Relapse Prevention Following First Episode Psychosis

CFMHN National Conference
Kelowna, British Columbia
October 2 -4, 2013

Heather Hobbs, RN & Elizabeth Ward, RN
Cleghorn Early Psychosis Intervention Program
Hamilton, Ontario, Canada

- Population 520,000
- Mix of inner city, urban, suburban & rural
- Situated on the shores of Lake Ontario, 60 km West of Toronto
- Fading industrial (steel) city, on the cusp of change with a thriving artistic community
- Higher than average unemployment
- Well-know mid-sized university
- Burgeoning immigrant & refugee population (mainly from Africa, Asia, Eastern Europe & the Middle East)
Cleghorn Program

- An Early Intervention in Psychosis (EPI) Program
- Part of Mental Health and Addictions Services at St Joseph’s Hospital, Hamilton
  - Ages 14 – 35
  - Clinical Interdisciplinary Team
    - Addictions counselor
    - Community Support Worker (peer)
    - Family Educator (RN)
    - RN Care-Coordinators
    - Occupational Therapists
    - Psychiatrists
    - Psychologist
    - Recreational Therapist
    - Social Worker
- Our Motto: “Working Together to make your first episode your last”
Provincial Policy & Standards

- EPION (Early Psychosis Intervention Ontario): a support and advisory body
- 2004: province wide funding for early intervention in psychosis
- 2011: Ontario EPI Standards
EPI Standards

Standard 3.5 Relapse Prevention

- **3.5.1** To reduce the need for hospitalization, the lead practitioner, client and family identify the client’s early warning signs for relapse as well as strategies the client and family can use to prevent or reduce the severity of a relapse.

- **3.5.2** In the event of a relapse the program has the capacity and protocols to assess and treat the client quickly.
Relapse and First Episode

- Symptomatic recovery has become a relatively attainable goal, with 80% experiencing remission within the first year.
- High relapse rate within five years of the first episode.
- Risk is reduced by maintenance antipsychotic treatment.
- Subsequent episodes are often more severe and necessitate higher treatment dosages.
Increased Risk for Relapse

- Medication Non-Adherence
- Persistent drug use
- ‘Carer’s’ criticism
- Poorer pre-morbid adjustment

# Two Pilot Projects

## Demographics

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>Mean: 24 years  Range: 18 - 31</td>
</tr>
<tr>
<td>Gender</td>
<td>Male = 17   Female = 10</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>SE Asian = 5  Afro-Car. = 2  Caucasian = 20</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Sz = 9, SzA = 5, Bipolar = 9, Substance induced = 1, NOS = 3</td>
</tr>
<tr>
<td>Substance Co-morbidity</td>
<td>Yes = 12  No = 15</td>
</tr>
</tbody>
</table>
| Side Effects*  | Yes = 5     No = 22  
*only reported side effect was weight gain |
# Demographic Data cont.

n = 27

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>High school:</th>
<th>Some = 4</th>
<th>Graduated = 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>College:</td>
<td>Some = 6</td>
<td>Graduated = 2</td>
</tr>
<tr>
<td></td>
<td>University:</td>
<td>Some = 3</td>
<td>Graduated = 5</td>
</tr>
<tr>
<td></td>
<td>PhD candidate = 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accommodations</th>
<th>With parents = 22</th>
<th>Supportive housing = 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With spouse = 2</td>
<td>Alone = 2</td>
</tr>
</tbody>
</table>

| In Relationship    | Yes = 7              | No = 20                 |

| Primary Income     | Family = 14          | ODSP = 5                |
|--------------------| Self = 5             | OSAP = 3                |
RPP Pilot Project #1

Goal: To examine the evidence and then develop a consistent approach to addressing relapse prevention with clients who have experienced a first episode of psychosis

Objectives:
- To make the first episode the last
- To support our clients into self-care
Review of Existing Relapse Prevention Approaches

