Enhancing Treatment Adherence Among Persons With Schizophrenia by Teaching Community Reintegration Skills

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Introduction by the column editors: **Rates of continuity of care from inpatient hospitalization to outpatient treatment currently hover around 50 percent (1). Clearly methods are needed to equip patients with the knowledge and skills that will enable them to bridge this continuity gap on their own without the aid of intensive case management, which is not available in most care settings. One such method, the community reentry module, has been reported to be effective in private and county hospitals (2,3). In this month's Rehab Rounds column, Elizabeth Rossotto, Ph.D., and her colleagues document the efficacy of this program as a link between inpatient and outpatient services. The module has achieved high rates of aftercare adherence and low rates of rehospitalization at the West Los Angeles Healthcare System, the largest Department of Veterans Affairs medical center in the United States.**

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Eight of the 16 lessons contained in the community reentry module (4) have been used with Department of Veterans Affairs (VA) patients with schizophrenia during acute, short-term inpatient hospitalization and then for their ongoing outpatient treatment. These eight lessons fall into four content areas: identification of symptoms of mental illness, medication management, relapse prevention, and the making and keeping of appointments in the community.

The curriculum is offered to inpatients in daily groups and to outpatients in weekly groups. The group sessions use structured learning activities such as motivational interviewing, video demonstrations, role playing, problem-solving exercises, and in-class and community assignments. Although both the inpatient and outpatient groups use the same material and activities for learning, the two groups are facilitated with different formats and different areas of emphasis.

The schizophrenia ward at the West Los Angeles VA Medical Center serves persons who have severely disabling, florid exacerbations of chronic schizophrenia. Because of constraints on duration of care and despite receipt of intensive psychopharmacotherapy, patients are often discharged before they have been fully stabilized on their medications and while they are experiencing residual psychotic symptoms. Because of the brevity of hospitalization and the symptomatic and neurocognitive deficits of the inpatients, the community reentry module was modified to include two lessons per group session per day for each of the four major skill areas. Four sessions are provided Monday through Thursday on a continuous basis, with open enrollment as patients are admitted and discharged.

Monday's session focuses on symptoms of mental illness, Tuesday's session is on medication management, Wednesday's is on relapse prevention, and Thursday's is on making and keeping appointments. To accommodate the nursing and discharge planning schedules of the unit and the distractibility and learning disabilities of the patients, each session lasts for 40 minutes. The sessions are held immediately after lunch and end with a smoking break. Although a manual and a tightly structured agenda form the basis of the sessions, group leaders, or trainers, are encouraged to use their own spontaneous teaching styles and to elicit participants' past and current experiences as they relate to the topics in the curriculum.

Outpatient phase

Although outpatients who continue to participate in the community reentry module after discharge may still be experiencing varying degrees of symptoms and neurocognitive impairment, they are generally markedly improved and able to tolerate less structure and longer (90-minute) sessions. Held in the mental health clinic, the outpatient sessions involve par-

ticipants in a more experiential process and focus on the application of patients' learned skills to their own unique life circumstances.

Each session begins with participants' descriptions of stressful and challenging life events encountered during the past week as well as their success in using the new skills they have learned in their everyday lives. This "go-around" process offers many opportunities for the trainer to engage the participants in problem solving and in revisiting the skills learned in previous sessions. Booster training is provided when needed, given that repetition is the "soul of learning" and is often necessary with persons who have schizophrenia. The "here and now" emphasis in the outpatient training sessions enhances group cohesion and the relevance and individualization of the learning.

Case example

Mr. J began his outpatient group session by reporting that he was experiencing more severe symptoms and had forgotten his scheduled appointment with his psychiatrist. The trainer explored this situation with Mr. J, gathering details about the nature of his symptoms and the reasons he missed his appointment. The trainer was neither confrontational nor judgmental. Rather, a Socratic approach was taken, which uses a problem-solving process to convert negative experiences into constructive learning for the future. This real-life situation provided an opportunity for the patient and the group leader to revisit material from two content areas of the community reentry module—relapse prevention and the making and keeping of appointments.

Group members were involved in the problem-solving process by helping to identify warning signs of Mr. J's relapse and developing ways of overcoming obstacles to keeping appointments. One participant described how he used a large calendar mounted on the inside of his bedroom door to remind him of each day's appointments. Another participant described how he was able to borrow someone else's telephone to contact the clinic to schedule a make-up appointment. Modeling and role playing with positive reinforcement was used to further solidify the learning and improve Mr. J's future use of disease self-management skills.

Impact of the module

Participation in the community reentry module was associated with a rate of continuity of care, as measured by completion of at least one outpatient visit, that was twice as high as that observed hospitalwide among persons with schizophrenia. Patients who participated in the inpatient module were approached about their interest in participating in the outpatient module on a research basis. After giving informed consent, persons with schizophrenia or schizoaffective disorder were randomly assigned to either the community reentry module (eight patients) or a psychoeducational group on mental illness (six patients), which featured a discussion group format focusing on a video, "What is Schizophrenia?" (4). Six patients assigned to the community reentry module (75 percent) kept their clinic appointments, compared with two patients (33 percent) in the psychoeducation program. None of the participants in the community reentry module required rehospitalization, whereas 50 percent of those in the psychoeducation program (three patients) had been rehospitalized at 12-month follow-up. This controlled trial of the outpatient adaptation of the community reentry module is ongoing, and the results described here should be viewed as preliminary.

Afterword by the column editors:

It is vitally important that skills training be continued from the inpatient to the outpatient phases of treatment. As described in the American Psychiatric Association's practice guideline for the treatment of schizophrenia (5), services must be adapted and sustained from the acute phase of the disorder to the stabilizing, stable, and recovery phases. When a particular skills training curriculum such as the community reentry module is available for use in both hospital and outpatient settings, it can serve as a functional bridge to help participants continue their care and to facilitate the trajectory from relapse to recovery.

As Dr. Rossotto and her colleagues found, it is absolutely essential for clinicians to individualize training and be sensitive to the obstacles and difficulties that each participant may have in applying the skills to his or her everyday life. When opportunities, encouragement, and reinforcement for the transfer of skills to the natural environment are made available through the combined efforts of the consumer, his or her family members, or other natural support persons, and the members of the treatment team, good outcomes accrue. Furthermore, as greater stability and recovery ensue from this personalized approach to training, consumers can take on more responsibility for managing their own needs and problems and achieving their goals, and less intervention from professional caregivers will be required. ♦

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