

Enhancing Quality and Utilization in Psychosis (EQUIP)

INTERVENTION MANUAL

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Last Revised May 23, 2003

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INTRODUCTION TO EQUIP

Schizophrenia is a debilitating, costly mental disorder, presenting significant challenges to patients and their families as well as to the healthcare organizations responsible for their care. Occurring in 1% of the U.S. population, schizophrenia accounts for 10% of permanently disabled people and 2.5% of all healthcare expenditures. Schizophrenia was largely untreatable until the 1950s, when antipsychotic medications such as chlorpromazine and haloperidol were developed and widely distributed. These medications represented dramatic breakthroughs but, while effective for some patients, caused frequent side-effects. A new medication, clozapine, improves symptoms in many patients who previously failed to respond to treatment; several additional medications have also been released (risperidone, olanzapine, quetiapine, ziprasidone) that, when appropriately used, cause fewer side-effects and improve quality of life for a large proportion of patients. Other beneficial advances include a psychosocial intervention approach, Assertive Community Treatment, that allows severely ill people to live successfully in community settings; interventions for families and caregivers to allow them to cope better with the illness while substantially improving outcomes in patients; and a vocational rehabilitation technology (Individual Placement and Support) that allows a substantial proportion of patients to return to competitive employment. Despite the availability and effectiveness of these strategies, the vast majority of people with schizophrenia who need these treatments do not receive them. Roughly half of people with schizophrenia receive no care at all in a given year. Those that receive some services often do not receive appropriate care: one-third or more receive medication management that is clearly inappropriate, while Assertive Community Treatment is only available to a small minority of patients. Not surprisingly, outcomes under usual care are much worse than those for patients receiving state-of-the-art treatment protocols, with higher rates of relapse and substance abuse and higher risk for homelessness, hospitalization, incarceration, or premature death.

The EQUIP project was funded by the Department of Veterans Affairs Health Services Research and

Development Service (VA HSR&D) to develop, implement and evaluate a collaborative care model for schizophrenia. EQUIP has been implemented at the Greater Los Angeles Healthcare System and the Long Beach Healthcare System in close collaboration with the VA Desert Pacific Mental Illness Research, Education and Clinical Center (MIRECC).

The EQUIP collaborative care model is designed to improve treatment through assertive management of care, involvement and education of caregivers, and feedback of clinical information to clinicians. The model extends proven illness self-management approaches to family members and other caregivers, since these individuals are a critical component of successful treatment for schizophrenia. It creates a collaborative environment within which psychiatrists are responsible for guideline-concordant prescribing, and case managers are responsible for ensuring access to needed treatment services. By implementing a collaborative care model, the project targets key problems in care identified in previous studies of treatment quality in schizophrenia (failure to coordinate and monitor care for individual patients, lack of attention to illness self-management skills, and a minimal availability of clinical information).

As part of the model, EQUIP employs a locally-developed computer system that interfaces with the VA's Computerized Patient Record System (CPRS). The system, "MINT" (Medical Informatics Network Tool), was developed by staff of the Desert Pacific MIRECC. It supports clinicians by improving the availability of clinical data and communication between members of the treatment team, and by providing feedback regarding the extent to which care is consistent with guidelines. The system has a browser-based component for project and data management, reports, and messaging between members of the clinical team. Clinicians use this interface to enter their assessment of a patient's symptoms, side-effects, and other problems in living. MINT also includes applications that reside on the clinician's PC. These applications provide feedback of clinical information and guideline information to psychiatrists, and facilitate messaging between psychiatrists and other members of the treatment team.

Overview of this Manual

This manual describes the two primary components of the EQUIP intervention in which the Care Coordinator has responsibility:

1	Use MINT to gather and manage patient data, which includes conducting Brief Assessments of patients
2	Monitor patient progress, assessing and working with intervention families, and ensuring all intervention patients receive a high level of care from their providers

MINT (Medical Information Network Tool) Overview

The informatics tool, MINT, provides real-time information to psychiatrists about their patients. An internet-based web system facilitates data entry and management, report generation, and care management. Additionally, compiled programs reside on the clinicians' PC and interact with CPRS. When a psychiatrist accesses the record of a patient, an interactive pop-up window is displayed. The window displays the patient's current and recent status including key symptoms and side-effects, compliance with treatment, stressors, medical needs and psychosocial functioning. The window also provides one-click access to treatment guidelines and allows communication between members of the treatment team and the research team.

Prior to a patient's visit with their psychiatrist, nurse clinicians trained in assessment instruments assess the patient's current status and enter the information into the web system. When the psychiatrist next sees the patient they are presented with this information via the pop-up window and can make use of it during their clinical encounter, compare current status with the previous visit status, agree or disagree with the assessments, and communicate with other members of the clinical team.

The text in this section will describe how to:

- Enroll new patients using MINT
- Enter patient consent information into EQUIP web database and CPRS
- Enter patient's consent to contact a family member into EQUIP web database and CPRS
- Login to the EQUIP website
- Add new DataForms for an enrolled patient
- Proofread and Edit DataForms for an enrolled patient
- Use the DataForm to conduct the Brief Assessment for a patient
- Provide information about the EQUIP pop-up screen

USING EQUIP WEB DATABASE AND MINT

Procedure for Enrolling New Patients and Other Mental Health Clinicians (Case Managers, Psychiatrists) and Care Coordinators using MINT

(1) How to enter a new patient into the EQUIP web database

- (a) Run MINT-Enroller by clicking on Windows Start menu → Programs → MINT → Mint-Enroller
- (b) Start CPRS and log in
- (c) Open the chart of the patient to be enrolled
- (d) Go to the task bar at the bottom of the screen and click on “MINT Enroller” to switch to the Enroller application
- (e) Two boxes appear: one on the left has information about the patient from the MINT database (empty if the patient has not yet been enrolled); one on the right has information about the patient from CPRS. If the patient is not already in the database, a button will appear saying “Enroll Patient”. Push the button. A message will appear saying that the patient has been added to the database.
- (f) Repeat steps 1-c through 1-e above for all patients to be enrolled

For all patients that are enrolled, a note must be placed in CPRS about their consent. Choose “research enrollment note” and use the template provided in CPRS. If there is no template at your site use the following template to write the note:

Protocol #: EQUIP Study
Promise #: [enter promise number for your site]

Patient #: [enter patient ID number]

Visit #: Patient Screening and Enrollment

Date of Visit: [enter date of visit]

Date of consent signed: [enter date of consent].

Location of study specific documentation (source document): Pt. Research chart, Room [enter room number]

Consent process was completed & the Pt. Signed the informed consent & given copy. Original consent filed in chart (see below).

For further information, contact [enter name of relevant staff].

Location of consent within chart: Original consent filed in Volume #[enter volume #]

Then the note must be signed.

(2) Enter all remaining patient information in the EQUIP web database

- (a) Start Internet Explorer
- (b) Use Favorites to open the EQUIP web page, or enter <http://10.180.1.76/equip> into Explorer
- (c) Log into the web page
- (d) Select “Participant Info”
- (e) Click on the name of the patient
- (f) Enter Patient ID (which is their EQUIP Project ID), Enrollment Date (which is the Baseline interview date), select site and principal provider. Enter gender, ethnicity, and height in inches. Enter the patient’s phone number and address. Also enter any other contact info including any useful information about how to get in touch with the patient.
- (g) If the patient has not yet been asked for the team to speak with his family/caregiver, indicate that by selecting “Patient not asked”. If the patient does not have a caregiver, click “No Caregiver.” If the patient refused consent for the team to speak to his family/caregiver, click “No.”

NOTE: A “Caregiver” is anyone in the patient’s life who provides them with emotional support and with whom the patient has regular contact (via phone or visits).

If the patient has given consent for the team to speak with his family/caregiver, click “Yes”, and enter contact information in the “Caregiver Contact Info” box. This can include caregiver names, phone numbers, when to call, or any other useful

information. Please note that if the patient has given consent for the team to contact his family/caregiver, you need to also enter a note in CPRS. Use the following template to write the note:

Consent to Contact Family/Caregiver

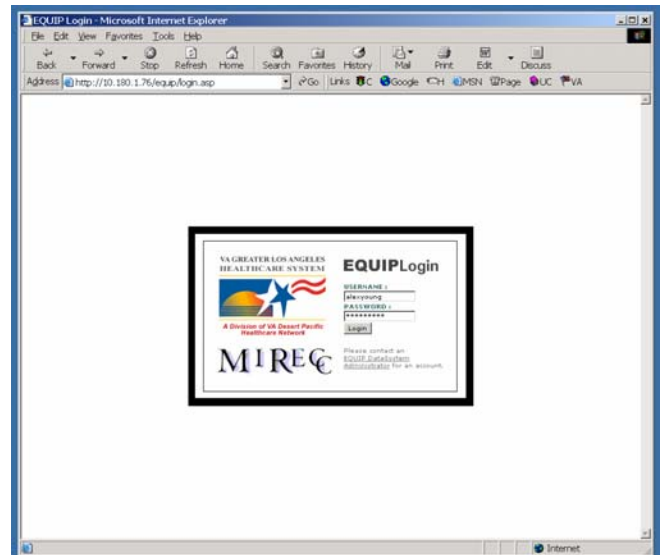
Edit note by choosing which person they have allowed us to contact.

- I discussed with the patient the potential involvement of their caregivers in the treatment process. The patient gave informed consent for the mental health treatment team to talk with their [mother/brother/sister/child] about their care. The patient understands that they can rescind this consent at any time in the future.
- (h) For patient status: All patients are “active”. “Inactive” status is reserved for patients who withdraw from the study.
 - (i) Repeat steps 2-d through 2-g for all patients enrolled.

For further information: contact alexander.young@med.va.gov or amy.cohen@med.va.gov

EQUIP Login Screen

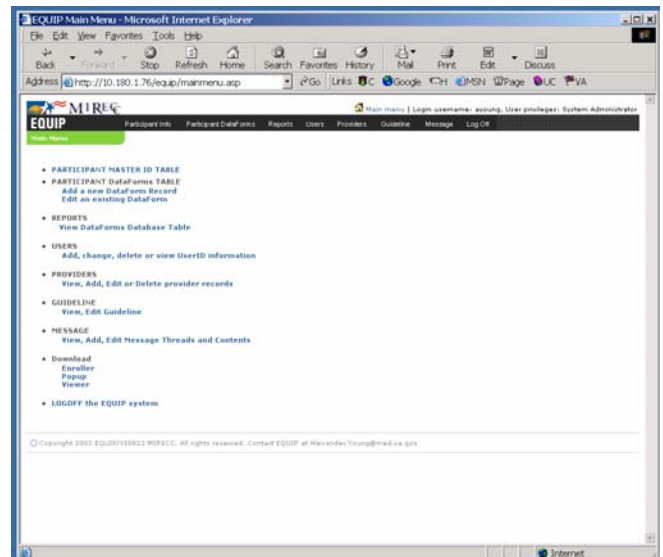
To gain entrance to the system, go to the following URL: <http://10.180.1.76/equip> and enter your username and password at the first screen shown to the right: **EQUIP Login Screen**.



