

Children's Developmental Disability Crisis Services Program Standards

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I. OVERVIEW

Children's crisis services in the Commonwealth of Virginia have historically been provided by a network of agencies and providers, each offering a different array of services. One of the missions of the Department is to ensure that needed crisis services are available to all children who are intellectually or developmentally disabled. Equally important is to build a network of supports and services designed to support the work of the crisis teams by addressing those factors that led to the initial need for a crisis response and providing appropriate aftercare options. While each region has tailored their Children's Crisis Services to the specific circumstances of their region, this document will outline a set of standards that will be met and followed by all programs across the Commonwealth. The intent is to create a well orchestrated Children's Crisis Service System that shall:

- Be trauma informed and have specially trained clinicians who recognize the symptoms of trauma, engage people with such histories effectively, and develop trauma-specific plans of care that reflect the needs of the individual.
- Have trained service providers who are knowledgeable about working with children with intellectual and developmental disabilities and their families. This includes expertise in the areas of neurocognitive and behavioral disorders in children, as well as family systems interventions.
- Provide education, training, and other prevention services to reduce the likelihood that the family system will reach a point of crisis.
- Provide crisis assessment and intervention services to children and their families who are in a state of crisis due to the symptoms of a psychiatric disorder or significant behavioral challenge (must meet crisis definition as outlined by the current DMAS medical necessity criteria).
- Work to maintain the child in the home, when doing so is in the best interest of the child, by resolving the immediate crisis and developing a plan of support to increase stability in the home.
- Refer and assist the family in linking the child to various treatment resources, should intervention in the home be insufficient to stabilize the situation and maintain safety for the family system.
- Collaborate with the child's treatment team (i.e. the child, parents and other family members, case manager, school personnel, in-home support

staff) to ensure that the crisis plan generated is adequate to resolve the immediate crisis and reduce the likelihood of future crises emerging.

- Measure outcomes through objective data and modify strategies as needed to meet the above goals.

II. PROGRAM DESCRIPTION

Each of Virginia's five Health Planning Regions (HPR) will operate a service system for children and families in crisis. Each program will be anchored to a specific CSB/BHA, who will be responsible for the fiscal and administrative oversight to the program designed for that region. Children's crisis services shall serve all children up to 18 years of age who have a developmental disability and co-occurring behavioral or mental health need. All five Regional crisis program shall provide a 24/7 crisis response to families with emergent behavioral and/or psychiatric needs. Obtaining a qualified clinical crisis response will occur within 1 hour in urban areas and within 2 hours for areas designated as rural.

Responding clinicians will provide assistance with de-escalation, initial assessment, and a safety plan for the immediate time period following the crisis.

The programs will also develop and implement crisis intervention plans in collaboration with the natural and professional support system to ensure effective implementation, link the family to additional services when needed, provide follow up, and work with the system of support to increase their knowledge of the individual's behavioral, psychiatric, and psychological functioning. The programs will also provide and/or facilitate training that the community deems necessary to better serve children with intellectual and developmental disabilities.

A. Definitions/Criteria

1. Developmental Disability:

Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a

developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. Admissions Criteria

Children's Developmental Disability Crisis Services as discussed in this document are open to all children and youth up to the age of 18. Children served under these standards must have a developmental disability. While children without a diagnosis of a developmental disability of some type may be served through regional programs as discussed in these standards, it is the mission of the Department to ensure that **all** children with a DD diagnosis are provided with comprehensive crisis services.

Additionally, all children served through the Children's Crisis Programs must meet medical necessity criteria as defined by Department of Medical Assistance Services (DMAS). Medical Necessity is defined as those services which are reasonable and necessary for the diagnosis or treatment of an illness, condition, injury, or to improve the function of a disability, consistent with community standards of medical practice.

3. Exclusion Criteria

Youth who are actively abusing substances and are in need of medical detoxification will be referred and linked to that service. While an initial crisis response will be available, intervention will be geared toward accessing appropriate medical treatment.

