Clinical Practices Advisory Panel Summary of Recommendations for Evidence-Based Practices to the Vermont Department of Mental Health

Sponsored by
Vermont Council of Developmental and Mental Health Services
137 Elm Street
Montpelier, VT 05602

January 2009

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Recommendations: Common to the Implementation and Review of Evidence-based and Other Clinical Practices by Clinical Practices Advisory Panel to the Vermont Department of Mental Health June 2, 2008

These recommendations to the Department of Mental Health (DMH) concern the treatment and service options available at the Designated Agencies (DAs). Recovery principles are always considered when evaluating the DAs practices and services. However, recovery is larger and more encompassing than treatment and services provided at DAs. DMH and the DAs must always view the larger recovery picture, and with each client determine if or how the treatment and services offered fits the client's pathway in recovery.

1 Agencies should be encouraged to take the initiative to seek out and review promising practices that would enhance their programming (see note 1).
2 The DMH and the DAs should collaboratively discuss and question the research and implementation policies for evidence-based practices (EBP) and other practices. The practice reviews should be for the purpose of making recommendations to DMH and should include the DAs clinical experiences, outcomes and compatibility with recovery principles (see note 1).
3 Agencies will be in different stages of change when implementing an EBP. Implementation of any EBP is a developmental process for DAs that requires significant changes around training, continual re-training a new work force and development of EBP leaders. EBP as a treatment option for clients also is a process involving progressing through the stages of change.
4 All agencies should be required to follow the recovery values as defined by the Vermont system of care, and the State should provide training and other necessary resources to implement and maintain the agency's ability to follow these recovery values at all system levels from frontline staff through the management of the agencies.
5 All treatments and services offered at the DAs to their clients participating in the Community Rehabilitation and Treatment (CRT) programs should be compatible with recovery principles.

6 DAs should be prepared to offer treatment options to each client. A client may not want a particular treatment or be one of the significant minority of people for whom a particular EBP is ineffective.

7 All agencies in Vermont should be encouraged to develop the peer leadership potential in their recovery programs. Designated agencies and the State should support the development and inclusion of peers and peer run programs as part of the system of care at the designated agencies and in the community. The support should include resources such as training and stipends for peers.

8 Agencies should be encouraged to help clients understand the array of treatments and supports that are available and the potential outcomes (positive and negative) associated with those interventions. Agencies should also help clients make informed decisions about choosing the treatments and supports that best match their individual needs and give them the best opportunity for success and recovery. In doing so agencies should help clients assess their current satisfaction in residential, vocational, educational, recreational and spiritual aspects of their lives and to assist them in changing any of those aspects in which they express dissatisfaction.

9 Whenever the State expects (requires or mandates) agencies to implement and maintain a practice, fidelity to a practice, or recovery principles the State should be expected to provide the resources necessary to implement and maintain the practice. These resources include but are not limited to:

    Appropriate reimbursement structures
    Appropriate staffing patterns
    Initial and continuing training for professional staff and peers
    Appropriate supervision
    Training Materials
    State consultation team to support practice quality and outcome-driven fidelity systems
    Reimbursement for participation in the statewide consultation team
    Information technology supports (e.g., computer systems, programming, and system compatibility among agencies and the State)
    Quality improvement activities
    Administrative assistance
    Administrative support for a statewide lending library

10 Practices implemented at the designated agencies should be considered in the local system of care plan quality improvement process by the designated agencies, Department of Mental Health and across the Agency of Human Services.

11 Decisions for implementation of a practice and reviews of a practice should take the stages of change of the agency's clients into consideration when doing an assessment of need.

12 The measurement of fidelity during a program review by the Department of Mental Health should help educate staff and inform the process.

13 When implementing a practice the Department of Mental Health should consider the burden additional requirements for monitoring fidelity place on the agencies.

14 Consistent Documentation Infrastructure improvements need to be developed that support standardized documentation applicable to multiple clinical programming within the designated system of care. The standardized documentation should include at a minimum screening, assessment, treatment planning, outcome measurement, and the reporting of clinical information.

