

Implementing Evidence-Based Practices in Vermont: A State Mental Health Authority Perspective

Site Visit Dates: September 2002 and April 2004

Overview in brief		
MH chief	Commissioner	
Placement of SMHA within State	Sub-division within an umbrella agency	
EBPs		
	Illness Management and Recovery	Family Psychoeducation
# sites using Implementation resource kits	2	2
# total sites	2	2
Statewide roll out planned??	under review	under review

This report on implementing evidence-based practices has been synthesized from a series of site visit reports that were completed at two points in time--one early in the implementation process for each State and another 15-18 months later near the point of expected full implementation. The site visits were conducted by 2-4 person teams composed of members of the MacArthur Foundation Network on Mental Health Policy Research. These visits were conducted with the cooperation of the individual States and the National Association of State Mental Health Program Directors (NASMHPD) and its Research Institute.

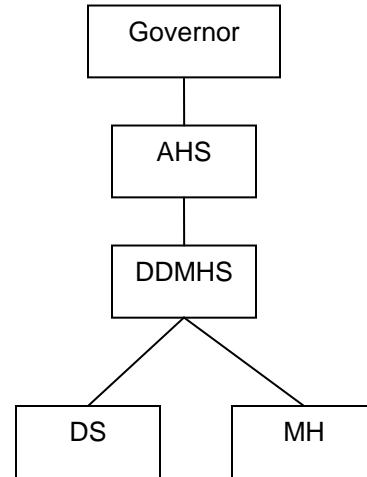
This report reflects the observations of the site visitors based on their synthesis of the views expressed by multiple individuals during the 1-2 days of each visit. Related facts from other documentary materials were also included to complete the longitudinal story of each site's implementation process. Every effort has been made to be accurate in this summary, but there may still be some remaining inaccuracies or differences of opinion about what actually was stated and the interpretations derived. Admittedly, the observations in this summary are based in part on the opinions of informants who spoke with us more than factual information. However, we believe that the perceptions of the informants reflect the multifaceted context in which EBPs are being implemented in each State. Each report has been reviewed by all of the site visitors and by officials of the respective State mental health authorities.

Background

Prior to July 1, 2005 The Department of Developmental and Mental Health Services (DDMHS) was comprised of central administrative services (CAS) and two programmatic divisions: the Division of Developmental Services (DS) and the Division of Mental Health Services (MH). The Director of DDMHS was directly accountable to the Secretary of the Agency of Human Services (AHS).

The Division of Mental Health is divided into adult and child units, and oversees the operation of the Vermont State Hospital. The state purchases services from ten community mental health centers (CMHCs). The CMHCs are privately operated not-for-profit agencies governed locally by citizen boards.

Approximately 85% of CMHC funding is from state or federal dollars and the remainder consists of employee assistance program services (EAP) or insurance contracts.



Organization of the Vermont Mental Health System

The mental health system uses a network of inpatient facilities, which includes the Vermont State Hospital and the psychiatric inpatient units of regional general hospitals. The Vermont State Hospital provides both acute and long term care and is also the site for forensic inpatient services. The Department of Developmental and Mental Health Services has also designated four local general hospitals with psychiatric units for acute (short stay) involuntary care.

Evidence-Based Practices (EBPs)

As part of the National Pilot Demonstration project Vermont is implementing the Family Psychoeducation (FPE) and Illness Management and Recovery (IMR) practices. (Vermont has also implemented supported employment (SE) state-wide and is in the process of implementing Integrated Dual Diagnosis Treatment (IDDT) statewide). Participants in the demonstration project were chosen by the State Mental Health Authority (SMHA) based on an RFP process, using four basic criteria: agency level of interest, knowledge and understanding of practices, agency contextual factors, and benefit to agency of training. At the start of the project

in April 2002, there were four agencies participating in the national demonstration project, two agencies for each Implementation Resource Kit (IRK). Initial EBP implementation was supported financially by the state.

EBP
Evidence-Based Practice

Each of the four agencies was asked to provide a plan regarding which clients would get the service and how the service would be implemented. Early discussions around the IMR practice indicated a desire to make alterations to the IRK to adapt it to be more consistent with principles and philosophies practiced in Vermont. Issues identified were the fit of the IMR with the Recovery Education Project and WRAP (Wellness Recovery Action Plans, one module of the multi-module psychoeducational curriculum) and the fit of FPE with the National Alliance for the Mentally Ill's (NAMI) Family-to-Family program.