4. Discharge Criteria

Effective crisis intervention services are by their very nature intended to be short term. Effective crisis services strengthen the existing support system and build the coping skills of the individual so that he/she can weather the daily stresses of life in a healthier way. Therefore, discharge from the crisis service is a measure of success. The decision to discharge an individual from crisis services should grow from a dialogue between the family, the existing treatment team, and the crisis service team. Discharge is likely appropriate when calls to the crisis line have been eliminated, school attendance is regular and not interrupted by behavior management interventions, the crisis plan has been in place for at least 15 days and has proven effective, and the child and family have been linked to services that will work on long term treatment and stabilization goals. Once a child is discharged from services, a written discharge summary will be completed within 7 business days.

5. Children's Crisis Service Advisory Council

The Children's Crisis Service Advisory Council consists of representatives from each of the CSB's located within the five Health Planning Regions. Representatives from school systems that provide programming to I/DD children will also be encouraged to participate. Additionally, private providers who are partnering with the fiscal agents administering children's crisis services will be represented on the council, along with family members or others who may represent an advocacy perspective.

The Council will meet quarterly either face-to-face or by conference call. The purpose of the Council is to ensure that a coordinated service system is developed, maintained and sustained by regular and plenary communication between CSB's and other stakeholders. The primary tasks of the Council are to regularly review service delivery, identify gaps and develop strategies for effective resolution; ensure that the resources of the partners are being used efficiently and effectively, and problem solve implementation issues that arise during the period of service under review.

B. Licensed Services

Children's Crisis programs are licensed by the Department of Behavioral Health and Developmental Services to provide an array of services including: ID Crisis Stabilization, ID Crisis Supervision, MH Crisis Stabilization, and MH Crisis Intervention. Data (see section 3.F.) will be collected by all Children's Crisis programs on services delivered and will be reported regularly to DBHDS.

1. ID Crisis Stabilization/Supervision:

Service Description:

Crisis stabilization is direct intervention (and may include one-to-one supervision) to persons with MR/ID who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained during and beyond the crisis period.

Service Objectives:

The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement.

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

Service Credentials:

A crisis stabilization clinical or behavioral intervention services provider must be licensed by DBHDS as a provider of outpatient services, residential services, supportive residential services, or day support services. In addition to meeting the above licensing requirements, the clinical services provider must employ or utilize qualified mental retardation professionals (QMRPs) (QIDP) licensed mental health professionals, or other personnel competent to provide clinical or behavioral interventions. These might include crisis counseling, behavioral consultation, or related activities to individuals with MR/ID who are experiencing serious psychiatric or behavioral problems.

The face-to-face assessment or reassessment required to initiate or continue this service must be conducted by a QMRP (QIDP).

The QMRP (QIDP) providing crisis stabilization services must have:

1. At least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities.
2. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; or a bachelor's degree in another field in addition to an advanced degree in a human services field; and
3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. To provide the crisis supervision component, providers must be licensed by DBHDS as providers.

<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={0E2B1682-F345-43CD-87EA-27ECF5CA3884}&impersonate=true&objectType=document&id={439DA59B-0E7B-46D8-9671-9338F477F071}&objectStoreName=VAPRODOS1>

2. MH Crisis Stabilization:

Service Definition:

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation.

Service Objectives:

The goals are to avert hospitalization or hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

Service Credentials:

Crisis Stabilization providers must be licensed by DBHDS as a provider of Nonresidential Crisis Stabilization or Residential Crisis Stabilization; Crisis Stabilization services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified Prescreener.

<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={55A77B4E-28A7-4A9C-B6E5-7DA9C2D71E5C}&impersonate=true&objectType=document&id={CF8A90C3-1055-42B0-9996-58108B375E18}&objectStoreName=VAPRODOS1>

3. MH Crisis Intervention:

Service Definition

Crisis intervention shall provide immediate mental health care, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention.

Crisis intervention services must be available 24 hours a day, seven days per week.

Service Objectives

- Prevent the exacerbation of a condition
- Prevent injury to the individual or others; and
- Provide treatment in the least restrictive setting.

