

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF PSYCHOSES

Modules L - Z Summary

PSYCHOSOCIAL REHABILITATION

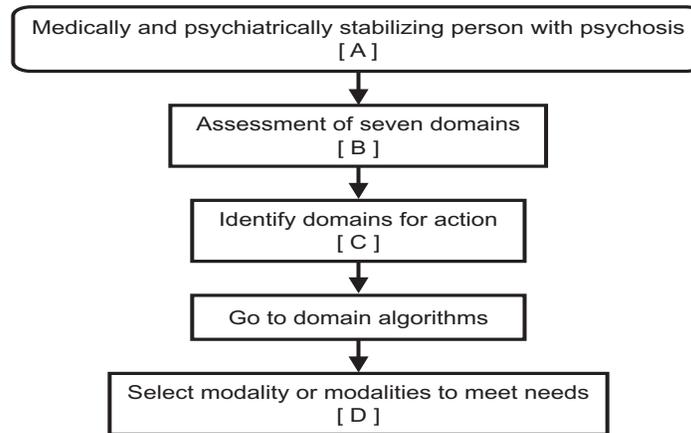
KEY ELEMENTS

- Each rehabilitation goal and treatment approach must be established with the veteran's active involvement.
- The safety of the veteran must be paramount.
- Each discharged veteran should be guaranteed access to needed care
- A proper discharge plan includes an arrangement for safe, stable housing.
- Each and every veteran should have the option of work or productive activity of some kind
- Each veteran and family should be educated about his/her disorder(s), resources for both the veteran and the family, and support groups
- The family should be encouraged to be involved in support for an affected family member
- Each veteran should be assigned a case manager, if needed
- Each veteran should have access to job skills training, if so chosen
- Each veteran should be assigned to a primary care team, either in a medical or mental health setting, to monitor medical conditions which may be masked by mental disorders
- Each veteran should have access to psychiatrists, psychologists, social workers, and nurses, as indicated, for medication management and to provide other needed services

Management of Persons with Psychoses

Psychological Rehabilitation

Core Algorithm



MODULE L: PSYCHOSOCIAL REHABILITATION

Medically and Psychiatrically Stabilizing Person with Psychosis

The first step is to determine whether the person is medically and psychiatrically stable. This is a check on whether action steps recommended earlier have indeed achieved their desired objectives and whether the person and clinician are ready to identify a domain for rehabilitation.

Assessment of Seven Domains

The next step is to determine which domain(s) of rehabilitation are appropriate. The checklist identifies seven domains for which psychosocial rehabilitation services are highly recommended, having demonstrated effectiveness based on controlled studies and/or expert consensus. This list is not restrictive, nor is it prescriptive. Clinicians should not restrict themselves to these domains, nor should they assume that each domain is equally appropriate for all persons.

Clinicians are encouraged to use the checklist for at least the following purposes:

1. Assess whether or not a person in recovery from a serious mental illness needs services for each of the domains listed.
2. Identify which rehabilitation services are available.
3. Consider possibility of needs for other rehabilitation services.

Identify Domains for Action

The clinician should identify, with the person's active participation, which domains apply. Making choices is essential in rehabilitation of persons with severe mental disorders. As a consequence, clinicians and persons are encouraged to collaborate in the process of identifying the domains, as well as selecting programs in which required services are available. The psychosocial rehabilitation section is designed as an interactive document with which the clinician assists the person in making choices and in selecting the essential services for rehabilitation.

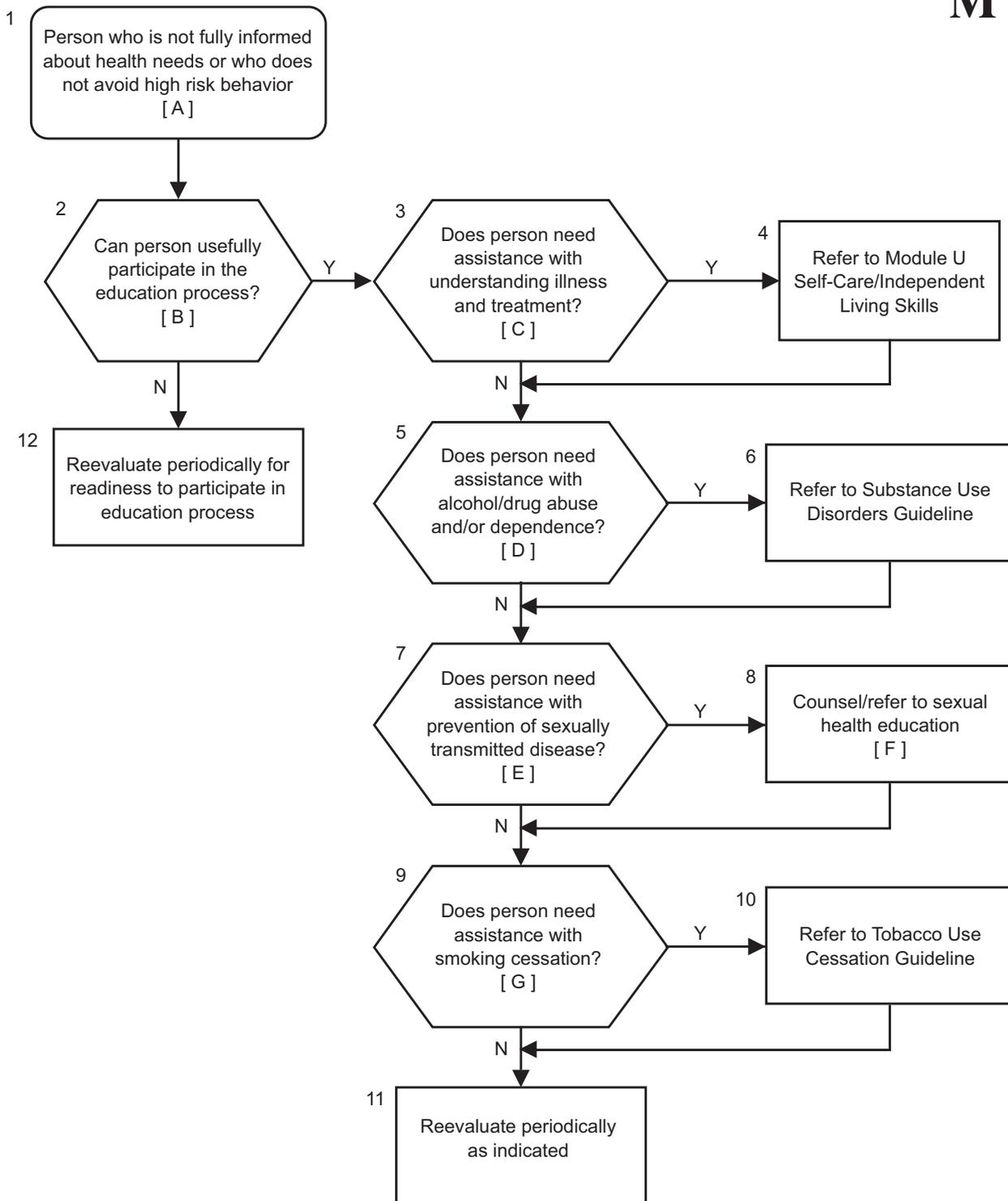
When reviewing the person's need to participate in any module, the clinician should also keep in mind that the person might need services in closely related areas. For example, many persons who experience difficulties in employment also need assistance in obtaining transportation to and from work. Although the Work Restoration Module cannot at present offer recommendations for solutions to persons' transportation problems, the clinician should attempt to identify resources to meet these additional needs.

Select Modality or Modalities to Meet Needs (Also See Grid in Appendix B)

In addition to the interventions that are suggested in each of the modules, the Psychosocial Rehabilitation Grid in Appendix B outlines specific services, programs, and modalities considered effective for each of the seven domains.

**MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
HEALTH EDUCATION ALGORITHM**

M



MODULE M: HEALTH EDUCATION

Person Who Is Not Fully Informed About Health Needs or Who Does Not Avoid High Risk Behavior

Persons treated in this module have a diagnosis of psychosis and have health education issues (indicated by a “False” response to the checklist question “Person is fully informed about all aspects of health needs, and avoids high-risk behavior”).

Physical health is closely tied to a person’s overall way of life. When considering a person’s health information needs, the clinician must consider not only the person’s existing level of knowledge about health issues, but also willingness to pursue good health practices and opportunities to put such practices into use. Module M should be seen as a guide to other modules in which physical health issues are treated. Some of the materials presented in the Independent Living Skills (ILS), Social Skills, Family Skills, and Case Management modules will be relevant to physical health education and should be reviewed.

