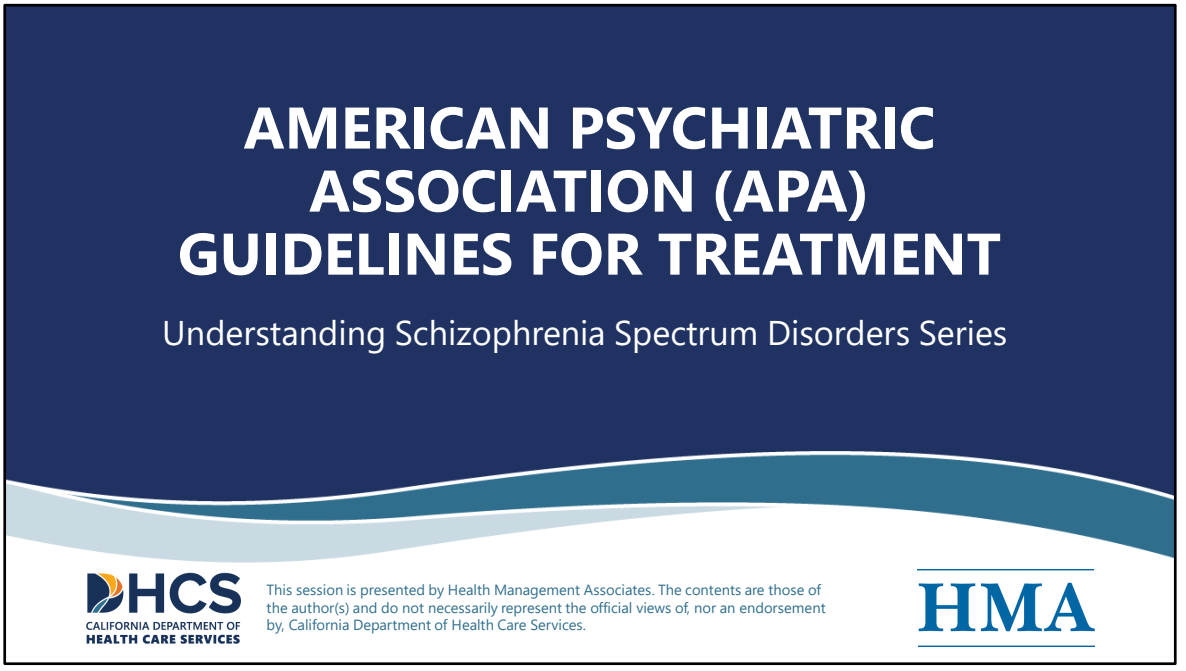
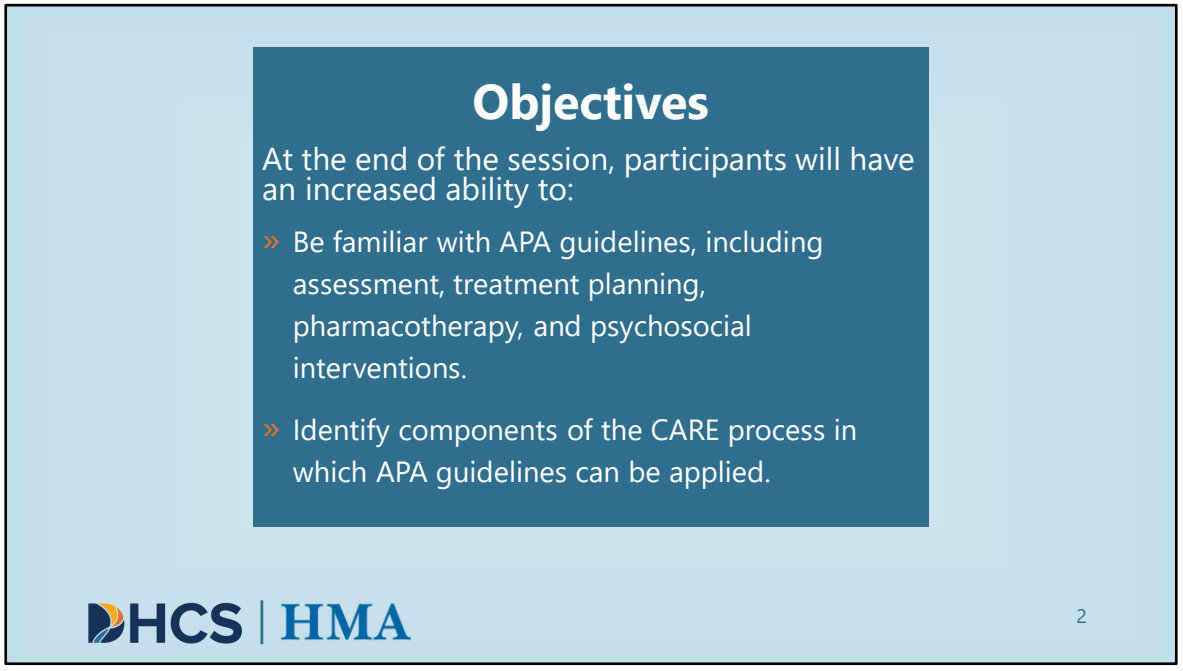


[Slide Image Description: This cover slide introduces the title and category of this training. It contains the logos for the California Department of Health Care Services and Health Management Associates.]

This presentation has not been reviewed by the American Psychiatric Association (APA) and does not necessarily reflect the official opinion of that organization.

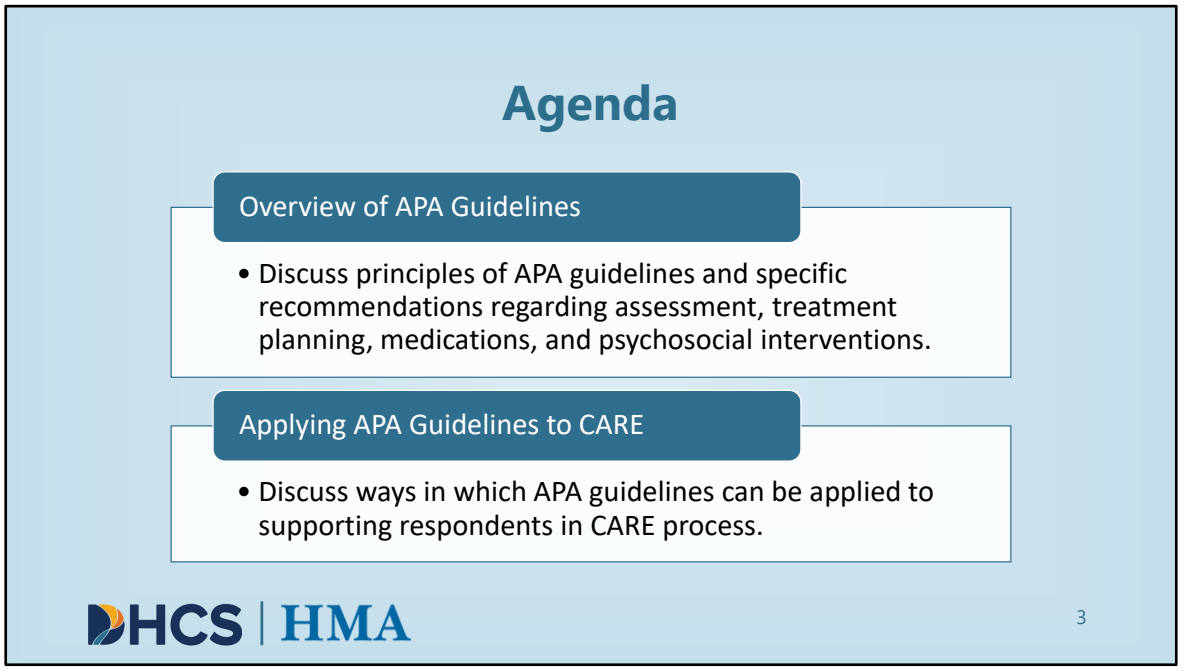
Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Be familiar with APA guidelines, including assessment, treatment planning, pharmacotherapy, and psychosocial interventions.
- Identify components of the CARE process in which APA guidelines can be applied.



[Slide Image Description: This slide shows the major sections of this training on a light blue background.]

The agenda for today:

- Overview of APA Guidelines:
    - Discuss principles of APA guidelines and specific recommendations regarding assessment, treatment planning, medications, and psychosocial interventions.
- Applying APA Guidelines to CARE:
    - Discuss ways in which APA guidelines can be applied to supporting respondents in CARE process.

Presenters

KATHERINE WARBURTON, DO

Statewide Medical Director
California Department of State Hospitals

MARC AVERY, MD

Principal
Health Management Associates

DEBORAH ROSE, PSYD

Associate Principal
Health Management Associates

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[Slide Image Description: This slide includes images of the presenters of this training on a light blue background.]

Dr. Katherine Warburton is the Statewide Medical Director for the California Department of State Hospitals, which has over 6,000 beds and is the largest forensic inpatient system in the county. She is an Associate Professor on the Volunteer Clinical Faculty within the UC Davis Division of Psychiatry and the Law. Dr. Warburton is board certified in psychiatry and forensic psychiatry. Her areas of interest include public policy, public forensic mental health care delivery systems, and inpatient aggression. She has presented both nationally and internationally and has published multiple peer reviewed articles on a variety of forensic topics. Dr. Warburton has produced two textbooks: Violence in Psychiatry and Decriminalizing Mental Illness. She is working on a third related to the treatment of schizophrenia. Dr. Warburton works at the national level on the board of directors for NRI and as a non-federal member of the Interdepartmental Serious Mental Illness Coordinating Committee.

