis Response System must meet the following standards):

- Successfully complete training in CPR, HIPAA, mandated reporting, problem solving and conflict management related to employment, developmental milestones, confidentiality and ethics and crisis intervention techniques including physical management techniques
- Completed a minimum of 48 semester hours of college courses in an accredited college or university
- Completed 40 hours of classroom training in Applied Behavior Analysis Basic principles of behavior, interventions as well as data collection and analysis.
- Operates under the direction of the Licensed Behavior Analyst
- The behavioral technician delivers direct services to the person being served.

### **Positive Behavioral Supports Facilitator**

Qualifications of Positive Behavioral Supports Facilitator

1. Bachelors or higher degree (human services field preferred) from an accredited university
2. At least 3 of the past 5 years of work experience supporting people with disabilities.

3. 40 hours of formal training in Positive Behavioral Support
4. 24 hours of mentoring with an endorsed PBS Facilitator
5. Endorsement by the Virginia Positive Behavior Support Board as a PBS facilitator
6. Shall conduct a Positive Behavior Support facilitation and plan development during the Intensive Transition Management process. This facilitation will include all members of the team that will be supporting this person when crisis services are terminated
7. The PBS facilitator will guide and support the team in developing a Person Centered Behavior Support Plan that all the team members agree to and can be effectively implemented using the resources available to the team

### **Crisis Supports Navigators (Children's Supports)**

#### Children's Crisis System Navigator

- 1) Shall hold a bachelor or a master degree from an accredited school of social work
- 2) Licensure in Virginia as a Social Worker
- 3) Extensive knowledge of Virginia service systems providing supports to children including but not limited to:
  - i) Education – School systems and DOE
  - ii) DSS
  - iii) Child Services Agency
  - iv) CSB
  - v) DMAS
  - vi) Child Advocacy Agencies
- 4) Experience in providing crisis supports and services to children and youth with ID/DD

#### Responsibilities:

- 1) Will provide comprehensive case management and service coordination for children and youth with ID/DD who are experiencing a crisis event
- 2) Will collect data on the frequency of need and the services available in their localities
- 3) Will build relationships with all stakeholders in their localities to aid families in navigating service systems that support children and youth after the crisis has been resolved
- 4) Will participate in all functions of the crisis services and trainings

- a. Will demonstrate all the Knowledge, Skills and Abilities that are required of a Crisis Coordinator AND
  - b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
  - c. Knowledge of federal, state, and local programs that have been developed for people with Intellectual/Developmental Disabilities including eligibility criteria and how to access these services AND
  - d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities Act (ADA) and their legal mandates as they relate to special education programs and the rights of people with disabilities.
- 5) Operates as primary agent of the Child Placing Agency and has extensive knowledge of therapeutic foster care regulations, process and system what.
- 6) Operates as the primary parent training provider – training other staff to provide the 30 hour parent training as well as providing direct parent training to families

## Attachment C

### Crisis Services for Children Diagnosed with Intellectual or Development Disabilities

Children's crisis services are needed to ensure supports to children and families preferably in their home. These services will be provided by staff who have experience and who are capable of providing appropriate clinical supports to ameliorate the crisis on-site; and determine the need for in-home or other community supports.

- a) Services will include crisis resolution, comprehensive case management, aiding families in navigating service systems that support children and youth after the crisis has been resolved;
- b) Demonstration and training of interventions to the family/caregiver and/or IDD service provider (if applicable) AND
- c) Observation of these interventions by the family/caregiver and/or existing IDD service provider (if applicable)

#### **Requirements:**

- a) Respond to crisis within designated time (1hr Urban, 2hrs Rural) of SPOE dispatch
- b) Address the crisis to mitigate any risk to health and safety on-site
- c) Determine disposition of Support Needs (in-home or out of home services)
- d) Make non-crisis appropriate referrals for follow-up (e.g. community/prevention services, emergency medical, CSB intake, etc.)

#### **Mission:**

To assist Families and their support systems in developing and maintaining a stable and happy home for children who have been identified as having an intellectual or developmental disability.