You can change your password once you enter the site by going to the main menu (written in blue next to the little house at the middle top of most of the web screens—see right screen).



On the **Main Menu screen**, the fourth bullet down is “Users”. Clicking on this link will take you to a screen that lists all the users of the EQUIP system. From there you can change your password.



Add DataForm Data

After you enter the username and password, you will be brought to this screen: **Add DataFrom Data**. It lists all the active patients. To add a DataForm, click on the blue ID number for the patient in which you are interested.

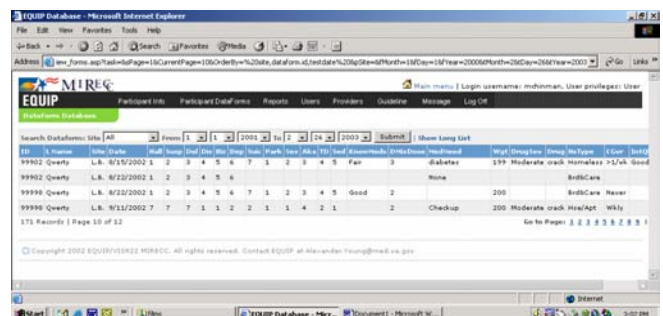
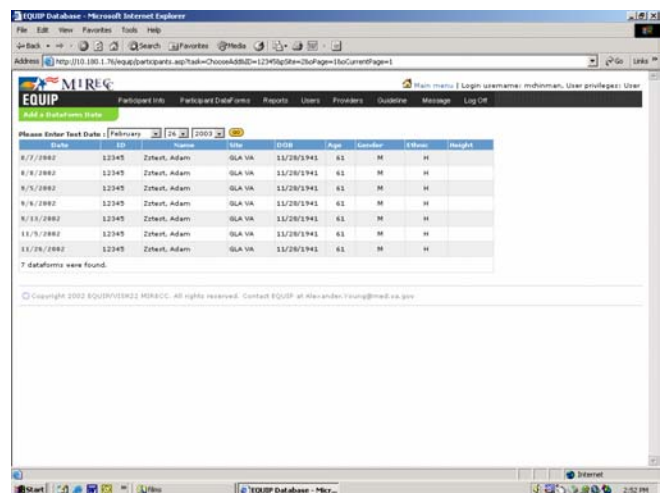
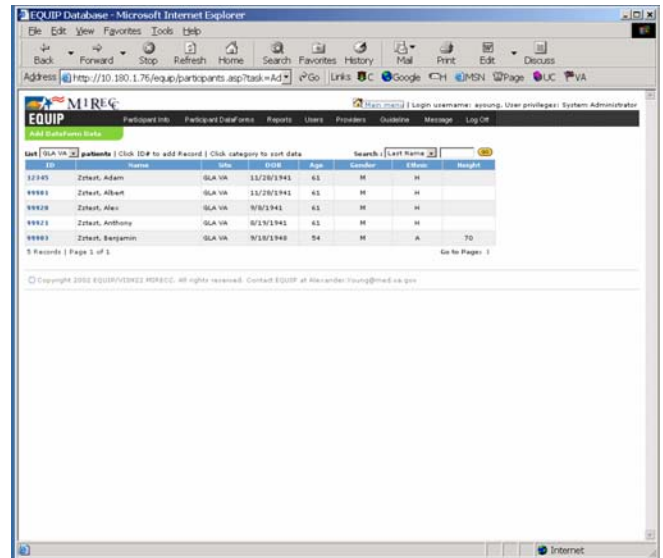
Add a DataForm Date

After you click on the blue ID number, you will be brought here, to the **Add a DataForm Date** screen. Above the blue bar there is a space to enter the month, day, and year of the assessment you are about to perform (today's date). Once you are finished entering the brief assessment date, hit "Go". Then you will be taken to the brief assessment screen (see Brief Assessment section for more details on this screen and how to complete it).

After you complete the DataForm for the Brief Assessment, you will need to proofread (i.e., edit) your data for correctness. This must all be done on the same day as you see the patient. You will not be allowed to edit your DataForms the day after you complete the assessment.

Proofreading your Brief Assessment: The DataForm Database

The way to check your assessments is to use the **DataForm Database**. This screen shows the assessment results of many patients all at once. You can access this under "Reports" from the black bar across the top of most screens. A drop down menu will appear. Choose "DataForm Records" and you will be brought to the screen below. From here, you can visually check the assessment for correctness. If you see an error, then you will need to edit the DataForm.

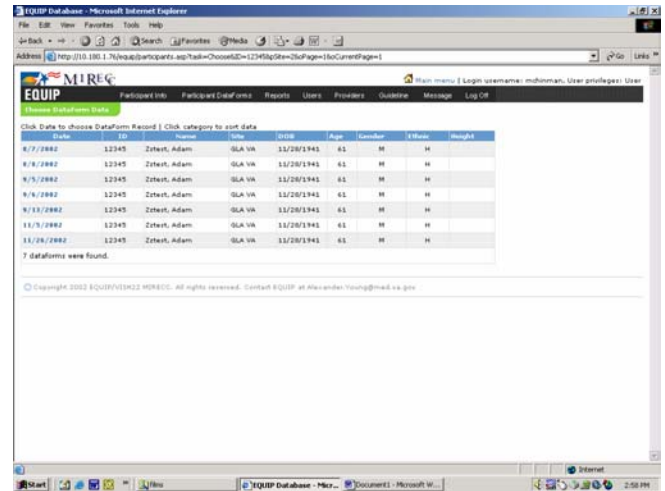


To edit existing DataForms: Choose DataForm Data

To proofread and edit your existing DataForms on the same day, click on “Participant DataForms”. It is listed at the top of most screens in the black bar. A drop down menu will appear. Choose the “Edit/delete DataForm” option. After that, a screen will appear called “Choose DataForm Data” that lists all the active DataForms. Click on the blue date for the one you want to edit. When you do that, the actual DataForm for the Brief Assessment will come up. Then you can edit the information.

When you are done, you have four choices:

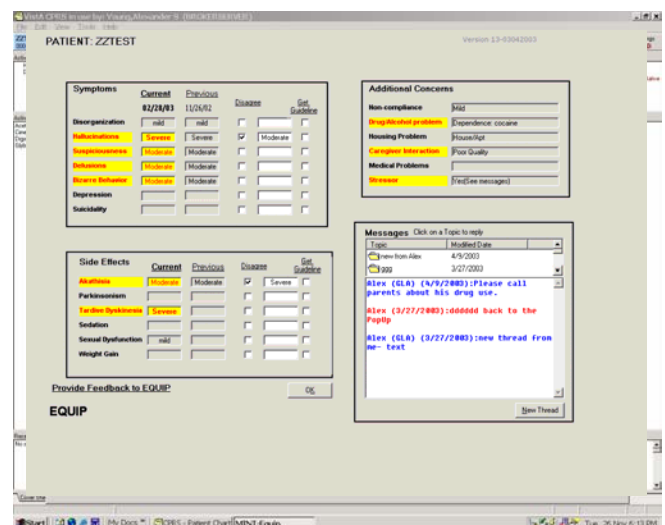
- Update – updates the form with the changes
- Update and send message – updates the form with the changes and sends a new message
- Delete – Deletes the whole DataForm
- Cancel – Leaves the DataForm as is



The Pop-up screen

After you enter the information into the DataForm for the Brief Assessment, it will be saved into the secure EQUIP database. Then, when a provider accesses that patient’s medical record in CPRS, the pop-up screen below will automatically appear. As you can see, it summarizes the information from the Brief Assessment and provides any message you may have sent. Any symptoms or side effects that are “moderate” or “severe” are highlighted. Any additional concerns will be highlighted. Click OK to go to the CPRS chart.

To redisplay the Pop-up after looking at a patient's record, go in the "File" menu in CPRS, and click "Refresh Patient Information". The Pop-up will appear again.



ENTERING BRIEF ASSESSMENTS IN EQUIP WEBSITE

The screenshot shows the EQUIP web application interface in a Microsoft Internet Explorer browser window. The page title is "EQUIP DataSheet - Microsoft Internet Explorer". The browser address bar shows "http://localhost:8080/EQUIP/". The page content includes a header with the EQUIP logo and navigation links: "Patient Info", "Patient Data/Forms", "Reports", "Users", "Profiles", "Database", "Message", and "Log Off". Below the header, there is a patient information section: "CASE ID NUMBER: 9999, NAME: QWERTY, HARRY, TEST DATE: 4/14/2003". The main form is divided into several sections, each with a blue header and a list of radio button options:

- Symptoms:** 1 = Not present, 2 = Very Mild, 3 = Mild, 4 = Moderate, 5 = Moderately Severe, 6 = Severe, 7 = Extremely Severe. Options include Hallucinations, Suspiciousness, Delusions, Disorganization, Suicidal Behavior, Depression, and Solitarity.
- SIDE EFFECTS:** 1 = Not present, 2 = Paradoxical, 3 = Mild, 4 = Moderate, 5 = Severe. Options include Parkinsonism, Sedation, Sex Problems, Akathisia, and TD.
- MEDICATION COMPLIANCE and KNOWLEDGE:** Days without Meds (last week) [3], Knowledge about Medications [2].
- MEDICAL NEEDS:** Radio buttons for N/A, None, Checkup, Current Problem, Weight, and lbs.
- SUBSTANCE ABUSE:** Radio buttons for N/A, None, Use, Abuse, Dependence, and Institution.
- CURRENT HOUSING:** Radio buttons for N/A, House/Apt, Board & Care, and Homeless.
- FAMILY / CAREGIVER:** Radio buttons for N/A, None, >1/Week, Weekly, Less, and Never.
- CAREGIVER INTERACTION QUALITY:** Radio buttons for N/A, Poor, Fair, and Good.
- RECENT STRESSOR:** Radio buttons for N/A, None, and Yes.
- TOTAL TIME SPENT WITH PATIENTS:** [minutes]

At the bottom of the form, there are three buttons: "Submit", "Submit & Send Message", and "Cancel". The browser's taskbar at the bottom shows the Start button and various application icons.

Before each psychiatric visit, the Care Coordinator will perform a brief assessment of the patient's symptoms, side-effects, treatment compliance, substance misuse, housing status, medical conditions, and family/caregiver relationships using the EQUIP web site shown above.