Dr. Marc Avery, from Health Management Associates, is a board-certified psychiatrist and a recognized national leader in the subject of person-centered, integrated psychiatric care for high-needs and safety net patients. He has had the privilege of

providing (and overseeing) behavioral health care services to many hundreds of individuals with schizophrenia spectrum and other psychotic disorders including working with families, supporters, peer service providers, and other persons who assist in the care and treatment of persons with schizophrenia spectrum and other psychotic disorders.

Dr. Deborah Rose, from Health Management Associates, is a New York State licensed clinical psychologist with a history of designing and scaling new initiatives in behavioral health services. She has extensive experience working with social service agencies, behavioral health centers, care coordination, supported housing, and homeless services. Dr. Rose has broad clinical experience with a variety of underserved populations in human services and has held executive leadership positions in community-based agencies and carceral settings. Earlier in her career, Dr. Rose oversaw Kendra's Law, an Assisted Outpatient Treatment (AOT) program in NYC. She was also Deputy Director of Behavioral Health across the Rikers Island jail system. She has strived to improve access to and delivery of person-centered services for adults living with mental illness, substance use disorders, and co-occurring conditions.

[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

Welcome to our training session on applying the APA guidelines for diagnosing and treating schizophrenia. In this session, we will first discuss the APA's evidence-based practices and protocols designed to enhance clinical accuracy and improve patient outcomes. Then, we will look at how these various recommendations and considerations can be incorporated into the CARE process, with considerations being given to the outpatient nature of CARE and the specific needs of the CARE population. Our goal is to equip you with the essential knowledge and skills needed to ensure that we are using evidenced-based practices to meet the unique needs of individuals. Because the unique aspects of schizophrenia spectrum and other psychotic disorders, it's not a one-size-fits-all approach. Rather, it will take applying these best practices with flexibility and taking a trauma-informed approach.

In the next couple of sections, my HMA colleagues, Dr. Marc Avery and Dr. Deborah Rose, will provide information about these best practices and how they apply to CARE.

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Key Principles of APA Guidelines

- Using evidence-based interventions whenever possible.
- Taking a person-centered approach.
- Working towards recovery.
- Fostering family support.
- Creating an integrated treatment team.
- Providing regular support and follow-up.

What is the American Psychiatric Association? How do they set their guidelines?

APA is the world's leading psychiatric organization for setting practice guidelines by:

- Identifying clinical questions.
- Leading multidisciplinary work groups.
- Performing systematic evidence reviews.
- Surveying expert opinion.
- Checking existing literature to update guidelines.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia (and the accompanying article published by APA). See also the APA's guideline development process.

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[Slide Image Description: This slide shows an individual smiling at another individual, an orange box highlighting the APA, and a list of key principles of APA Guidelines.]

The American Psychiatric Association (APA) is a leading national behavioral health organization with almost 40,000 members involved in practice, research, and academia across more than 100 countries. Utilizing its connection to the world's largest community of psychiatric experts, the APA uses a comprehensive process for developing evidence-based guidelines for psychiatric practice. This process involves:

- Identifying key clinical questions in the psychiatric field.
- Leading multidisciplinary work groups—including subject matter experts and patient/family advocates—to provide input.
- Performing systematic evidence reviews to assess the strength of supporting research and determine the risk of bias in individual studies.
- When high quality research evidence is limited, APA will survey a large panel of experts to gain a directional opinion on the topic.
- After they are published, APA guidelines are updated regularly according to literature searches tracking recent developments and best practice.

In 2020, the APA updated their guidelines for the treatment of schizophrenia. We will

discuss three buckets of their guidelines. Each of these buckets is informed by the following principles:

- **Using evidence-based treatments and interventions whenever possible.** The APA guidelines recommend the use of well-studied and verified treatment and interventions. What does "evidence-based" mean? This term refers to those interventions that have undergone rigorous study to verify that they are effective. Many of the recommendations (especially for medications) are graded according to the available evidence. The guidelines are periodically updated as more developments and results come in.

- **Taking a person-centered approach:** APA stresses that their guidelines should be implemented "in the context of a person-centered treatment plan." A person-centered approach means taking a humanistic approach to care. It promotes the idea that the person with schizophrenia is an integral and central part of the care team – and that self-determination and self-management should pervade all services and care as much as possible. Person-centered care involves observing a person and thinking about what it is they are trying to show others. Think about an individual's mental health, culture, strengths, and preferences.

- **Working toward recovery/embracing the principles of recovery as an approach to care:** The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "supporting a process of change that supports the individual's overall health, wellness, and ability to live a self-directed life that allows for achievement of one's full potential." Rehabilitation services aim to help individuals with schizophrenia improve their functioning and quality of life. This may involve vocational rehabilitation to assist with employment, educational support, housing assistance, and skills training to promote independence and community integration. See more information about recovery here: https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf.

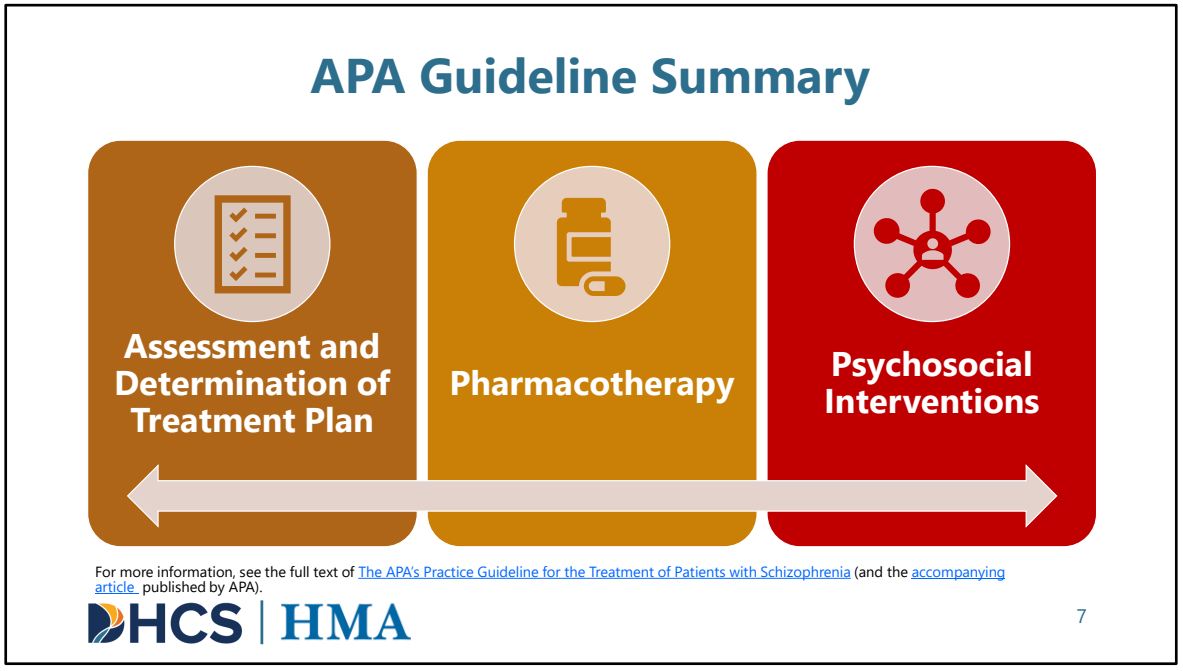
- **Fostering family support:** Involving family members in the treatment process can be beneficial for individuals with schizophrenia. Family support and education programs can help family members understand the condition, learn how to provide effective support, and cope with the challenges of caring for a loved one with schizophrenia.

- **Creating an integrated treatment team:** The APA recommends an integrated treatment approach that addresses the multiple dimensions of schizophrenia, including biological, psychological, and social factors. This may involve collaboration among psychiatrists, psychologists, social workers, case managers, and other mental health professionals to provide comprehensive care.

- **Providing regular support and follow-up:** Regular monitoring and follow-up are essential components of schizophrenia treatment. This includes ongoing assessment of symptoms, medication adherence, side effects, and functioning, as well as adjustments to treatment as needed to optimize outcomes.

It's important to note that treatment approaches may vary based on individual factors such as symptom severity, co-occurring conditions, personal preferences, and available resources. Treatment decisions should be made in collaboration with a qualified health care provider who can tailor interventions to meet the specific needs of each person with schizophrenia.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia (and the accompanying article published by APA). See also the APA's guideline development process.



[Slide Image Description: This slide shows three boxes and icons highlighting the key areas of APA's guidelines and an arrow crossing over the three boxes.]

The APA buckets their guidelines into three areas:

1. Assessment and Determination of Treatment Plan.
2. Pharmacotherapy.
3. Psychosocial Interventions – a category that includes all other treatments including models of care and specific therapies.

Under each of these areas, APA gives recommendations and suggestions (giving a rating associated with its evidence-base). The goal of their guidelines is to improve the quality of care and treatment outcomes. In the development of these guidelines, they sought to balance the benefits and potential harms of available treatments.

