

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

**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):

<b>If the inadequate response was:</b>	<b>For persistent positive symptoms</b>	<b>For persistent negative symptoms</b>
To a conventional antipsychotic (e.g., Thorazine, Mellaril, Prolixin, Navane, Haldol)	<b><i>Switch to a newer atypical antipsychotic</i></b>	<b><i>Switch to a newer atypical antipsychotic</i></b>
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	<b><i>Switch to clozapine</i></b> <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](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](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](http://www.psych.org/clin_res/pg_schizo_3.cfm#c)

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<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](http://www.psych.org/clin_res/pg_schizo_3.cfm#c)

TIMA project:

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General information:

[http://www.psych.org/clin\\_res/pg\\_schizo.cfm](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](http://www.psych.org/clin_res/pg_schizo_3.cfm#c)

General information:

[http://www.psych.org/clin\\_res/pg\\_schizo.cfm](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](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.