Can Person Usefully Participate in Education Process?

Identify those persons who will be able to understand and use the information they receive during health education interventions.

As discussed above, physical health is the outcome of not only knowledge, but also interest in and opportunity to pursue good health practices. The clinician should evaluate the person to assess:

- Ability to understand and remember the information?
- Interest in changing health behavior in this area? and
- Ability to pursue better health practices?

If the answer to any of these questions is “no,” it may be advisable to reassess the person at a future time and refer to physical health education when better prepared or living in different circumstances.

Does Person Need Assistance with Understanding Illness and Treatment?

Identify the person who could benefit from learning more about illness and its treatment.

The clinician should talk with the person and try to determine whether the person has a good understanding of the illness. If the person has good conceptual skills but lacks specific information about this illness, refer to Module U for information about self-care skills training.

Does Person Need Assistance with Alcohol/Drug Abuse and/or Dependence?

The clinician should screen for alcohol and drug abuse or dependence, using an accepted screening instrument (see Module A, Annotation N). The clinician should also look for other signs of alcohol or drug use, such as arrests for alcohol or drug-related activities, or records of alcohol/drug-related hospitalizations or outpatient visits. The clinician should also try to determine the person’s level of interest in lessening or stopping dependence on alcohol or drugs. Even a minimal level of interest on the person’s part should be supported by referral to the proper treatment program.

Does Person Need Assistance with Prevention of Sexually Transmitted Disease?

Identify the person who could benefit from information about the prevention of Sexually Transmitted Diseases (STDs).

The clinician should ask the person about sexual activity and safe sexual practices. Because sexuality is a sensitive topic, the clinician should also look for other evidence of the person’s need for STD information in clinical history. A history of STDs would indicate a need for counseling in this area.

Counsel/Refer to Sexual Health Education

Provide the person with an understanding of healthy sexual practices and support the person in being assertive in preventing STDs.

The sexuality of men and women with schizophrenia and other psychotic disorders should be acknowledged and addressed. The identified vulnerability of the chronic mentally ill to high-risk sexual behavior and their concomitant lack of knowledge about the consequences of such behavior constitute appropriate indication to address sexual issues with persons with psychoses (Goisman et al., 1991).

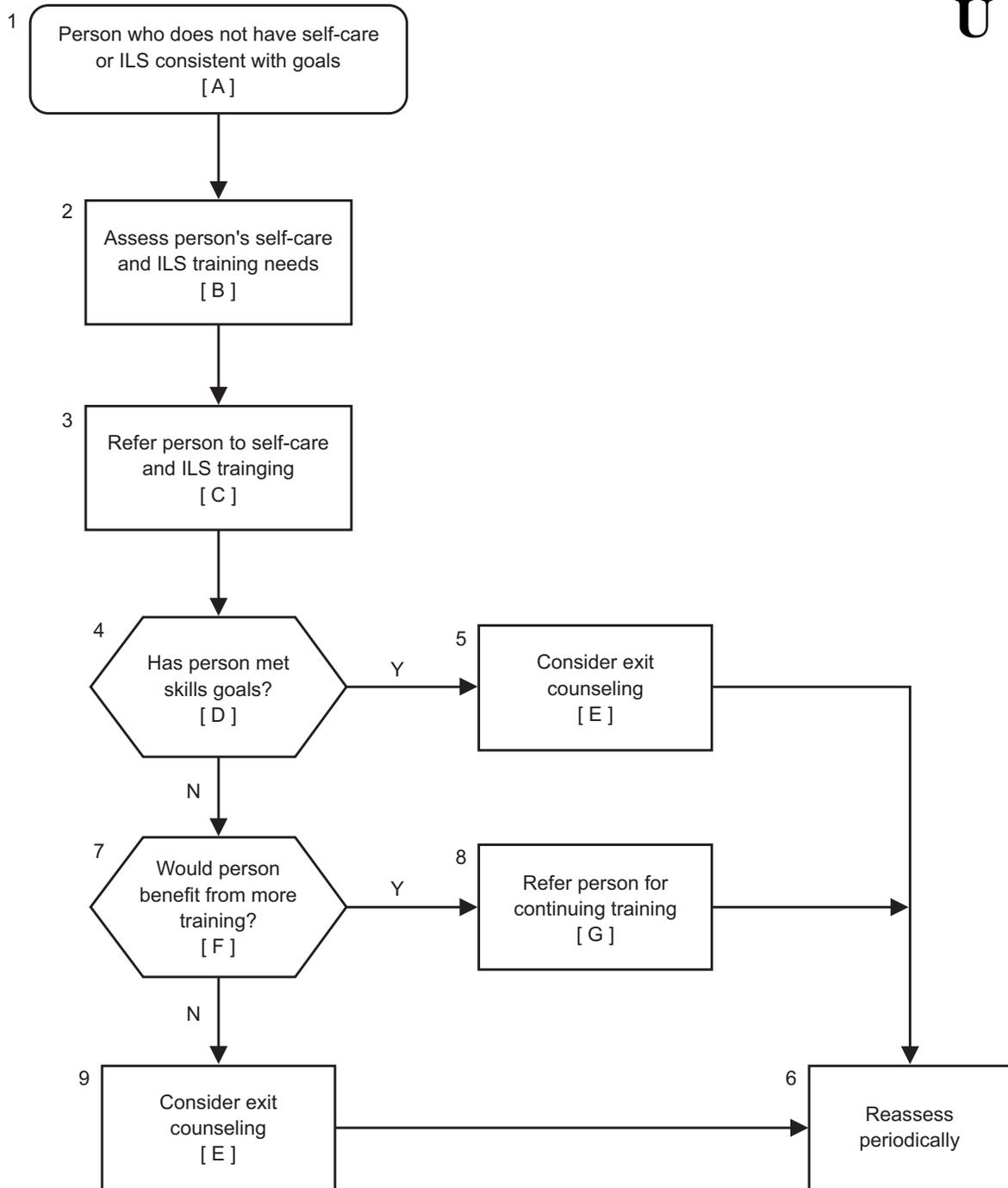
Does Person Need Assistance with Smoking Cessation?

Identify the person who could benefit from assistance with smoking cessation.

The clinician should screen for tobacco use, using an accepted screening instrument. The clinician should also try to determine the person’s level of interest in lessening or stopping tobacco use. Even a minimal level of interest on the person’s part should be supported by referral to the proper treatment program (refer to Tobacco Use Cessation Guideline).

MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
SELF-CARE/INDEPENDENT LIVING SKILLS (ILS) ALGORITHM

U



MODULE U: SELF-CARE/INDEPENDENT LIVING SKILLS (ILS)

Person Who Does Not Have Self-Care or Independent Living Skills Consistent With Goals

Persons treated in this module have a diagnosis of psychosis and have self-care or Independent Living Skills (ILS) issues (indicated by a “False” answer to the checklist question “Person has self-care and ILS consistent with living arrangement goals”).

Housing loss and rehospitalization are potential negative outcomes that may result from self-care or ILS deficits. Improvements in the person’s self-care or ILS skills may not only lessen the threat to housing stability, but may also create a feedback effect of improvements to the person’s social skills, employment prospects, and overall quality of life.

Assess Person’s Self-Care and Independent Living Skills Training Needs

Identify the specific skill deficits for which the person needs training.

Self-Care and ILS skills cover multiple areas. The clinician should assess each of these areas:

1. Medication and symptom self-management
2. Communication and social interaction
3. Problem-solving
4. Personal care and hygiene
5. Shopping
6. Cooking
7. Using transportation
8. Money management
9. Maintaining a schedule
10. Leisure skills

Refer Person to Self-Care and Independent Living Skills Training

Obtain the best mix of skills training modalities to meet the person’s needs and improve self-care skills.

Self-care and ILS training programs vary in focus, and they may teach combinations of skills. The clinician should try to identify a program that focuses on the person’s particular skill deficits. If this is not possible, more general programs may also be helpful to the person. Some studies have found improvements in skills not specifically taught in their programs.

Skills training studies fall into two groups: studies of Cognitive Behavioral Therapy (CBT), and studies of other types of training. CBT appears to be useful for a

number of outcomes. CBT was significantly more effective than other therapies for symptom reduction, improvement in self-esteem, and reduction of cognitive deficit.

Has Person Met Skills Goals?

Determine to what extent the person has met the goals established for the self-care/ILS training program.