IMR
Illness Management and Recovery

IRK
Implementation Resource Kit

FPE
Family Psychoeducation

Initial controversy over IMR and FPE has led the state to adopt a consensual approach to decisions about whether and how to bring up new practices. A new state committee was formed, the Clinical Practices Advisory Committee (CPAC), in order to vet new practices and initiatives with key stakeholder groups. This group is reviewing both of the EBP practices implemented during the EBP demonstration project.

At the time of the March 2004 visit, Vermont was in the midst of pending organizational changes, budget reductions, a crisis with the state mental hospital, and emerging priorities. These distractions may have resulted in a slower implementation process than was initially anticipated. By the time of the second site visit however, the SMHA had become more involved with the EBP implementation effort than it was at the start of the project. The SMHA involvement included deploying a staff person to follow each site, and monthly phone conferences with all the sites and trainers throughout the course of the project.

SMHA
State Mental Health Authority

Providers indicated that educating staff, especially new staff, how to have empowering relationships with consumers is more important than these two specific EBPs. Providers also are asking for help conceptualizing how the various EBPs fit together, i.e., how Assertive Community Treatment, Illness Management and Recovery, Supported Employment, and Integrated Dual Diagnosis Treatment might fit together for the consumers served by these practices. Therefore, DDMHS is not ready to mandate that these two practices be implemented statewide.

DDMHS
Department of Developmental and Mental Health Services

Leadership

Since the beginning of the EBP project, Vermont's governor ran for the Presidency, a new Governor was elected, and a governmental reorganization has taken place that has moved the mental health division into the health department. Despite these potentially destabilizing factors, the SMHA commissioner was reappointed by the new Human Services Secretary and the key staff in Adult Services has been consistent. This consistency provided some initial stability through the reorganization despite the concerns that staff, community providers, and consumers have about the reorganization. Overall, leadership changes have not had a substantive impact on the implementation of EBPs.

There have also been changes within the state among consumer groups and EBP providers. Unfortunately, the continuity of staff at the state level has not been mirrored by the sites implementing the IRKs. Only one of the four demonstration sites was not impacted significantly by staff turnover that directly affected the implementation of the EBP project. Further, the engagement of EBP implementation sites' upper management has been limited. It has taken time for site management to become engaged in the EBPs and to think of them as part of the routine process of service delivery.

A more positive change has occurred among consumer advocates, however. The concerns expressed initially by Vermont Psychiatric Survivors (VPS) and the National Alliance for the Mentally Ill (NAMI) about IMR and FPE have dissipated somewhat. NAMI has had several leadership changes and is not quite as engaged statewide as at the beginning of the EBP project. Even still, the new Executive Director indicated that the issues that originally caused the fears of families and consumers have not materialized. Further, VPS and consumers in general no longer feel threatened by the new EBPs. The VPS leader feels Vermont learned a lot about implementation of EBPs in this process and about how to work together to resolve differences. She and the NAMI Executive Director participate in the monthly conference calls with the state about these IRK practices.

The SMHA remains committed to evidence based practices and endeavors to stay engaged with evidence based practices. In their continuing efforts, the SMHA is becoming more engaged in both the IMR and FPE EBPs and is performing more outreach to agencies. The SMHA participates in a monthly conference call with the four EBP sites' program leaders, VPS, and NAMI leadership, and are held without the Dartmouth Psychiatric Research Center

EBP
Evidence-Based
Practice

SMHA
State Mental Health
Authority

IRK
Implementation
Resource Kit

IMR
Illness Management
and Recovery

FPE
Family
Psychoeducation

NAMI
National Alliance for
the Mentally Ill

VPS
Vermont Psychiatric
Survivors

(PRC). In the opinion of some of the sites, this is a good step that signals the real transfer of EBP ownership from the PRC to the SMHA.

Financing

The Community Rehabilitation and Treatment (CRT) program operates under the auspices of Vermont's Medicaid 1115b waiver, the Vermont Health Access Plan, and reimburses providers on case rates that reflect the average cost of providing services to individuals with particular service needs. In order to participate in the CRT program, an individual must meet several eligibility criteria, including: a diagnosis of major mental illness, a long-term disability, and a recent history of intensive and ongoing mental health treatment (multiple psychiatric hospitalizations or six consecutive months of outpatient treatment). This waiver program allows the state considerable flexibility regarding the services that can be provided under this funding mechanism.

The Vermont mental health system has experienced increased financial pressures recently. A state hospital crisis and decertification has resulted in an inability to draw down federal dollars for state hospital services; further, many provider organizations are currently at 40 days of net assets, rather than the recommended 60 days. Despite these dynamics however, the community providers have received inflationary and case load rate increases in the past several years in each year of the EBP implementation project.