#### **Target Population:**

People under 18 years of age who have experienced a crisis event that their family and support system needed assistance to resolve.

**Licensed as:**

The program should be licensed under the following categories via DBHDS

07	006	Outpatient Srv /Crisis Stabilization #3	A mental health non-residential crisis stabilization service for adults/children/adolescents
03	013	STARTID Supportive In-Home Srv	A START intellectual disability supportive in-home service for children, adolescents and adults
07	010	Outpatient Srv-ABA	A mental health outpatient community-based applied behavioral analysis service

02	010	DD Day Support Srv #5	An developmental disability day support service for (population served)
02	009	ID Day Support Srv #4	An intellectual disability non center-based day support service for children and adolescents.
16	006	Intensive Care Coordination Service	An intensive care coordination service for children and adolescents

The program should also be licensed by VA DSS as a Child Placing Agency certified to Provide Treatment Foster Care Case Management Services to allow for direct out of home placement of children when needed. (See reference materials at [HTTP://WWW.DSS.VIRGINIA.GOV/FAULTY/LCPA.CGI](http://www.dss.virginia.gov/faculty/lcpa.cgi))

**Services available:**

- 1) Full array of family support and training services that teach ALL members of the extended family system the skills needed to promote wellness and independence. With additional specific skills in how to help with upset events and how to help children learn new skills.
- 2) Recognition of early warning signs of impending crisis events and steps to take avert the crisis as well as teach self-management skills
- 3) Phone support
- 4) In home coaching
- 5) Direct services to child/family/support system:
  - i) Crisis de-escalation
  - ii) Development and implementation of a short term crisis support plan designed to maintain stability while the support systems are activated and strengthened
  - iii) Medical screening and referral for evaluation and treatment of medical conditions

- iv) Family and support system assessment to include development of a comprehensive support plan and teaching how to effectively implement that plan
- v) Behavior assessment and/or Functional Analysis to include direct intervention provided by the crisis staff as well as the development of a Behavior Support Plan
- vi) Parent training
- vii) Intensive in home respite services
- viii) System connection facilitation
- ix) Temporary placement in a therapeutic foster home
- x) Referral to inpatient services as a last resort when needed to assure the safety of the individual, family and/or system of support

**Initiation of Crisis Services:** The primary focus here is on quick de-escalation rather than long term effects. When there is no other viable alternative to assure the safety of the individual and/or family/support system the individual is expected to remain in their home, work or educational setting.

**1. Receive referral contact**

- a. Phone, Fax, E-Mail, IM...."
- b. Develop rapport with person referring
- c. Ascertain if referral is appropriate to children's ID/DD crisis service

**2. Initial triage will determine the following**

- a. If life threatening events are occurring at that moment
- b. The type of crisis
- c. The behavior that pose a risk of harm to self or others
- d. What is currently being done and what resources are on site
- e. What has worked for this behavior in the past
- f. If this is new onset or long standing behavior
- g. If there have been recent medical issues
- h. If there is reason to suspect medical issues as primary driver or contributing in crisis event

### **3. Initial response**

- a. Decide how quickly to visit
- b. Decide who should go on the visit
- c. Decide what equipment and supplies to bring to the visit
- d. Assemble and dispatch the team of responders who go to the location of the individual who is identified as being in crisis
- e. The Team should include
  - i. A medical professional with the capability to quickly rule out immediate biological issues
  - ii. A behavior analyst with the capability to quickly determine the current environmental function of the behavior causing the crisis response
  - iii. A person who can help the family system to process the event, reorganize and begin to make some short term changes
  - iv. A person who has authority to activate additional services as needed
  - v. A person who can provide direct intervention to the person in crisis

### **4. On site triage**

- a. Identify the people involved
- b. Identify the risk level
- c. Identify the resources available
- d. Identify the immediate cause/function of the behaviors causing the crisis event
- e. Set immediate outcome stability criteria (behavior and time)

### **5. Stabilize**

- a. Change environment relative to the immediate cause/function of the behaviors causing the crisis event
- b. Set criteria for moving to next phase (behavior and time)

### **6. Analyze**

- a. Observe individuals response to intervention
- b. Observe supporters response to intervention
- c. Talk with person in crisis and people who support that person
- d. Determine what they indicate the causes were for a progression to a crisis event
- e. Determine what an acceptable short term outcome would be for all parties (stability criteria–behavior and time)
- f. Determine what changes they would be willing to make for the short term (24 to 48 hours)
- g. Conduct a brief review of available documents regarding the person in crisis (MAR, medical HX, case/shift notes etc.)