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

Service Credentials

Crisis Intervention providers must be licensed as a provider of Emergency Services by DBHDS; Crisis intervention shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener.

<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={55A77B4E-28A7-4A9C-B6E5-7DA9C2D71E5C}&impersonate=true&objectType=document&id={CF8A90C3-1055-42B0-9996-58108B375E18}&objectStoreName=VAPRODOS1>

C. Service Description

All children's crisis programs in the Commonwealth of Virginia are licensed by the Department of Behavioral Health and Developmental Services. Ultimately, each region will have a service system in place that includes all of the following components: mobile crisis response, in home support to implement elements of crisis stabilization plans, availability of residential crisis stabilization beds (respite beds) and accessibility to training and expertise within the areas of behavioral treatment, childhood psychopathology, Autism Spectrum Disorder, Developmental Disability, and the development of individualized plans for crisis prevention.

1. Required Elements

Although comprised of services from various agencies that are regionally operationalized, Children's Crisis Services will provide the following service elements:

- Accessibility to children's crisis services 24 hour services, 365 days of the year
- The ability to respond to the location of the crisis or to an agreed upon location within 2 hours in rural areas and within one hour in urban areas
- Clinical staff who are well trained to work with ID/DD children and youth with co-occurring mental health and behavioral symptoms, including the development and implementation of crisis intervention strategies.
- Access to a central point of contact, who is familiar with the entire service array of the region and can link families with appropriate services once the initial crisis has resolved.
- Provision of specialized and individually tailored training provided to families, school personnel, mental health clinicians, and others who work and live with children with ID/DD and co-occurring mental health disorders.
- Development of Crisis Education and Prevention Plans.
- Provision of post crisis services to support the implementation of crisis stabilization interventions, as well as to ensure that the crisis is fully resolved before reducing services.
- Development and maintenance of MOUs between CSBs and other community partners to meet the needs of the treatment population.

2. Referral, Intake and Assessment

Written and/or telephone referrals will come to the Child Navigator or designee. If a telephonic referral is received, it must be documented on a referral form. Calls for general information that are NOT in relation to a specific individual need not be documented in writing.

Children's crisis receives both emergent and non-emergent referrals from a variety of sources, including community providers and case managers. Referral sources are contacted by Children's Crisis Team Members when the referral is received and follow-up is initiated. This takes place within 24 hours or on the next business day. Intakes into the Children's Crisis program are scheduled within 10 business days of the initial contact with the referring party. When they occur, exceptions to the 10-day rule are made to accommodate the referring party. In the event that a referral source does not respond to multiple attempts to schedule an in-person intake assessment, a letter will be sent to the referral source reminding them of the need to schedule the intake appointment. If there is no response to this correspondence within 15 days, then an additional letter will be sent indicating that the continued lack of response will result in the case being closed. Such letters will include a specific date by which the referral source must reply to retain the case on open status.

If the referral is crisis in nature, the response will occur more immediately. The on-call clinician will respond to the site of the event or an agreed upon location within 1 to 2 hours and will complete a crisis assessment at that time. This will ensure that the individual is admitted to children's crisis services without delay, and a more formal intake process will be scheduled after the immediate crisis has passed. In the event that the crisis resolves with an admission to a psychiatric inpatient unit, children's crisis services will continue to be involved and actively working through the intake process to the extent possible so that the individual may access transitional services as they return to the community.

Elements of an intake/admissions process must include the collection of demographic data, completion of release and consent forms, basic medical information, the creation of an initial crisis plan, and orientation to Children's Crisis services. Intakes are conducted through a face-to-face meeting that includes Children's Crisis staff, the individual, family, case manager, and as many other members of the individual's support team as possible. To supplement the elements noted above, additional clinical assessment procedures, gathering of medical records and previous psychological evaluations, and information regarding psychiatric history are obtained during the intake process. The intake/admissions process allows for active collaboration between the individual and his/her team of

providers, and should include as many members of the individual's care network as possible.