The EBPs are funded through the CRT program using the 1115b waiver. Building on the flexibility inherent in the waiver program, the state has developed specific coding guidelines to capture staff time spent doing activities required in evidence-based practices. The SMHA had anticipated using Block Grant funds for IMR training. However, due to the negative reaction of consumers to IMR, the State's Mental Health Planning Council voted not to recommend use of block grant funds to support IMR or FPE implementation.

From state general funds, \$15,000 was provided to each site as incentive funding to defray some of the costs associated with the implementation of the IRKs. While these dollars were clearly viewed as incentive funding, in FY 03 the provider sites were having their CRT budgets cut. From the provider perspective, participating in the IRK Project resulted in considerable financial burden that was not anticipated. Additional implementation costs

EBP
Evidence-Based Practice

PRC
Psychiatric Research Center

SMHA
State Mental Health Authority

CRT
Community Rehabilitation and Treatment

IMR
Illness Management and Recovery

FPE
Family Psychoeducation

IRK
Implementation Resource Kit

were associated with staff training, participating in the research components of the project, time spent on site visits, time spent on fidelity assignments, and time spent on staff supervision. The initial incentive/start-up funding was helpful, but the maintenance of training is fiscally challenging due to the need to have on-going training for all the SMHA initiatives.

SMHA
State Mental Health
Authority

Regulations

No EBP specific regulatory changes were made in Vermont to facilitate the implementation of the IRKs.

EBP
Evidence-Based
Practice

Training

As in the other states involved with the IRK initiative, the state is responsible for a half-time trainer. The IRK sites provided suggestions to enhance the training while balancing budget constraints. The suggestions include the SMHA having an on-going statewide EBP training operation. Sites view this as a viable mechanism to alleviate the training burden.

IRK
Implementation
Resource Kit

PRC staff indicated that they would change the manner in which they provide IMR training to practitioners. Specifically, they would make it more flexible. While in contrast, the PRC indicated that the FPE training could be more structured.

PRC
Psychiatric Research
Center

Sites in Vermont indicated that they desired more consultation and training time from the PRC. The rationale for needing more assistance included the need for more supervisory skills development. Some sites struggle with staff supervision when left to do the practice on their own. In their opinion, they did not learn enough from training to improve their daily practice and get the fundamental understanding of the clinical practice. However, one of the site program leaders indicated that it makes a difference if staff knows the IRK thoroughly.

IMR
Illness Management
and Recovery

In order to facilitate family engagement, one center is providing more staff FPE EBP skills training. Additionally, they have discussions at weekly team meetings, periodically have the staff psychologist attend family and consumer group meetings, and include EBP information in their monthly newsletter. This center found that simply using a more informal staff title of “family coordinator” has strengthened their FPE program and resulted in more consumer and family member engagement.

FPE
Family
Psychoeducation

There have been some critiques of the IMR IRK in Vermont. At least one consumer advocate finds the practice inflexible and suited more for those living in group settings and for staff that have lower caseloads or are working with captured populations. The “course-like” nature of the IRK does not seem to fit the non-linear nature of life, even though the information provided as part of the practice is good. She feels the IMR training needs to stress flexibility in using IMR and in working with individual clients. More emphasis on the role of the consumer in making decisions about IMR would be helpful as well. Further, the IMR sites indicated that IMR is built on the assumption that the case manager already has a good relationship with the client, which raises the question of how IMR will work with new clients.

IMR
Illness Management
and Recovery

IRK
Implementation
Resource Kit

Quality Monitoring

From the perspective of infrastructure, the Department has had a long-standing commitment to using data and analysis in its management and decision support systems. Besides data monitoring and analyses, a major ongoing function of the information system in Vermont is to produce variance reports to review services provided at the different case rate levels that have been established. This allows program managers to monitor services being delivered.

The IMR sites indicate that there is no structured way to get outcomes for this practice. Early in the demonstration, state implementers were concerned how to differentiate these EBP services from other, similar services that the state was already delivering. The state feels that overall, the different level of skill and commitment of the site leadership has an impact on the implementation of the practice and ultimately on the fidelity scores for the practices.

EBP
Evidence-Based
Practice

For both practices, fidelity scores have been increasing steadily. However, the increases have not been dramatic or significant from one evaluation period to another. This suggests that on-going training and technical assistance might be more helpful for these practices. Staff turnover at the agency level may also be affecting these scores. At the time of the second site visit, there had been recent changes made to the fidelity assessment tool due to more things being added to the EBP pilots. This resulted in a longer fidelity review.