15 Data elements need to be developed that can be used to monitor both individual client's progress, and when aggregated program-level performance. These elements can then be incorporated in the electronic medical records system when it is available.

16 The agencies should be responsible for using available data to prevent unintentional "drift" in fidelity to EBPs, and to appropriately modify practices to be best practices that are most effective for the agency's clients.

17 The designated agencies and State should consider the implementation of treatment programming that is consistent across designated agency divisions based on best practices principles for the population served. This will not only make treatment available to more consumers, but also increase the ability of the designated agencies to maintain the quality of their practices especially at the smaller agencies.

Recommendations: Assertive Community Treatment Clinical Practices Advisory Panel to the Vermont Department of Mental Health June 1, 2007

> Assertive community treatment (ACT) is appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment. These individuals are often heavy users of inpatient psychiatric services, and they frequently have the poorest quality of life (Phillips, Burns, Edgar, et al., 2001).

This is a very good description of the client who should be included in an ACT program. The one addition is that ACT is not for clients who have an Axis II personality disorder diagnosis.

1. An agency should consider the implementation of an ACT program if the agency's clients have had a sustained high rate of hospital and emergency use.
2. Agencies should not be required to establish an ACT program, but agencies could choose to incorporate the principles of ACT into outreach programs. These principles described by Phillips, Burns, Edgar, et al. (2001) are.
    - Services are targeted to a specified group of individuals with severe mental illness.
    - Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.
    - Team members share responsibility for the individuals served by the team.
    - The staff-to-consumer ratio is small (approximately 1 to 10).
    - The range of treatment and services is comprehensive and flexible.
    - Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
    - There is no arbitrary time limit on receiving services.
    - Treatment and support services are individualized.
    - Services are available on a 24-hour basis.
    - The team is assertive in engaging individuals in treatment and monitoring their progress.
3. There is a large impact on an agency when a program change to ACT is made, because ACT requires a complete change in program structure. It is advisable to make the conversion in the Community Rehabilitation and Treatment program at

one time. If an agency chooses to implement an ACT program, the State should provide the support for the complete reorganization.

4. Since ACT can appear to be coercive. Training should be offered on an ongoing schedule statewide by expert trainers on ethical standards and recovery principles, and the agencies should offer a program of supervision in these areas.

These are the Clinical Practices Advisory Panel's recommendations specific to ACT. There are also recommendations common to most practices included in Appendix Z of the report that are applicable to ACT.

Phillips, S., Burns, B., Edgar E., Mueser, K., Linkins, K., Rosenheck, R., Robert E. Drake, R., & McDonel Herr, E. (2001). Moving Assertive Community Treatment into standard practice. *Psychiatric Services*, *52*(6), 771-779.

Recommendations: Dialectical Behavior Therapy Practices Clinical Practices Panel to the Vermont Department of Mental Health June 2006

1. Dialectical Behavior Therapy (DBT) should be available in Vermont, but not all agencies should be expected to implement the practice. However, all consumers who need and want DBT should have access to treatment.
2. The agencies implementing DBT should be expected to adhere to the structural guidelines as first described by Marsha Linehan[1,2]. To be adherent, the program must, at a minimum include the five processes:
   - Motivation
   - Education
   - Cognitive-behavioral therapy
   - Phone consultation
   - Consultation Group (Supervision)
3. Because there are minimal means to assess adherence to DBT practices at this time, the State needs to develop a measure to determine if DBT practices are adherent. The State should provide the resources so that the adherence measurement process doesn't disrupt the work of the programs, or increase their responsibilities.
4. The State DBT Consultation Team should be fully supported by the State, because it is essential for maintaining the quality of DBT practices in a rural state like Vermont.
5. The advisory panel recommends DBT as an effective treatment modality for a variety of clinical presentations, not limited to a diagnosis of Borderline Personality Disorder.
6. The State should consider the implementation of DBT programming in other designated agency divisions. This development of DBT education and skills will not only make DBT treatment available to more consumers, but also increase the ability of the designated agencies to maintain the quality of their DBT practices especially at the smaller agencies. In particular DBT is important to have available in children's services as a preventive measure against children and adolescents becoming future adult Community Rehabilitation and Treatment clients.
7. If the State were to mandate that DBT be implemented as part of designated agency requirements, the State should then also fully fund the implementation and necessary on-going training, reference materials, and expert consultation to assist the designated agencies to maintain adherence and fidelity to DBT. For example:

- Expert educational programs should be funded on a regular basis by the State. Attendance in those programs should be free to practitioners who are adherent to the practice.
- Hours that staff persons spend in education and supervision in the practice should be credited to the case rate for CRT, or for reimbursement in a fee-for-service environment.

8. Clients with Borderline Personality Disorder also often have co-occurring disorders like depression, anxiety, posttraumatic stress, and/or substance use. When a client has co-occurring disorders in addition to Borderline Personality Disorder, each disorder needs to be treated as primary in an integrated manner.

[1]Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

[2]Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford Press.

Recommendations: Family Psychoeducation Clinical Practices Advisory Panel to the Vermont Department of Mental Health July 7, 2008

1 Diverse options for family psychoeducational practices and supports should be developed in the Vermont system of care that recognizes the value of support to the “Consumer and Family”. These resources can be both internal and external to the designated agencies (DAs). Because, not every client and family needs formal therapeutic family interventions, some people just need recovery-oriented family based services. One of the challenges in this field is intervention matching (Mueser, 2008).

2 Provider agency staff should be knowledgeable about the resources for family psychoeducational practices and supports in the community. A staff person can be given in the responsibility in her/his job description and be held accountable for being knowledgeable about and tracking family psychoeducational practices and supports available in the community, and keeping staff informed.

3 If appropriate psychoeducation and support options are not available at a DA or in the community, then the agency should seek to collaborate with community partners, the Department for Mental Health and statewide organizations like NAMI-VT or Vermont Psychiatric Survivors (VPS) to develop the resources locally. However, it is not an agency's responsibility to develop the community psychoeducation and support services.

Client, Family and Agency Culture

4 The DAs and the Community Rehabilitation and Treatment (CRT) programs in particular should continually foster a culture that promotes family participation. The culture should recognize the value of programming that reflects a client's whole family. Family in this context is synonymous with community support network, and includes family members, and friends like peers, clinicians, and educators. All of whom can be an integral part of the client's recovery team. The DAs cultural commitment can be clearly stated in the agency's mission statement.

5 Clients should be made aware of the range of education and supports relevant to their individual and family needs at the agency and in the community.

6 A welcoming orientation to the CRT program should include a discussion with the client about including her/his family members. If the client chooses and consents for family members to be included, then the clinician should determine the family members' levels of interest in participating in “Family Work”. A tool for this purpose can be made part of the intake and ongoing assessment process. The tool should identify people to include, but should also identify people the client wishes to avoid. Efforts to welcome family members do not have to be limited to intake. Ongoing opportunities for including family and other supporting people

should be made. The door should always be open, since people are ready to enter at different times.

7 A client's confidentiality has to be respected. However, even when a client has not given consent and family members are inquiring, the provider can give general information about a diagnosis, services available and make a referral to family support groups, web sites, etc.

Family Psychoeducation and Support Implementation

8 Opportunities for family psycho-education should be available in each designated agency's community that include:
   - Education about disorders, treatments, and supports are available to clients and families.
   - Clients and families have support available.
   - Problem solving, focused on the issue of relapse and/or recovery issues is available.

9 The curriculum for any formal therapeutic family interventions or community programs should be broad and include not only biological information about mental illness, but also include the spiritual and social aspects of life.

10 Agencies should not be required to implement the Family Psychoeducation (FPE) model developed by McFarlane. However, if the DAs that wish to implement an evidence-based practice (EBP) that focuses on family psychoeducation and supports, selecting a common practice, like the McFarlane model of FPE, Falloon's Behavioral Family Therapy (BFT), or another practice that has a structured format for implementation should be considered. This will allow for State funded training, and opportunities for access to consultation and support.