The Care Coordinators will arrange these assessments by using the current VA scheduling system to determine which patients are coming in for appointments each week and then meeting with them for 20 minutes before that appointment. The schedule of all the enrolled patients' appointments can be accessed through the EQUIP system. Go to "Reports" on the black menu bar at the top of most screens. A drop down menu will appear. Choose "Patient Appointments". Then you will be brought to a screen that lists all the enrolled patients' appointments. You can change the site or the time period (this week, next week, next 2 weeks, this month, next 2 months). Then, the Care Coordinators can sort through all the enrolled patient appointments and find those appointments that are specifically for the intervention patients (which are the only patients who receive the brief assessment).

RATING GUIDELINES FOR THE BRIEF ASSESSMENT FORM

Patient Symptoms

Overview

The symptom ratings below (based on the BPRS) provide an efficient, rapid evaluation procedure for assessing symptoms and changes in symptoms in psychiatric patients. Each symptom has a general description and suggested questions to ask a patient. You do not need to ask all the questions each time, the questions are meant to be a guide to collecting the information needed to make a rating. Keep in mind:

- Information to use. Use all available information when making ratings, including interview with the patient, observations of the patient, reports from providers, and information from family members or caregivers.
- Timeframe. When asking these questions, you will need to give the patient a timeframe within which to respond (e.g., “Have you heard voices in the *past week*?”). Unless otherwise indicated, the period of time covered by this assessment should be the past week.
- BPRS ratings. The following is a general guide for all the BPRS items:
 - 1 No symptoms**
 - 2-3 Mild symptoms (could be a variant of normal)**
 - 4-5 Moderate symptoms – should be addressed clinically**
 - 6-7 Severe symptoms – should be addressed clinically as soon as possible**

Each of these general guidelines should be kept in mind while making ratings. However, additional information is presented for each of the specific BPRS items to further help guide the ratings.

The BPRS rating system used by EQUIP was originally developed by Joseph Ventura and colleagues at UCLA and the VA. More information can be found in the article: Ventura J, et al, A. Brief Psychiatric Rating Scale (BPRS) expanded version (4.0). *Int J Methods Psychiatr Res.* 1993; 3:227-243.

Hallucinations are reports of perceptual experiences in the absence of relevant external stimuli. It is useful to monitor the severity of hallucinations during the past week using the Brief Psychiatric Rating Scale (BPRS). Rate the degree to which functioning is disrupted by hallucinations, including preoccupation with the content of hallucinations, and functioning disrupted by acting out on the hallucinatory content. Include thoughts aloud or hearing a voice inside head if a voice quality is present.



Questions to ask during the brief assessment include:

1. Have you heard any sounds or people talking to you or about you when there has been nobody around? What does the voice/voices say? Did it have a voice quality?
2. Do you ever have visions or see things that others do not see?
3. [If present, ask]: Have these experiences interfered with you ability to perform you usual activities/work? How do you explain them? How often do they occur?

1 Not Present

2 Very Mild

While resting or going to sleep, sees visions, smell odors, or hears voices, sounds, or whispers in the absence of external stimulation, but no impairment in functioning.

3 Mild

While in a clear state of consciousness, hears a voice calling their name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations, or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.

4 Moderate

Occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.

5 Moderately Severe

Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.

6 Severe

Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.

7 Extremely Severe

Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.

Suspiciousness is the presence of an expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. A psychotic symptom, suspiciousness is common in schizophrenia. Rate the severity of suspiciousness during the past week. When rating, include persecution by supernatural or other nonhuman agencies (e.g., the devil).



Questions to ask during the brief assessment include:

1. Do you ever feel uncomfortable in public?
2. Does it seem as though others are watching you?
3. Is anyone going out of their way to give you a hard time, or trying to hurt you?
4. Do you feel in any danger?
5. [If present, ask]: Has this interfered with your ability to perform your usual activities/work? How often have you been concerned that [use patient's description]?
6. Have you told anyone about these experiences?

1 Not Present

2 Very Mild

Seems on guard. Reluctant to respond to some "personal" questions. Reports being overly self-conscious in public.

3 Mild

Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her public, but this occurs only occasionally or rarely. Little or no preoccupation.

4 Moderate

Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.

5 Moderately Severe

Same as 4, but incidents occur frequently, such as more than once per week. Patient is moderately preoccupied with ideas of persecution OR patient reports persecutory delusions expressed with much doubt (e.g., partial delusion).

6 Severe

Delusional -- speaks of Mafia plots, the FBI, or other poisoning his/her food, persecution by supernatural forces.

7 Extremely Severe

Same as 6, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.

Delusions consist of unusual, strange or bizarre thought content. Delusions are common in schizophrenia. Rate the degree of unusualness, not the degree of disorganization of speech. Delusions are clearly false or bizarre ideas that are expressed with full conviction. Consider the patient to have full conviction if he/she has acted as though the belief were true. Include thought insertion and broadcasting.



Questions to ask during the brief assessment include:

1. Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV?
2. Can anyone read your mind?
3. Are thoughts put into your head that are not your own?
4. Have you felt that you were under the control of another person or force?
5. [If present, ask]: How often do you think about [use patient's descriptions]?
6. Have you told anyone about these experiences?

1. Not Preset

2. Very Mild

Ideas of reference (people may stare or laugh at him/her), ideas of persecution. Unusual beliefs in psychic powers, spirits, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.

3. Mild

Same as 2, but reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions but without full conviction. The delusion does not seem to be fully formed, but is considered as one possible explanation for an unusual experience.

4. Moderate

Delusion present, but no preoccupation or functional impairment. May be an encapsulated delusion or firmly endorsed absurd belief about past delusional circumstances.

5. Moderately Severe

Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.

6. Severe

Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.

7. Extremely Severe

Full delusions present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking.

Disorganization is the degree to which speech is confused, disconnected, vague or disorganized. A psychotic symptom, disorganization is common in schizophrenia. Rate the severity of disorganization during the past week. Unlike some of the other BPRS items, ratings are made based on the observation of both the patient's behavior and speech. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate the content of speech (delusions).

1 Not Present**2 Very Mild**

Peculiar use of words or rambling but speech is comprehensible.

3 Mild

Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality or sudden topic shifts.

4 Moderate

Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.

5 Moderately Severe

Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking, or topic shifts most of the time OR 3-5 instances of incoherent phrases.

6 Severe

Speech is incomprehensible due to severe impairments most of the time. Many BPRS items cannot be rated by self-report alone.

7 Extremely Severe

Speech is incomprehensible throughout interview.

Bizarre Behavior consists of behaviors, which are odd, unusual, or psychotically criminal. Bizarre behavior generally occurs when schizophrenia is inadequately treated. Rate the severity of bizarre behavior during the past week. Ratings should be based on self-report and observed behavior, and are not limited to behavior during the interview period. Include inappropriate sexual behavior and inappropriate affect.



Questions to ask during the brief assessment include:

1. Have you done anything that has attracted the attention of others?
2. Have you done anything that could have gotten you into trouble with the police?
3. Have you done anything that seemed unusual or disturbing to others?

1 Not Present

2 Very Mild

Slightly odd or eccentric public behavior (e.g., occasionally giggles to self, fails to make appropriate eye contact) that does not seem to attract that attention of others OR unusual behavior conducted in private (e.g., innocuous rituals) that would not attract the attention of others.

3 Mild

Noticeably peculiar public behavior (e.g., inappropriately loud talking, makes inappropriate eye contact) OR private behavior that occasionally, but not always, attracts the attention of others (e.g., hoards food, conducts unusual rituals, wears gloves indoors).

4 Moderate

Clearly bizarre behavior that attracts or would attract (if done privately) the attention or concern of others, but with no corrective intervention necessary. Behavior occurs occasionally (e.g., fixated staring into space for several minutes, talks back to voices once, inappropriate giggling/laughter on 1-2 occasions, talking loudly to self).

5 Moderately Severe

Clearly bizarre behavior that attracts or would attract (if done privately) the attention of others or the authorities (e.g., fixated staring in a social disruptive way, frequent inappropriate giggling/laughter, occasionally responds to voices, or eats non-foods).

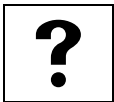
6 Severe

Bizarre behavior that attracts attention of others and intervention by authorities (e.g., directing traffic, public nudity, staring into space for long periods, carrying on a conversation with hallucinations, frequent inappropriate giggling/laughter).

7 Extremely Severe

Serious crimes committed in a bizarre way that attracts the attention of others and the control of authorities (e.g., sets fires and stares at flames) OR almost constant bizarre behavior (e.g., inappropriate giggling/laughter, responds only to hallucinations and cannot be engaged in interaction).

Depression includes sadness, unhappiness, anhedonia (e.g., not receiving pleasure from activities that used to be pleasurable), and preoccupation with depressing topics (e.g., can't attend to TV or conversations due to depression), hopelessness, loss of self-esteem (dissatisfied with self or worthlessness). Depression is common in people with schizophrenia. Rate the severity of depression during the past week. When rating, do not include vegetative symptoms such as motor retardation, early waking, or lack of motivation (which often accompany the "negative" syndrome).



Questions to ask during the brief assessment include:

1. How has your mood been recently?
2. Have you felt depressed (sad, down, unhappy, as if you didn't care)?
3. Do you find that you have lost interest in or get less pleasure from things you used to enjoy, like family, friends, hobbies, watching TV, eating?
4. [If present, ask]: How long do these feelings last? Have they interfered with your ability to perform your usual activities/work?

1 Not Present

2 Very Mild

Occasionally feels sad, unhappy or depressed.

3 Mild

Frequently feels sad or unhappy but can readily turn attention to other things.

4 Moderate

Frequent periods of feeling very sad, unhappy, moderately depressed, but able to function with extra effort.

5 Moderately Severe

Frequent, but not daily, periods of deep depression OR some areas of functioning are disrupted by depression.

6 Severe

Deeply depressed daily but not persisting throughout the day OR many areas of functioning are disrupted by depression.

7 Extremely Severe

Deeply depressed daily OR most areas of functioning are disrupted by depression.

Suicidality includes desire, intent or actions to harm or kill oneself. Suicidality is common in schizophrenia. Research has shown that up to half of patients will make a suicide attempt and about 10% will die by suicide.

Special attention should be paid to suicidality in the presence of command hallucinations, and to whether a patient is thinking of suicide, since suicidal ideation is the best predictor of a subsequent suicide attempt in schizophrenia. The coexistence of substance abuse also increases the risk of suicidal behavior. Families, caregivers, and friends can be helpful in determining the risk of self-harm and in assessing the patient's ability to care for themselves.



