



# **NASDDDS Annual Meeting**

## **November 12 – 14, 2003**

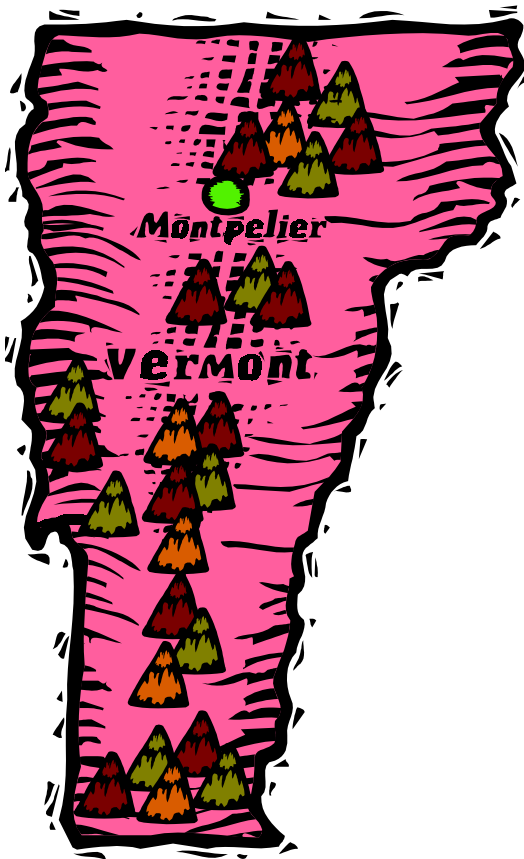
---

**Building a System that is  
Responsive to Crises:**

***Vermont's Experience***

# A Bit of Background About Vermont

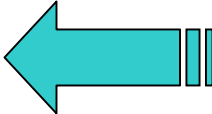
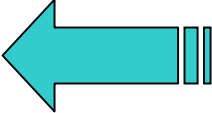
---



- Serve just under 3,000 people
- No state institution
- No sheltered workshops
- No state-run services
- People receive agency-managed, self-managed, family-managed or shared-managed supports

# What Do We Mean by Crisis?

---

- Medical
- Behavioral 
- Psychiatric/emotional 
- Forensic
- The list goes on....

This presentation will focus on these two areas.

# Prevention First

---

- Restraint free system isn't a reality yet
- Focus on supportive vs confrontational approaches
- Vermont's evolved from "Guidelines on Restrictive Procedures" to "Behavior Support Guidelines"

*"I think that any approach that enhances a person's sense of values and dignity is worth a lifetime of trying. Behavior change should be seen as growth rather than a series of defeats and surrenders."*

*- Herb Lovett*

# Protection is Paramount

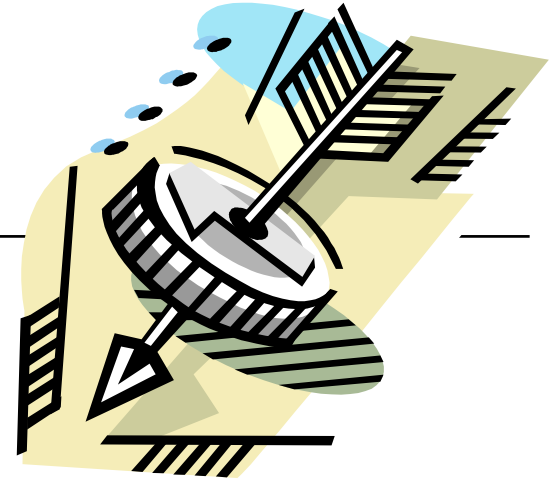
---

- A person in crisis is not trading treatment for civil and human rights
- Be specific about what practices are prohibited, for example:
  - Face-down restraints
  - Restraints that rely on pain for control
  - Restraints that restrict breathing
  - Restraints for the convenience of staff
- Professional review committees
- State Human Rights Committee