11 Agencies implementing an evidence-based family psychoeducational practice should be expected to maintain fidelity to the components of the practice as measured by the fidelity assessment tools developed by the practice's developers. If a fidelity scale has not been developed, then every attempt should be made by supervisors to have clinical staff follow the model.

12 Agencies in Vermont who choose not to implement the McFarlane Model of FPE or other EBP for family psychoeducation and support are encouraged to implement and have available the components that underlay the practice.
   - Encouragement of family involvement using quality engagement and alliance techniques
   - Psycho-education available to clients and family members that meets their needs
   - Teaching problem solving skills and coping strategies to meet current challenges related to relapse and recovery issues
   - Support for clients and family members

13 Consumer group leaders should be considered for the McFarlane model of FPE or other clinician led FPE practices where appropriate boundaries are maintained.

14 A time-limited family psychoeducation program should be available at an agency or in the community, because experience has shown many family members are interested, but committing the time for a long-term program is not possible. This psychoeducation program could be more of a public health intervention open to the community.

15 DMH should consider supporting models other than therapist lead family psychoeducational practices provided at a DA. Community alternatives may be a better fit for the specific needs of individual clients and their families. These alternatives include NAMI-VT's Family-to-Family and support groups for family members, and the peer lead Wellness Recovery Action Plan (WRAP) process organized by Vermont Psychiatric Survivors.

Recommendations: Dartmouth Illness Management and Recovery Clinical Practices Advisory Panel to the Vermont Department of Mental Health. December 2005

Dartmouth Illness Management and Recovery should be available in designated agencies in Vermont, but not all agencies should be expected to implement the practice. The agencies implementing Dartmouth Illness Management and Recovery should be expected to maintain high fidelity (see Appendix D) to all components of the practice as measured by the fidelity assessment tools developed by the practice's developers (see Appendices E and F). In this case the State should provide the resources necessary to implement and maintain the fidelity of the Dartmouth Illness and Recovery program.

All agencies in Vermont who choose not to implement Dartmouth Illness Management and Recovery are encouraged to implement the components that under lay Dartmouth Illness Management and Recovery. Agencies implementing one or more of the components of Dartmouth Illness Management and Recovery should be able to modify these components as necessary.

All agencies in Vermont should offer recovery-based options to their clients participating in the Community Rehabilitation and Treatment programs.

All agencies in Vermont should be encouraged to develop the peer leadership potential in their recovery programs.

Not all clients are ready to participate in a recovery intervention. To avoid a failure experience clients' agencies are encouraged to assess the readiness of clients to participate.

All agencies should be required to follow recovery principles as defined by the Adult State Standing Committee, and the State should provide training and other necessary resources to implement and maintain the agencies ability to follow these recovery principles at all system levels from frontline staff through the management of the agencies.

Whenever the State expects (requires) agencies to implement and maintain practices, fidelity to practices or recovery principles the State should be expected to provide the necessary resources.

Recommendations: Integrated Dual Disorder Treatment Clinical Practices Panel to the Vermont Vermont Department of Mental Health January 2007

Recommendation 1
Implementation of Integrated Dual Disorder Treatment

All agencies will be required to have the capacity to make available the following core components of IDDT practice to consumers as the State makes the resources available.