It is expected that a provisional crisis education and prevention plan (CEPP) be completed within 15 days of admission to the Children's Crisis program or at the conclusion of the crisis intervention plan, for those individuals who come into services initially as a result of a crisis event. While it is understood that initial plans will not be as comprehensive as is optimally desired, they will be sufficient to provide timely support to the system while additional information gathering and discussion are occurring. Although all CEPP's are considered to be working documents that will evolve over time, it is expected that a "final" plan will be available to the support team within 45 days of its initiation. Crisis education and prevention plans must include the following elements:

- a detailed summary of the current crisis event, including both immediate and remote antecedents, if known;
- information regarding current mental status;
- psychiatric and medication history;
- active medical problems, both chronic and acute;
- recent stressors;
- strengths;
- specific objectives related to increasing adaptive behavior;
- individualized interventions to support meeting defined goals;

The responsibilities of each regional children's crisis Navigator must include: reviewing all crisis call information maintaining a high level of knowledge about services and providers throughout the region, linking families to appropriate services, and paving the way for this linkage to be successful (i.e. explaining the nature of the services that are available, ensuring that the receiving agency receives adequate background and referral information, setting up initial appointments for families, explaining reimbursement procedures, etc).

3. Community Crisis Response

"Crisis" is defined as a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress; or any situation or circumstance in which the individual perceives or experiences a sudden loss of his/her ability to use effective problem-solving and coping-skill

<http://www.dbhds.virginia.gov/library/document-library/chapter%20105%202013.pdf>

Calls for mobile crisis response for children may come from a variety of sources. These sources include: CSB Emergency Services, Department of Social Services, schools, pediatricians, community providers, families, law enforcement, and the juvenile court system. Each Health Planning Region has established a framework to create a 24/7 crisis line to be maintained, allowing for a single point of entry into crisis response services.

This crisis line provides direct access to an on-site response when the need for this is indicated. In general, the children's crisis service operates from the point of view that on-site responses are most often necessary. However, there will be cases when they are not clinically advisable, such as when telephone only consultation is sufficient to resolve the situation. However, whenever a child is beginning the TDO process (pre-screening) and the children's crisis program is notified, an on-site response is required. Each regional program will be responsible for ensuring that this system is implemented appropriately and consistently across all CSB's within their geographic area of responsibility.

To build a well-coordinated system of crisis response, each area within the five HPR's will document all calls related to children's crisis services on a triage/crisis response form. Please note that triage forms must be completed, even in the event that services are not ultimately provided. A triage form will be used for follow-up and tracking and will collect at least the following information:

- The date and time of the call
- Basic demographic information about the individual, including diagnosis
- The source of the call (i.e. family, DSS, school, etc)
- The nature of the crisis or problem
- The time of departure to a face to face response
- The arrival time to the site of the crisis
- Documented consultation with all parties involved, if such consultation is necessary
- Summary of resolution, including plans for follow up and referral

Each of the five regions will support at least one fulltime position, called a Navigator for the purpose of this document. One of the primary responsibilities of this position is to follow up with family after an initial

crisis to ensure that services were implemented appropriately and that no additional support, beyond linkages to other services, is needed.

4. Daily Triage Phone Consultation

Every weekday morning, the Navigator or designee will facilitate a triage call with all crisis staff on call during the past 24 hours. The purpose of the call is to review on-call activity and plan for follow-up, discuss crisis plans and discharges and have an opportunity for general clinical consultation. Minutes will be maintained. A call log will be maintained to provide information about each call that is received as well as any notes taken as a result of the call. Additional information will be entered into the EHR so that it becomes part of the clinical record. Daily triage calls will help to ensure a truly coordinated system of care and will facilitate information and resource sharing while building a more cohesive team.

5. Crisis Calls/Response Process

In order for community partners to be able to contact Children's Crisis, there is always at least one designated Children's Crisis Mobile Crisis Team Member on call for each region 24 hours a day, 7 days a week.