**7. Generate hypothesis as to cause of crisis**

- a. Assessment of current resources in home
- b. Assessment of environmental function of behavior leading to the crisis
- c. Assessment of resources of family system

**8. Generate short term solution**

- a. Based on assessment formulation of plan to avert additional crisis events for 1 to 3 weeks while secondary prevention efforts are underway

**9. Test the effectiveness of the solution by trying it out**

- a. Crisis staff will implement the proposed solution
- b. If it is ineffective revise the intervention until it has the desired effect
- c. If it is effective, discuss the intervention strategies with the family/support providers to assure they are in agreement with the intervention. Educate and negotiate as needed to obtain agreement as to the intervention that will be implemented
- d. If there are changes to the previous plan, crisis staff will implement the new plan to assure it is effective and repeat the steps above until a plan can be agreed upon that is effective

**10. Short term plan for maintaining stability**

- a. Write out solution that was agreed to and tested
- b. Write out one page instruction sheet that indicates what to do when the individual engages in particular behaviors or when specific events occur
- c. Include steps to take if plan does not appear to be working
- d. Plan may include ongoing services by the crisis team (or portion of that team) on a 24/7 basis until secondary services have been developed and effectively implemented

**11. Handoff to supporters**

- a. Teach the people supporting the person in crisis and/or the person in crisis how to implement each step in the plan
- b. Have the people implementing the supports demonstrate actually doing each step in the plan until they can do it at a level that will maintain stability

**12. Continue to observe** implementation until your previously set stability criteria has been maintained for the time length you previously identified

**13. Treat** any medical issues that appear to have caused or were caused by the crisis event on site if at all possible

**14. Out of home services**

- a. If needed due to in home supports being insufficient to meet the needs of the family system the crisis team will assist with out of home living arrangement
- b. Preference for placement is in the following order:
  - i. Relative
  - ii. Therapeutic foster care
  - iii. Children's crisis unit
- c. As a last resort to protect the individual from harm to themselves and/or protect the family/support system from harm by the individual, the individual may be referred for admission to a psychiatric hospital
- d. Transportation to any out of home services will be provided by the Crisis Program staff unless it is deemed too dangerous to do so

**15. The team that supports the individual will meet within 24 hours of the crisis event**

- a. The goal of this meeting is development/revision to the plan of services and interventions that are designed to build capacity in the family system and avert events returning to crisis levels
- b. Team at this juncture includes the entire family system as well as professionals who were already supporting the individual/family, any extended support systems, educational system, Community Services Board, DD Case Manager, etc.
- c. If the family/support system is not connected with needed services the System Navigator will work with the family/support system to develop and implement a plan to gain access to the needed services
- d. The goal is to develop a comprehensive plan that will build the capacity of the family system to avoid future crisis events as well as to provide the skills that will allow the family to provide the support and guidance to the child that will result in the maximum development of skills and independence possible for that person
- e. If additional information is needed to complete this process the team will assure that the assessments are conducted within one week
- f. As soon as results are available the team will reconvene and decide on the specific services and providers to implement those services
- g. The team will continue to monitor the effectiveness of the supports closely until such time that the data indicates the services/supports have been effective and are no longer needed or can be modified to lower levels of external support

**Staffing:**

All staff in the DDCRS will be capable of responding to an individual of any age who have been diagnosed as having intellectual and/or developmental disabilities. In order to accomplish this, Crisis Coordinators and Community Crisis Professionals will be trained to assure that they have the knowledge, skills and abilities to provide the needed services to all age groups.