Before assigning the person to any self-care/ILS training program, establish measurable goals with the person and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the person’s progress: feedback from program staff, the person’s report of status, and other relevant feedback from family members or community contacts.

Consider Exit Counseling

Identify the person who is ready to exercise self-care/ILS skills without clinician supervision.

Some persons may eventually attain a level of self-care/ILS skills in which they no longer require assistance with activities of daily living. The decision to release the person from self-care/ILS training should be reached together by the clinician and the person. When this occurs, the clinician should remind the person of the availability of refresher sessions or further training whenever needed.

Would Person Benefit from More Time in Training?

Determine whether the person who has not met training goals might benefit from more time in the current training program.

Before assigning the person to any self-care/ILS training program, establish measurable goals with the person and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the person’s progress: feedback from program staff, the person’s report of status, and other relevant feedback from family member or community contacts.

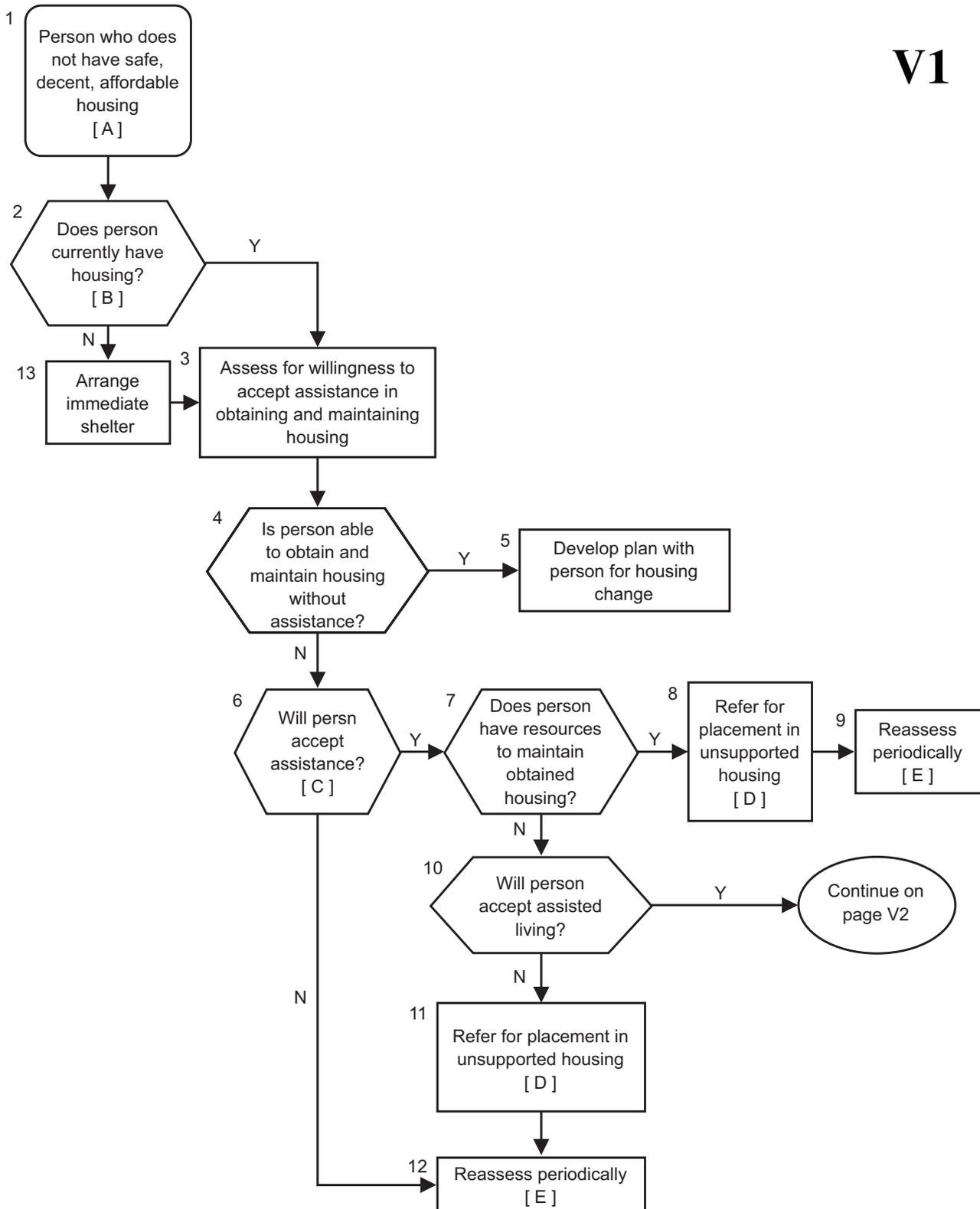
Refer Person for Continuing Training

Give the person more time to benefit from training.

If the person expresses an interest in remaining in the current training program, and program staff agrees, it may be advisable for the person to remain in the current program. If the person feels frustrated by the current training program, it may be advisable to refer to a different level of training program.

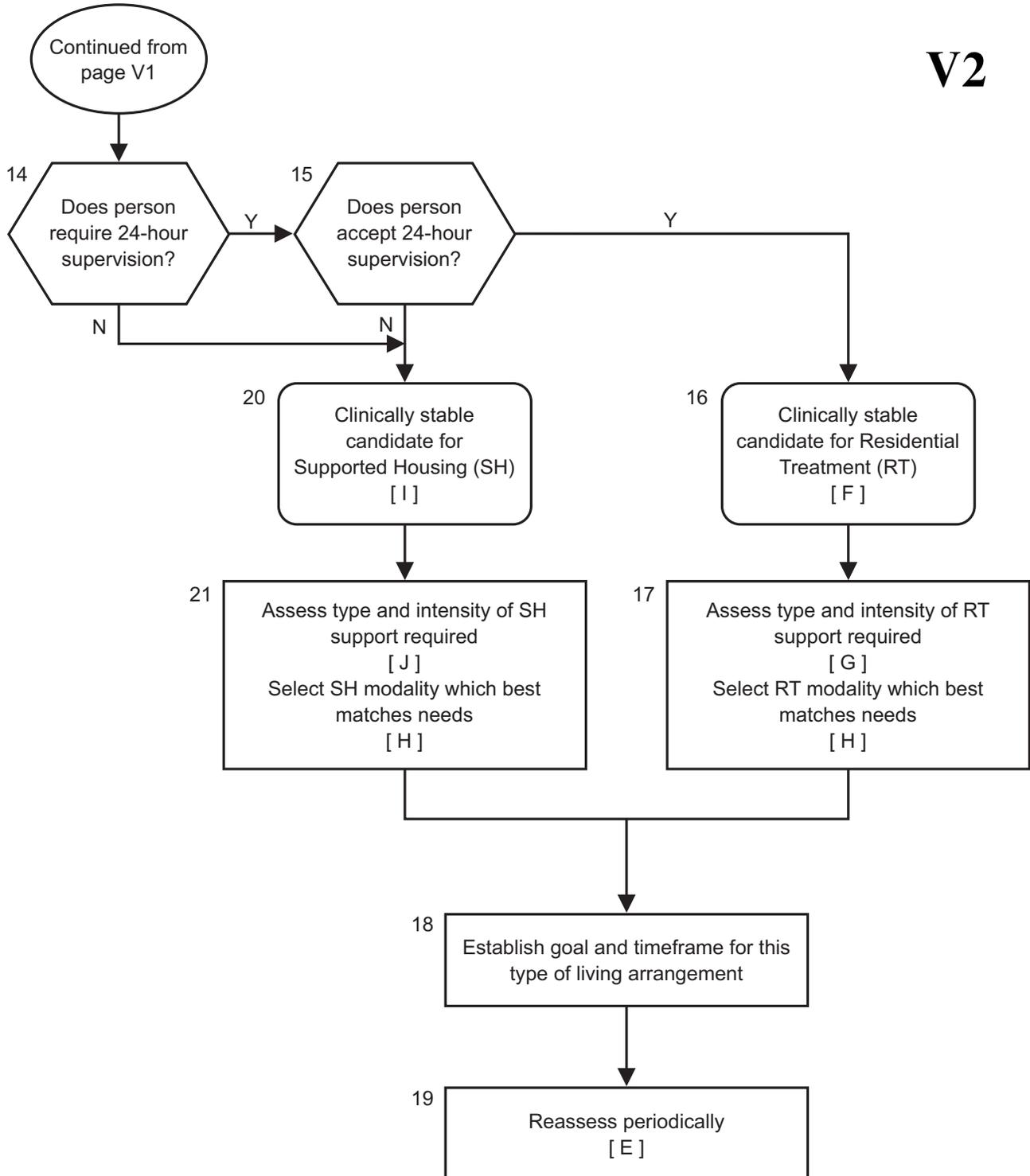
MANAGEMENT OF PERSONS WITH PSYCHOSES PSYCHOSOCIAL REHABILITATION HOUSING ALGORITHM

V1



MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
HOUSING ALGORITHM

V2



MODULE V: HOUSING

Person Who Does Not Have Safe, Decent, Affordable Housing

Persons treated in this module have a diagnosis of psychosis and have a housing problem (indicated by a "False" answer to the checklist question "Person has safe, decent, affordable, stable housing that is consistent with treatment goals").