Crisis calls come from a variety of sources. Although not an exhaustive list, Children's Crisis Services may receive emergency calls for assistance from: CSB Emergency Services, Hospital Emergency Departments, Mobile Crisis Teams, Clinical Homes, Community Providers, Families, Law Enforcement, and the individuals needing assistance or experiencing the emergent situation.

- a) Should the Children's Crisis program receive a call directly from a provider other than CSB Emergency Services or from the individual his/herself, upon completion of that call, the Children's Crisis Team Member or the provider may collaborate with Emergency Services for their assistance/involvement.
- b) If the Children's Crisis Team Member feels there is imminent danger they should immediately call 911 or instruct the caller to contact 911. Children's Crisis staff will present to the site of the call as soon as possible to assist in supporting the individual, assisting other responders with information or consultation, and ensuring that there is communication with the point of final disposition.
- c) Children's Crisis personnel do NOT supplant the responsibility of the local CSB to pre-screen individuals for inpatient admission. However, Children's Crisis personnel will support the pre-screener by responding to the call

with the Emergency Services worker. Should an in-person response be clinically contraindicated, this rationale will be clearly documented on the call log and in the individual's EHR if they have been admitted to the Children's Crisis program. However, follow up to ensure that the clinical issue is appropriately addressed is required as is follow-up with DBHDS to ensure follow up has been effective. Dependent upon reason for clinical contraindication, a plan will be developed to mitigate any contraindication of future Children's Crisis involvement. When aware of the situation, if an ECO or TDO is issued, crisis staff will remain with the individual until an appropriate bed is located or the individual is stabilized within the emergency room setting. Children's Crisis staff will attend the initial hearing, either in person or via telephone, and will maintain weekly contact with the individual and hospital staff for the initial duration of the admission. For those admissions extending beyond three months, monthly contact will be maintained but will be increased to weekly as the individual approaches discharge. Children's Crisis staff will also participate in monthly team meetings and discharge meetings unless there is a specific contraindication for this involvement. Attendance at team meetings may be combined with individual visits as needed. Whenever a children's crisis staff visits with an individual during an inpatient stay, a consultation note documenting the visit, pertinent mental status information, and any recommendations made to hospital staff will be completed and a copy given to nursing or social work staff.

- d) When children's crisis staff accompanies an Emergency Services worker to assess an individual, the Children's Crisis Team Member will complete a triage form to document:
- Demographic information about the individual in distress
 - The presenting issue or reason for the call
 - The children's staff receiving the call
 - The time of the call
 - Consultation with all parties involved, if necessary, to determine nature of the crisis
 - The outcome of the call
 - The name and signature of the responding clinician
- e) After a crisis call is received, Children's Mobile Crisis Team Member(s) will arrive within two hours for calls within rural areas and one hour within urban areas. Written elements of the assessment will be minimal due to the critical nature of the call and will include a triage form (see elements above), release of information, and a written crisis assessment only.

- f) All calls and initial interventions will be documented on the triage form with additional documentation entered into the individual's EHR to ensure the completeness of the clinical record.
- g) All calls coming into the crisis line will not require an on-site response. There are times when such responses are neither efficient nor clinically indicated. The following are potential reasons why an in person response may not be indicated:
 - a. when the person experiencing an emergent situation is placed in a different setting such a respite facility, crisis stabilization unit or alternate residential setting (i.e. family member; friend; etc)
 - b. when the caller (individual, family member, provider) makes it clear to the Children's Mobile Crisis Team Member that immediate response is not requested
 - c. when the person is identified as not being eligible for Children's Crisis services
 - d. when over the phone consultation is sufficient to mobilize the individual's coping skills and mitigate the crisis.

Following a crisis response, if the individual is not already enrolled into Children's Crisis Services, contact is made with the support system in order to initiate a referral.

6. Crisis Prevention/Community Education

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. The use of crisis services most often follows severe maladaptive behaviors on the part of the child (e.g., assault or property destruction or serious self injury), resulting in the entire family system experiencing stress. Crisis prevention planning can provide a long-term strategy to assist families in building more effective coping skills so that high stress situations are dampened before a crisis emerges.