Following these guidelines doesn't guarantee success for everyone. They're not the only right ways to evaluate and care for someone, and they don't rule out other acceptable methods. The APA stresses that the final decision about how to assess, treat, or do a medical procedure should be made by the doctor who's directly taking care of the individual. The treatment team should consider the patient's psychiatric

evaluation, other medical information, and the different options available. Ideally, they should work with the individual and take into account their personal and cultural preferences, how likely the individual is to follow the treatment plan, and the outcomes they are working toward.

We will be touching on each of these buckets, but for a more in-depth discussion, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia (and the accompanying article published by APA).

APA Guideline Summary:
Assessment and Determination of Treatment Plan

- Thorough assessment and evaluation, including:
  - Treatment goals.
  - Symptoms.
  - Trauma history.
  - Mental and physical health, including substance use.
  - Psychosocial and cultural factors.
  - Risk of suicide.
  - Risk of aggressive behavior.
- Quantitative measurement of symptoms and impairments.
- Documented, comprehensive, and person-centered treatment plan.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.

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[Slide Image Description: This slide shows an orange box highlighting Assessment and Determination of Treatment Plan, with an icon of a checklist.]

As we go over the APA guidelines, consider how this applies to the CARE Act process.

APA recommends the following regarding an assessment and determination of a treatment plan:

1. **Thorough assessment** that includes the reason for evaluation; treatment goals and preferences; psychiatric symptoms and trauma history; substance use, treatment and physical health history; psychosocial and cultural factors; mental status including cognition; and an assessment of risk of suicide and aggressive behaviors. We'll note that APA uses the term treatment, while others will use the term recovery.
2. **Quantitative measurement** "to identify and determine the severity of symptoms and impairments of functioning that may be a focus of treatment." This can take the form of published measurement tools, such as the Dimensions of Psychosis Symptom Severity Scale or the Positive and Negative Syndrome Scale. Or they can be impromptu measures such as rating overall quality of life (QOL) on a scale from 1

to 10. Either way, the idea here is to measure symptoms over time to be able to determine whether improvement is being made as treatment progresses.

3. **Documented, comprehensive, and person-centered treatment plan**, which should include evidenced-based treatments and medication.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.

APA Guideline Summary: Pharmacotherapy

- APA recommends persons with schizophrenia be treated with an antipsychotic medication.
- The actual medication dosage often needs adjustment over time, as well as management of side effects.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.

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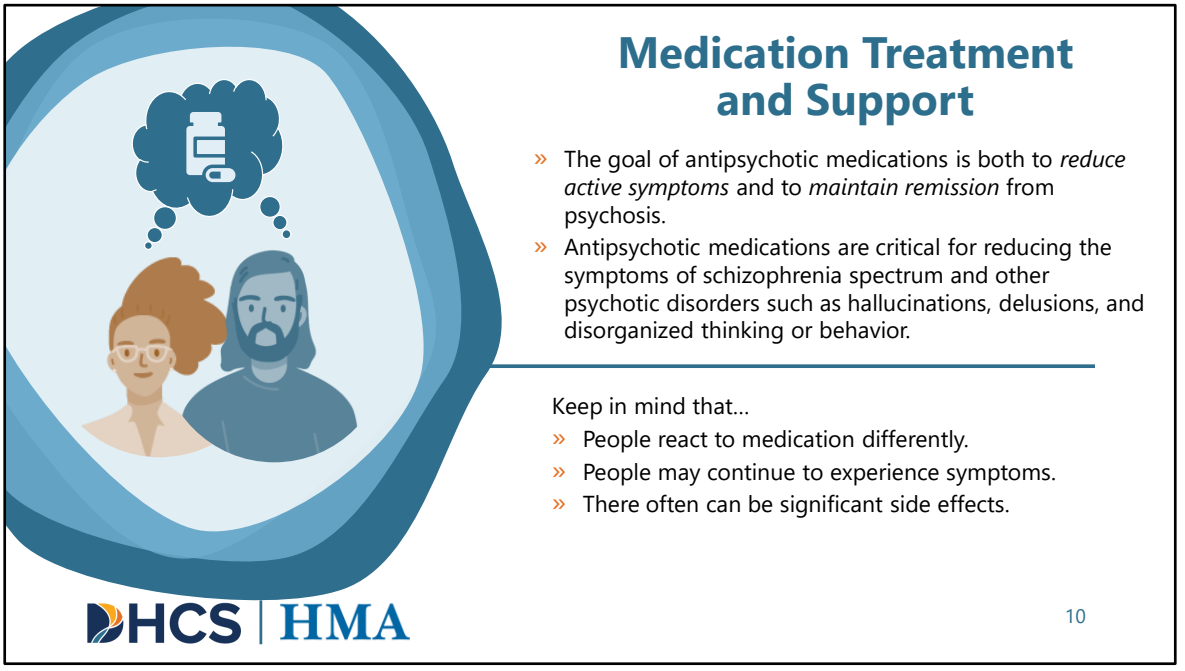
[Slide Image Description: This slide shows a yellow box highlighting Pharmacotherapy, with an icon of a pill bottle and an image of shelves in a store.]

1. Psychiatric medications are clumped into different classes—each for different purposes. The class of medications that are used to treat the psychotic symptoms of schizophrenia are called "antipsychotic medications," and there are over a dozen available. It's not incumbent on the courts and counsel to know the various medications and recommendations. However, the courts can help ensure that the prescriber is carefully considering and calibrating medications to meet the needs and goals of the individual CARE participant.
2. The APA guidelines make suggestions for prescribing and monitoring individuals with antipsychotics, while monitoring for effectiveness and side effects, continuing even when symptoms have improved and ideally treated with the same antipsychotic.
3. The APA guidelines also make suggestions for addressing the side effects associated with antipsychotic therapy, such as involuntary muscle contractions, parkinsonism (which can cause slowed movements, stiffness, and tremors), or movement disorders (such as fidgeting or moving your face or body that can't be controlled).

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.



[Slide Image Description: This slides shows a person along with an individual representing a clinician. A bottle of pills is shown with a description of medication support and considerations.]

Antipsychotic medication is an important component in offering persons relief from their symptoms and in making it possible for gains in other aspects of their recovery.

A person with schizophrenia spectrum or other psychotic disorders may be prescribed various types of psychiatric medications, and it can often be confusing to the outside viewer about the purpose and benefit of each of them.

The main goal of antipsychotic medication use is to both reduce active symptoms and to maintain remission from psychosis, even once those symptoms are in better control.

Antipsychotic medications require ongoing monitoring by someone who specializes in psychiatric medication prescribing because people may react to medication differently. Dosage sometimes needs to be adjusted or switched to a different antipsychotic. Antipsychotic medications may be effective for some but not all symptoms, and antipsychotic medications have significant risks of side effects.

Keep in mind that:

- People react to medication differently.
- People may continue to experience symptoms.
- There often can be significant side effects.

Long-Acting Injectable (LAI) Antipsychotics

Cases for Suggested Use

- The person prefers such treatment.
- A history of poor or uncertain adherence.

Benefits

- More convenient than daily dosing.
- May improve medication adherence.
- Help prevent relapse and rehospitalization.

Considerations

- Side effects are similar to oral forms.
- Pain/discomfort with injections.
- Logistical issues.

For more information on LAI antipsychotics, see the systematic review.

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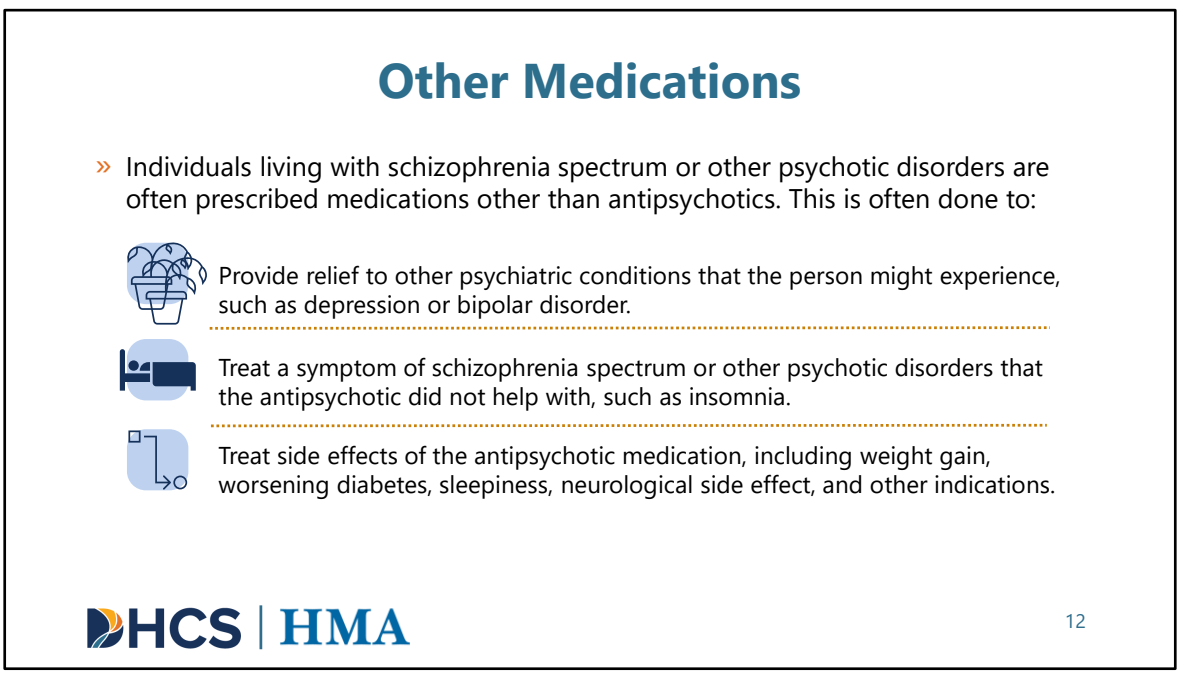
[Slide Image Description: This slide shows a medical professional with gloves wiping an elderly individual's arm while holding a needle in the other hand. It has three boxes highlighting suggested use case, benefits, and considerations.]