Homelessness is a major public health problem among persons with severe mental illness (Multiple studies have demonstrated that housing stability reduces the need for resource-intensive treatment, including inpatient services. Two safety issues require particular attention.

- Housing for persons with psychosis should not be above a second floor level unless precautions are taken so that they cannot jump from the windows. This step should be taken because over 10% of persons with serious mental illness commit suicide.
- Persons with mental illness should not be housed in areas of high drug traffic. This is particularly important if the person has a substance dependence or abuse problem.

Does Person Currently Have Housing?

Determine urgency of the housing problem.

If the person has no idea where to sleep tonight, plans to sleep on the street, or plans to sleep in a dangerous environment, the answer should be "no." Otherwise, the answer is "yes."

Will Person Accept Assistance?

Identify and engage persons willing to participate in a housing intervention.

The provider should distinguish the person's refusal of all ongoing care from unwillingness to engage in a collaborative effort to resolve a housing issue. Some persons refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction).

Refer for Placement in Unsupported Housing

Unsupported housing is an environment where there is no provider to furnish ongoing support. This is an appropriate choice for the person who will not accept an assisted living situation, or who has the resources to maintain housing once it has been obtained.

Reassess Periodically

Reassessment of initial plans should occur periodically. The person's progress and goals should be reassessed and the treatment plan updated at least annually. Plans should also be reviewed after significant clinical change (e.g., hospital admission, relapse and accomplishment of care goals).

Clinically Stable Candidates for Residential Treatment

Persons have a diagnosis of psychosis, have a housing problem (indicated by a "No" answer to the checklist question "Person has safe, decent, affordable, stable housing that is consistent with treatment goals"), and do not meet the criteria for involuntary treatment. In addition, such candidates do not have the resources to maintain housing without assistance, will accept an assisted living situation, and require and will accept 24-hour supervision.

Assess Type and Intensity of Residential Treatment Support Required

Residential Treatment (RT) includes a variety of modalities in which a provider supplies, arranges for or confirms and monitors the provision of ongoing, periodic support, which assists the person in maintaining housing in the community. This includes professional services provided by paid caregivers, but also "natural supports" in which those providing direct support are not paid caregivers. This may also include mutually supportive client networks.

Select Residential Treatment or Supported Housing Modality Which Best Matches Needs

A wide range of services may be available. A listing of possibilities, with associated evidence, is listed in Appendix B, Psychosocial Rehabilitation Grid.

Clinically Stable Candidate for Supported Housing

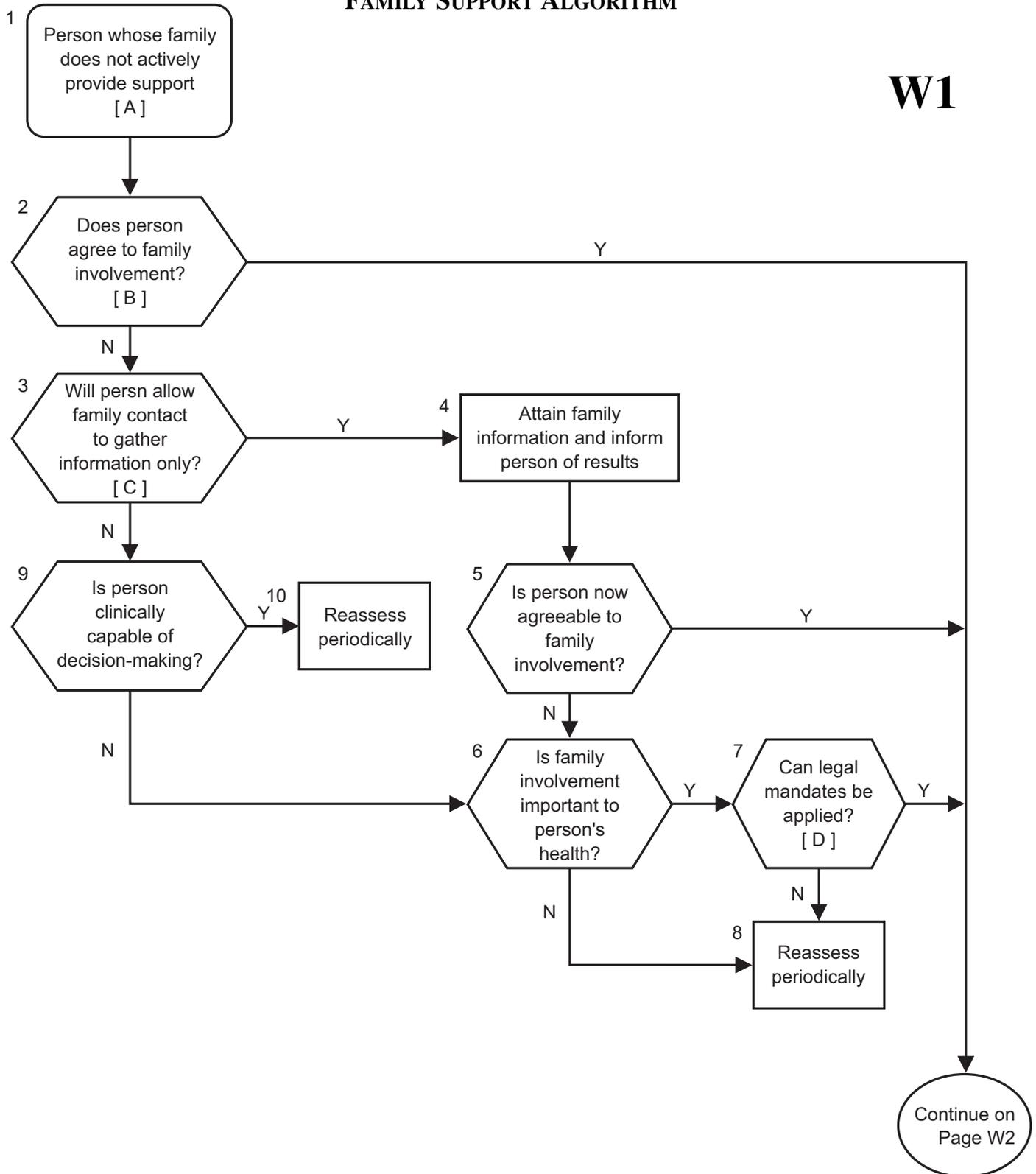
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Assess the Type and Intensity of Supported Housing (SH) Support Required

SH includes a variety of modalities in which a provider supplies, arranges for or confirms and monitors the provision of ongoing, periodic support that assists the person in maintaining housing in the community. This includes professional services provided by paid caregivers, and also "natural supports" in which the persons providing direct support are not paid caregivers.