# Key Points

---

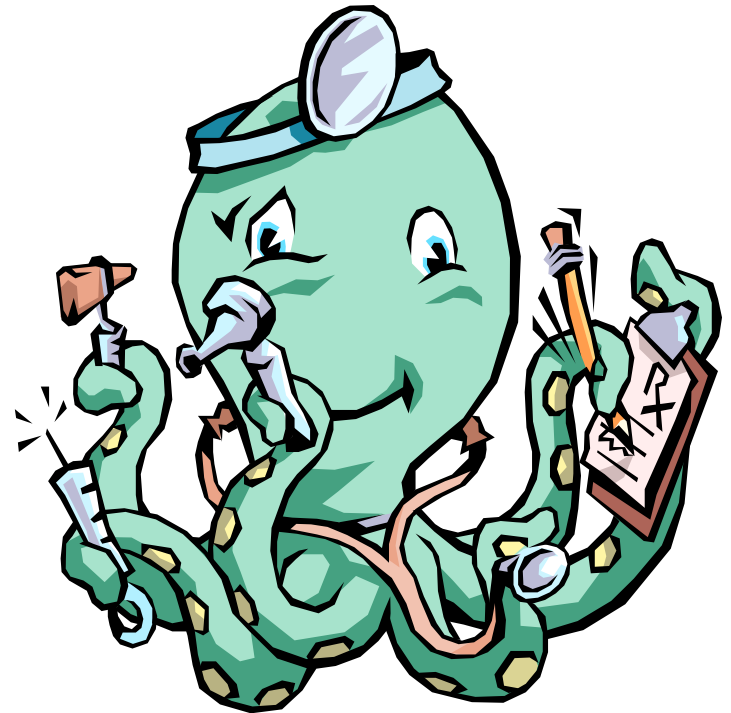


- Building a system that is responsive to crises
- Not the same as building a crisis responsive system
- Individualized approach absolutely critical
- Ownership of issues; “do what it takes” mentality critical
- Expectation of local crisis response
- “Informed” psychiatrists are essential

# What Does an “Informed” Psychiatrist Mean?

---

- Understands that behaviors are symptoms
- Treats the condition; not the symptoms
- Not loners; understand importance of team work
- Willing to accept others as “experts”



# Doctors – Place and Time

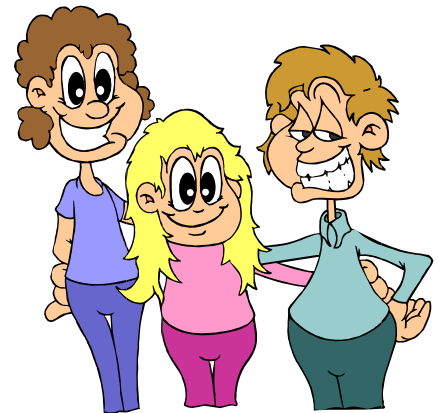
---

- Ph.D.'s or M.D.'s have their place in evaluation, assessment and training
- Direct support professionals have equal role
- Training is essential
- Partnerships need to be developed
  - Local hospitals
  - State hospital
  - Between providers
  - Between State and providers/regions