Questions to ask during the brief assessment include:

1. Have you felt that life wasn't worth living?
2. Have you thought about harming or killing yourself?
3. Have you felt tired of living or as though you would be better off dead?
4. [If present, ask]: How often have you thought about [uses patient's description]?
5. Did you (Do you) have a specific plan?

1 Not Present

2 Very Mild

Occasional feelings of being tired of living. No overt suicidal thoughts.

3 Mild

Occasional suicidal thoughts without intent or specific plan OR he/she feels they would be better off dead.

4 Moderate

Suicidal thoughts frequent without intent or plan.

5 Moderately Severe

Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviors.

6 Severe

Clearly wants to kill self. Searches for appropriate means and time OR potentially serious suicide attempt with patient knowledge of possible rescue.

7 Extremely Severe

Specific suicidal plan and intent (e.g., "as soon as _____ I will do it by doing X"), OR suicide attempt characterized by plan patient thought was lethal or attempt in secluded environment.

Medication Side Effects

Monitoring side-effects is an important part of treatment. Patients who experience difficult side effects will be less likely to continue with their medication regimens. The side effects are often monitored through observation, but there are also questions listed below that can be used to determine how much the side effects are affecting a patient's life. There are many possible side effects of psychiatric medication. The ones that Care Coordinators will be asked to assess (and are the most common) are:

- Sexual Problems
- Sedation
- Tardive Dyskinesia
- Akathisia
- Weight & weight gain

Sexual Problems

When asking about sexual problems due to medications, the primary problems experienced by **males** are a decrease in libido, and a change in erectile or ejaculatory functions. With specific antipsychotic medications, including thioridazine and risperidone, retrograde ejaculation has been reported. The primary problems experienced by **females** are a decrease in libido, menstrual irregularities or a stop in menses, and inappropriate lactation from their breasts.

Sexual dysfunction occurs most often with the older antipsychotic medications and risperidone. It is relatively uncommon with olanzapine, quetiapine and clozapine. Sexual dysfunction can often be improved by reducing the antipsychotic dosage (if possible) or switching to a medication with a low risk of sexual dysfunction. If dose reduction or a switch to an alternative medication is not feasible, yohimbine or cyproheptadine can be used, however, they are usually not effective. If problems persist, physical explanations should be ruled out.



Questions to ask during the brief assessment include:

1. To rule out physical explanations: Do you have any physical problems that could be contributing to the problem (e.g., results of surgery)?
2. To rule out relationship explanations: What is the status of your relationship with your partner?
3. How is your situation now different from before? How did you perform before?

For men:

1. Are you able to obtain and maintain an erection?
2. Are you able to achieve orgasm as before?

For women:

1. How often are you having your period?
2. Has your menstrual flow changed (become heavier or lighter)?
3. Have you noticed any lactation from your breast (undergarments are wet)?

1 Not Present

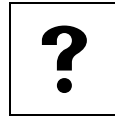
- 2 **Possible**; unclear if the patient even has the problem, very intermittent symptoms that do not inhibit sexual functioning
- 3 **Mild**; the presence of characteristic symptoms, but not to an extent that it causes a problem with sexual functioning
- 4 **Moderate**; clearly present; should be looked at--but not necessarily immediate; somewhat impairing of sexual functioning
- 5 **Severe**; has a significant problem with sexual functioning; cannot perform sexually

Akathisia

Akathisia is one of the most common and distressing adverse effects of antipsychotic drugs, being associated with poor compliance with treatment and therefore an increase risk of relapse. Patients with akathisia are also at elevated risk for developing tardive dyskinesia. Akathisia is characterized by somatic restlessness. Patients complain of an inner sensation of restlessness and an irresistible urge to move various parts of their bodies. Objectively, this appears as increased motor activity (e.g., rocking while sitting or standing, lifting feet as if marching on the spot and crossing and uncrossing the legs while sitting). The most common form involves pacing and an inability to sit still.

A common problem in assessing patients with akathisia is distinguishing this side-effect from psychomotor agitation associated with psychosis. Mistaking akathisia for psychotic agitation and raising the dose of antipsychotic medication usually leads to worsening of the akathisia, while treating psychotic agitation as akathisia (by adding a beta-blocker) will have little benefit.

If possible, it is ideal for patients to be observed while they are seated and then standing while engaged in neutral conversation (for a minimum of 2 minutes in each position). More information on rating akathisia can be found in the article: Barnes TR. A rating scale for drug-induced akathisia. *Br J Psychiatry*. 1989;154:672-676.



In addition to observation, questions to ask during the brief assessment include:

1. Do you feel restless? How often? What situations do you feel restlessness the worst?
 2. How bothered do you feel by your restlessness?
- 1 Not present;** No evidence of awareness of restlessness. Observation of characteristic movements of akathisia in the absence of a subjective report of inner restlessness or compulsive desire to move the legs should not be classified as akathisia
 - 2 Possible;** occasional fidgety movements; could be within normal range; non-specific inner tension
 - 3 Mild;** presence of characteristic restless; shuffling movements of the legs/feet, or swinging of one leg, while sitting, *and/or* rocking from foot to foot or “walking on the spot” when standing, *but* movements present for less than half the time observed. Awareness of restlessness in the legs and/or inner restlessness worse when required to stand still. Condition causes little or no distress.
 - 4 Moderate;** clearly present as described in (3) above, which are present for at least half of the observation period or combined with characteristic restless movements such as rocking from foot to foot when standing. Patient finds the condition distressing.
 - 5 Severe;** constantly engaged in characteristic restless movements, *and/or* has the inability to remain seated without walking or pacing, during the time observed. The patient reports a strong compulsion to pace up and down most of the time and feeling a great deal of distress.

Tardive Dyskinesia

Tardive dyskinesia (TD) is a hyperkinetic abnormal involuntary movement disorder caused by sustained exposure to antipsychotic medication. It typically affects neuromuscular function in the oral-facial region (e.g., look for unusual grimacing, frowning, blinking, smiling, or odd repetitive movements of the jaw or tongue). Rapid movements of the arms, legs, and trunk may also occur. Impaired movements of the fingers may appear as though the patient is playing an invisible guitar or piano. The movements are usually choreoathetotic, though other antipsychotic-induced movement disorders also have a tardive form. TD occasionally interferes with manual dexterity and eating. Diaphragmatic involvement produces grunting, difficulty in speaking, and, sometimes, in breathing.

With older antipsychotic medications, TD occurs in about 4% of adults per year. In older adults and geriatric populations, rates of TD are much higher. Be especially alert for these symptoms in the older patients. If TD is allowed to persist over time, the likelihood of reversibility diminishes. The second generation antipsychotic medications cause much less TD. Clozapine causes no TD, and the risk with quetiapine also is probably very low. While good data is lacking, olanzapine and risperidone appear to cause TD in about 0.5% of adults per year. It is too early to know the risk with ziprasidone, but one might expect it to be similar to risperidone. Movements in TD may worsen with emotional stress, volitional motor activity, and attempts to inhibit portions of the dyskinesia. On the other hand, movements decrease with sedation and disappear during sleep. Movements tend to be worse in the afternoon and least severe just after the patient has awoken in the morning (Hyde et al 1995).

Hyde TM, Egan MF, Brown RJ, et al (1995). Diurnal variation in tardive dyskinesia. *Psychiatry Res* 56:53-7.

Use observation or self-report to determine whether the patient has the following:

- Mild (in early stages) or exaggerated movements of the tongue and lips
- Bulging of the cheeks
- Unusual or inappropriate chewing movements
- Unusual or inappropriate blinking
- Blepharospasm
- Grimacing
- Unusual or inappropriate arching of the eyebrows
- Movements of the extremities and trunk, including choreoathetoid-like movements of the fingers, hands, arms, and feet
- Truncal involvement that produce rocking and swaying and rotational pelvic movements
- Grunting, difficulty in speaking or breathing

1 Not present

2 **Possible**; unclear if the patient has the symptoms, or very intermittent

3 **Mild**; occasional TD symptoms; little or no impairment

4 **Moderate**; clearly present; should be looked at--but not necessarily immediate; somewhat impairing

5 **Severe**; constant; should have immediate attention by MD; clearly impairing

Sedation

Sedation is the single most common side effect of antipsychotic medications. Many patients experience some sedation, particularly during in the initial phases of treatment. Most patients develop some tolerance to the sedating effects with continued administration. This can take between a few days and a few weeks. For agitated patients, the sedating effects of these medications in the initial phase of treatment can have therapeutic benefits. However, when sedation persists into maintenance treatment, causing daytime drowsiness, it becomes a problem. A key part of determining the amount of sedation due to the psychiatric medications is also determining whether the patient is using drugs or alcohol (see substance abuse section in this manual).



Questions to ask during the brief assessment include:

1. Do you have trouble staying awake and alert all day even after a good night's sleep?
2. Have you been experiencing periods during the day when you feel extremely drowsy?
3. Is being tired during the day interfering with your daily activities?
4. How are you sleeping at night?

1. Not present

2. **Possible**; unclear if the patient has the symptoms (i.e., may be tired for another reason, or very intermittent)
3. **Mild**; occasional sleepiness during the day; little or no impairment
4. **Moderate**; clearly present; should be looked at--but not necessarily immediately; somewhat impairing
5. **Severe**; feels sedated daily; needs attn from MD; clearly impairing

Weight and Weight Gain

Weight gain is one of the most important side-effects of the newer second generation antipsychotic medications. Being overweight places an individual at increased risk for diabetes, hyperlipidemia, morbidity and death due to a variety of causes. Given their high risk for obesity from obesity and other causes, all patients with schizophrenia should have their weight monitored. It is helpful to calculate a patient's Body Mass Index (BMI). BMI equals an individual's weight in kilograms divided by the square of their height in meters. A BMI calculator is available at www.nhlbhsupport.com/bmi/bmicalc.htm and a table for figuring BMI is available at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. Normal BMI is between 19 and 25, overweight BMI between 25 and 30, and a BMI above 30 indicates obesity. People with a BMI between 19 and 22 live the longest.

Medication Compliance & Knowledge

Days without Meds (past week; past few months)

It is critical that patients remain compliant with their medication regimens.



Questions to ask during the brief assessment include:

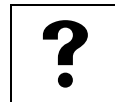
1. In the past seven days, were there any days in which you did not take your medication?
2. Since I last saw you, on average, how many times have you missed taking your medication?

If the last week is typical of the patient's medication compliance, use that week only to rate. If the last week is atypical, use an average rating over the past few months to more closely represent the patient's typical medical compliance.

0 days	3 days	6 days
1 day	4 days	7 days
2 days	5 days	

Knowledge about Medications

Patients who have a better knowledge of their medications and what they do for them may be more likely to remain compliant to their regimens. Ask the patient to tell what their medication regimen is, including names of all the drugs, the doses, and what each medication is supposed to do for them (in layman's terms, e.g., "It helps with my thinking").