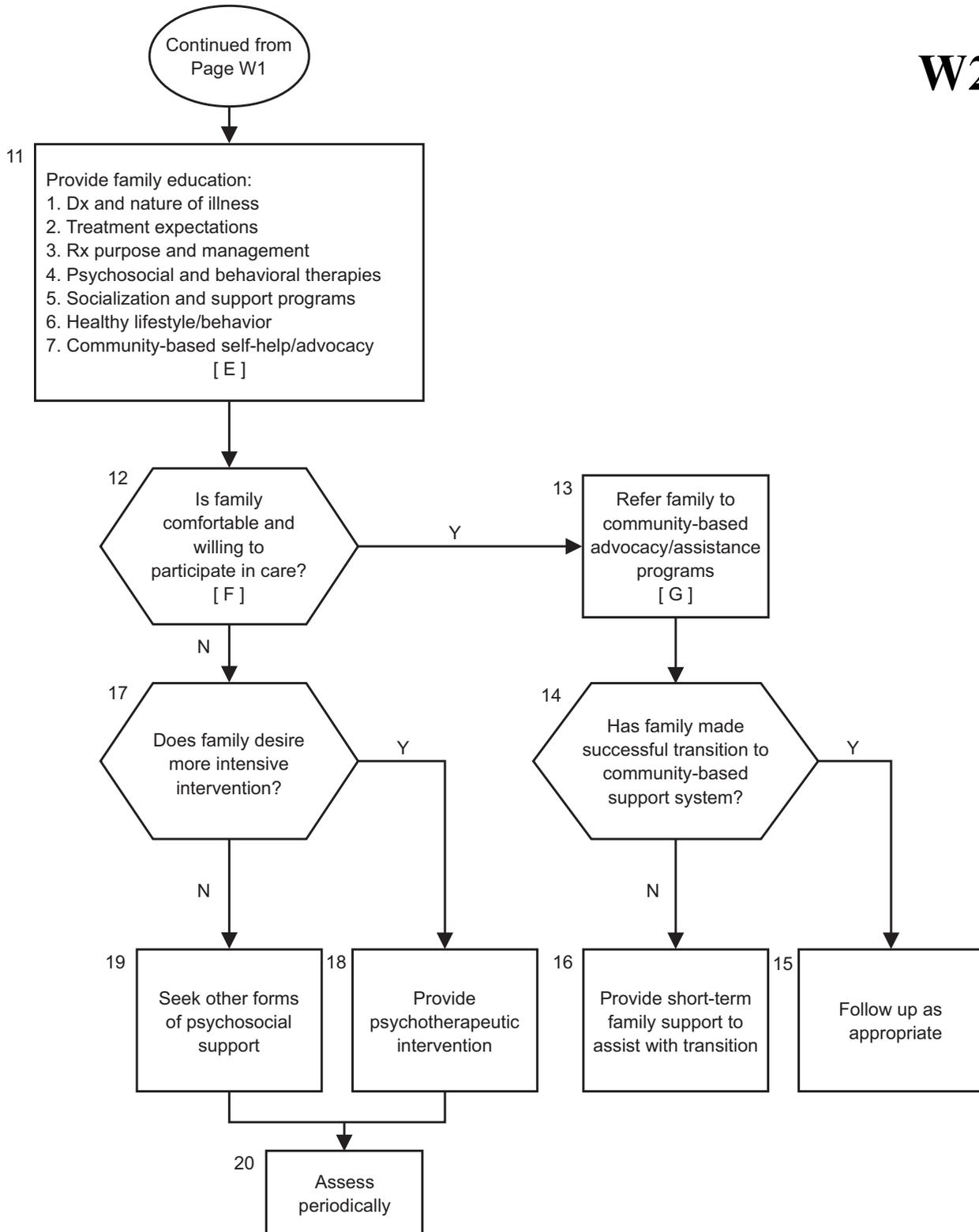
MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
FAMILY SUPPORT ALGORITHM

W1



MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
FAMILY SUPPORT ALGORITHM

W2



MODULE W: FAMILY SUPPORT

Person Whose Family Does Not Actively Provide Support

Persons treated in this module have a diagnosis of psychosis and have a family support issue (indicated by a "False" answer to the checklist question "Family actively supports person, and is very well-informed").

When a person is struggling to live with schizophrenia, family support can be of vital importance. Not all families will provide the understanding and support the person needs. Family support programs should be considered for any person whose family:

- Does not understand schizophrenia
- Does not accept that the person is legitimately ill
- Has unrealistic expectations for the person's treatment outcome
- Actively or passively undermines the person's treatment program
- Does not assist the person in activities of everyday life

Family education and family support programs can help families of persons with schizophrenia to build better communication skills, to develop empathy for the ill person, and to learn techniques to aid the person in movement toward recovery.

Does Person Agree to Family Involvement?

The person's family, relatives, and/or attorney reside "outside" the circle of confidentiality and as such are not entitled to obtain clinical information regarding the person without the express consent of the person (Applebaum, 1991). The person's right to consent is embedded in the legal precedents inherent in the right to privacy as well as the ethical constraints expressed in the Hippocratic Oath.

Will Person Allow Family Contact to Gather Information Only?

Refusal of family involvement may reflect the person's response to family pressures and the intrusive nature of their demands. Families, on the other hand, may feel frustrated at being excluded from participation in the treatment of a significant other, particularly if they have been the primary caregiver. The clinician must balance

the potential benefits to be gained from family inclusion with maintaining the viability of the therapeutic alliance and trust established with the person that is the cornerstone to successful treatment. The clinician may be able to build on the therapeutic alliance to demonstrate the advantages of family participation at a level comfortable for the person through limited family intervention in information gathering.

Can Legal Mandates Be Applied?

Determine when it is necessary to override the person's wish to exclude family from the treatment program.

The decision to breach confidentiality must be taken seriously with caution and substantial justification. Advice of both legal counsel and the Ethics Committee is recommended.

Provide Family Education

Help families of persons with schizophrenia build better communication skills, develop empathy for the ill person and learn techniques to aid the person in movement toward recovery.

As noted in a recent literature, review numerous studies "confirm the potential advantages and benefits of services to families and family education." The potential benefits of family education include:

- Decrease in frequency of relapse
- Decrease in hospitalization
- Encouragement of compliance with medication
- Increased sense of self-efficacy in managing the relative's illness
- Improvement in negative symptoms
- Increase in families' knowledge about schizophrenia
- Increase in satisfaction with care

Family education and family support programs, however, should not be seen as "quick-fixes." Pharoah, et al., (1999), note that "Patients and their families must be willing to spend a significant amount of time in contact with health services" to gain these benefits. Likewise, Solomon, et al., (1997) recommended, "Family education should be available as needed rather than compressed into

a narrow time period.” The timing of family interventions should also be considered. As noted by Dixon, et al. (2000), the merits of a program may depend on whether it is provided at an early or later phase on the illness.

Is Family Comfortable and Willing to Participate in Care?

In Dixon, et al., (2000), the first element that should be assessed before recommending family education is “the interest of the family and patient.” They also recommend assessing “whether the patient and family would choose family psychoeducation instead of alternatives available in the agency to achieve outcomes identified.”

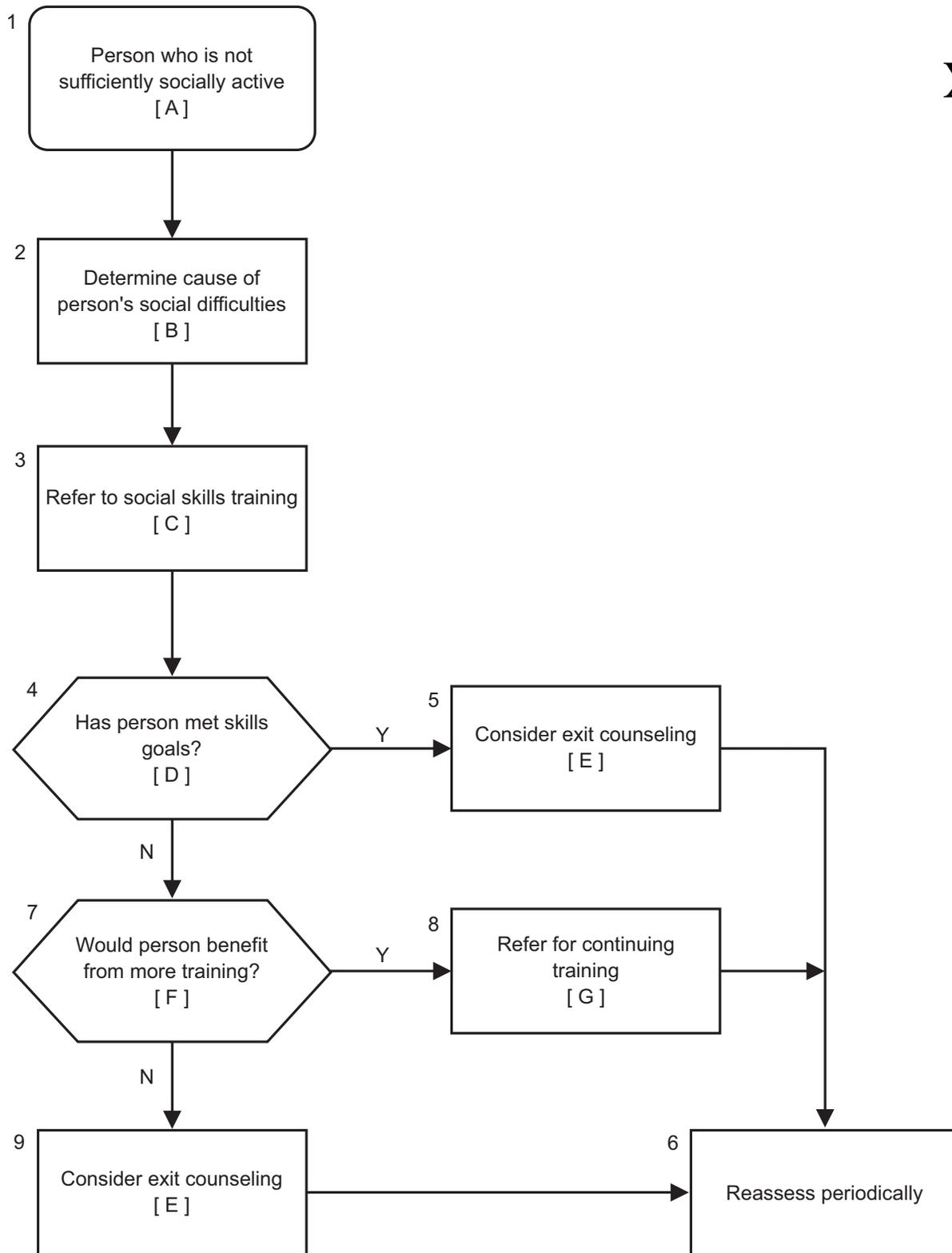
Refer Family to Community-Based Advocacy/Assistance Programs