Each region operates a service system that supports the child and family through the immediate crisis and works with the system to build a plan of prevention. Prevention services must include at a minimum:

- Effective training of the system of support on best practices for working with the individual child. This training should be offered to all members of the support team (family, school, other community partners).
- A training plan that provides education to the larger system in order to build expertise and capacity to serve children with intellectual and developmental disabilities effectively. Trainings should be offered regularly to be responsive to the requests of

stakeholders, and include a mechanism for evaluating the quality of the training.

- In home supports to ensure that the family achieves competence in implementing elements of a crisis stabilization plan, behavioral support plan or other professionally recommended interventions.

Additional prevention activities may include linking the family to on-going treatment options (i.e. family therapy, behavioral intervention; occupational interventions), teaching the child effective coping strategies, and/or working with the child's IEP process for improved support at school.

a) Prevention Calls

Often times, calls will come into the crisis line, although they are not crisis in nature. Rather, they reflect the daily challenges and stressors that individuals or families will experience as they navigate their social environment. At these times, Children's crisis staff can intervene to assist the child or their family with problem solving, providing reassurance, or coaching them through the application of a coping skill that they are working to develop. These types of responses are vital to building independence and personal self-efficacy. They also provide natural opportunities to practice implementing coping skills in response to real stressors. These calls are preventive in nature, both because they focus on skill building and because they help the person address the immediate situation before it escalates.

b) *The Crisis Education and Prevention Plan (CEPP)*

The CEPP is an individualized, client-specific written document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the circle of support to assist the individual in addressing problems in a healthy way while teaching healthy coping skills that the individual can apply independently.

The CEPP serves as the foundational document that explains the rationale for various interventions and describes those interventions operationally so that they can be implemented effectively by the system of care. Every individual who receives crisis services will receive a CEPP. Occasionally, there may be a situation when a CEPP is not needed. Children's Crisis team members facilitate individual Crisis Education and Prevention Planning meetings. Ideally, meetings are scheduled within 7 days of receiving the initial referral and are conducted as soon as possible

thereafter. These meetings are scheduled so as to include as many of the individual's support network as possible. Team members should include the children's crisis staff, the individual, the family, and other community partners. The purpose of the meeting is to gather information, discuss goals, and begin to develop a plan to assist the individual and his or her caregivers during times of difficulty. Following the initial meeting, children's crisis staff will complete additional assessments, interview informants, and do behavioral observations within the individual's primary settings.

Crisis Education and Prevention Planning meetings are scheduled within 7 days of referral and are held as soon as practical. A full and comprehensive CEPP should be written within **45** days of initiating the process. The CEPP is considered to be a working document, and it is to be modified as needed and reviewed frequently to ensure all elements of the plan are understood by the support system and are effective. It is expected that this document will be referenced frequently during the early stages of intervention such that the language of the plan becomes incorporated into the individual's daily life.

c) Community Training

Building the capacity of the community to work effectively with children and youth with co-occurring developmental and mental health needs is imperative to crisis prevention. Each region has developed a training plan that provides education to the larger system in order to build the expertise needed to serve children and families with intellectual and developmental disabilities. Training plans ensure the development of an array of educational opportunities for families and providers within their communities. Approaches for implementing this service will be based upon the needs of the region, while taking into consideration training resources already in place. The Regional REACH program/Child Mobile Crisis Program and Advisory Councils or their designee will be responsible for assessing the training gaps in their region, developing training materials and conducting workshops, as well as coordinating the delivery of trainings by topic experts outside of the home agency. Trainings must occur regularly, be responsive to the needs that data identify as well as requests of stakeholders, and include a mechanism for evaluating the quality of the program. Additionally, sessions may include, but are not limited to, the following topics:

- Childhood behavioral disorders
- Trauma in childhood
- Intellectual disability in children
- Crisis intervention strategies
- Basics of functional assessment

- Basics of behavioral intervention
- Understanding Autism
- Effective Parenting
- Mental illness in childhood

d) Outreach (systemic)

Each Regional Program, along with the clinicians assigned to the crisis response teams, will consistently engage in community outreach to community providers, the school system, law enforcement, and other community partners who interact with children with ID/DD and co-occurring behavioral health disorders. This outreach will take the form of attending meetings, providing printed information about children's crisis services, and conducting informational sessions about services offered and how they can benefit the family system.