- The APA guidelines *suggest* that patients receive treatment with a long-acting injectable (LAI) antipsychotic medication if they prefer such treatment or if they have a history of poor or uncertain medication adherence.
- LAI medications can reduce the need to remember to take a medication. Instead, a person can receive an injection from every two weeks to six months, depending on the preparation. Some patients find this more convenient, and many improve medication adherence. LAI antipsychotics have also been proven effective in preventing relapse and rehospitalization due to the slow release and long half-life, which can reduce the risk of abrupt loss of efficacy if an individual misses a dose.
- There are some considerations – side effects, pain/discomfort of injection, and logistical issues (since it needs to be administered by a clinician). Additional reactions may include injection site pain, skin thickening, infection, erythema, nodules, lumps, bleeding, and tenderness.

For more information on LAI antipsychotics, see the systematic review.



[Slide Image Description: This slide shows three bullet points that describe reasons why an individual with schizophrenia spectrum or other psychotic disorders could be prescribed medication other than antipsychotics.]

Persons with schizophrenia spectrum or other psychotic disorders are often prescribed other medications as well.

Of course, they often receive “medical” medications such as blood pressure medications, diabetes medications, etc.

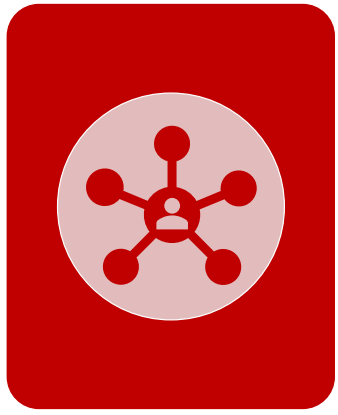
An individual living with schizophrenia spectrum or other psychotic disorders are often prescribed medications other than antipsychotics. This is often done to:

- Provide relief to other psychiatric conditions that the person might experience, such as depression or bipolar disorder.
- Treat a symptom of schizophrenia spectrum or other psychotic disorders that the antipsychotic did not help with, such as insomnia.
- Treat side effects of the antipsychotic medication.

APA Guideline Summary:
Psychosocial Interventions

APA guidelines include a range of psychosocial interventions that would be appropriate at different points for an individual with schizophrenia:

- Coordinated specialty care (CSC) program.
- Cognitive behavioral therapy (CBT).
- Psychoeducation.
- Supported employment services.
- Family interventions.
- Interventions aimed at developing self-management skills and enhancing person-oriented recovery.
- Cognitive remediation.
- Social skills training.
- Supportive psychotherapy.
- Assertive community treatment (ACT).



For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.

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[Slide Image Description: This slide shows a red box highlighting Psychosocial Interventions, with an icon of a network with an individual in the middle.]

We have discussed the first two categories of the APA guidelines, and now we will discuss the third: psychosocial interventions. The APA guidelines include a range of psychosocial interventions that would be appropriate at different points for an individual with schizophrenia.

These interventions include:

- **Coordinated specialty care (CSC) program** – *For individuals with a first episode of psychosis, CSC programs have been developed that integrate a number of evidence-based interventions into a comprehensive treatment package led by a multidisciplinary team. These services may include an early intervention program that focuses on first episode of psychosis and assertive community treatment (ACT).*

- **Cognitive behavioral therapy (CBT)** - *APA recommends that patients with schizophrenia be treated with cognitive behavioral therapy for psychosis (CBTp). CBT emphasizes helping individuals learn how to understand and adjust their way of thinking through various exercises.*

- **Psychoeducation** - *APA recommends that patients with schizophrenia receive psychoeducation, a therapeutic approach focusing on providing individuals with information intended to change their cognitions, beliefs, affect, and behaviors.*

- **Supported employment services** - *Supported employment differs from other vocational rehabilitation services by providing assistance in searching for and maintaining competitive employment concurrently with job training, embedded job support, and mental health treatment.*

- **Family interventions -** *An important aspect of good psychiatric treatment is involvement of family members, person(s) of support, and other individuals who play a key role in the patient's life. Family interventions are systematically delivered, extend beyond conveying of information, and focus on the future rather than on past events.*

- **Interventions aimed at developing self-management skills and enhancing person-oriented recovery -** *Illness self-management training programs have been applied to help address many chronic conditions and are designed to improve knowledge about one's illness and management of symptoms. Goals include reducing the risk of relapse, recognizing signs of relapse, developing a relapse prevention plan, and enhancing coping skills to address persistent symptoms, with the aim of improving quality of life and social and occupational functioning.*

- **Cognitive remediation -** *Cognitive remediation approaches are intended to address cognitive difficulties that can accompany schizophrenia, with the aim of enhancing function and quality of life. A number of different cognitive remediation approaches have been used, typically in group or computer-based formats, in an effort to enhance cognitive processes such as attention, memory, executive function, social cognition, or meta-cognition*

- **Social skills training -** *APA suggests that patients with schizophrenia who have a therapeutic goal of enhanced social functioning receive social skills training. Social skills training has an overarching goal of improving interpersonal and social skills but can be delivered using a number of approaches. These include cognitive-behavioral, social-cognitive, interpersonal, and functional adaptive skills training. Social skills training is delivered in a group format and includes homework assignments to facilitate skill acquisition.*

- **Supportive psychotherapy -** *Supportive psychotherapy is commonly a part of the treatment plan in individuals with schizophrenia who are not receiving other modes of psychotherapy. The focus of supportive psychotherapy is reality based and present*

centered. It commonly aims to help patients cope with symptoms, improve adaptive skills, and enhance self-esteem, although descriptions of the goals of supportive psychotherapy have varied. Examples of techniques used to foster these goals include reassurance; praise; encouragement; explanation; clarification; reframing; guidance; suggestion; and use of a conversational, nonconfrontational style of communication.

- **Assertive community treatment (ACT)** - *APA recommends that patients with schizophrenia receive ACT if there is a history of poor engagement with services leading to frequent relapse or social disruption (e.g., homelessness; legal difficulties, including imprisonment). ACT is a multidisciplinary, team-based approach in which patients receive individualized care outside a formal clinical setting. Thus, individuals may be engaged in their homes, workplaces, or other community locations.*

APA specifically calls out ACT as a recommended treatment for those that have a history of low engagement with services and social disruption, such as homelessness and justice involvement. We are going to discuss this intervention more on the next slide.

Also, keep in mind that we are talking about the APA's guidelines in this training. There are some other components that are important to CARE, including housing, that you don't see on this specific list of the APA's psychosocial interventions but are still important generally.

For more information, see the full text of The APA's Practice Guideline for the Treatment of Patients with Schizophrenia.

Assertive Community Treatment

- A team-based approach to care – with the team "wrapping around" the individual to provide adequate and tailored support.
- Providing care where and when it is most effective, in the community.
- Focus on autonomy, recovery, and wellness.
- Evidence indicates positive impacts, including reduced hospitalization and improvements in symptom management, housing stability, and quality of life.

For more information, including research on effectiveness, see The Critical Ingredients of Assertive Community Treatment article.

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[Slide Image Description: This slide shows an image of a George circled by images of other individuals that represent the team caring for George.]

We wanted to highlight assertive community treatment (ACT). It is an evidence-based program that provides a team-based approach to care – with the team "wrapping around" the enrolled person – providing care where and when it is most effective and emphasizes community-based (rather than clinic-based) services. ACT is like a clinic on wheels. This type of approach is especially appropriate for the CARE population because it's a 24/7 approach with a higher emphasis on coordination among services and providers.

The ACT team is made up of a mental health counselor or social worker, substance use counselor, case manager, psychiatrist or nurse practitioner, nurse, peer, and others. The team structure allows for the individual to be supported by a multidisciplinary integrated team. Generally, the recipient meets with at least three ACT team members each month, which six or more contacts in the community each month.

We mentioned taking a "person-centered" approach and considering the holistic mental/physical needs, preferences, experiences, and strengths. ACT can be a vehicle

for taking a person-centered approach. Instead of the individual coming to a medical clinic to be treated, for example, a mobile team will support an individual living in the community regardless of location – the person can be in a private home, a shelter, street homeless, or in a supportive housing residence. The ACT team will follow the person in the community.

The focus of many ACT programs is building independence (through skills training, building emotional resilience, etc.), recovery (using recovery-focused approach to serious mental illness), and wellness (through prevention, integration of physical and mental healthcare, taking a strengths-based approach, etc.).

How ACT works in your county may look different, but there will be commonalities: an emphasis on holistic needs, a multidisciplinary team, and meeting the individual where they are.