Anchor the family in community-based programs that enhance the family’s sense of empowerment and ability to manage the stressors of caregiving and management.

With the completion of family psychoeducation, families may still require sustained community-based support to maintain problem-solving skills and optimize their use of social networks, community and health service systems. Such support may also allow families to develop further their sense of empowerment to advocate for better care.

MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
SOCIAL SKILLS ALGORITHM

X



MODULE X: SOCIAL SKILLS

Person Who is Not Sufficiently Socially Active

Persons treated in this module have a diagnosis of psychosis and have social skills issues (indicated by a “False” answer to the checklist question “Person is sufficiently socially active”).

The importance of social skills to persons with severe mental illness is twofold: first, social skills enable the person to engage in social activities that improve quality of life; and second, the increased self-esteem from mastery of social skills may lead to improvements in other areas of the person’s life. Social skills training may take place in formal settings (social skills classes) or informal settings (discussion groups, recreation groups, etc.). Such training may take place in an inpatient setting, at an outpatient facility, or in community locations.

Determine Cause of the Person’s Social Difficulties

Identify the skills deficits or other factors causing the person to experience social difficulties. Persons may experience social difficulties for many reasons. The clinician should try to determine which of these factors is relevant:

- Does the person have difficulty with emotional control?
- Does the person lack knowledge of basic social rules?
- Does the person have social skills but lack interest in socializing?
- Does the person have social skills but is out of practice in using them?
- Does the person have an interest in socializing but does not have opportunities to socialize?

Refer to Social Skills Training

One of the first decisions the clinician and person should make is the location of social skills training. Many clinicians favor a combination of inpatient and outpatient services that can provide a controlled transition from the hospital to the community. Some clinicians favor enrolling persons in outpatient socialization while they are still in inpatient status, to forestall the difficulties of dependency associated with institutionalization.

Increasingly absent are those socialization services embedded in high-intensity, long-term care facilities (for example, as lengths of inpatient stay decline, the notably effective token economies are less available). On the other hand, lower-intensity inpatient services such as Psychiatric Residential Rehab Treatment Programs (PRRTPs) are increasingly available.

Has Person Met Skills Goals?

Determine to what extent the person has met social skills goals.

Before prescribing social skills training or introducing the person to socialization venues, establish measurable goals with the person and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the person’s progress: social skills trainer feedback, the person’s report of status, and other relevant feedback from family members or community contacts.

Consider Exit Counseling

Assist the person in becoming fully independent in exercising social skills.

Some persons will eventually attain competency in social skills. The person who has reached this stage is ready to practice those social skills and to gain benefits from social interactions. The clinician can be helpful by assisting the person in identifying social venues in which the person can participate. Ideally, these should allow the person to form relationships with persons in the wider community. The clinician should also support the person in efforts to join such venues, whether by sponsorship, provision of information about the venue (for example public transportation routes that serve the location), or simply by providing encouragement and suggestions for success.

Would Person Benefit from More Training?

Determine whether the person would benefit from more time in the current form of treatment.

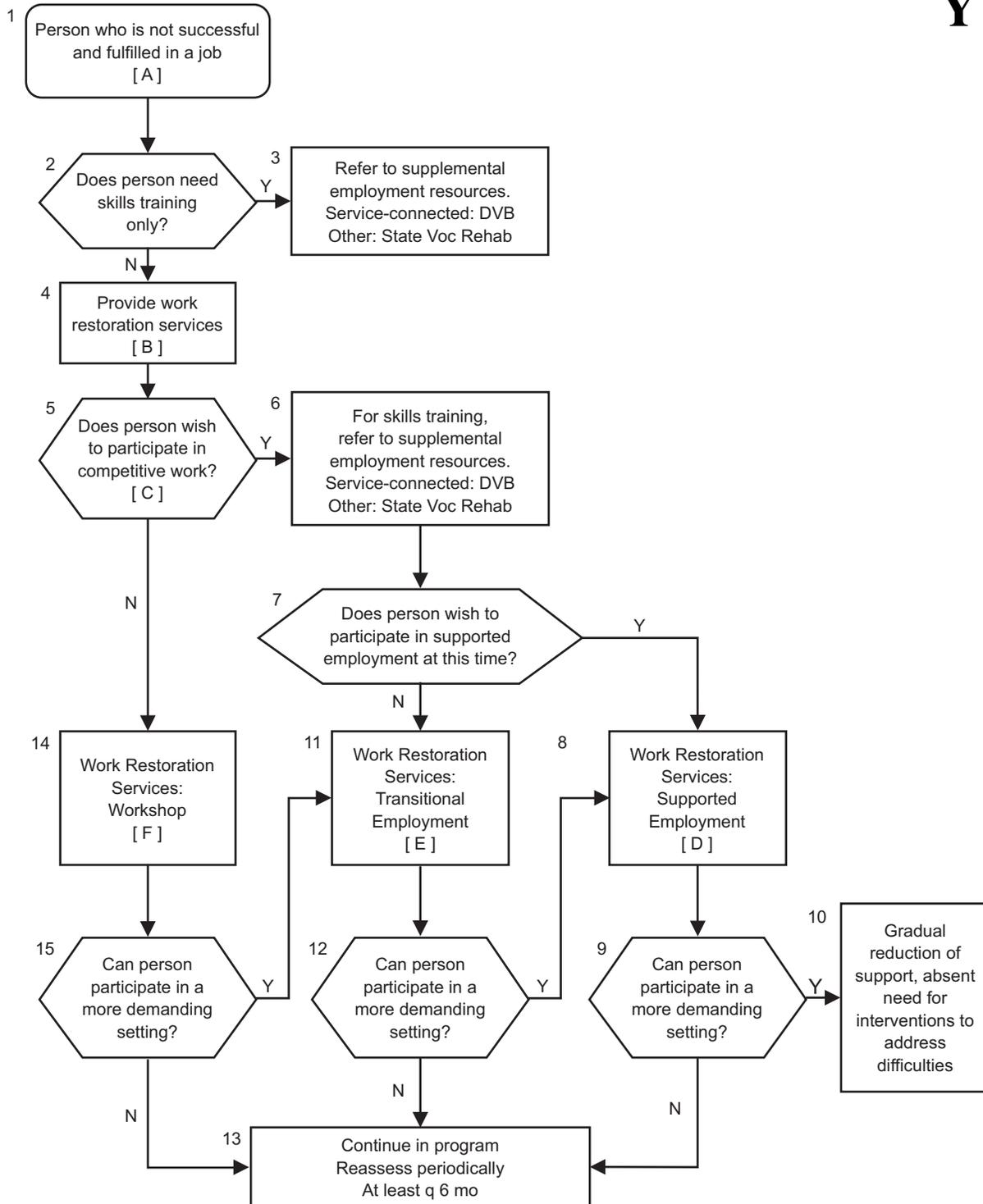
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Refer for Continuing Training

If the person expresses an interest in remaining in the current training program, and program staff agrees, it may be advisable for the person to continue the current program. If the person feels frustrated by the current training program, it may be advisable to refer to a different level of training program.