7. Follow-Up

All children's crisis programs will provide follow up services to families they are with whom they are actively working. Cases opened to the children's crisis service system will receive at least monthly phone calls for a period of 90 days following the end of the crisis plan to ensure that the child's system is still stable. Referrals to additional services may be recommended when needed and technical assistance through the initial process offered. Follow up services can be extended 90 days when indicated.

Additionally, families will be encouraged to complete a satisfaction survey related to their experience with crisis services. This may be completed either over the phone, mail or electronically. Surveys will ideally be sent to providers within 7 days after a crisis plan ends.

8. Emergencies and Use of Restraints

Each regional children's mobile crisis team maintains a plan of action for appropriate staff response to psychiatric, behavioral, medical and/or other emergencies that place individuals in imminent danger of harm. The fiscal agents of these programs all have agency policies and procedures for the use of physical management in emergency situations. All physical management programs in use throughout the CSB's and Health Authorities acting as fiscal agents for children's crisis programs are licensed by the Department of Behavioral Health and Developmental Services.

All children's mobile crisis team members are trained in their agency's physical management program and will receive annual retraining to ensure skill retention.

9. MOU

One of the most critical MOU functions is to develop a crisis support continuum. This includes development of agreements and collaboration with mobile crisis teams and first responders for increased diversion and collaboration with hospitals regarding admittance and discharge planning and transition.

III. Staff Qualifications

The Children's Mobile Crisis Teams consist of qualified staff who are educated and trained to provide services to individuals with DD. Children's Mobile Crisis Team Members are qualified to provide:

- Crisis assessment, stabilization & intervention;
- Symptom assessment & management;
- Consultation and training to individuals, families, and other service providers;
- System linkages;
- Support services or direct assistance to ensure individuals obtain the basic necessities of daily life.

The Child Navigator is responsible for ensuring that the Children's Mobile Crisis Team members comply with minimum licensure guidelines and demonstrate core competencies as related to crisis services, mental health disorders, and developmental disabilities. To facilitate this, DBHDS in conjunction with the regional partners have developed a set of core competency trainings to ensure that a well-informed and knowledgeable workforce responds to crisis situations and is available to provide effective treatment and follow up care. All newly hired children's crisis staff must complete a structured training and mentoring program to ensure that they are sufficiently trained to meet the service standards listed above. While additional training related to general operating procedures, agency-specific practices and documentation is included in the orientation of Children's Crisis staff, structured training is provided in the following areas, according to the timelines specified:

1. To be completed within 30 days of hire
 - Introduction to the Children's Crisis program, including history, mission of the program, roles within the team, documentation requirements,
 - Introduction to crisis assessment and intervention planning
 - Introduction to Developmental Disability, including Autism and dual diagnosis
 - Introduction to Trauma Informed Care
2. To be completed within 60 days of hire
 - Introduction to waiver services and the different waivers available

- Introduction to the Mental Status Exam
 - Assessing and evaluating symptoms and behaviors
 - Medication and medical causes of behavior
 - Developing long-term goals and treatment planning
3. To be completed within 90 days of hire
- Orientation to the Diagnostic Manual
 - Orientation to family systems and ECO maps
 - Orientation to Systems Theory, including working with the interdisciplinary team and communication strategies between systems
 - Behavioral interventions, including overviews of Positive Behavior Support, Applied Behavior Analysis, and behavioral management
 - Discussion of special populations (i.e. forensic issues, trauma, and sexual reactivity).