Questions to ask during the brief assessment include:

1. What are all the medications you take? How often?
2. What do each of the medications do for you?

Poor; Doesn't know names/dosage/or concrete description. Concrete description of medication(s) only (e.g., four blue pills, a monthly shot, etc.)

Fair; Medication(s) names and some information about dose

Good; Medication(s), specific dosage (e.g., Olanzapine 6mg in am and pm or 2x daily), and what the medication does

Medical Needs & Concerns

All veterans are supposed to have a general medical examination (a “physical”) at least once every year if there are no other medical problems that require more frequent attention. Ask the patient when they had their last physical and if they have any ongoing medical problems. Since those with severe mental illness are often poor historians about their own lives, you will also be able to find this information in their CPRS medical record. If the patient does have a medical condition, you will need to find out from them or from the medical record what is needed to properly manage the problem.



Questions to ask during the brief assessment include:

1. When was your last physical?
2. Do you have any ongoing medical problems?
3. Do you feel uncomfortable or pain for long periods?
4. Are you currently taking any medication for physical problems?

Not available; Not able to obtain the needed information to make a judgment.

None; Has no medical problem that requires attention, has had a physical within a year.

Needs General Check up; Has NOT had a general physical in over a year

Has specific current problem (write in)

In the web system, there is limited space to write the medical problems. Focus on documenting problems that require an intervention, problems that are poorly managed, or problems that the physician should otherwise be aware of. Use common abbreviations when possible, such as “HTN” for hypertension.

Please weigh participants at each brief assessment.

Weight: _____ lbs.

Alcohol & Other Drug Abuse

Substance abuse is common in this population and can be extremely disrupting to the patients' lives. It often complicates the use of psychiatric medications, drains all their financial resources, leads to involvement in the criminal justice system, and prevents them from obtaining stable housing or employment.

Determine how disruptive drugs or alcohol have been in various domains of their lives (social, occupational, psychological, or physical) in the past MONTH.



Questions to ask during the brief assessment include:

1. How much drug/alcohol do you typically use?
2. Have you ever tried to cut down how much you use but could not?
3. Have you felt guilty about how much you use?
4. Have others told you that you need to cut down how much you use?
5. Do you feel you need to use more to get the same effect?
6. Does your use get in the way of getting things done in your life (like work/finding a job, keeping up your home/looking for a home, having relationships)

Not available; Not able to obtain the needed information to make a judgment.

None; Patient has not used drugs during this time interval or patient has a history of use but is on methadone or is participating in other types of drug treatment and is currently not using.

Use; Patient has used drugs during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.

Abuse; Client has used drugs during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior and housing problems. Problems have persisted for at least one month.

Dependence; Meets criteria for "Abuse" plus at least three of the following:

- greater amounts or intervals of use than intended
- much time spent obtaining or using substance
- frequent intoxication or withdrawal interferes with other activities
- important activities given up because of drug use
- continued use despite knowledge of substance-related problems
- marked tolerance
- characteristic withdrawal symptoms
- drugs taken to relieve or avoid withdrawal symptoms

Example of Dependence: Binges and preoccupation with drugs have caused client to drop out of job training and non-drug social activities.

Institutionalization; Meets criteria for "Dependence" plus related problems are so severe that they make non-institutional living difficult and as a result, the patient is currently residing in a treatment facility of some type (e.g., residential treatment facility, inpatient hospitalization for substance abuse, halfway house, etc).

Write in the blank space provided where the patient is institutionalized.

More information about diagnosis of substance misuse can be found in the "DSM" manual: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR*. Washington, DC: American Psychiatric Press; 2000.

Current Housing

A significant proportion of psychiatric patients experience homelessness (about one third although it is difficult to estimate). Although the impairments that accompany severe mental illnesses and their medications can make it difficult to obtain stable housing, the lack of affordable housing in many urban areas also contributes to the problem.

Homelessness makes it difficult for those with a severe mental illness to stabilize their lives and can also be associated with substance abuse. Even when sufficient financial arrangements are made for a homeless individual, there may be resistance because of the “requirements” that come with an independent, housed lifestyle (avoiding substance use and other persons who engage in that lifestyle, paying rent regularly, maintaining the apartment or house). Often “transitional” housing arrangements are good ways to bridge the gap between homelessness and independent living.



Questions to ask during the brief assessment include:

1. Where have you lived in THE LAST TWO WEEKS?
2. If they have changed locations within the last two weeks: Where were you living most recently?
3. Have you been staying with friends or relatives? If so, is that a permanent arrangement, or are you expected to leave soon?
4. Have you been staying at a shelter?
5. Have you been staying outside?

Not available; not able to obtain the needed information to make a judgment

House/Apartment; This is when they have their own house or apartment that they own or rent, even if it is through a program such HUD’s Section 8 or Shelter Plus Care programs. Could also be an apartment in which they have paid staff visit to provide support or that they live with a family member or caregiver.

Board & Care; Use this category to indicate if the patient is living in any type of structured living arrangement as indicated by paid staff either working (more than just a visit) or live on the premises

Homeless; Rate the patient as homeless if they have either:

- slept outdoors, in an abandoned or public building, an automobile, a shelter, or at someone else’s residence temporarily for 7 out of the last 14 days

OR

- temporarily housed with no long-term plan, for example received a notice-to-quit and/or eviction papers or a request to leave the home of family, caregiver, friend, or significant other and has no plan for housing; or is temporarily residing in a hotel or motel but only has funds for a short stay, again with no plan after that stay

Family/Caregiver Contact

This item establishes how much contact the patient has with their family.



Questions to ask during the brief assessment include:

1. Do you have any family?
2. How much contact do you have with them?

Not available; Not able to obtain the needed information to make a judgment

None; lives alone; cares for self; Has no family
> **1/week;** Two or more contacts with family per week

Weekly; One contact with family per week

Less than weekly; Less than one contact with family per week

Never; Has no or rare contact with family

Quality of Caregiver Interactions

This item relates to how well the patient is interacting with his or her family or caregiver. The information used to rate this item may be obtained through patient report, family/caregiver report, or staff observation of family interactions.



Questions to ask during the brief assessment include:

1. How have you and your family or caregiver been getting along since we last spoke? Any difficulties?
2. Has your family or caregiver been prompting or nagging you about anything since we last spoke? Did you argue? What about? (If they say yes, ask for specifics—Did relatives raise their voices? Throw things? Did anyone get hurt or call the police?)
3. How does your family or caregiver feel about you being on medication and coming to the VA? Do they help you with any of your care (e.g. reminding you of appointments, filling your prescriptions, giving you a ride)?
4. Since we last spoke, has your family or caregiver been pleased or alternatively, worried about how you are doing? How can you tell?

Not available; not able to obtain the needed information to make a judgment

Poor; Reports from patient, family, or caregiver of frequent arguments or heated verbal discussions; threatening behavior between any family member or caregiver and the patients; frequent calls from family member or caregiver to the clinic with signs of distress (angry, crying, etc); family member or caregiver talking with hostility to patient; patient reports family members or caregivers are frequently angry with him/her; family members or caregivers demonstrate little understanding of illness (e.g., may encourage patient to use substances with them, not take meds, miss appointments at clinic, etc) or actively avoiding each other

Fair; occasional reports of family or caregiver arguments, but not as bad as above; family members or caregivers have at least limited insight into relative's illness; do not overtly act against treatment recommendations

Good; No overt signs of conflict in family or with caregivers; members speak empathetically about each other; family or caregiver has good insight into relative's illness and supports participation in treatment (e.g., provides rides, reminds patient of appointments, etc); family members or caregivers may express overt warmth to each other

Recent Stressor

Severe mental illnesses can exacerbate when the individual is under stress. Therefore, it is important to identify important stressors for the patient, and to monitor stressors.



Questions to ask during the brief assessment include:

1. Have you been under any stressors lately?
2. Have you experienced any big changes in your life recently?
3. Are you feeling “overwhelmed” by something recent in your life?

If an important stressor is identified, information on the stressor should be entered in the messaging component of the MINT system (see below for more information on messaging).

Duration with Patient

Enter the total time spent with the patient in minutes.

ENDING THE BRIEF ASSESSMENT

Providing Feedback to the Patient

In order to educate and empower the patient to be aware of his current symptom and side effect status, it is important to end the brief assessment by providing feedback to the patient. Ideally, the Care Coordinator would write down the most significant symptoms or side effects that are currently affecting the patient.

For example:

Date: 5/15/03

Current Problems: Worries about being followed (Delusions), voices (Hallucinations), weight gain (20 lbs over last 4 months)

Do not include the patient's name or any identifying information (project ID, SSN, Last 4 SSN) on this card in case the patient loses it.

As an alternative, the Care Coordinator can provide this feedback verbally to the patient. The idea here is that the patient becomes educated about his illness, aware of his current problems, improves his ability to self-monitor and identify problems.

Submitting a Message

It may be necessary to send the provider a message about what was learned in the assessment. The Care Coordinator should send a message to the provider when the patient discloses the presence of

- a stressor (describe the nature of the stressor)
- significant distress with family or caregivers (describe the nature of the problems)
- medical problems
- poor medication compliance (more than two days per week on average missing medications)
- recent or prolonged homelessness
- any other important clinical development that a provider should know

To send a message hit the “submit and Send Message” button at the bottom of the brief assessment form.



In addition, if the Care Coordinator conducts the Brief Assessment after the patient has had an appointment with the Psychiatrist, the Care Coordinator should send a message to the patient's Psychiatrist and case manager (if there is one) about issues that need to be addressed as soon as possible.

FAMILY OR CAREGIVER ASSESSMENT

Signs of Family Stress

In addition to the two Family items in the Brief Assessment, the Care Coordinator should be alert for signs of conflict and stress within the family or with caregivers. Family/caregiver stress is related to poorer outcome in schizophrenia, especially in service systems with few resources for patients. Signs of stress typically include:

1. Patient reports of conflict with relatives or caregivers
2. Frequent calls from a relative or caregiver to the clinic complaining about the patient
3. Signs of distress (tearfulness, irritation) from a relative or caregiver when interacting with staff
4. Patient not doing well clinically—frequent hospitalizations or crises.

In the EQUIP project, staff should be continually alert to any of these signs, as they suggest that the family or caregivers might benefit from more education and support. Questions addressing these topics should be standard components of routine clinical follow-ups.