MANAGEMENT OF PERSONS WITH PSYCHOSES PSYCHOSOCIAL REHABILITATION WORK RESTORATION SERVICES ALGORITHM

Y



MODULE Y: WORK RESTORATION SERVICES

Person Who is Not Successful and Fulfilled in a Job

Persons treated in this module have a diagnosis of psychosis, have an employment issue (indicated by a "False" answer to the checklist question "Person has a job which provides adequate income and fully utilizes skills"), and agree to participate in work restoration services.

The Expert Consensus Guideline Series for the Treatment of Schizophrenia provided significant support for provision of "a transitional or supported employment program specialized for clients with severe mental illness." Vocational treatment in the work restoration model was very highly rated by the panel of clinicians surveyed, and was considered the treatment of choice for stable outpatients.

Provide Work Restoration Services

Identify and engage persons with employment issues who can benefit from implementation of an SE (Supported Employment) intervention.

All persons who wish to participate in paid employment should be given the opportunity to receive supportive employment services. Symptom severity, poor vocational histories, or questionable readiness for or interest in competitive employment should not be reasons for exclusion

Does Person Wish to Participate in Competitive Work?

Identify candidates for participation in some form of competitive work.

The vocational specialist should engage in finding a work site for the person that matches the person's interests, skills and limitations (Drake, et al., 1994). Prior opinion held that lack of improvement or benefit from participation in employment is usually related to cognitive deficits rather than symptomatology. While evidence continues to be found to support this opinion (Bell, et al., 2001), other recent studies present a complex picture of multiple causation. These studies also suggest that all persons may benefit from participation in employment, regardless of cognitive status (Blankertz and Robinson, 1996). Researchers have found a wide variety of factors influencing success in employment. These include self-motivation (Gowdy and Carlson, 2001), severity of

negative symptoms (Goldberg, et al., 2001), work history and job difficulties (Becker, et al., 1998), and self-perceived physical health (Dixon, et al., 2001). The range of results presented suggests that each person should be assessed not only for cognitive defects, but also for level of motivation work history, etc.

Refer to Work Restoration Services: Supported Employment (SE)

Foster success in a competitive work environment.

The Expert Consensus Guideline Series for the Treatment of Schizophrenia (1997) provided significant support for provision of a "transitional or supported employment program specialized for clients with severe mental illness." Further studies continue to uphold this model. Drake, et al., (1999) found that for achieving competitive employment, the ongoing support of an SE program is superior to an Enhanced Vocational Rehabilitation model in which services are delivered by a group of rehabilitation agencies. Similarly, Dr et al. (1994) found that eliminating day treatment and replacing it with a SE program can improve integration into competitive jobs in the community. New studies also continue to demonstrate the superiority of SE over prevocational training for obtaining competitive employment. Clark, et al., (!((*) showed that individual Placement and Support participants were significantly more likely to find work, to work more hours, and to have higher earnings that were "Group Skills Training' participants. In a meta-analysis of 11 randomized clinical trials, Crowther, et al. (2001) concluded "supported employment is more effective than prevocational training at helping people with server mental illness obtain competitive employment."

For those persons referred to an SE program, Becker, et al., (1998) points to an area for caution. In their survey of a series of unsatisfactory job terminations, Becker found that "unsatisfactory terminations" were associated respectively with multiple problems on the job that were related to interpersonal functioning, mental illness, dissatisfaction with the job, quality of work, medical illnesses, dependability, and substance abuse." Their results suggest that supported employment programs need to address job

maintenance with interventions that identify and address different types of problem as they arise.

Refer to Work Restoration Services: Transitional Employment

Foster success in a transitional employment situation.

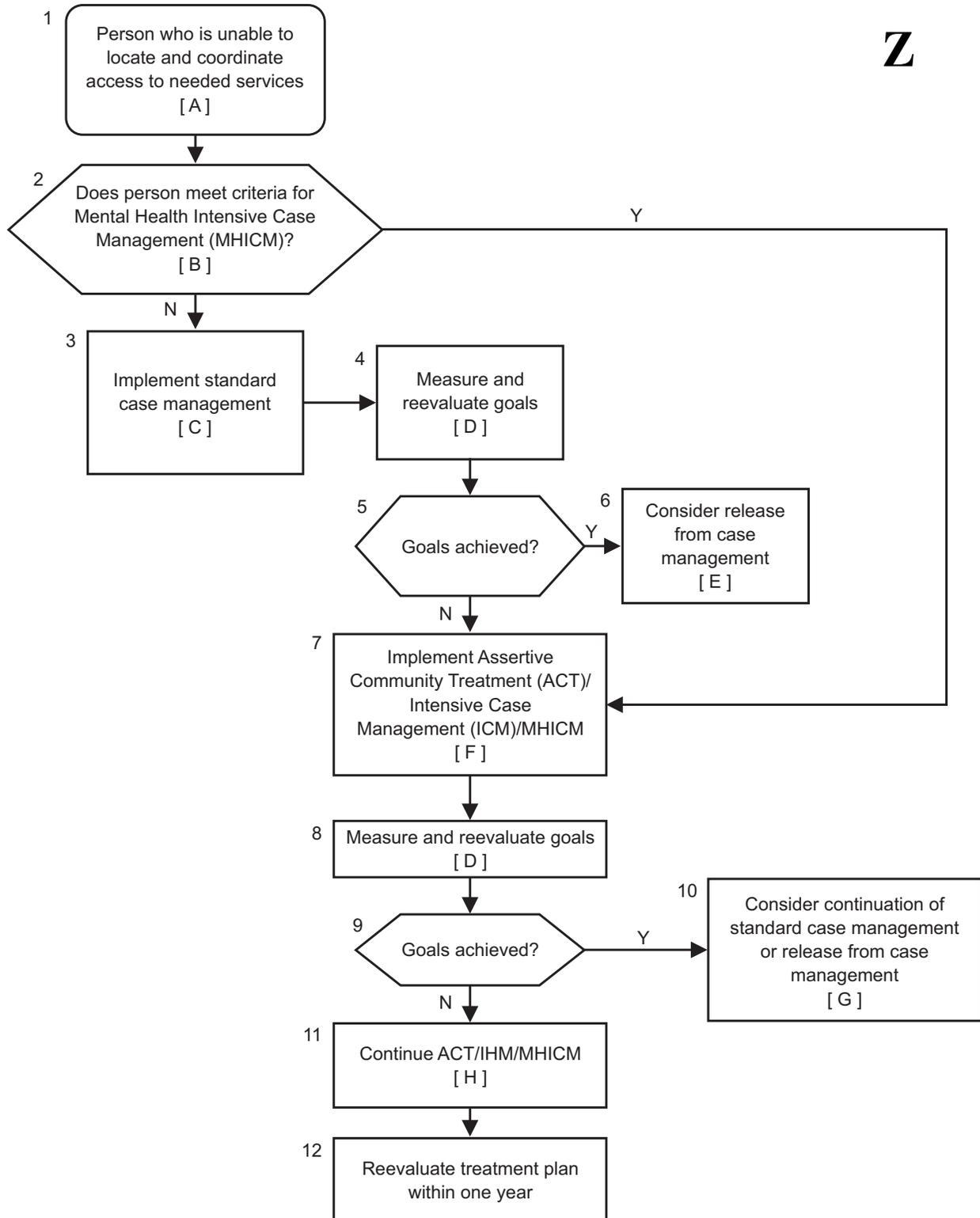
Transitional employment, in which the person experiences work in normal places of business on a temporary basis, is not a major focus of the contemporary literature on SE. One study did, however, find a positive outcome of such employment. When clients in an employment

specialist program were taught work skills and attitudes in group and individual sessions and through a trial work experience, all participants experienced “skill gains and positive changes in work attitudes.” (Blankertz and Robinson 1996).

Refer to Work Restoration Services: Workshop

Foster success, on multiple dimensions, in a workshop setting. The value of a workshop or sheltered employment experience seems to be as therapy rather than simply as an economic activity.

**MANAGEMENT OF PERSONS WITH PSYCHOSES
PSYCHOSOCIAL REHABILITATION
CASE MANAGEMENT ALGORITHM**



Z

MODULE Z: CASE MANAGEMENT

Person Who Is Unable to Locate and Coordinate Access to Needed Services

Persons treated in this module have a diagnosis of psychosis and have case management issues (indicated by a “False” answer to the checklist question “Person is able to locate and coordinate access to needed services”).