Core components of the IDDT practice for clients with mental health and substance use disorders include:

- Welcoming environment (Non-stigmatizing)
- Engagement
- Trained practitioners
- Screening
- Comprehensive assessment
- Treatment planning matched to progress monitoring of the stage of change, treatment and recovery
- Motivational interviewing techniques
- Cognitive Behavioral Therapy (CBT) specifically focused on treatment and relapse prevention for clients with co-occurring mental health and substance use disorders
- Medication management
- Relapse prevention techniques
- Case Management for clients with co-occurring mental health and substance use disorders with the case managers being knowledgeable and supportive of community and peer resources and supports
- Psycho education for co-occurring mental health and substance use disorders
- Crisis management with staff trained in co-occurring disorder treatment not simply medical model interventions

Recommendation 2
Scope of Permissible Dual Disorder Treatment Practice

- There needs to be an identified permissible scope of practice in the credentialing section in the Community Rehabilitation and Treatment (CRT) policy and procedure manual, which should be included in an Appendix A (Permissible Scope of Practice).
- The scope of practice recommended includes following components:

Trained practitioners

Welcoming environment (Non-stigmatizing)

Engagement

Motivational interviewing techniques

Screening

Comprehensive assessment

Treatment planning matched to progress monitoring of the stage of change, treatment and recovery

Cognitive Behavioral Therapy (CBT) specifically focused on treatment and relapse prevention for clients with co-occurring mental health and substance use disorders

Medication management

Relapse prevention techniques

Case Management for clients with co-occurring mental health and substance use disorders with the case managers being knowledgeable and supportive of community and peer resources and supports

Psycho education for co-occurring mental health and substance use disorders

Crisis management with staff trained in co-occurring disorder treatment not simply medical model interventions

Group interventions specific to co-occurring mental health and substance use disorders

Family based treatment interventions specific to co-occurring mental health and substance use disorders

Contingency management specific to substance use disorders that minimizes coercion

Drug testing and screening

Residential Treatment

Recommendation 3
Implementation Process

- Agencies should be allowed to implement IDDT core components over time.

  Implementation of IDDT is a process that requires substantial changes in an agency. For example, quality treatment is based on empathetic and trusting relationships between clients and staff, and competence to deliver quality treatment is achieved and maintained with an ongoing training curriculum, supervision and coaching of the staff. Agencies need time to hire and train the right staff. Especially important to successful implementation is finding among the staff or hiring a lead staff person to be the champion for the practice.

- Agencies implementing IDDT should be allowed some variation in the practice, but agencies should be expected to make available the core components listed in Recommendation 1.

  This is because IDDT is a combination of treatment components with variable amounts of research supporting use of the individual components, and work on the practice is continuing to develop it into a fully evidence based practice. Further, agencies have very different clinical populations and clinical resources available.

Recommendation 4
Peer Participation

- We strongly encourage designated agencies and the State to support the development and inclusion of peers and peer run programs as part of the system of care at the designated agencies and in the community. The support should include resources such as training, credentialing and stipends for peers.

  It has long been recognized that peer supports are extremely valuable in the long term stabilization of psychoactive substance use issues. This is especially true when co-occurring mental health issues are involved as well.

Recommendation 5
Quality Improvement and Consistent Unduplicated Clinical Documentation

- It is recommended that treatment for dual mental health and substance use disorders should be included in the local system of care plan quality improvement process by the designated agencies, Division of Mental Health and across the Agency of Human Services, which should be common to all practices.

- Designated agencies should offer ongoing training and supervision on the critical elements of the permissible scope of practice to all staff providing IDDT. Cognitive Behavioral Therapy (CBT) should receive specific attention because it is often difficult to grasp the principles of the practice and the potential for harm is high if used in a coercive manner.
- Designated agencies should offer ongoing training and supervision on ethical standards and confidentiality related to working with clients with dual mental health and substance use disorders to all staff providing services to these clients.
- Infrastructure improvements need to be developed that support standardized documentation applicable to multiple clinical programming within the designated system of care. The standardized documentation should include at a minimum screening, assessment, treatment planning, outcome measurement, and the reporting of clinical information.
- Data elements need to be developed that can be used to monitor both individual client's progress, and when aggregated the program-level performance. These elements can then be incorporated in the electronic medical records system when it is available.
- This standardization can assist in the development of a consistent clinical dialogue related to, making appropriate treatment referrals, progress monitoring and eliminating redundancy in documentation to reduce the time required for staff completing the forms and to reduce the burden on clients. In addition the information derived from the records can inform the quality improvement process.