# Children's vs. Adults' Response

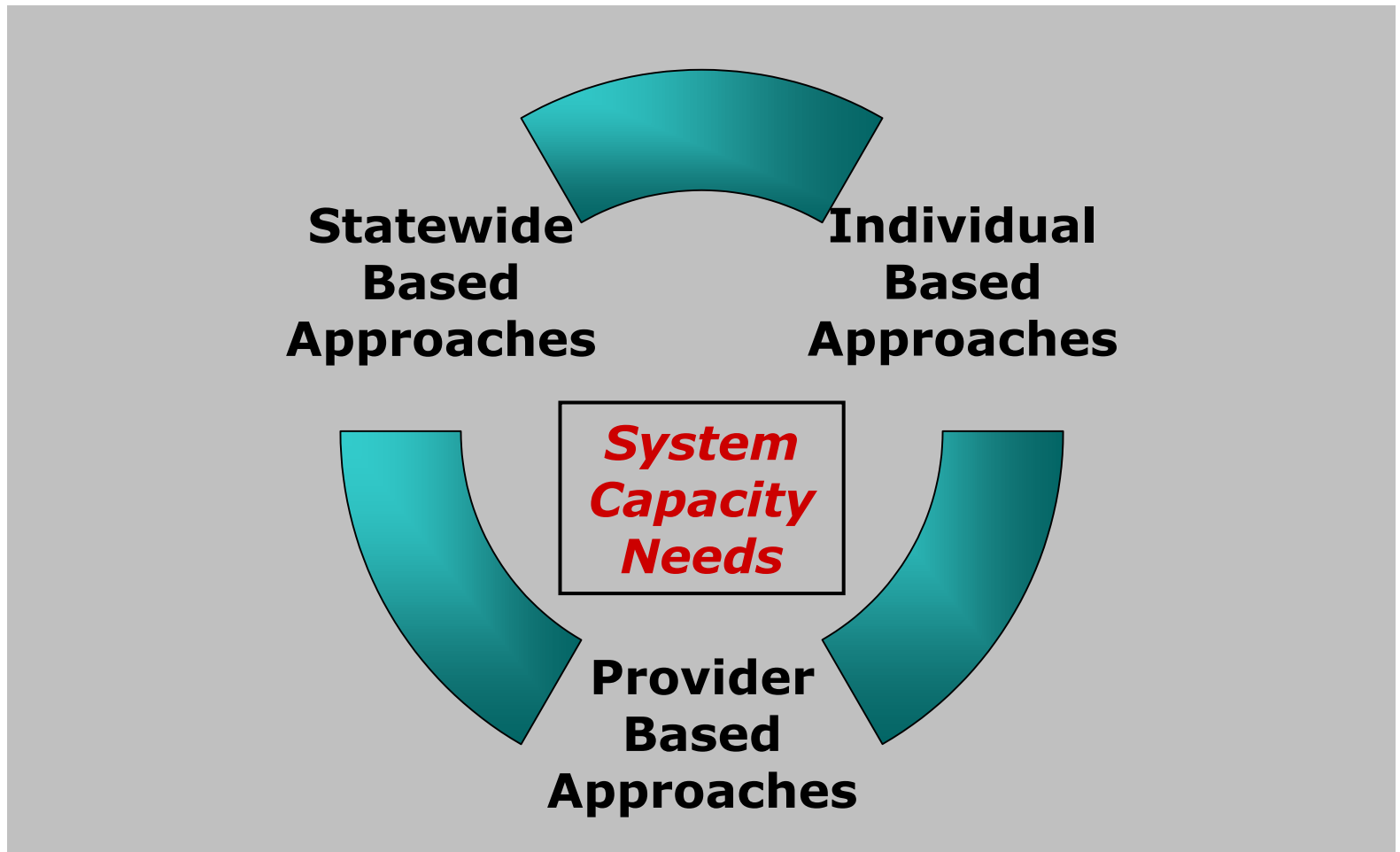
---

- Individual and/or local response even more important for kids
- Family and school interactions add to complexities
- Coordination is key
- As with adults, successful strategies need to be carried over to other environments
- Often 1<sup>st</sup> time away from home/parents
  - Think about having parents stay with the child



# Crisis System -- Multidimensional

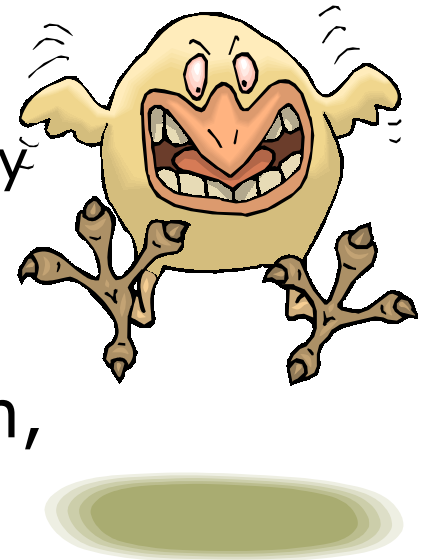
---



# Individual Based Approach

---

- Cookie-cutter approaches won't work
- Meet the person where he or she is in the moment
- Analyze the situation and responses
  - Reaction of support workers, family and others to situation BIG factor
- Individualized funding
- Communication, communication, communication



# Provider Based Approaches

---

- Vary depending on size
- Encourage creativity
- Range from “on call” systems
- To transitional crisis homes
- To contracted “emergency” respite
- To staffing an individual in a hotel room
- To full-fledged staffed crisis bed