Case management is a form of treatment that assists the person diagnosed with psychosis in surviving and optimizing adjustment in the community. Most persons enter the case management mode of treatment because they are high users of expensive modalities such as inpatient care. In case management, one person, or a team of providers, assumes overall management of the person’s care. In standard case management, the case manager (CM) usually makes contact with the person in the clinic. In more intensive models of case management such as Assertive Community Treatment (ACT), Intensive Case Management (ICM), or the VA’s Mental Health Intensive Case Management (MHICM), the CM normally conducts outreach to the person in the community. The frequency of contact between the CM and the person is typically higher than the frequency of contact in a customary outpatient setting. CMs provide continuity of care for the person in the mental health system. The CM addresses not only the manifest symptoms of the illness but also psychosocial problems affecting the person’s housing, transportation, application and attainment of entitlements, attainment of food, Activities of Daily Living (ADLs), attendance at psychiatrist and therapist appointments, and employment. Many CMs are paraprofessionals acting under professional supervision.

Does Person Meet Criteria for Mental Health Intensive Case Management?

Determine the level of case management services required by the person. A person meets the criteria for MHICM after 30 days of inpatient care, 3 admissions in one year, or failure of standard case management (VHA Directive 2000-034).

Evaluate Needs; Implement Standard Case Management

Ensure that the person receives needed services when incapable of independently obtaining these services.

In the standard type of case management (also known as brokered case management), the CM performs the function of a service broker. The CM’s role is to connect the person with needed services and to coordinate care among various service providers.

The functions of a CM in standard case management include:

- Assessment
- Planning
- Linking of services
- Monitoring
- Advocacy

Most standard case management programs do not offer 24-hour coverage for clients. The point of contact between persons and CMs in this model is usually the clinic.

Because case management is an established practice in psychiatric rehabilitation, studies comparing case management to no case management are not plentiful. One study of this type did find standard case management to be significantly superior to no case management for substance abuse, income, and housing outcomes (Cox, et al., 1998). Most studies in the current literature compare standard case management to one or more intensive forms such as ACT/ICM/MHICM. In these studies intensive case management proved to be more effective than standard case management (Phillips, et al., 2001).

Cost is an important consideration in assessing the value of case management. Unfortunately, the cost evidence is sketchy. Wolff, et al. (1997) and Johnson, et al., (1998) both found routine case management to contribute to a lower total cost of care.

Measure and Reevaluate Goals

Determine to what extent the person has met the goals established for the case management program.

Before assigning the person to a form of case management, establish measurable goals with the person and determine a schedule for reevaluation. At the time of reevaluation, review all available evidence for the

person's progress: CM feedback, the person's report of status, and other relevant feedback from family members or community contacts.

Consider Release from Case Management

Determine whether the person can function successfully without the support of a CM.

The exit case management strategy is an area in need of further study. Although a few of the studies consulted for this module presented one-to-three year follow-up data for program participants, none systematically examined the effects of discontinuing case management for these persons. When case management services are withdrawn, some people appear to relapse and lose many of the gains they had attained (Mueser, et al., 1998). However, the clinician should never assume the person would need case management services indefinitely. Each person should be seen as possessing the potential for independence as the key tenet of the "recovery philosophy.

Implement Assertive Community Treatment (ACT)/Intensive Case Management (ICM) /Mental Health Intensive Case Management (MHICM).

Ensure that the person receives needed services when incapable of obtaining these services independently.

The rate of CM contact with clients is much higher than in other forms of case management (Burns, 1995).

Although standard case management compares favorably in some respects to more intensive forms of case management, the literature supports the overall superiority of ACT/ICM. The evidence for better outcomes in ICM varies by topic area. For physical and mental well-being outcomes, one study each found superior outcomes for death or harm (Tyrer, et al., 1999) physical health (Lehmann, et al., 1997) and medication compliance (Dixon, et al., 1997). Three studies found intensive case management superior in the area of substance abuse (Cox et al., 1998; Drake et al., 1998; McHugo et al., 1999). The largest body of evidence exists for clinical outcomes (Gater et al., 1997; Herman et al., 2000; Johnson et al., 1998; Lehman et al., 1997; Morse et al., 1997; Rabins et al., 2000; Rosenheck & Neale, 1998; Wolf et al., 1997).

For quality of life outcomes, studies found ACT/ICM superior for overall quality of life (Chandler et al., 1996a; Chandler et al., 1996b; Drake et al., 1998; Holloway & Carson, 1998; Lafave et al., 1996; Lehman et al., 1997; Sellwood et al., 1999), housing (Chandler et al., 1996a; Cox et al., 1998; Lafave et al., 1996; Lehman et al., 1997; Morse et al., 1997; Rosenheck and Neale, 1998; Susser et al., 1997), social functioning (Chandler et al., 1996a; Gater et al., 1997; Issakidis et al., 1999; Sellwood et al., 1999), employment (Chandler et al., 1996a; Chandler et al., 1996b); and income (Chandler et al., 1996a; Cox et al., 1998; Gater et al., 1997).

In program-related areas, ACT/ICM also demonstrated higher effectiveness: satisfaction with care (Chandler et al., 1996a; Gater et al., 1997; Holloway & Carson, 1998; Joy et al., 1999; Morse et al., 1997; O'Donnell et al., 1999; Rosenheck & Neale 1998; Tyrer et al., 1999a; Wolf et al., 1997), loss to follow-up (Chandler et al., 1996b; Herinckx et al., 1997; Issakidis et al., 1999; Johnston et al., 1998; Joy et al., 1999; McHugo et al., 1999; Tyrer et al., 1999b; Wolff et al., 1997), intensity of contact with the treatment program (Calsyn et al., 1998; Chandler et al., 1996a; Gater et al., 1997; Holloway and Carson, 1998; Morse et al., 1997; Wolff et al., 1997), and family burden (Chandler et al., 1996a; Joy et al., 1999).

For cost and service use outcomes, one study each found superior outcomes for inpatient cost (Wolff et al., 1997), psychiatric outpatient visits (Lehman et al., 1997), and medical outpatient visits: (Blow et al., 2000). Four studies found superior outcomes for total cost of care (Chandler et al., 1998; Rosenheck & Neale 1998; Tyrer et al., 1998). Five studies favored ACT/ICM for community cost (Chandler et al., 1996a; Gater et al., 1997; Lehman et al., 1997; Morse et al., 1997; Rosenheck & Neale, 1998). Six studies favored ACT/ICM for reducing hospital length of stay (Blow et al., 2000; Chandler et al., 1998; Gater et al., 1997; Lehman et al., 1997; Mares & McGuire, 2000; Tyrer et al., 1999b). And ten studies found ACT/ICM to be superior in reducing hospital admissions and readmissions (Blow et al., 2000; Chandler et al., 1996a; Chandler et al., 1996b; Chandler et al., 1998; Essock et al., 1998; Havassy et al., 2000; Issakidis et al., 1999; Joy et al., 1999; McHugo et al., 1999; Rosenheck & Neale 1998; Tyrer et al., 1998).

Program Fidelity

Program fidelity is an important consideration when looking at the outcomes of ICM or ACT programs as compared to other forms of case management. Phillips et al. (2001) have produced an exhaustive checklist of elements that must be met for a program to be considered faithful to the ACT model. They also distill these elements into principles of ACT:

- Services are targeted to a specified group of individuals with severe mental illness.
- Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the ACT team.
- Team members share responsibility for the individuals served by the team.
- The staff-to-consumer ratio is small (approximately 1 to 10).
- The range of treatment and services is comprehensive and flexible.
- Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
- There is no arbitrary time limit on receiving services.
- Treatment and support services are individualized.
- Services are available on a 24-hour basis.
- The team is assertive in engaging individuals in treatment and monitoring their progress.

McHugo et al. (1999) have found that ACT programs that are faithful to the model are more successful: “The findings suggest that local modifications of the ACT model or failure to comply with it may jeopardize program success.” Fidelity studies for MHICM are not yet complete.

Consider Continuation of Standard Case Management or Release from Case Management

Identify persons who may be able to move from ACT/ICM/MHICM to less intensive case management services.

Some studies have shown that decreasing the intensity of case management, for example moving a person from ICM to standard case management, is detrimental. This is especially true if the person is a high user of services (Mueser et al., 1998).

Continue Assertive Community Treatment/Intensive Case Management/Mental Health Intensive Case Management

Identify the person who is best served by remaining in the current form of case management.

No evidence currently exists for a positive outcome when persons are reassigned to less intensive case management or are released from all case management. Because of this, caregivers should carefully consider each person’s individual progress before considering a change to standard case management or exit case management.