**Children’s Crisis System Navigator**

- 1) Shall hold a bachelor or a master degree from an accredited school of social work
- 2) Licensure in Virginia as a Social Worker
- 3) Extensive knowledge of Virginia service systems providing supports to children including but not limited to:
  - i) Education – School systems and DOE
  - ii) DSS
  - iii) Child Services Agency
  - iv) CSB

- v) DMAS
  - vi) Child Advocacy Agencies
- 4) Experience in providing crisis supports and services to children and youth with ID/DD

**Responsibilities:**

- 1) Will provide comprehensive case management and service coordination for children and youth with ID/DD who are experiencing a crisis event
- 2) Will collect data on the frequency of need and the services available in their localities
- 3) Will build relationships with all stakeholders in their localities to aid families in navigating service systems that support children and youth after the crisis has been resolved
- 4) Will participate in all functions of the crisis services and trainings
  - a. Will demonstrate all the Knowledge, Skills and Abilities that are required of a Crisis Coordinator AND
  - b. Advanced skill in crisis intervention, conducting assessments and/or evaluations, and developing interventions using accepted standards of care AND
  - c. Knowledge of federal, state, and local programs that have been developed for people with Intellectual/Developmental Disabilities including eligibility criteria and how to access these services AND
  - d. Advocacy experience and knowledge of the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities Act (ADA) and their legal mandates as they relate to special education programs and the rights of people with disabilities.
- 5) Operates as primary agent of the Child Placing Agency and has extensive knowledge of therapeutic foster care regulations, process and systems.
- 6) Operates as the primary parent training provider – training other staff to provide the 30 hour parent training as well as providing direct parent training to families

**Training:**

Training records are to be maintained, which document that all DDCRS staff have participated in training and passed an examination demonstrating their competence in all crisis protocols and relevant applicable trainings. Mobile team members and intensive support staff shall be trained in but not limited to the following:

- 1) Assessing the crisis
- 2) Onsite operations
- 3) Referral decision criteria
- 4) Person Centered Thinking [HTTP://WWW.DBHDS.VIRGINIA.GOV/ODS-PersonCenteredPractices.htm](http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm)
- 5) Required crisis Physical intervention curriculum (at least one of the following)
  - Crisis Prevention Institute (CPI) [WWW.CRISISPREVENTION.COM](http://www.crisisprevention.com)
  - Handle with Care Behavior Management System, Inc. [WWW.HANDLEWITHCARE.COM](http://www.handlewithcare.com)
  - Mindset [WWW.MINDSETCONSULTING.NET](http://www.mindsetconsulting.net)
  - Safe Crisis Management [WWW.JKMTRAINING.COM](http://www.jkmtraining.com)
  - Human Empowerment Leadership Principles (HELP) [WWW.CAPSCANHELP.COM](http://www.capscanhelp.com)
  - Professional Crisis Management (PCM) [WWW.PCMA.COM](http://www.pcma.com)
  - Safety- Care (QBS, Inc) [WWW.QBSCOMPANIES.COM](http://www.qbscompanies.com)
  - Therapeutic Options of Virginia (TOVA) [www.therops.com/node/12](http://www.therops.com/node/12)