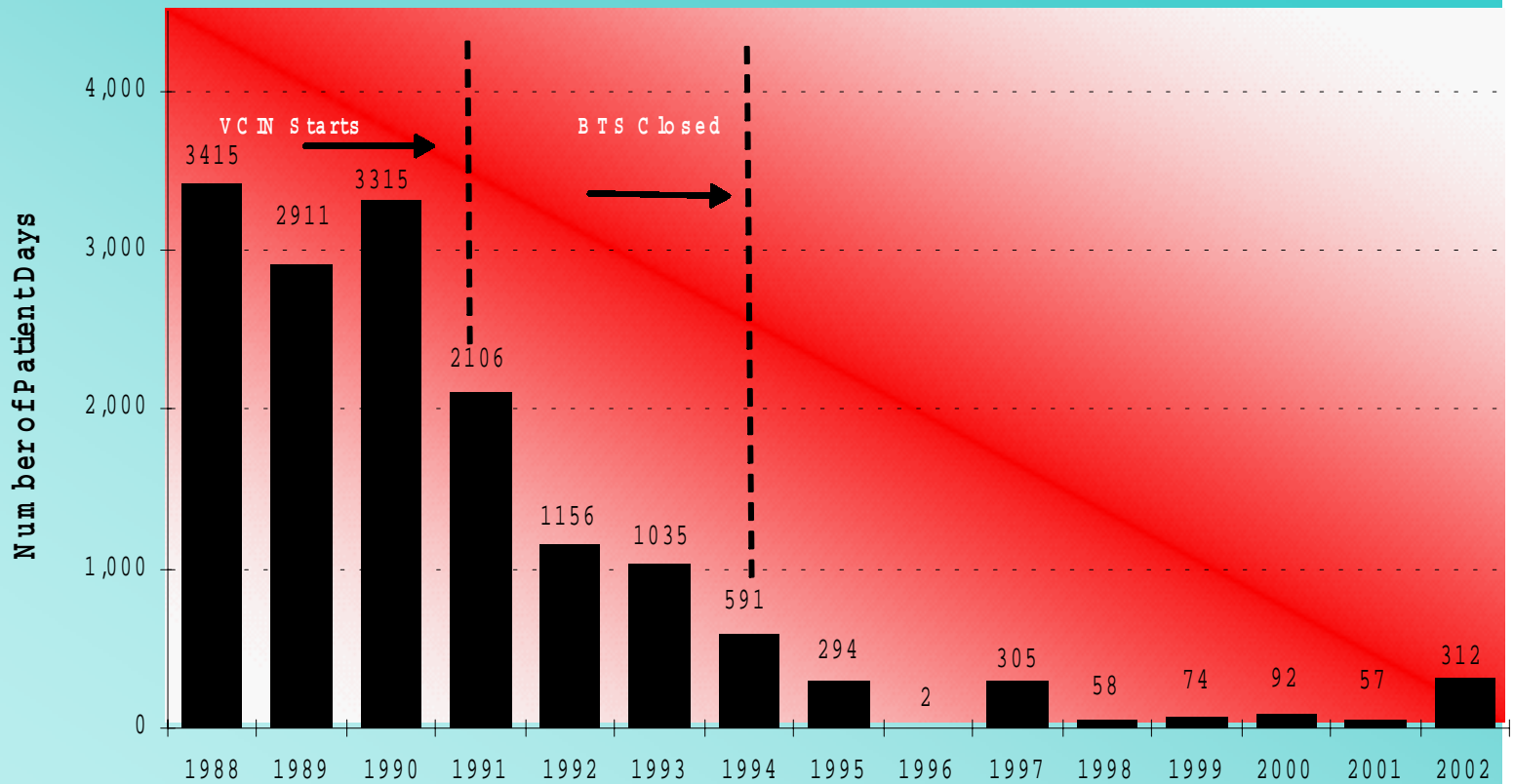


# Statewide Based Approaches

---

- Community-based services need community-based crisis response
- Started ***Vermont Crisis Intervention Network*** 12 years ago
- 3 Levels
  - Level 1 – Regional discussion groups; emerging issues/situations
  - Level 2 – On-site consultation from VCIN staff
  - Level 3 – Crisis bed response; VCIN bed or provide staff locally
- Directly reduced use of institutions for crises

# Utilization of the VSH



# Creative, Stable Financing

---

- Capacity funding; not use-based
- Flexible; capacity needs will change
- Insurance premium based model
- As system grows in numbers and complexities, so does need for crisis responses and funding
- Vermont's has doubled in 10 years
  - 3.0% of waiver funding; \$2.5 million
  - About equally split between individual/local responses and statewide response

