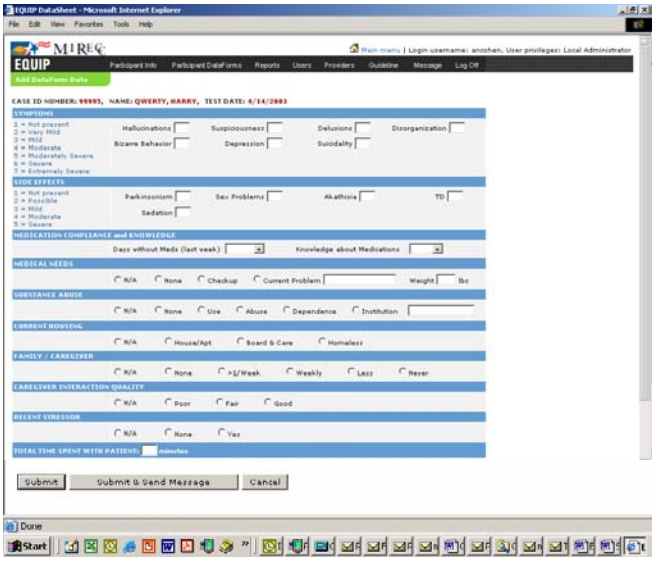
ENTERING BRIEF ASSESSMENTS IN EQUIP WEBSITE



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 you ability to perform you 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 you 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.nhlbisupport.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.