- 6) Cardiopulmonary Resuscitation (CPR), AED use
- 7) First aid
- 8) Documentation standards and expectations
- 9) Basic behavioral principles, analysis and intervention  
[HTTP://WPS.PRENHALL.COM/CHET\\_COOPER\\_APPLIEDBEH\\_2/](http://wps.prenhall.com/CHET_COOPER_APPLIEDBEH_2/)
- 10) FBAD presentation Attached
- 11) Basic Behavioral interventions – see attached, Chapter 5
- 12) Child development [HTTP://CHILDDEVELOPMENTINFO.COM](http://childdevelopmentinfo.com)
- 13) General orientation to helping people. Getting Ready to Help training. See attached
- 14) Characteristics of intellectual and developmental disabilities – genetic anomalies in physical and behavioral characteristics -  
[HTTP://WWW.MERCKMANUALS.COM/PROFESSIONAL/PEDIATRICS/LEARNING\\_AND\\_DEVELOPMENTAL\\_DISORDERS/INTELLECTUAL\\_DISABILITY\\_ID.HTML,](http://www.merckmanuals.com/professional/pediatrics/learning_and_developmental_disorders/intellectual_disability_id.html)
- 15) [HTTP://WWW.NICHD.NIH.GOV/HEALTH/TOPICS/PAGES/INDEX.ASPX,](http://www.nichd.nih.gov/health/topics/pages/index.aspx)
- 16) Current Crisis program training on VA System structure- Specific contacts and roles – specific to region and city
- 17) Review of Local resources for support
- 18) Training Interim crisis and cross system plan development
- 19) Verbal behavior - [HTTPS://SECURE.COURSEWEBS.COM/ABA.FIT/PAGECATALOG.ASPX -](https://secure.coursewebs.com/aba.fit/pagecatalog.aspx)
- 20) Relational Frame Theory - [HTTP://EN.WIKIPEDIA.ORG/WIKI/RELATIONAL\\_FRAME\\_THEORY](http://en.wikipedia.org/wiki/Relational_Frame_Theory)
- 21) DM-ID - [HTTP://WWW.DMID.ORG/ -](http://www.dmid.org/)
- 22) Procedure for discriminating medical conditions in Crisis events and the behavioral effects of various medical conditions –see attached Procedure for discriminating medical conditions
- 23) Precision teaching techniques and discrete trial instruction techniques – [HTTP://WWW.BINDER-RIHA.COM/PT\\_DI.PDF,](http://www.binder-riha.com/PT_DI.pdf)
- 24) Psychotropic medications and side effects listed in Medscape.com -  
[HTTP://REFERENCE.MEDSCAPE.COM/DRUGS/PSYCHIATRICS -](http://reference.medscape.com/drugs/psychiatrics)
- 25) Determining Capacity to consent/ consent process during crisis event – Human rights -  
[HTTP://WWW.VACSB.ORG/MISC/GUIDE%20TO%20CONSENT%202012%20REVISION.PDF](http://www.vacsb.org/misc/guide%20to%20consent%202012%20revision.pdf)

26) Quick Case formulation and treatment planning –

[HTTP://WWW.SPRINGERPUB.COM/PRODUCT/9780826106049](http://www.springerpub.com/product/9780826106049)

27) Checklist for Behavior support plan- development and training others to use- see attached

28) Parent Training – See attached 30 hour curriculum

29) Data collection, display and analysis See attached, Defining and measuring behavior and Excel single subject graphs

The following is a list of required knowledge, skills and abilities for Crisis Coordinators and Community Crisis Professionals.

#### Knowledge

1. Knows the specific crisis program and demographic information about the program
2. Knowledge of characteristics of ID and DD diagnoses
3. Knowledge of role of crisis manager
4. Knowledge of role of the larger team
5. Knowledge of the role of crisis response versus the role of the Individual Support Team
6. Knowledge of how to provide direction over the phone re: utilization of on-site resources to momentarily stabilize the situation
7. Knowledge of how to determine providers comfort with any delay in on site services
8. Knowledge of the effects of known medical conditions on behaviors of an individual
9. Knowledge of the physical and behavioral effects and side effects of psychotropic medications
10. Extensive knowledge of behavioral assessment techniques
11. Basic knowledge of how to teach others to implement behavioral supports/interventions
12. Knowledge of specific environmental changes and how to implement them
13. Good knowledge of behavioral patterns associated with medical and environmental issues
14. Extensive knowledge of a variety of short term interventions
15. Extensive knowledge of data collection and analysis techniques for single subjects
16. Extensive knowledge of available resources, what they can and cannot do and how to activate them
17. Understand that all behavior makes perfect sense from the point of view of the person engaging in that behavior
18. Knows that if you want the person to give up or change their current behavior you need to make sure the preferred behavior pays off better than the unwanted behavior and that if you can at least momentarily change the environment so the person can get what they want , the unwanted behavior will stop
19. Comprehension of typical developmental milestones and capabilities/limitations based on developmental level
20. Comprehension of behavioral effects of various genetic conditions and physical brain insults due to illness or injury
21. Knowledge of the aging process and the effects of aging on individuals with identified genetic conditions and physical brain insults due to illness or injury

