The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

From Psychiatric Advance Directives to the Joint Crisis Plan

Psychiatric advance directives aim to help people retain control over their treatment when incapacitated. Although strategies exist to help consumers develop directives without provider involvement, many consumers engage a provider in creation of directives to facilitate decisions about treatment, confirm details of previous treatment, ensure timely access to the document, or provide clarification.

Joint crisis plans, which promote these goals through meetings between consumers and providers facilitated by an independent mental health professional, have been associated with reduced involuntary hospitalizations in the United Kingdom. In 2005–2006, we pilot tested this intervention in the United States to determine the feasibility of its completion and use.

The study was conducted at two publicly operated clinics and one affiliated nearby hospital in New York City serving a predominantly low-income Latino population. The inpatient unit and crisis response team directors agreed to store copies of plans if participants wished, but this was not possible at the psychiatric emergency room.

We included consumers admitted to a psychiatric inpatient service at least once in the past two years with a diagnosis of psychotic or bipolar illness. Inpatients and those in mandated community treatment were excluded.

After recruitment, an investigator not affiliated with clinic services met with the participant and case manager (or psychiatrist, if no case manager was involved) to discuss and record the participant's preferences for the plan's content. To finalize it, the investigator held a meeting with the participant, case manager, psychiatrist, and other relevant professionals. The investigator encouraged the participant to bring a caregiver, friend, or advocate. The aim was to discuss stakeholders' views on crisis management and to negotiate mutually acceptable solutions. The selection of information and the exact wording were the participant's choice alone. Legal documentation was not used because New York State advance directive legislation does not cover advance instructions.

Besides a description of routine care and regular medication, content included relapse indicators, what had or had not helped in previous relapses, steps to avert hospitalization, and procedures if hospitalization occurs. For example, a participant said that he disliked the nickname used by some clinic attendants and that it made him more irritable during relapse. Many participants identified medications that had caused side effects or asked that their usual medication simply be restarted; similarly, all stated whom they wanted with them in the emergency room and who could and could not visit them if hospitalized. One participant asked whether he could be placed in a single room with encouragement to share after a couple of days.

After confirming the draft with the participant and, if the participant requested significant changes, with the providers, the investigator distributed the final copy to the participant and others whom the participant designated. Another interviewer administered a questionnaire to participants for their views of the intervention shortly thereafter and again 12 months later.

The intervention was completed for all 20 participants. Of 17 participants interviewed, all but one felt it probably or definitely reflected their wishes. At 12 months, all 16 participants interviewed agreed that they would recommend the plan to others, and most agreed that they had become more involved with their care (N=9) and had a better understanding of their illness (N=10).

Case managers, who also received questionnaires, thought participants learned about their illness and felt less anxious about what might happen in a crisis. One stated that the process allowed participants to talk about problems that providers had felt were too sensitive; another thought it had helped a participant avoid hospitalization. Two cited its usefulness for family members. None raised liability concerns.

Of eight participants hospitalized, one consulted the plan during this crisis and during another crisis that did not lead to hospitalization. One participant's relative brought the plan to the emergency room for physicians' review while the participant was there. The director of the inpatient unit, where copies were kept for all hospitalized participants, stated that only one participant's care was incongruent with the plan's content, when the patient had made a serious suicide attempt; the seriousness of the attempt, rather than the written preferences, determined care. Two other participants reported difficulties in implementing the plan: one whose preferences were not carried out in the emergency room and another who struggled to remember the content during a crisis. In summary, the intervention was welcomed by consumers and providers, and the results provide evidence that it promoted shared decision making. Further work is needed if such plans are to be used by emergency service providers.

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Therapeutic Homework to Support Recovery From Severe Mental Illness

Therapeutic homework refers to activities that clients complete between their visits with mental health workers. The aim of such homework is to facilitate progress toward treatment goals. There is an increasing body of research indicating that homework completion is associated with improved outcomes of psychotherapy across a wide range of clinical disorders (such as depression and anxiety). However, there is limited research into the role of homework in mental health case management for people with severe mental illnesses such as schizophrenia. Many mental health service providers are actively involved in delivering specific client interventions such as skill development, activities to improve physical health, and the promotion of medication adherence. All of these, at least in theory, require practice in natural community environments for successful integration into the person's everyday life. Systematic homework implementation has a critical role in supporting people with serious mental illness to achieve their recovery goals.

The collaborative recovery model (CRM) is a case management approach to operationalize contemporary recovery principles—hope, meaning in life, and personal responsibility—in clinical practice. Our research team has been conducting a formal evaluation of the CRM, as part of the Australian Integrated Mental Health Initiative (AIMhi).

This evaluation has involved training hundreds of mental health workers from government and nongovernment mental health services across four Australian states. Systematic homework implementation is one of six core training components of the CRM. Within this model, collaboratively developed homework assignments are used to promote progress toward the person's recovery goals and encourage client self-management, responsibility, and skill development.

An early topic of the homework training is the suitability of the term "homework." For many clients (and case managers) the term feels negative because it is associated with unhappy school experiences or might seem overly paternalistic. We use the term because it is used in treatment manuals and the research domain. However, in practice we encourage clients and clinicians to use terms that they both find acceptable, such as "home exercises" or "home practice."

Homework training also emphasizes a systematic approach to homework administration that involves collaborating with the client to identify how often, in what length of time, where, and when the homework should be completed. In addition, a written record of the homework providing these details is required. Our research has shown that although over 90% of mental health workers say they use homework, in practice only 15% write down the details for clients as noted above. Written details can help address cognitive problems some people with psychosis experience, such as difficulties with memory or planning. A homework assignment pad is provided that includes prompts (where, when, how often, and so on) to structure an assignment, guide the worker and client, ensure the assignment is sufficiently behaviorally specific, and provide a written record. The pad is carbonized, enabling the client and case manager to retain a copy of the assigned homework for subsequent review. Research suggests that such written details are associated with better homework completion and more positive treatment outcomes than assignments without written reinforcement.

The training does not prescribe the types of homework assignment to be implemented. However, we direct workers toward examples of treatment manuals that include recommended assignments because these are evidence-based resources. Given the idiosyncratic needs and goals of individuals with serious mental illness, we emphasize principles of implementation and encourage workers and clients to collaboratively develop homework that can be linked to the person's own recovery goals. For example, a 24-year-old woman diagnosed as having schizophrenia was living in supported accommodation. To address her recovery goal of being more independent, one of the homework assignments she developed with her case manager involved visiting a real estate agent and viewing a potential apartment.

As part of the AIMhi trial, case managers were encouraged to implement homework on at least a fortnightly basis. In practice only around 50% of trained workers implemented any homework using written forms. Of those who used the homework forms, the frequency of assignment was much lower than suggested. Despite this result, our preliminary findings indicate a significant association between the number of written assignments and treatment outcomes, such that more frequent homework was associated with more positive outcomes on measures of symptom distress and psychological functioning. The major challenge is getting mental health workers to more consistently use systematic homework procedures to support their clients in progressing toward their recovery goals.

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