For each content area noted above, staff must complete and pass an objective comprehension test. While formalized training as outlined above serves as the minimum necessary to prepare staff to provide crisis and prevention service, completing these is not sufficient to ensure competency across areas. Therefore, in addition to the tasks outlined above, in-coming Children's Crisis staff must complete a process of supervision and mentoring. This process must include at a minimum:

- Weekly individual supervision for the first 90 days of service
- Group supervision twice per month for the first 120 days of hire
- Shadowing of at least 6 in person crisis responses, with three of these being purely observational and three being handled as a team
- Observation by clinical staff of at least 6 in person crisis responses in which the new staff independently (to the degree appropriate) provides the assessment and intervention
- Observation of at least two trainings conducted by Children's Crisis staff and delivered to family or other community partners.
- Completion of one training provided to family or other community partner that is observed by licensed clinician or supervisory staff
- Development of a formal case presentation, prepared under the direct supervision of a licensed clinician, and delivered to the larger Children's Crisis Team for peer feedback (to be completed within the first 90 days of service)
- Review and feedback on all Crisis Education and Prevention Plans by licensed or licensed eligible staff for the first 120 days of service

The above activities must be completed and documented in the employee's personnel record. The trainings and supervision practices as described in these

standards ensure that competencies are grown over time. However, just as important as developing competencies is establishing that staff retain high levels of competencies throughout their service to the program. Therefore, after completing their first year of satisfactory service, all Children's Crisis staff will receive the following supports:

- At least 15 hours of continuing education in topics related to mental health, trauma informed care, intellectual disability, developmental disability, behavioral supports or related topics. All training should be commensurate with the level of expertise of the receiving staff.
- Direct observation of clinical service delivery with feedback provided at least every 6 months for all clinical staff. At the discretion of the Child Navigator, this requirement may be made less stringent for those staff with a proven track record of success within the program.
- Review of written work (CEPP's, progress notes, crisis assessments, etc.) at least yearly with written feedback provided of all reviews.

IV. MONITORING AND EVALUATION OF SERVICE QUALITY:

It is expected that each program will be invested in providing a high quality of service to children and their families and resolving problems that may arise along the way. More formalized quality monitoring will include:

- Participation in the DBHDS Quality Monitoring Tool process

A. Data Collection

All data will be entered into and maintained by the statewide Data Store. Each Region will receive system user licenses for 2 data entry users, (more available at additional costs that are program incurred) to facilitate efficient data entry. Data elements related to the tenets of the DOJ settlement agreement will be documented in the Data Store, with reports built from this source available at the Department's request. Additionally, each Regional Program will track trends in the use of crisis services and gather information about the population served (i.e. age, nature of disability, geographic area, etc) in their respective Health Planning Region. In addition to establishing needed clinical information, these data will be useful in service and financial planning. Data elements related to crisis response will be entered into the Data Store within 5 business days of the end of the crisis event. Requests by DBHDS for additional data will be responded to promptly.

B. Complaint Process

All children's crisis programs are committed to providing the best possible quality of service. To maintain this commitment, each program must follow their own internal process and policies and procedures for

investigating and resolving complaints. This includes reporting to agency internal advocate and or Human rights advocate as appropriate.

Following are expectations for the complaint process in addition to each regional existing process:

1. Each Region will develop a complaint form that is offered to any stakeholder of family member who is expressing a significant concern.
2. Complaint forms must include space for the nature of the complaint, what was done to resolve it (if applicable) and the name and contact information of the person making the complaint.
3. Completed complaint forms will go to the Fiscal Agent of the program or designee. A copy should be submitted electronically to DBHDS. DBHDS will not respond to complaints at this level but will use the information for tacking purposes.
4. Anonymous complaints may be used for information purposes by the Fiscal Agent if desired but do not need to be submitted to DBHDS unless special circumstances are evident.
5. Upon receipt of the written complaint, the Fiscal Agent or designee will make contact with the agency, provider, or family making the complaint. This initial contact should be made within 48 hours of the complaint being received. Next steps should be determined and documented on the complaint form.
6. Within 10 days from the point of initial contact a resolution should be presented to the complaining party. If this is accepted, the case is closed. If no resolution is garnered, the complaint should be forwarded to the Director of Community Support Services or designee.

Children’s Crisis Contacts can be found at:

<http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/crisis-services>