## Skills

1. Can quickly and accurately identify self to stressed people
2. Can quickly request and document the identity of person calling
3. Can quickly request and document the location of person in crisis
4. Can quickly request and document the description of crisis
5. Can quickly request and document if individual in crisis has ID/DD label
6. Is able to effectively interview all the people involved in the crisis including calming strategies for the reporter
7. Able to stay focused on immediate crisis issues and defer longer term issues
8. Basic ability to discriminate the effects of known medical conditions on the behaviors that are causing the crisis event
9. Ability to classify the crisis event based on severity of risk to self and others
10. Able to effectively provide direction over the phone re: utilization of onsite resources to momentarily stabilize the situation
11. Able to accurately determine support person's comfort with any delay in on site services
12. Able to match level of risk with level of resources needed to contain the risk
13. Exceptional observation and classification skills – focused on factual information
14. Advanced behavioral diagnostic/behavioral assessment skills
15. Ability to set explicit outcomes based on risk, tolerance of setting and resources
16. Ability to direct other people to take specific actions
17. Skills to identify specific environmental changes and implement them
18. Ability to set specific outcomes
19. Ability to effectively reframe observations and provider feedback into useable information that is understandable by the support people
20. Advanced ability to synthesize and analyze information to come up with coherent(logical) and usable hypothesis
21. Good negotiation skills to develop agreeable outcomes
22. Basic logic skills
23. Treatment planning skills
24. Ability to run a variety of interventions
25. Ability to capture usable data set and evaluate that data
26. Ability to write specific instructions in language provider can understand and follow
27. Ability to develop measurable data set for the provider
28. Able to accurately and briefly describe the events, working hypothesis, intervention effects and ongoing issues that need resolution
29. Ability to provide effective corrective feedback and encouragement
30. Basic behavioral skills training competence
31. Ability to evaluate the provider's performance in providing the skills and determine if additional resources are needed
32. Ability to effectively communicate with people who do not use spoken language
33. Ability to change communication style to accommodate developmental level of the people being served

## Ability

1. Ability to find humor in odd situations
2. A genuine caring and concern for other humans especially those that are in distress
3. Excited by the opportunity to help someone in great distress even if there is some risk
4. Ability to detect and appreciate small changes in behavior that indicate improvement or lack thereof
5. Ability to remain optimistic about other people's behavior -Able to depersonalize any unwanted behavior or actions by the person they are trying to help and continue providing services regardless of the person's behavior
6. Ability to continue working to help another person until successful, able to use multiple approaches and techniques including novel approaches and will continue until successful
7. Ability to be highly creative – very flexible in implementing supports, able to take what an individual indicates they want and find a way to get it for them or an approximation of what they want while at the same time diminishing or eliminating any unwanted byproducts
8. Able to stay focused on outcomes more than the process or form of what they do
9. Able to discriminate priorities for short term and long term outcomes based on the momentary circumstances
10. Ability to make quick decisions without second guessing themselves realizing that not all decisions will be the best one but willing to learn from each crisis' debriefing
11. Able to set explicit outcomes – can quickly identify very specifically what the intervention or support is designed to achieve and how they will know it has been accomplished
12. Ability to become more focused and organized under stress and respond more quickly as a crisis accelerates
13. Ability to continuously obtain more knowledge. Focus on why the situation is occurring and why the intervention put in place either worked or didn't and the ability to use that information to modify the intervention to make it more effective
14. Ability to use feedback provided to them about their performance to improve their own knowledge, skills and abilities

## Attachment D

Training Documents for Children's and General Crisis services