Recommendation 6
System of Care for Dual Disorder Treatment

- Successful outcomes may be dependent on appropriate levels of care beyond Community Rehabilitation and Treatment (CRT) outreach services. Additional statewide and regional treatment resources need to be developed and funded such as, but not limited to:

  Integrated residential treatment programs

  Co-occurring capable inpatient facilities

  Shelters that accept clients with co-occurring disorders

  Developing and supporting peer community based resources
- Training curriculum should be offered on an ongoing schedule statewide by expert trainers on IDDT core competences and the permissible scope of practice to these agencies that provide treatment services.
- Training curriculum should be offered on an ongoing schedule statewide by expert trainers on ethical standards and confidentiality related to

working with clients with mental health and substance use disorders to these agencies.

Recommendation 7
Funding of Practices

- When and where the State mandates IDDT implementation as part of a designated agency's requirement, the State will fully fund the infrastructure to support the practice. This includes but is not limited to:

  Appropriate reimbursement structures

  Appropriate staffing patterns

  Initial and continuing training for professional staff and peers

  Appropriate supervision

  Training Materials

  State consultation team to support practice quality and outcome-driven fidelity systems

  Reimbursement for participation in the state-wide consultation team

  Information technology supports (e.g., computer systems, programming and system compatibility among agencies and the State)

  Quality improvement activities

  Administrative assistance

  Reimbursement for urine/drug screening

  Administrative support for a statewide lending library

Recommendation 8
Agency Scope of Dual Disorder Treatment Practices

- The State should consider the implementation of dual disorder treatment programming in other designated agency divisions based on best practices principles for the population served. This development of dual disorder treatment will not only make treatment available to more consumers, but also increase the ability of the designated agencies to maintain the quality of their dual disorder practices especially at the smaller agencies.

Recommendations: Medication Management Hospital and Community Psychiatrists to the Vermont Department of Mental Health July 2008

1. Electronic-record-based and on-line evidence-based medicine guidelines/algorithms are needed. The health care system should to provide these tools to assist psychiatrists to find the pertinent evidence for decisions quickly. Whenever, information technology systems are upgraded or replaced by the State or agencies decision support capabilities should to be included.
2. Continuing medical education (CME) should teach and reinforce research paper-reading skills.
3. CME optimally should be independent of drug company influence.
4. The Departments of Health and Mental Health should lead the development of a State of Vermont policy for the interaction of physicians with pharmaceutical companies.
5. Patient education (e.g., risk/benefit of medication, side effects) should be offered during appointment time with the psychiatrist to improve outcomes, but the psychiatrist's time is limited. Therefore, in addition patients should be encouraged to take part in psychoeducation provided through the community mental health center or through peer and family support groups.
6. The informed consent and treatment planning process should consider and include letting the patient know about medication and non-medication treatment options such as cognitive behavioral therapy (CBT) and psychosocial therapies that may be more effective.
7. Medication Reconciliation, listing all prescription and nonprescription medications when a patient comes into the hospital, again at discharge and at other appropriate times should be routine.
8. A release to give the medication list to the receiving agency should always be sought from an inpatient prior to discharge.
9. When a patient is in the hospital or residential setting the psychiatrist should make her/his best effort to communicate with the community psychiatrist with ongoing responsibility for the patient before making permanent changes to the patient's medications. Currently reaching the community psychiatrist can be difficult and time consuming. EMRs will be needed to accomplish this recommendation fully.
10. Effective psychopharmacological treatment, therapies and/or prevention of the diversion of prescribed drugs requires identifying and addressing co-morbid substance abuse disturbance.

The group endorsed the following seven of Dr. Osser's recommendations.