Brief Telephone Screen

After obtaining consent from the patient and mailing information about self-help resources (see Page 48 under “Information Dissemination”), three attempts will be made to contact each patient’s key relative or caregiver on the phone so Care Coordinators can introduce themselves to this person, describe the EQUIP project briefly, and ascertain whether they have any concerns regarding the patient’s 1) level of symptoms; 2) level of side-effects; and 3) compliance. Care Coordinators will also inquire about how the relative or caregiver is coping with the relative’s illness and whether they have any other concerns about the patient.

Also at this time, the Care Coordinator should inquire whether the person has every attended

NAMI meetings and what his/her experiences were (Appendix A). If the relative or caregiver has never been to a meeting, or had a negative experience, the provider can inquire about this situation, discuss issues of reluctance (e.g. one bad meeting does not mean the organization is not worthwhile—sometimes you have to go to a few different ones to find a good match), and problem-solve any impediments to attendance (e.g. transportation, child-care issues).

One year after this initial contact, the Care Coordinator or another staff member will again call the relative or caregiver and repeat the questions in Appendix A.

CONTACTING FAMILY WHEN DIFFICULTIES ARISE

If a Care Coordinator has concluded that the patient or their family or caregiver have significant difficulties, they will refer the patient to the provider at their clinic who has received special training to provide the EQUIP family/caregiver education and support intervention (described below). The criteria for determining whether the patient and their families or caregivers require this intervention are any one of the following (this only applies to those patients who have regular contact with their family or caregiver):

- Patient reports significant stress in their relationship with their family or caregiver
- Patient is hospitalized for psychiatric care
- Patient evidences a noticeable decline in medication compliance
- Patient’s family or caregiver calls the provider and/or Care Coordinator stating that the patient has become difficult to manage

MONITORING AND INTERVENTION

Based on the results of the brief and family assessments, the Care Coordinator may need to draw extra attention to certain areas of a patient's life for a certain period of time. Monitoring will allow the Care Coordinator to take action if a particular area does not improve or worsens. When this is the case, the Care Coordinator will need to place a note in the "tickler" file to this effect in order to remind himself or herself that this area needs to be more closely monitored.

EQUIP Tickler File

The tickler file is a box that houses index cards for the enrolled patients. It is designed to organize key information about each patient and help the Care Coordinators in following up. Each patient has his or her own card. Within the box there are three tabs, one entitled "this week", one entitled "next week", and another entitled "in two weeks". Behind these tabs are tabs for each letter of the alphabet. First, all the intervention patients are filed according to the first letter of their last name. The Care Coordinator will prepare for the following week on a Friday by pulling out cards for patients who have an appointment out of the alphabetized listing and placing the card in the "this week" tab. They also will move up any patient cards in the "in two week" tab to the "next week" tab and any "next week" cards to the "this week" tab. When the patients from "this week" are seen, the Care Coordinator will make any notations on the cards that is necessary (reasons for doing so are presented throughout the manual) and either file it back into the alphabetized list (if no follow up is needed) or into one of the "next week" or "in two weeks" tabs if follow up is needed. Behind the alphabetized list are all the cards for patients in the care as usual group. These cards for care as usual patients are made available in case a patient moves to the intervention group.

If the brief assessment shows that the patient has severe problems or that they have not improved after being in treatment for several weeks, the Care

Coordinator will need to take action. This could be in the form of making a suggestion to the provider through the note field of the brief assessment form, calling the provider directly to discuss the issue, or in some instances calling the patient or the patient's family. When this type of action is taken, notes should also be made in the tickler file to remind the Care Coordinator of any follow up that is needed.

In general:

No symptoms and side effects, no social problems need to be contacted every three months for brief assessment.

Moderate symptoms and side effects need to be contacted monthly for brief assessment.

Severe symptoms and side effects need to be contacted weekly for brief assessment.

The following are guidelines for how to decide the type of ongoing monitoring or intervention that is needed. The suggestions found here will not apply to every patient, and do not substitute for a clinician's judgment. They are, instead, information drawn from a number of sources, including, in particular, treatment guidelines. For further information, the following guidelines may be of particular interest:

Veterans Health Administration. *Clinical Guideline for Management of Persons with Psychoses, Version 1.0*. Washington, DC: Department of Veterans Affairs; 1997.

American Psychiatric Association. Practice guideline for the treatment of patients with schizophrenia. *American Journal of Psychiatry*. 1997;154: 1-63.

Lehman AF, Steinwachs DM. Translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. *Schizophrenia Bulletin*. 1998; 24:1-10.

Patient Symptoms

With appropriate antipsychotic medication, psychotic symptoms such as *hallucinations, bizarre behavior, suspiciousness, delusions, disorganization*, can be reduced to Mild or below in most patients with schizophrenia. Substantial improvement should be seen within 1 to 4 weeks on a medication dosage. Therefore, Care Coordinators can monitor a patient's situation when first starting a new medication regimen in order to assess its effectiveness. Any symptoms rated in the moderate range might not warrant immediate action, but just more close monitoring in the next several weeks to a month to see if the issue resolves.

If these symptoms are not improving after three months, or remain at Moderate or above for three months, one should determine whether the patient is taking the prescribed medication on a daily basis. The Care Coordinator should not only make sure to complete the medication compliance section on the brief assessment form, but should prompt the psychiatrist and case manager (if there is one) to also assess the patient's medication compliance as well.

Here are some guidelines for the initial treatment for an acute episode of psychotic symptoms.

For a first episode patient with predominantly positive symptoms	<i>Newer atypical antipsychotic (risperidone, olanzapine, quetiapine, aripiprazole)</i>
For a first episode patient with both prominent positive and negative symptoms	<i>Newer atypical antipsychotic</i>
For a patient who has a breakthrough episode despite good compliance with a conventional antipsychotic	<i>Switch to a newer atypical antipsychotic</i>
For a patient who is noncompliant with oral medication or has persistent denial of illness	<i>Switch to a long-acting depot antipsychotic (e.g., haloperidol decanoate)</i>

Here are some guidelines for a patient with an inadequate response to initial treatment. (The duration of the treatment trial should be 3–8 weeks in patients with little or no therapeutic response or 5–12 weeks in patients with a partial response):

If the inadequate response was:	For persistent positive symptoms	For persistent negative symptoms
To a conventional antipsychotic (e.g., Thorazine, Mellaril, Prolixin, Navane, Haldol)	<i>Switch to a newer atypical antipsychotic</i>	<i>Switch to a newer atypical antipsychotic</i>
To a newer atypical antipsychotic	Switch to a different newer atypical antipsychotic <i>or</i> Raise the dose of the atypical antipsychotic	Switch to a different newer atypical antipsychotic
To sequential trials of conventional and newer atypical antipsychotics	<i>Switch to clozapine</i> <i>or</i> Switch to another newer atypical antipsychotic <i>or</i> Raise the dose of the newer atypical antipsychotic	Switch to clozapine <i>or</i> Switch to another newer atypical antipsychotic
To multiple previous antipsychotic trials including clozapine (persistently refractory)	There is no definite expert consensus	

(***Bold italics*** = treatment of choice)

Medication Side Effects

If any of the side effects in the brief assessment such as *Sexual problems, Akathisia, TD, Sedation* are rated as Moderate, the Care Coordinator should ask the patient if these problems are related to any medication noncompliance they may be exhibiting. Any comments about side effects should be noted in the note field of the brief assessment form and in the tickler file for monitoring to see if the psychiatrist takes action to resolve the side effects (switches to another medication, adds a side effect medication, reduces the dose, etc.). If the treating psychiatrist does not take action to resolve side effects, the Care Coordinator should call and problem-solve with the psychiatrist.

The following are general guidelines to follow when addressing side effects:

Akathisia

Changing to a different antipsychotic medication should be considered. Antipsychotic medications differ in the frequency with which they cause akathisia. The second generation antipsychotic medications cause much less akathisia than older medications. If a patient is on an older antipsychotic medication, a switch to a second generation agent should strongly be considered. Of the second generation medications, akathisia is most likely to be caused by risperidone and ziprasidone, less likely by olanzapine, and rarely (if ever) by quetiapine. Clozapine does not cause akathisia.

Another first line treatment of akathisia is propranolol in doses of 20-160 mg/day (tid or qid dosing). If this fails, or only partially relieves this side-effect, benzodiazepines can be useful. Lorazepam and clonazepam are common choices. Lowering the antipsychotic medication dosage is another option. Anticholinergic medications are generally not effective in reducing akathisia.

References & For More Information:

APA guideline:
http://www.psych.org/clin_res/pg_schizo_3.cfm#c

TIMA project:

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html>

General information:

http://www.psych.org/clin_res/pg_schizo.cfm or
<http://www.mirecc.org/resources.shtml>

Tardive Dyskinesia

In patients who have TD, a reduction in antipsychotic dosage should be considered. For instance, the dose can gradually (over 12 weeks) be reduced by 50%. Frequently, this will lead to a decrease or remission of tardive dyskinesia. An initial increase in TD after withdrawal or dose reduction (withdrawal dyskinesia) may also occur in some patients.

If dose reduction is not advisable or effective, the best choice is to consider switching to a medication with little potential to cause or worsen TD. For patients with severe or progressive TD, clozapine is the treatment of choice. Quetiapine may also be a good option, though there is little data on this. For the patient with mild TD that is not causing functional or cosmetic problems, switching from an older medication to olanzapine, risperidone or ziprasidone may be reasonable.

References & For More Information:

APA guideline:

http://www.psych.org/clin_res/pg_schizo_3.cfm#c

TIMA project:

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html>

General information:

http://www.psych.org/clin_res/pg_schizo.cfm or
<http://www.mirecc.org/resources.shtml>

Sedation

When significant sedation persists, options include lowering of the total daily antipsychotic dose, consolidating divided doses into one night-time dose, or changing to a less sedating antipsychotic medication. Among the older medications, low-potency agents, such as chlorpromazine, cause the most sedation. Among the second generation antipsychotic medications, clozapine and quetiapine

cause the most sedation. Sedation is less likely with olanzapine, risperidone and ziprasidone.

References & For More Information:

APA guideline:

http://www.psych.org/clin_res/pg_schizo_3.cfm#c

TIMA project:

<http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html>

General information:

http://www.psych.org/clin_res/pg_schizo.cfm or

<http://www.mirecc.org/resources.shtml>

Sexual Dysfunction

Sexual dysfunction can often be improved by reducing the antipsychotic dosage (if possible) or switching to a medication with a low risk of sexual dysfunction. If dose reduction or a switch to an alternative medication is not feasible, yohimbine or cyproheptadine can be used, however, they are usually not effective.