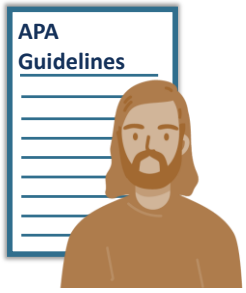
What is the evidence that ACT can work?
Evidence indicates positive impacts, including reduced hospitalization and improvements in symptom management, housing stability, and quality of life.

Note that in California, some or all elements of ACT may be present in Full-Service Partnerships (FSPs), but an FSP is not an ACT team. Both program models incorporate a multidisciplinary team to provide wrap-around services, but ACT might include aspects of more intensive services that would be appropriate for those with untreated schizophrenia spectrum and other psychotic disorders (such as more frequent touches and 24/7 availability).

For more information, including research on effectiveness, see The Critical Ingredients of Assertive Community Treatment article.

Ideas in Action

- List some of the key components of the APA's recommendations that you think might be helpful to keep in mind when supporting CARE respondents.
- For example:
  - Individualize the medication approach.
  - Use a wraparound approach staffed by a multidisciplinary team.
  - Tailor psychosocial interventions to the respondent's needs that reflect the interventions in the CARE agreement or CARE plan.
  - Incorporate natural and chosen supports as possible and approved by the respondent.



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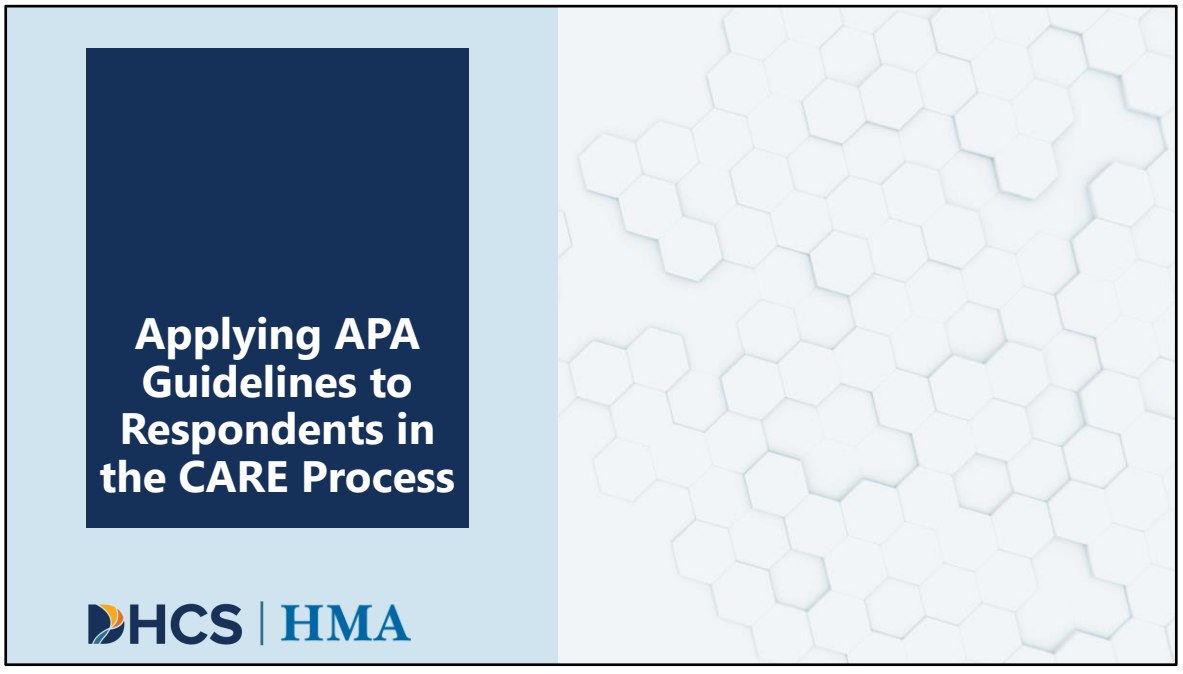
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

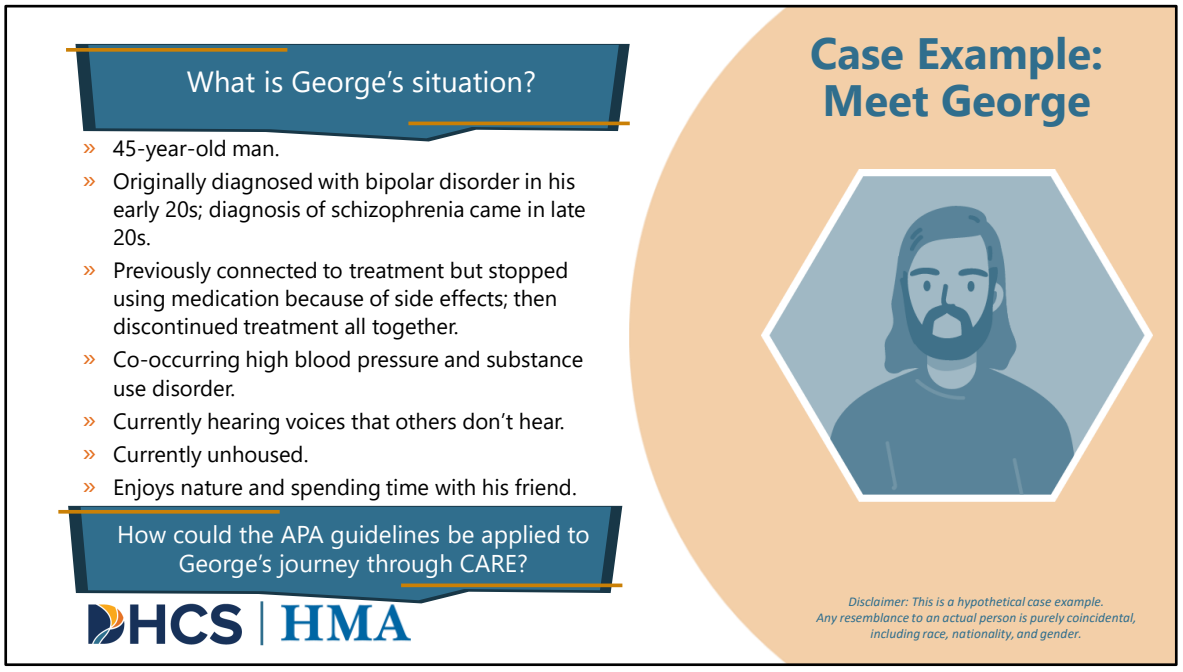
List some of the key components of the APA's recommendations that you think might be helpful to keep in mind when supporting CARE respondents.

For example:
- Individualize the medication approach.
- Use a wraparound approach staffed by a multidisciplinary team.
- Tailor psychosocial interventions to the respondent's needs that reflect the interventions in the CARE agreement or CARE plan.
- Incorporate natural and chosen supports as possible and approved by the respondent.



[Slide Image Description: This is a section divider slide to indicate a major section of this training.]

We just talked about the guidelines that APA has put out for the treatment of individuals with schizophrenia; now we are going to talk about ways in which those guidelines could be applied throughout the CARE process.



[Slide Image Description: This slide shows an image of an individual depicting George and a description of George's situation.]

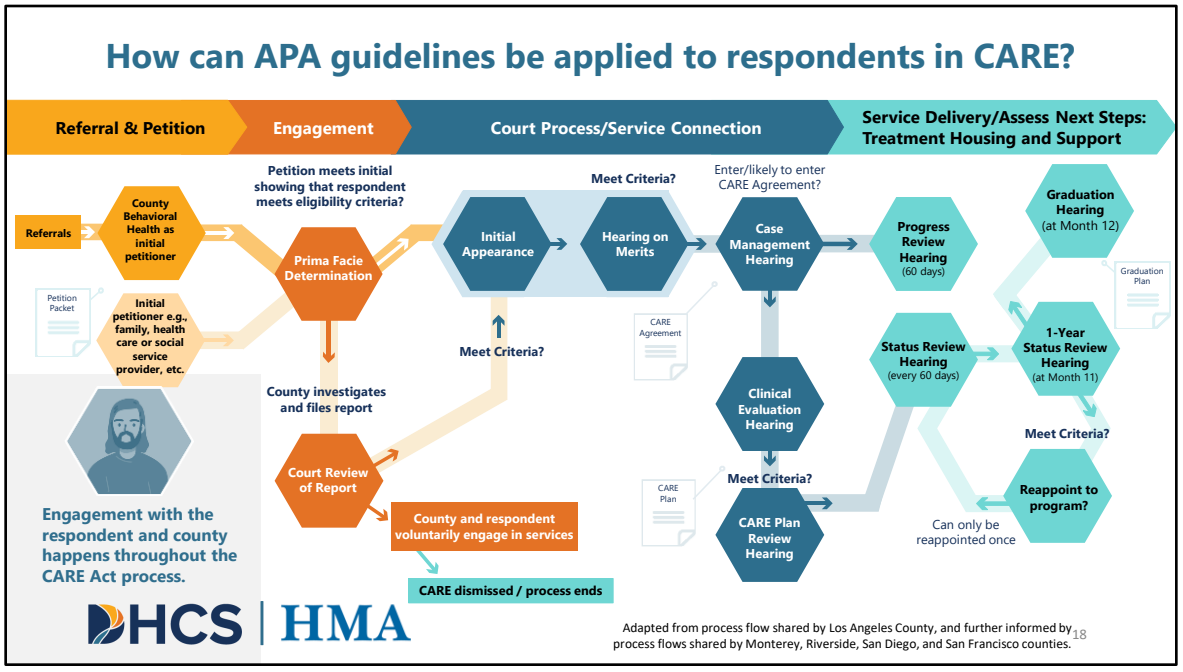
We are going to use a case example to explore the features of schizophrenia through the lens of a case example: George.