11 Make one medication change at a time, with adequate dose and duration of therapy.
12 In the treatment of schizophrenia, strongly consider Clozapine after two adequate monotherapy trials of other antipsychotics representing distinct chemical classes.
13 In a non-emergency situation when there is no significant response to a monotherapy allowing for a legitimate trial of dose and duration, switch to a different agent rather than adding a second medication also allowing for an appropriate trial of dose and duration.
14 When initiating a medication, select the least expensive alternative of comparable clinical effectiveness. This requires maintaining easy and ready access to accurate price information.
15 Check for potential drug-drug interactions (DDIs) before prescribing (see, DDI online program: http://www.genelex.com/.).
16 Use lithium in preference to Valproate as first-line treatment for bipolar disorder.
17 Treat insomnia as a symptom that requires diagnosis and treatment specific to the diagnosis.

Recommendations: Social and Independent Living Skills Teaching an Addendum to Dartmouth Illness Management and Recovery Clinical Practices Advisory Panel to the Vermont Department of Mental Health June 1, 2007

These recommendations for the UCLA Social and Independent Living Skills Modules (SILS) are an addendum to those made for the practice Dartmouth Illness Management and Recovery (DIMR), and are specific to SILS. DIMR was the first practice reviewed by the Clinical Practices Advisory Panel. Now that the Panel has reviewed several additional practices, it has become apparent that there are recommendations common to most mental health practices. A draft of these common recommendations is included in Appendix E of the report.

DIMR teaches a very specific set of skills. The SILS modules are an extension of DIMR to more skill areas that are necessary for living successfully in the community that include social skills and activities of daily living (ADL).

The Panel's review has focused on three of many social and independent living skills curricula available. These are the SILS, *Social Skills Training for Schizophrenia: A Step-by-Step Guide* (Bellack, Mueser, Gingerich, & Agresta, 2004), and the work done at the Center for Psychiatric Rehabilitation at Boston University. The SILS modules may be preferred for implementation in Vermont for several reasons.

- The Vermont State Hospital (VSH) has implemented the SILS Modules. The continuity achieved by implementing the SILS Modules at the community mental health centers (CMHC) can make the learning of the skills easier for people who are entering or leaving VSH.

- The teaching materials for the SILS modules are very complete, which will reduce preparation time and increase fidelity.
- The UCLA Social and Independent Living Skills Modules are the most rigorous and well-defined program for teaching these skills.
- DIMR and the UCLA Modules are compatible without being redundant.

Recommendations Specific to Social and Independent Living Skills

1. All agencies should have the capacity to provide SILS or equivalent evidence-based practice to consumers who need and want to learn either in a group or individually.
2. Skills should be taught to people who wish to participate, and the teaching of skills should not be imposed on anyone.
3. The teaching methods for SILS are the most essential and researched elements of the practice. The effectiveness of SILS teaching is dependent on competent teachers who use the teaching technology faithfully. Competent skilled staff members both professionals and para-professionals have been able to teach SILS with fidelity. Using a teaching approach for SILS is more empowering and consistent with recovery principles than if the practice is conceptualized as treatment.

   The teaching methods described in the manuals for the UCLA SILS Modules are not exclusive to the Modules, but the material in the Modules is very complete, and it is recommended that these methods be followed. The methods include:

   - Anyone regardless of impairments should be included in SILS teaching. Never underestimate anyone's ability to learn.
   - Assessment is important to be able to meet each student where he/she is, which includes determining the person's long and short-term goals.
   - Careful assessment allows skills teaching plans to be individualized to the person. Plan goals should be attainable, specific, include positive and functional behaviors, consistent with the person's rights and responsibilities and chosen by the person.
   - Skills lessons can be taught 1-on-1, but classes are considered the best environment for learning because classes allow interactions that are more natural.
   - Class groups are more effective when they are made up of people with varying levels of skill. Because having people with varying skill levels in the class groups allows the less experienced members of the group to observe the more experienced.
   - Peers who have mastered the SILS skills should be able to become group leaders.

- No error learning teaching includes direct supervision, exposure to peer role models in class, reward for successive approximations, numerous reviews, and positive critical feedback.
- Information should be presented in small chunks with specific concrete steps, slowly, repetitively, and consistently.
- Multiple teaching methods and media are used to accommodate each student's learning style and abilities.
- Explicit homework given to allow for practicing skills learned in class in real-life situations.

