Clinical & Crisis Services

I. Priorities – What to Keep

A. The complete Vermont Crisis Intervention Network (VCIN) program.
B. All current Agency Crisis support beds
C. Designated Agency and Specialized Service Agency Crisis response programs. I.E. DS Agency pager systems
D. Retain all current Hospital and Emergency Room staffing that have demonstrated expertise in recognizing psychiatric conditions versus simply determining that an act is due to behavior only

II. Priorities – What to Explore

A. Increase local/agency crisis bed capacity
B. Expand agency expertise for crisis response
C. Recruit clinicians who are open to working with individuals who are served by the DS system
D. Create a system that allows Designated Agencies and Specialized Service Agencies to share good support practices with each other

III. Summary Sheets

A. Ideas to Move Forward
    1. Would like to have more prevention/proactive – not reactive
    2. Large portion of folks we serve have had traumatic experiences
    3. Should build these programs proactively
    4. "Crisis bed" – more than just a bed. Creates extended opportunities
    5. Self-advocacy is a support. Don't forget more peer supports
    6. Question peer supports for crisis
    7. Come together to develop more training and education for people graduating into the field
    8. Is there any way to tap into One Care funding? Agencies providing lots of free service to hospital
    9. Equity – asking people did you check outside for Medicaid provider with no recognition of whether they are experienced or not. A money driven practice
    10. Dual expertise. DS/MH – what support will best help someone
    11. Explore ARIS ability to do rapid background check

12. Flexibility of mobile crisis – coming to you – Also familiar person (know and trust) Needs to be individualized
13. Some Agencies – Case Manager on call 24/7
14. All comes back to funding
15. Focus on prevention and connect to "How do you make a meaningful life?" Get them connected to people
16. Early intervention
17. Somewhere to catch them
18. More (Too much focus) on credentials tied to name. Don't Pidgeon hole people into degrees. There are many skilled non-mastered people
19. MORE TRAININGS of all kinds

IV. Work Sheets[1]

A. What is Working / Want to Preserve [red dots]

Clinical

1. Preserve access to clinical supports locally with people who have enough time to build relationships (therapeutic) with expertise (DD experience) +1 [5]
2. Maybe group therapy if needed – more preventative lower end stuff
3. Preserve clinical supports in individual budgets [1]
4. More therapists using facilitative communication therapy during therapy
5. Starting to be greater focus on medical needs [1]
6. Lots of equine and music therapy
7. DBT groups (positive feedback) with trained therapists +2
8. Regular medication checks for anxiety [1]
9. Strategies from Doctor (calming, breathing for panic attacks) [1]
10. Self-advocacy helps people feel less isolated [4]
11. Keep having nurses at Agencies – Attend psychiatric meetings +1 [1]
12. Keep having requirements for annual check up to include mental health screening
13. ABA supports [2]
14. Alternative therapies, massage, tapping, yoga, OT/sensory approach [2]
15. Access mobile consults, VCIN [2]
16. Expanded HCBS funding [1]

[1] The "+ number" indicate the number of times a concept was mentioned if more than once. The "[numbers in brackets]" indicate the number of dots (either red or green) used to prioritize the concepts.

17. Trauma informed care trainings. Service Coordinator provided immediate access +2
18. Developing local expertise for staff training for dementia care
19. Include cohesive teams around individuals to develop support plans [1]
20. Preserve – Hospital and Emergency teams more likely to recognize psychiatric conditions. Has changed care [4]
21. In house trained therapists [2]

Crisis Services

1. Caring staff at the Vermont Crisis Intervention Network (VCIN)
2. Opportunities for support breaks (Respite and VCIN) +2
3. VCIN conducts home consultations +1 [3]
4. Medication delivery teams
5. VCIN in total +3 [6]
6. Designated Agency / Specialized Service Agency crisis pager and crisis response system +2 [5]
7. Active response to crisis (staff)
8. Individualized crisis supports with fresh / new supporters +1
9. In house clinical staff support for crisis
10. Training on crisis response at all levels +4 [2]
11. DBT as a clinical tool [1]
12. Detailed crisis plans for each individual as needed +2 [3]
13. Regular crisis meetings with staff and individual or individual's team
14. Teaming responses with mental health / law enforcement / department of corrections [3]
15. Strong clinical staff with expertise
16. Central Vermont Medical Center positive responses [1]
17. Case managers on call 24/7 for UVS
18. Planned and integrated crisis supports. Done in proactive planning [2]
19. Agency crisis support beds [10]
20. Preserve respreads funding for crisis supports [1]

B. What are the challenges?

Clinical

1. Limited access to ABA and behavioral supports for individuals and families. (Not enough preventative with lower level needs) (too much focus on higher needs) +1
2. Traditional clinical interventions not necessarily effective