What is George's situation?

- 45-year-old man.
- Originally diagnosed with bipolar disorder in his early 20s; diagnosis of schizophrenia came in late 20s.
- Previously connected to treatment but stopped using medication because of side effects; then discontinued treatment all together.
- Co-occurring high blood pressure and substance use disorder.
- Currently hearing voices that others don't hear.
- Currently unhoused.
- Enjoys nature and spending time with his friend.

As we walk through this presentation, consider how the APA guidelines could be applied to George's journey through CARE.

Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.



[Slide Image Description: This slide shows a process flow with an example of pathways through the CARE Act process.]

How can we apply the APA's principles and guidelines to a respondent like George in the CARE process? As we were discussing the APA guidelines, you hopefully began to see how these guidelines could inform the county behavioral health (BH) team's approach in working with the respondent throughout the CARE process, from beginning to end. This visual highlights the key elements in the CARE process where APA guidelines can be applied, including voluntary engagement; the county investigation; the clinical evaluation; and importantly, the CARE agreement, CARE plan, and graduation plan.

_____

Description of flow:

1. Informal and formal referrals can be made to the county behavioral health (BH) agency.
2. Petitioner files a petition. This can be county BH or another initial petitioner.
3. There will be a Prima Facie Determination to see if the respondent meets the criteria.
    - If someone other than the county BH agency is the petitioner, and if the

respondent is found to meet the criteria, the county BH agency will investigate and file a CARE report.
    - If they do not voluntarily engage in services and the county BH report finds that the respondent meets the criteria, they will progress to the initial hearing.

1. If the respondent meets the criteria, there will be an initial appearance (with the petitioner present). There will also be a hearing on the merits (which can be combined with the Initial Appearance).
2. If the respondent still meets the criteria, then there will be a Case Management Hearing.
    - If it is determined in this hearing that a CARE agreement is likely to be reached, then there will be at least one progress review hearing (but potentially there could be more).
3. If it is determined at the Case Management Hearing that a CARE agreement is not likely to be reached, the court will order a Clinical Evaluation and then a hearing to review. That evaluation is required to include an assessment of respondent's capacity to make an informed decision around psychiatric medications.
4. If the clinical evaluation finds that the respondent is eligible, a CARE plan will be developed and then reviewed in a hearing.
5. There will then be a status review hearing at least every 60 days.
6. At month 11, there will be a one-year status review hearing to determine next steps:
    - The respondent will graduate (and have a graduation hearing at month 12).
    - The respondent will be reappointed to the program, which can only happen once.

Engagement Activities

- Engagement happens throughout the CARE process.
- Multidisciplinary team with a wraparound approach (e.g., ACT, FSP).
- Consider family and peer support involvement.
- Apply a trauma-informed approach.

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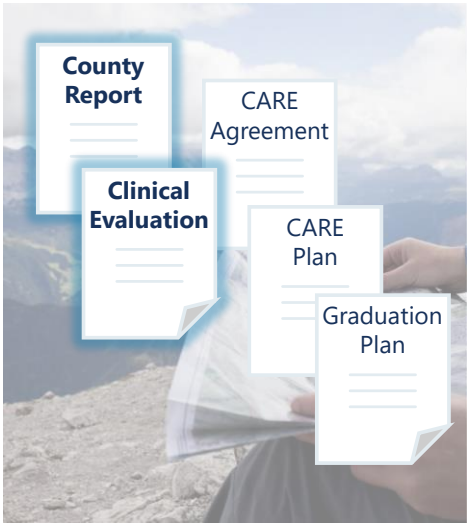
[Slide Image Description: This slide shows multiple hands together and lists engagement activities.]

Let's look at how these APA guidelines can inform engagement activities with the respondent throughout the CARE process and highlight the best practices that the APA speaks to, to support the individual's engagement in CARE. Remember the key principles of the APA guidelines include taking a person-centered approach and providing regular support and follow-up. As we look at engagement in CARE, there are many ways this can be applied.

- Engagement with the respondent is a critical component of CARE. Engagement is not limited to initial engagement activities but takes place throughout the CARE process to support the person's ongoing engagement and retention in CARE.
- The multidisciplinary, wraparound approach that an ACT team utilizes (or similar models, such as Full-Service Partnership [FSP]) is key to providing the trauma-informed, person-centered approach to effectively engage these individuals into treatment and services.
- Including peers on the team also supports the recovery approach. Including families – as approved by the respondent – can support an informed and collaborative

approach that individualizes the respondent's care.

- An essential element of successful engagement is providing a trauma-informed approach – including developing trust and rapport, supporting physical and psychological safety, and supporting the individual's choices throughout the process. These and the other principles of the trauma-informed approach clearly align with the tenets of CARE.



Assessment & Evaluation in CARE

To reflect APA guidelines, the county report and clinical evaluation could include:

- Goals and preferences.
- Trauma history.
- Substance use.
- Psychosocial and cultural factors.
- Mental health treatment and physical health history.
- Mental status including cognition.
- Evaluation of suicide risk.
- Aggressive behavior risk.

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[Slide Image Description: This slide shows images of papers representing a county report, clinical evaluation, CARE agreement, CARE plan, and graduation plan. The county report and clinical evaluation papers are highlighted with a list of their components.]

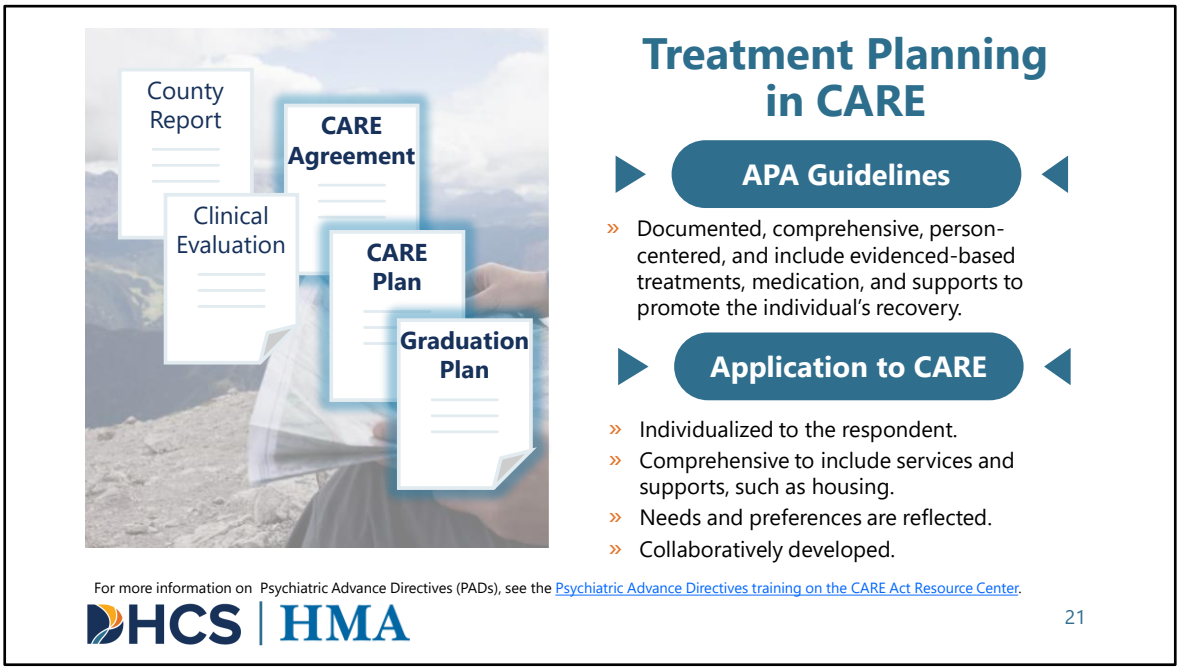
Another way that the APA's guidelines can be applied to the CARE process is through effective evaluation and assessment in the initial county report and later the clinical evaluation.

The APA speaks to the guidelines for county BH teams to provide a thorough assessment and evaluation. Both the county report and clinical evaluation are required to speak to engagement in, and eligibility for, CARE but should also be comprehensive in nature and cover the elements that we discussed earlier.

In order to reflect APA guidelines, the county report and clinical evaluation could include the respondent's goals and preferences; trauma history; substance use history; and psychosocial and cultural factors. These are in addition to the mental health evaluation that should include current symptoms; mental health and physical health treatment history; a mental status evaluation; and of course, evaluation for suicide risk

and aggressive behavior risk.

After a petition is filed to evaluate George's eligibility for CARE, consider how the county report and the clinical evaluation could include his goals and preferences and how they could capture elements of his past—such as trauma, substance use, mental health treatment, and physical health. They can also document his mental status, including cognition, and risk of harm to himself and/or others. These assessments can build a foundation for understanding George on a holistic level.



[Slide Image Description: This slide shows images of papers representing a county report, clinical evaluation, CARE agreement, CARE plan, and graduation plan. The CARE agreement, CARE plan, and graduation plan papers are highlighted. This slide also includes a definition of APA guidelines and methods for application to CARE.]