References & For More Information:

APA guideline:

http://www.psych.org/clin_res/pg_schizo_3.cfm#c

General information:

http://www.psych.org/clin_res/pg_schizo.cfm or

<http://www.mirecc.org/resources.shtml>

Weight and Weight Gain

Weight gain should be detected early so action can be taken before the patient is very overweight. Antipsychotic medications differ in the frequency with which they cause weight gain. Weight gain is common with clozapine and olanzapine. These cause short-term weight gain that averages about 10 pounds, and long-term weight gain that can be much greater. Ziprasidone causes little weight gain. Risperidone, quetiapine and aripiprazole cause weight gain at a rate between olanzapine and ziprasidone. Most older antipsychotic medications can also cause weight gain, though less so than olanzapine or risperidone. An exception is molindone, which may not cause weight gain.

There is relatively little research regarding the management of weight gain with antipsychotic medications. Switching to a medication with less

potential for weight gain is probably the most effective strategy. One can try lowering the dosage of the current medication, but this is often not effective. A number of pharmacologic strategies have been proposed that consist of adding an augmenting medication, however, none are convincing enough to be recommended. If a patient is taking a concomitant medication that causes weight gain, such as Depakote or paroxetine, one should consider changing or discontinuing it.

The cornerstone of weight management is dietary control and exercise. Overweight patients should receive ongoing counseling regarding control of diet, plus consultation from a nutritionist when needed. A program for increasing activity and exercise should be strongly considered, with consultation from primary care, physical therapy and wellness programs. More information on weight gain management can be found at http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/profmats.htm.

Medication Compliance & Knowledge

If patients report missing days of medication, inquire what prevented them from following the prescribed regimen and note their reasons in the note field of the brief assessment form (e.g., perhaps it is the side effects of the medication?). If they have missed 1 or 2 days, then monitor their medication compliance and reassess, as it may have been a temporary situation. Make a note in the tickler file to this effect. If they have missed more than 2 days or are repeatedly noncompliant, direct action needs to be taken.

Actions that may be useful are:

- The use of a pill box (if disorganization is the issue)
- Switching to a medication with less side effects (if side effects are the issue)
- Switching to a long acting/depot medication (especially if lack of insight is the issue)
- Patient and family education about the medication
- Motivational interviewing in which patients are shown that medications will help them achieve their personal goals

The Care Coordinators should monitor the treatment to see if any of these actions are being taken (make a note in the tickler file to this effect). If not, the Care Coordinators may want to call the provider to suggest these options and discuss what would be the best action to take given the circumstance.

Medical Needs & Concerns

Patients often have serious medical needs that are often not well treated, especially obesity, HIV risk behavior, smoking, hypertension, medical complications of substance abuse, diabetes, cardiovascular problems. Care Coordinators will need to monitor any issues listed in the “current problem” field and need to make sure that any scheduled check-up appointments are kept. Care Coordinators should use the tickler file to remind themselves of appointments and then access the patient’s medical record to assess whether the appointment was kept. If the appointment was not kept, the Care Coordinators should inform the provider to take action.

In addition to monitoring specific medical problems, patients should also receive annual physical exams to prevent problems or catch them early. The following tests are recommended for all patients on an annual basis:

- Obtain weight and height
- Blood pressure
- Medical history/physical examination
- Complete blood count

Also consider the following tests depending on circumstances:

- Blood chemistry screen
- Electrocardiogram
- Dental checkup
- Pelvic examination/pap smear
- Drug screen
- Tuberculin skin test
- Lipid profile
- Mammography (women)
- Prostate specific antigen
- Hepatitis screening
- HIV testing

The Care Coordinators should use a calendar to make note of when it is time for their patients to receive an annual exam and use the tickler file to remind themselves to monitor whether these appointments are being kept.

Alcohol & Other Drug Abuse

The first appearance of a “Use” rating in the substance abuse section of the brief assessment may only require monitoring to assess whether the behavior is truly indicative of a more serious problem. Care Coordinators should make a note in the tickler file to monitor future ratings of substance abuse.

If the patient has an “Abuse” or more severe rating, action needs to be taken. Sometimes inpatient hospitalization may be required, first to detox and then to start treatment. An aspect of care that is very important in substance abuse treatment is follow-up. For example, if a patient is admitted to an acute substance abuse treatment facility, they will then need to start outpatient treatment immediately after discharge to ensure a continuity of care. It is important that their provider check to see if the patient did keep and continues to keep those outpatient appointments. Another critical aspect of care is to have the patient’s primary provider communicate regularly with the substance abuse provider and/or hospital staff in order to coordinate medications, reinforce the same message, and share information. Finally, family treatment is also beneficial for patients who are substance abusing.

The Care Coordinator should access the patient’s medical record prior to inpatient discharge to ensure that the following inpatient substance abuse treatment activities are taken:

- Schedule the first outpatient appointment within 1 week.
- Provide enough medications to last at least until the first outpatient appointment.
- Provide an around-the-clock phone number to call for problems before the first outpatient appointment.
- Regularly discuss the treatment and discharge planning with outpatient and other mental health providers.

If these activities are not in place, then the Care Coordinator should send a note to the inpatient provider to remind them.

The Care Coordinator should access the patient’s medical record, ask the patient, or ask the provider to ensure that the following outpatient substance abuse treatment activities are taken:

- Visit the patient in the hospital prior to discharge (if relevant).
- Call the patient after discharge with a reminder about the first outpatient appointment.
- Provide an around-the-clock phone number to call for problems before the first outpatient appointment.
- Call patient to reschedule if the patient fails to attend the initial outpatient appointment.
- Call family or supervised living facility to seek help in getting the patient to the clinic if patient fails to attend the initial outpatient appointment.
- Regularly discuss the treatment with inpatient (if currently hospitalized) and other mental health providers.

Again, if these activities are not in place, then the Care Coordinator should send a note to the provider to remind them.

Current Housing

Although homelessness requires immediate action, this process can often take a great deal of time depending on the length of time the patient has been homeless and their previous history of homelessness (never been homeless or been homeless for a very short time in the past vs. a long history of housing “failures” and homelessness). Options include trying to find the patient transitional housing or a permanent residence. These efforts require a great deal of coordination on the part of both the provider and the patient. Efforts often include screening interviews, completing forms, obtaining medical check-ups, etc. Both providers and patients should be monitored to ensure that these activities are completed on a timely basis.

Below are types of housing that are available:

- **Brief respite/crisis home:** an intensive, structured, supervised residential program with on-site nursing and clinical staff who provide in-house treatment; 24-hour awake coverage typically provided by nursing staff
- **Transitional group home:** an intensive, structured, supervised residential program with on-site clinical and paraprofessional staff who provide daily living skills training. Treatment may be provided in-house or residents may attend a treatment or rehabilitation program; paraprofessional staff typically provides 24-hour awake coverage.
- **Foster or boarding home:** a supportive group living situation owned and operated by lay people; staffing usually provided around the clock (staff typically sleep in the home)
- **Supervised or supported apartment:** a building of single or double occupancy apartments with paraprofessional residential managers on site or with one or more sources of external supervision, support, and assistance (e.g., periodic visits by case managers, family, or paraprofessionals)
- **Living with family:** one or more relatives assume responsibility for providing supervision and assistance. Family members may or may not work

during the day and 24-hour supervision is usually not provided.

- **Independent living:** an apartment or home that is maintained with no in-house structure, supervision, external support, or assistance

After a move is made to transitional or permanent housing, it is important that providers continue to support their patients and communicate with housing staff (if in a housing facility that has such staff). This not only involves working concretely with patients to ensure that they remain housed (i.e., ideally using a more skills-focused approach, including house maintenance, food shopping, paying bills, etc.), but also includes discussions about the development of a new “housed” identity (e.g., creating new social networks, taking part in community life, thinking about work, etc.). Care Coordinators should ensure that providers are doing such activities once a week until the patient is more stable.

Family/Caregiver & Quality of Family/Caregiver Interactions

A strong body of scientific literature supports the hypothesis that family or caregiver interactions can play a significant role in the outcome of a serious psychiatric illness such as schizophrenia, bipolar illness, and depression. Furthermore, a growing body of evidence suggests that most mental health agencies do not provide the services and support to families or caregivers that would be likely to improve their ill relative's prognosis. To meet this need, EQUIP has a family/caregiver intervention that is comprised of three components: 1) offering families or caregivers information on community resources and support (e.g., local NAMI and Family-to-Family meetings) either through the mail or at the first educational meeting; 2) offering sessions of brief family/caregiver education; and 3) offering ongoing telephone support, with the provision of additional face-to-face meetings if necessary.

Information Dissemination. For all intervention patients who provide consent, EQUIP staff will provide their family members or caregivers with written information about resources available to them. Appendix B has a template of the cover letter that can be used for this mailing. All patients who agree will have this information sent to their families or caregivers.

The written material will be educational brochures and a list of local NAMI (formerly known as the Alliance for the Mentally Ill) meetings and family support groups available to EQUIP families or caregivers. Appendix C has a copy of text that can be used to describe NAMI. Appendix D has the LA County NAMI Affiliate List for 2003.

Many families or caregivers benefit from participating in support groups for serious psychiatric illnesses. There is usually no charge for attendance at these groups, and they can be a tremendous source of information and support for both patients and relatives or caregivers. After the family or caregiver is mailed the information about

NAMI, the Care Coordinator should follow-up with them by phone (see Brief Telephone Screen above on page 37). Again, Care Coordinators should monitor whether the information was distributed. If not, the Care Coordinators should contact the provider to problem-solve.

Brief family/caregiver education and support. Three 45-minute individual sessions will be offered; they can be scheduled weekly or biweekly, depending on staff and family or caregiver availability. The overall goals of the session are to 1) teach participants information to promote treatment adherence and 2) provide an opportunity to problem-solve issues confronting the family or caregiver which likely influence patient outcomes (e.g. substance use, high levels of fighting, etc). Sessions should be active and clinicians are directive, but empathic with members. Each session will be structured and centered on an educational handout—1) facts about schizophrenia; 2) the stress-vulnerability model, and 3) medications and early warning sign planning. In addition, approximately 20 minutes of each session should be allocated to helping the family or caregivers resolve a specific issue of concern to them. Work on one problem may continue throughout the three sessions, or one or two other problems can be addressed if the first is resolved. In Appendix E are checklists that address all the information that is to be addressed in each of the three sessions. Use the checklists to ensure that all the key points were addressed. The checklists should be kept on file for reference for further family or caregiver contact.

Care Coordinators should monitor whether the sessions are being implemented and whether or not the patients and their families or caregivers are attending. If not, the Care Coordinators should contact the family/caregiver intervention provider and the family or caregivers (if needed) to problem-solve.

A note in the medical record needs to be made by the family/caregiver intervention provider following each session. The note should include who attended and briefly summarize the discussion. A VA

encounter form needs to be completed for this note as well.