3. Lack of clinicians with expertise in IDD and offending +4
4. No preventative care / not enough
5. Inconsistent supports by service coordination, based on knowledge Lack of knowledge of supports and the supports available for individuals
6. Not enough trained staff (clinical, community supports, service coordination, home providers, etc.) +1
7. Lack of knowledge and oversight for complex medical needs.
8. Timeliness of supports starting +2
9. Lack of supports for Alzheimer's and dementia (clinical and medical) in early onset +1
10. Distance to specialize therapies +2
11. Communication, facilitated communication, American Sign Language, other languages and cultures – interpreter struggles
12. Lack of training for above communication (ex. I hour interpreter/ day not enough) Leads to lack of communication in crisis +1
13. Not enough times for friends out of country who provide support. Too much isolation. Lonely +1
14. Traditional AA model not a good fit for IDD
15. Lack of access to groups +1
16. More complex needs for people +1
17. Primary care increasingly uncomfortable with prescribing regular due to psychotropic needs
18. Time lack to get clinician up and running once they are located
19. Lack of funding
20. Lack of Medicaid providers/Medicare
21. Finding certified providers for equine therapy limits ability to access. Is the certification needed?
22. Substance abuse expertise and co-occurring issues finding experts familiar with IDD
23. Having waiting lists for therapeutic, especially kids, is a challenge
24. Marijuana – what are people's rights – Hot, Hot, Hot
25. Case load pressures, lack of clinician's time to build relationships.
26. Case managers saying they don't have enough time
27. Emergency Departments lack of IDD expertise

Crisis Services

1. Self-managing families are left without Designated Agency supports +1
2. Individuals transferring out of crisis supports before baseline is achieved +1
3. Emergency Department is unable to diagnose at baseline versus crisis +1
4. Emergency Department does not know DSS / IDD supports in general +1
5. Emergency responders do not understand ASD and non-verbal individuals
6. Crisis placements disrupt normal everyday lifestyles
7. To few resources (i.e., funding and crisis beds) +4
8. To few crisis respite providers +2
9. Background check policy prohibits hiring +1
10. To few therapists who work in the DS system +2
11. More online training around crisis response
12. Dual / Integrated eligibility process issues
13. High cost of staffing / respite for crisis situations
14. Funding caps and resources are not able to meet individual needs in all cases (i.e., out of state placements)
15. Lack of sophisticated principle of support training +2
16. When needing to have individuals transported by supporters when they are dangerous, so that they can access an emergency department for screening. Waiting in the ER is also an issue
17. Psychiatric inpatient supports are limited
18. Presumption of behavior as the issue by non-DS supports (Diagnostic Overshadowing)
19. Proving a crisis need for Equity funding
20. Not enough value in prevention at the State level
21. Non-guardian family is not included in most crisis support planning

C. What do we need to explore / learn about? [Green dots]

Clinical

1. Should we hire psych nurses to supplement and help facilitate. APRN-Advance practice registered nurses [3]
2. Looking at developing regional wellness program to include healthy cooking, mindfulness, art therapy, cooking on a budget, etc. [3]
3. Need more high medical need knowledge [1]
4. Agencies having adaptive equipment to assist with personal care. Ex. Track lift [1]
5. Clinics don't have wheelchair access scales +1

6. Having backup trained staff and crisis plans for people with high medical needs and behavior plans +1 [1]
7. Needs driving services (explore) [2]
8. Expanded agency expertise for crisis +1 [9]
9. Explore better partnerships with educating community with IDD Example; emergency rooms [2]
10. Explore alternative work for people whose traditional jobs are too stressful [2]
11. Explore getting "One Care" to serve outside of Home and Community based services [1]
12. Explore payment options for agencies to provide preventative services to people not on home and community-based services +1 [2]
13. Explore attracting clinicians into our field X1 [8]
14. Are there emerging therapies Vermont is not yet accessing? +1 [1]
15. Explore more oversight and supervision of consumer needs Especially high needs people [1]

<u>Crisis Services</u>

1. Expanding communities to be more inclusive
2. Integrated mobile crisis with expertise (DS, MH, SA, TBI, etc.) +1 [3]
3. Non-verbal skills improvement for evaluators [0]
4. More agency collaboration [2]
5. Look for support / info from Flourishing Communities [1]
6. Increase funding / resources for crisis supports +1 [6]
7. More support for VT Training Consortium activities +2 [0]
8. More vigilance to understanding crisis history in ongoing support provision [1]
9. Explore best / promising practices from agencies and share the information system wide [6]
10. Explore rapid approvals using ARIS to find crisis respite supports [1]
11. Increase local crisis beds +3 [11]
12. Increase VCIN beds [1]
13. Explore other responses (i.e. peer supports)
14. Build capacity / training for supporting individuals with DS/MH/TBI/SA/etc. (psychiatric beds) [3]
15. Adventure based therapy