We've talked about how the APA guidelines can inform engagement and evaluation activities with CARE respondents. Now let's talk about treatment planning, particularly regarding the CARE agreement, CARE plan, and the graduation plan.

APA speaks to the importance of a documented, comprehensive, and person-centered treatment plan that includes evidenced-based treatments, medication, and supports to promote the individual's recovery.

When we think about the elements that the CARE Act speaks to with regards to the CARE agreement, CARE plan, and graduation plan, they very much align with these APA recommendations. CARE speaks to the need for:

- Individualized care.
- A comprehensive plan that includes services and supports, such as housing.
- Respondent choice and preferences being reflected.

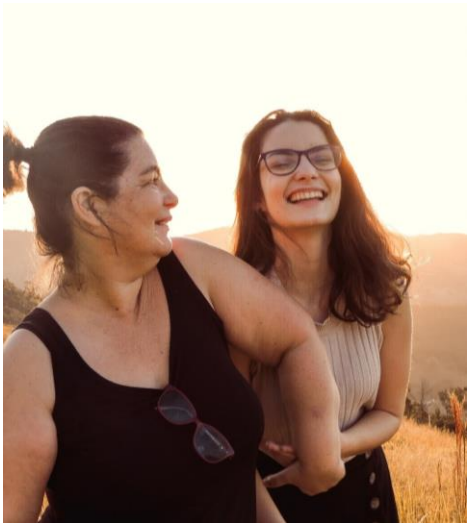
- CARE agreements or CARE plans being developed collaboratively.
- Inclusion of a volunteer supporter, if the respondent has approved this person to be involved.

Although a psychiatric advance directive (PAD) is not a formal documentation required through the CARE Act, it is included as a component of graduation from CARE. A PAD is a tool of empowerment that supports recovery and ensures the respondent's choices and preferences are heard. Creating a PAD is another opportunity to apply the APA guidelines and principles in treatment planning.

For more information on PADs, see the Psychiatric Advance Directives training on the CARE Act Resource Center.

Fostering Family Support in CARE

- Formal Roles:
  - Petitioner.
  - Volunteer supporter.
- Informal Roles:
  - Providing support.
  - Promoting recovery.
  - Attending hearings (at the request of the respondent).



See the Family Resource Guide for more information on the roles of family in CARE.

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[Slide Image Description: This slide shows a picture of two smiling women]

APA speaks to the importance of family involvement in the client's care where possible. The CARE Act allows for formal ways a family member could be involved, such as initiating the process by filing a petition or acting as the respondent's volunteer supporter (at the request of the respondent).

Even if they aren't volunteer supporters, family members can still support the respondent in the CARE process. They might do this by providing support, promoting recovery, or attending hearings at the request of the respondent.

Respondents at the beginning of their journey in CARE may not be ready to engage with their family members, but this can be an ongoing conversation with how/when to foster family support.

See the Family Resource Guide for more information on the roles of family in CARE.

Medications & the CARE Act

- If respondent is not likely to enter into a CARE agreement, the court may direct the county BH agency to conduct a clinical evaluation.
- The clinical evaluation, including an analysis of recommended medications, is utilized to create the CARE plan, to be reviewed by the court.
- Medically necessary stabilization medication can be a component of a CARE agreement or CARE plan.
- If the judge determines that the person lacks capacity to give informed consent for medications, then medications may be court ordered.

For more information on the topic of "decisional capacity" and "informed consent" as it relates to medication, see the training at CARE-Act.org .

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[Slide Image Description: This slide shows a pharmacist reaching for medication in a pharmacy and lists details around medications in the CARE Act.]

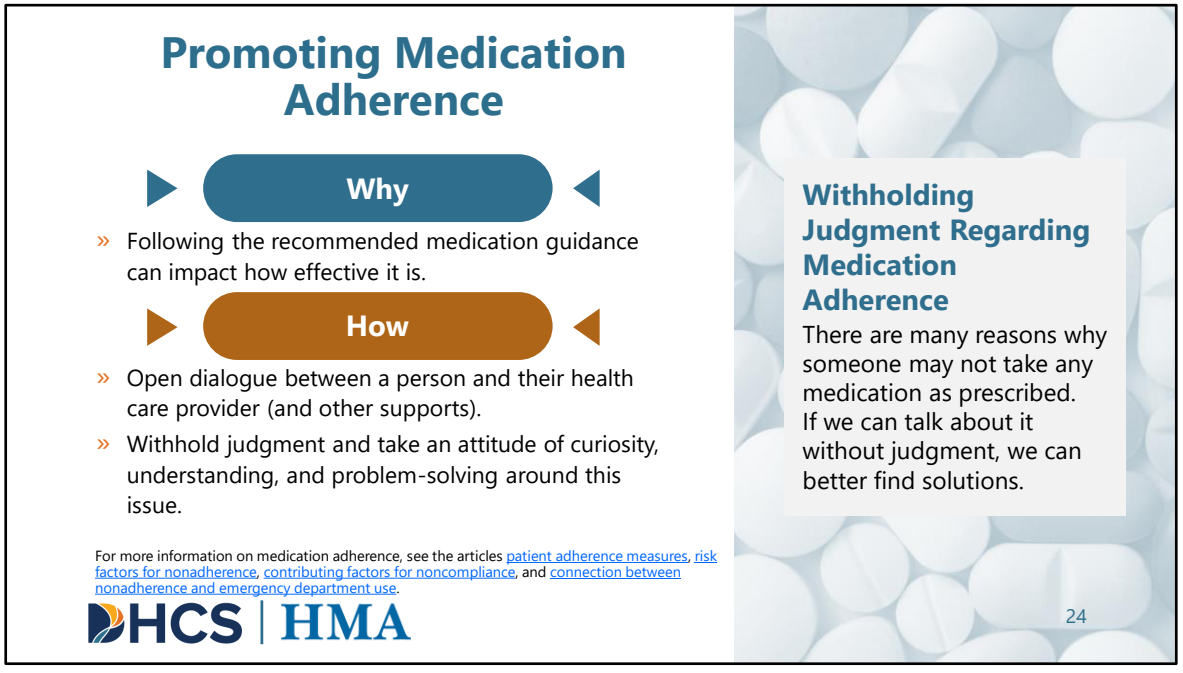
How do medication recommendations get incorporated into CARE Act proceedings?

- Medications may be a component of either the CARE agreement or CARE plan.
- Clinical Evaluation:
    - If respondent is not likely to enter into a CARE agreement, the court may direct the county BH agency to conduct a clinical evaluation, which must include an analysis of medication recommendations and whether the clinicians feel the respondent has the capacity to make informed decisions around these medication recommendations.
    - The county BH agency may call upon a licensed prescriber staff member to complete this portion of the evaluation. When appropriate, the respondent and their chosen family and/or supporters would participate in these discussions.
- The recommendations in the clinical evaluation are then utilized in the creation of a CARE plan, to be reviewed by the court.
    - Medically necessary stabilization medications may be included in the CARE plan if the respondent lacks the ability to give informed consent.

- Then during the clinical evaluation hearing, the judge utilizes the clinical evaluation to allow the county BH prescriber to prescribe these important medications to the respondent, even though they lack capacity to give informed consent. In this case, the medications become "court ordered."
- How is this different? Well, under normal circumstances all medications—including antipsychotics— are prescribed ONLY after the person gives informed consent to receive them. This means that they received sufficient information to base their consent on (e.g., understand their condition, the role of medication, and risks of not taking medication), and they must have the capacity to make a reasoned decision. But, when a respondent is not currently able to give informed consent, this can serve as a barrier to getting that important medication prescribed.
- Being "court ordered" doesn't mean that the medication will be forcibly administered, but it does make that medication more readily available at the time and place when the respondent is able and willing to receive it.
- Even with this court order, respondents should still receive appropriate information about medication, including involvement in medication discussions using techniques to promote a therapeutic alliance, such as motivational interviewing or problem-solving strategies.
- A side benefit of the court order is in providing the clinical team with the ability to help create a pattern of medication adherence. Often, simply explaining that it is an order of the court will help the treatment team encourage the respondent to accept a medication.

In the case of George, county BH notes in the clinical evaluation that long-acting injectable medications might help improve adherence, but George is scared of needles and was adamant he was not open to this treatment. In speaking with George, a psychiatrist found that George was open to taking oral medications again. The prescriber notes in the evaluation that since medications cannot be forcibly administered, George may be more likely to adhere to oral antipsychotic medication as part of his CARE plan.

For more information on the topic of "decisional capacity" and "informed consent" as it relates to medication, see the training at CARE-Act.org .



[Slide Image Description: This slide shows an image of pills with a description of why and how to promote medication adherence.]

The Why of Promoting Medication Adherence

"Adherence" in a clinical context means that a person's behavior aligns with the treatment, medication, or other guidance provided by a health care professional. For any treatment related to physical or mental health, following the recommended guidance for a medication can impact how effective it is. Particularly with antipsychotic medications, they tend to work best when a person takes that medication regularly over time. For instance, ongoing use of antipsychotic medication can be very important in maintaining clinical stability, including staying out of a psychiatric hospital. However, research suggests that adherence to antipsychotic medication can be challenging – up to half of persons fail to take their medication regularly even after a psychiatric hospitalization – often leading to relapse of psychosis and re-hospitalization.