Ongoing family/caregiver support. After completing the educational intervention, family/caregiver intervention provider will make monthly 15 minute calls to families or caregivers for the next three months, and then quarterly after that (frequency can be increased if family is having a difficult time) throughout the fifteen month protocol. During these calls staff will inquire about) how the relatives or caregivers and patient are doing, 2) any urgent issues needing action, and 3) medication compliance. If staff feels that issues needing attention are unresolved by the phone call, the family or caregivers will be invited in for one-two sessions of consultation and problem solving.

Again, Care Coordinators should monitor whether these calls are being completed. If not, the Care Coordinators should contact the provider to problem-solve.

A note in the medical record and a corresponding VA encounter form needs to be made by the staff member making these telephone calls.

Recent Stressor

The Care Coordinator should monitor to see if appropriate action was taken to resolve the situation that caused the stress (“problem-focused” approach if possible) or action was taken to address the patient’s reaction to the stress, perhaps with an adjustment of medication (“emotion-focused” approach). The Care Coordinator should continue to assess this stressor to see if it resolves. If the psychiatrist or case manager (if there is one) does not intervene, the Care Coordinator should contact one or the other to problem-solve. The Care Coordinators should use the tickler file to remind themselves to follow-up.

Additional Interventions

In addition to the specific interventions listed above, the Care Coordinator should intervene to minimize interruptions in their patients' treatment. For example, patients may not show for an appointment or drop out of treatment. Also, a provider may fail to ensure a minimum amount of contact that is clinically necessary.

When a patient misses an appointment: The Care Coordinators should access the medical record to see if the patient has rescheduled. If they missed, write a note to the psychiatrist and to the case manager (if there is one) to inform them. At the next brief assessment, ask the patient about what happened and what would be helpful for them to make future appointments. Again, write a note to the psychiatrist and to the case manager (if there is one) to inform them about this discussion. If the patient continues to miss appointments, call the provider to problem-solve. This could include working with the family (if possible) to help ensure the patient keeps clinical appointments.

When a patient drops out of treatment: First, Care Coordinators could call the provider to assess the situation that precipitated the premature drop out and help to problem-solve. Also, if needed, the Care Coordinator could call the patient and encourage them to return to treatment. In this discussion, it is helpful to empathize with their ambivalence to attend treatment, but stress that treatment often can help them reach the goals they have for themselves. Also, discuss the specific reasons they dropped out and assess whether changes can be made in the way treatment can be delivered to them. The Care Coordinator could suggest that the provider involve the family (if possible) to help bring the patient back into treatment. If the provider is not able or does not feel comfortable doing so, the Care Coordinator could call the family if consent has previously been obtained. If a patient is "lost"--- can't be reached by phone or through their contact person--- a letter can be sent. Appendix F has a template letter for treatment dropouts.

When a provider fails to ensure a minimum amount of contact that is clinically necessary: Patients ought to be seen about once per week during times of acute exacerbations of symptoms and about once per month when more stable. The Care Coordinator should monitor the treatment of all their patients to ensure this level of contact (which could include seeing them). If patients are not receiving this level of care, then the Care Coordinator should send a note to the provider suggesting that a patient should be seen or contacted over the phone if necessary.

When a patient is hospitalized for psychiatric reasons: The Care Coordinator should access the patient's medical record prior to inpatient discharge to ensure that the following inpatient treatment activities are taken:

- Schedule the first outpatient appointment within 1 week.
- Provide enough medications to last at least until the first outpatient appointment.
- Provide an around-the-clock phone number to call for problems before the first outpatient appointment.
- Regularly discuss the treatment and discharge planning with outpatient and other mental health providers.

If these activities are not in place, then the Care Coordinator should send a note to the inpatient provider to remind them.

Appendix A: Initial Family Call

[Pending Final Approval of Instrument]

Appendix B: Family Cover Letter

Fill in date

Dear ***(fill in name of relative/caregiver)***,

(fill in name of patient) is currently receiving services at the ***(Long Beach or Sepulveda)*** Veteran's Administration Healthcare Center and ***(fill in name of patient)*** has given us permission to talk with you. We are interested in improving communication between you and the clinical team, as part of high quality care for patients.

We, at the VA Mental Health Clinic, want you to know that the VA Healthcare System and the local community have resources to help support caregivers. We have included these resources with contact numbers. We hope that you might find these resources of assistance.

Additionally, we have included the name and phone number of the clinical team providing services to ***(fill in name of patient)*** . Please feel free to call us.

(Name of Care Coordinator or Patient Care Manager)
(Long Beach or Sepulveda) Mental Health Clinic
Phone:

Appendix C: NAMI Information Letter Insert

Enclosed is the NAMI affiliate list that includes locations, days and times of NAMI caregiver support meetings around Los Angeles County. These meetings are open to any caregiver or family member and the majority of individuals find these meetings very helpful.

The National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders. NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases.

Founded in 1979, NAMI has more than 210,000 members who seek equitable services for people with severe mental illnesses, which are known to be physical brain disorders. Working on the national, state, and local levels, NAMI provides education about severe brain disorders, supports increased funding for research, and advocates for adequate health insurance, housing, rehabilitation, and jobs for people with serious psychiatric illnesses.

In addition to 1,200 state and local affiliates in the United States, NAMI has affiliates in the District of Columbia, Puerto Rico, Canada, and American Samoa, and has helped start sister organizations in Australia, Japan, and the Ukraine.

The NAMI website is also very helpful and provides quite a bit of information about mental illness, advocacy, and self-help. It is www.nami.org

Appendix D: Los Angeles County NAMI Affiliate List for 2003

[See .pdf file of NAMI LA County Affiliates[

[Substitute a link to a NAMI web-site if one exists that has the same information]

Appendix E: Family Session Checklists

EQUIP FAMILY INTERVENTION
Education about Schizophrenia Session

Patient Name: _____

Patient ID# _____

Clinician's Name: _____

Date of Session: ____ / ____ / ____

Length of session: _____ minutes

Family Members Attending

Relationship to Patient

Did patient attend? Yes No

REMOVE THIS PAGE AND STORE SEPARATELY FROM THE INTERVIEW

Patient ID# _____

Session _____ **EDUCATION ABOUT SCHIZOPHRENIA
& IDENTIFICATION OF PROBLEM**

_____ Outline Session Agenda

_____ Inquire about crises: Describe: _____

_____ Inquire about medication compliance: Describe current compliance: _____

_____ Handout and minimum 20 minute review of education materials covering points in summary

_____ Schizophrenia is a biological disorder which result from an imbalance in brain chemicals

_____ Schizophrenia develops in about 1 in 100 people

_____ Common symptoms of schizophrenia include: positive symptoms (hearing voices, holding irrational beliefs), negative symptoms (apathy, little emotion, poor attention and concentration), and cognitive difficulties

_____ Medications can dramatically reduce symptoms of schizophrenia

_____ Clarification of presenting problem: Describe: _____

_____ Ask family re: questions/Issues pressing til next session

_____ Distribute stress vulnerability handout to be read prior to next meeting

_____ Confirm appointment for next session: Appt. Date: _____ Appt. Time: _____

Comments/Other Issues

EQUIP FAMILY INTERVENTION
Stress Vulnerability Model Session

Patient Name: _____

Patient ID# _____

Clinician's Name: _____

Date of Session: ____ / ____ / ____

Length of session: _____ minutes

Family Members Attending

Relationship to Patient

Did patient attend? Yes No

REMOVE THIS PAGE AND STORE SEPARATELY FROM THE INTERVIEW

Patient ID# _____

Session _____ **STRESS VULNERABILITY MODEL**

_____ Outline Session Agenda

_____ Inquire about crises: Describe: _____

_____ Inquire about medication compliance: Describe current compliance: _____

_____ Brief summary (5-10 minutes) of educational information from last session

_____ Minimum 20-minute review of education materials covering points in summary

_____ Schizophrenia develops in a person with a biological vulnerability for the disorder which is triggered by life stress

_____ Protective factors such as antipsychotic medications and avoiding alcohol and substance use reduce biological vulnerability

_____ Good communication and problem-solving skills, and a supportive home environment, can reduce life stress

_____ Families can support the patient to take meds, avoid substances, develop communication and problem-solving, praise patient for small recovery steps, and get help quickly if needed

_____ Continue problem-solving on presenting problem: Describe issues discussed:

_____ Ask family re: questions/Issues pressing til next session

_____ Distribute medication handout to read prior to next session

_____ Confirm appointment for next session: Appt. Date: _____ Appt. Time: _____

Comments/Other Issues

EQUIP FAMILY INTERVENTION
Education about Medication/ Early Warning Signs Session

Patient Name: _____

Patient ID# _____

Clinician's Name: _____

Date of Session: ____ / ____ / ____

Length of session: _____ minutes

Family Members Attending

Relationship to Patient

Did patient attend? Yes No

REMOVE THIS PAGE AND STORE SEPARATELY FROM THE INTERVIEW

Patient ID# _____

Session _____ **EDUCATION ABOUT MEDICATION/DEVELOP AN EARLY WARNING SIGNS PLAN**

_____ Outline Session Agenda

_____ Inquire about crises: Describe: _____

_____ Inquire about medication compliance: Describe current compliance: _____

_____ Brief summary (5-10 minutes) of stress-vulnerability information obtained

_____ Minimum 20 minute review of education materials covering points in summary

_____ Antipsychotic medications reduce schizophrenic symptoms and prevent relapses

_____ Medications must be taken regularly to control symptoms

_____ Antipsychotic medications have some side effects, but they are usually manageable

_____ Alcohol, drugs and stress lessen the effectiveness of antipsychotic medications

_____ Antipsychotic medications are not addictive

_____ Complete early warning sign plan

_____ Continue problem-solving on presenting problem: Describe issues discussed:

_____ Ask family re: questions/Issues pressing in near future

_____ Present plan for ongoing telephone contact (monthly, then tapered): Note plan:

Comments/Other Issues

Appendix F: Treatment Dropout Letter Template

Insert Date

Dear ***[insert patient's name]***,

I am writing to you on behalf of your psychiatrist, ***[insert psychiatrist's name]***, and the outpatient psychiatry team at the Sepulveda VA. We have noticed that it has been a long time since we last met with you, and we have been unable to reach you by phone.

I am interested in getting in touch with you to see how you have been doing since we last spoke. I would like to set up a time for you to come in to my office to see me. This should take no longer than 15 minutes. It is important that I hear from you.

Please call me at ***[insert contact number]*** or stop by the Mental Health Clinic to see me.

I look forward to hearing from you.

Thank you,

[insert Care Coordinator's name]

Mental Health Clinic
[insert site]VA Healthcare Center

Phone: ***[insert contact number]***