4. Agencies implementing an evidence-based social and independent living skills curriculum should be able to modify the curriculum as necessary.
5. People teaching social and independent living skills need to be always aware of the Vermont system of care values while teaching. The content of manualized lessons is important, but the presentation by the teacher makes all the difference. The teaching should be empowering, non-stigmatizing, and non-patronizing.

Recommendations: Supported Employment Clinical Practices Advisory Panel to the Vermont Department of Mental Health June 2008

Supported employment should be focused on in the Community Rehabilitation and Treatment (CRT) programs in Vermont, because people with a severe and persistent mental illness who hold competitive jobs for a sustained amount of time show benefits of improved self-esteem, better symptom control, and improved life satisfaction (Bond, 2004).

1 Access to Supported Employment Services

- Consumers of CRT services, based on their individual preferences, should be offered and have support from their treatment teams to obtain competitive employment in the community.
- An evidence-based supported employment practice should be maintained in all the CRT programs in Vermont.

2 **Diversity of Supported Employment Practices**

- The Individualized Placements and Supports (IPS) model should be allowed to be one of several possible options for supported employment services, because the IPS model is a model with strong experimental evidence, but it is not the only model with a strong evidence base.
- Implementation of the IPS model should not require other supported employment practices or activities that have demonstrated similar benefits to be terminated.

3 **Fidelity**

- Designated agencies should be allowed flexibility in the implementation their evidence-based supported employment practice when based on informed judgment that takes into consideration the available data for the consumer population and the resources available in the community.
- If the IPS model is practiced as part of a CRT program, the practice should maintain fidelity that can be defined as a score of fair fidelity on the Supported Employment fidelity scale (see Appendix D). An equivalent measure of fidelity should be established if another evidence-based supported employment is implemented.

- Fidelity assessment should include a procedure for sign-off by the provider being reviewed. The provider may not agree with a fidelity scale rating or wish to add additional information to explain the deviation from the fidelity scale based on local data.
- Fidelity scale definitions should be consistently used to define terms like competitive employment, reasonable pace, or rapid job search. Commonly understood terms will promote understanding among the partners in the system of care for supported employment.

4 **Training and Consultation**

- There should be base level training every year for community mental health center (CMHC) and vocational rehabilitation (VR) workers. Because there are high rates of staff turnover, and job development for consumers with a severe mental illness is a very specialized skill. There is also an absolute need to keep excitement and enthusiasm among the staff, and appropriate training can help keep these levels high.
- The base level training should be at a time and place that allows the maximum number of frontline staff to attend.
- A consultation group that includes the most experienced staff from the CMHCs should be the vehicle for disseminating training for supported employment as well as developments in the field related to empirically supported and promising practices for the more experienced workers and managers.

5 **Outcomes**

- Outcome benchmarks based on the number of consumers wanting supported employment services, their age, and physical health should be established for each CRT program. Other important factors include the availability of jobs in the community, and other community resources like transportation.
- Surveys, that include more than consumer satisfaction, should be conducted on a regular schedule to determine the characteristics of the consumer population in each CRT program (e.g., percentage asking to work) as well as community variables like transportation and number of jobs available.
- Collection of the appropriate outcome and fidelity data should be a priority, because the data are essential elements of the feedback loop for the management of supported employment practices at the CMHCs.

6 **Implementation Evaluation**

- Supported employment practice evaluation needs to be done when a program is well established as well as at the time when it is being implemented. After a practice is well established and the support provided during implementation is not available, conditions in the CRT program may be very different. For example, caseloads may have grown, well-

trained workers may have left, and supervisors may have their attentions drawn to other priorities.

7 Resource Management

- Designated agencies that offer supported employment services in their CRT programs and other programs like Developmental Services or JOBS should be allowed to integrate the programs to be able to utilize employees more effectively, and reduce redundant contact with business partners who are the employers.