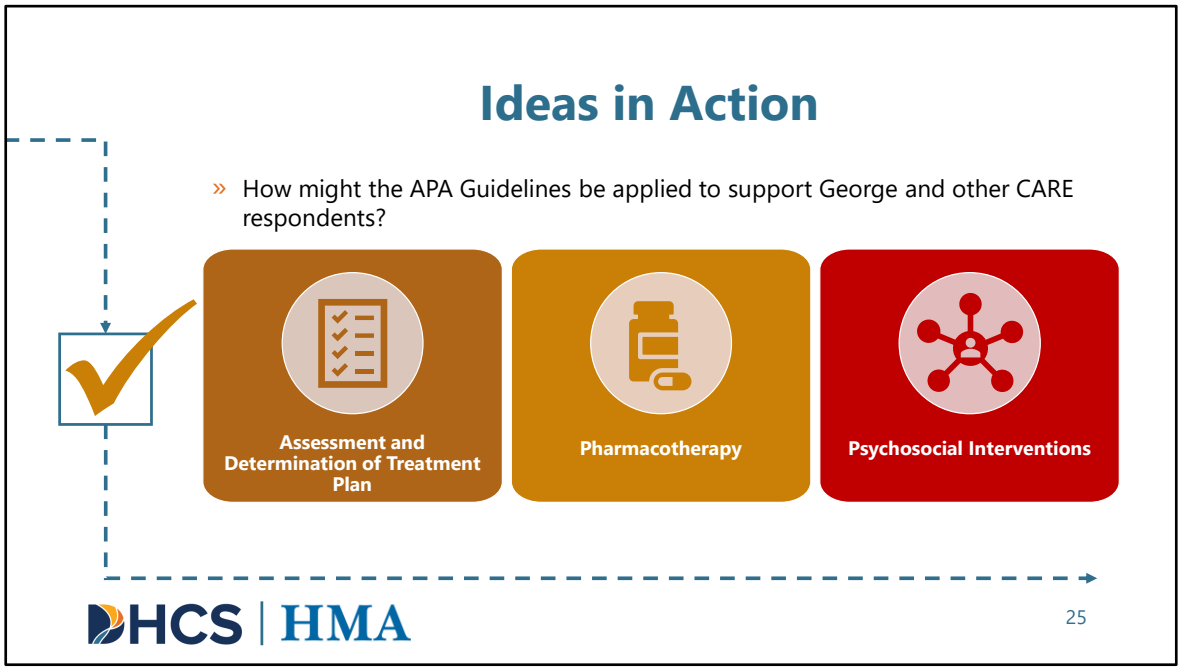
The How of Promoting Medication Adherence

One particular challenge of the pill form of antipsychotic medications is the need to

take the pill by mouth every day. This requires a fair amount of determination, preparation, and a regular routine to be successful. This is often challenging for some persons with schizophrenia spectrum and other psychotic disorders. For those persons, there is an option for long-acting injection antipsychotic medications. In individuals who choose this option, injections that occur every one to six months replace the need for a daily pill. The decision whether to use a long-acting injectable is just like any other medication decision and should be made in partnership with the provider, the person, and their support system. This is especially true because in many instances there is a protocol for transitioning from the pill to injection format that needs careful attention.

It's important to advocate for an open and honest dialogue between individuals and providers about medication adherence. Lack of adherence is very common with all types of medications, not just psychiatric. And the list of potential reasons for non-adherence is very long, like troubling side effects; perception that the medication isn't working; that it's not a part of their daily routine; or that they can't afford medication. We should avoid blaming individuals for adherence problems and instead take an attitude of curiosity, understanding, and problem-solving around this issue.

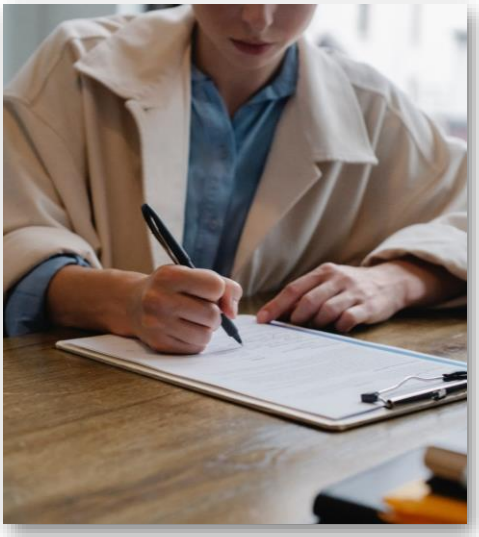
For more information on medication adherence, see the articles patient adherence measures, risk factors for nonadherence, contributing factors for noncompliance, connection between nonadherence and emergency department use.



[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

How might the APA Guidelines be applied to support George and other CARE respondents?

- Ensure each respondent receives a careful, thorough, and intentional assessment/evaluation.
- Involve the respondent in a person-centered, recovery-oriented treatment plan.
- Intentionally approach conversations around medication to maximize effectiveness and adherence.



Guidelines for Treatment at a Glance

- Take a person-centered approach regardless of the treatment plan.
- Wraparound services, such as those provided by ACT, can be especially effective.
- Antipsychotic medications are crucial and should be approached in a way to maximize benefits and adherence.

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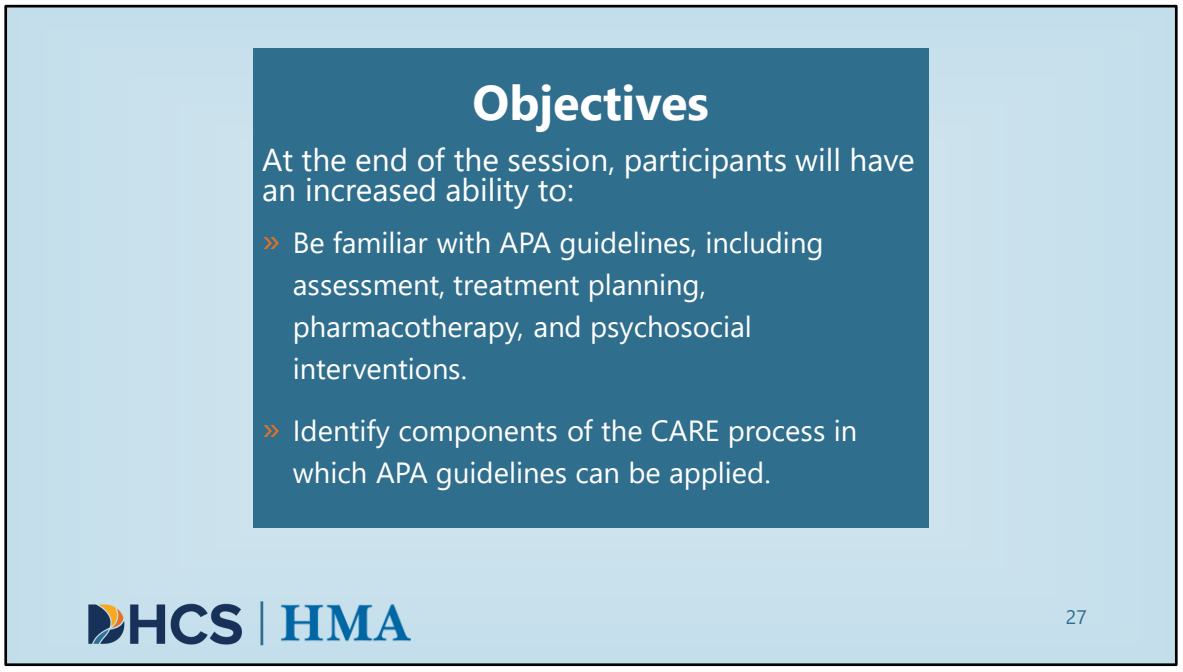
[Slide Image Description: This slide shows an image of an individual signing a paper on a clipboard with a summary of guidelines for treatment at a glance.]

Guidelines for Treatment at a Glance:

- Take a person-centered approach regardless of the treatment plan.
- Wraparound services, such as those provided by ACT, can be especially effective.
- Antipsychotic medications are crucial and should be approached in a way to maximize benefits and adherence.



[Slide Image Description: This slide shows the learning objectives for this training with a light blue background.]

At the end of the session, participants will have an increased ability to:

- Be familiar with APA guidelines, including assessment, treatment planning, pharmacotherapy, and psychosocial interventions.
- Identify components of the CARE process in which APA guidelines can be applied.

Next Steps

- Visit CARE-Act.org for resources (including recordings of past trainings) and to submit questions/TA requests.
- View the other trainings in the Understanding Schizophrenia Spectrum Disorders series:
  - Institutionalization and Criminalization of Persons with Schizophrenia Spectrum Disorders
  - Course and Outcomes
  - Clinical Features and Diagnosis

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[Slide Image Description: This slide shows bullets with next steps. It contains decorative arrows.]

Please let us know how we can best support your teams. Contact info@CARE-Act.org with questions, join the communications listserv, and submit requests and feedback for CARE Act TTA. Please also visit the CARE Act Resource Center website for training decks and recordings, which will be added two weeks after each training.

View the other trainings in the Understanding Schizophrenia Spectrum Disorders series:

- Institutionalization and Criminalization of Persons with Schizophrenia Spectrum Disorders
- Course and Outcomes
- Clinical Features and Diagnosis

[Slide Image Description: This slide shows the CARE Act website and the email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing the CARE Act. The website is **CARE-Act.org,** and our email address is **info@CARE-Act.org.**