- Wellness Recovery Action Plan (Copeland, 2001)
- COPE (Early Psychosis Prevention Intervention Centre, Melbourne, Australia)
- Relapse Prevention Plan (Mood & Psychosis Early Intervention Team, CMHA, Toronto)
- Card Sort Exercises (Agius et al, 2006)
Generation of the Relapse Prevention Plan (RPP)

Our team determined a need for a brief, user friendly approach that focused on 6 key statements

1. Things I do to stay well are
2. Stressors/triggers to try and avoid are
3. Early warning signs of relapse for me are
4. If my symptoms start coming back or my family/friends are worried about me I will
5. My current medications are
6. What should I do if I start thinking about changing or stopping my medications
Summary of tools used:

- 2-page written RPP
- Wallet card electronic template; writable pdf
- Wallet card holder
Relapse Prevention Plan Facilitation: Stage 1

RPP process is developed in partnership with client, clinical team and family when possible

First Appointment:

- Generate a timeline of early warning signs, stressors and triggers
- Discuss 6 key areas and create written RPP agreement, final draft with client and family together
Relapse Prevention Plan Facilitation: Stage 2

Appointment 2:

- Client works with team member to create the wallet RPP
- Wallet RPP is generated by client on the computer and produces a small, portable folding document
Things I do to Stay Well

(Using clients’ own words)

- Includes healthy lifestyle: sleep, eating, exercise
- Includes specifics re alcohol & substances
- Includes stress-management techniques
- Includes medications
Stressors/triggers to try and avoid are:

- Leaving stuff till the last minute
- Staying up too late
- Skipping my meds
- Worrying about finances when I’m by myself
- Smoking weed
- Doing nothing and having too much time to think
Early Warning Signs of Relapse for me

- Over-thinking things – everything seems different
- More rebellious – swearing more than usual
- Talking about having a haircut like John Frusciante
- Doing more drumming than usual
- Losing sleep
- Not hungry
- Feeling agitated
- Family or friends say: “something is the matter”
If my symptoms come back I will

- Talk to my sister
- Call Cleghorn: 905 540 6586
- If after hours, contact COAST: 905 972 8338
What should I do if I start thinking about stopping or missing my medications?

- Contact Cleghorn to discuss
- Don’t stop the medications on my own
Cleghorn-RPP Findings

- 1st Pilot phase: 13 RPPs were completed and the process was tracked and evaluated
- A survey was completed for feedback from clients, family and clinicians
Client Feedback

- Felt comfortable with the process and found the content comprehensive
- Especially liked the wallet document; portability of the tool provides a sense of reassurance "a plan in my pocket"
- Reported feeling more confident about preventing a relapse after completing the Cleghorn-RPP process
Family Feedback

- Found the process valuable and felt positive about discussing relapse and prevention
- Appreciated the wallet card as something the client could have with them
- Felt the process should be introduced early; felt reassured having a clear, specific plan and recommended scheduled reviews
Clinician Feedback

- Described the Cleghorn-RPP process as clear and found the tools to be user-friendly and concrete.
- Clinicians have been referring back to the Cleghorn-RPP in follow up discussions with clients.
- Clinicians have been using the Cleghorn-RPP to assess mental status using the client’s own language, symptom history, and triggers.
RPP has been observed to be a brief, clinically relevant tool for clients, families and clinicians

**For clients:** promotes client empowerment to self-care

**For families:** assists families in supporting the wellness of their loved ones

**For the clinical team:** serves as a brief check-up tool using the client’s own words

**For community partners:** has the potential to be used as a communication tool enabling collaborative care for clients & families
RPP Pilot Project #2

Goals

- To enhance engagement by having clients generate their own definition of ‘relapse’
- To assess medication adherence
- To gauge the level of insight
- To decide the optimal time to introduce the RPP process
2nd Pilot

2nd Pilot: 14 RPPs completed:

- Definitions
- Insight Scales
- Medication Adherence Scale
- Timing
All but one client was able to articulate a (good) definition – eg:

- “Going back to an unhealthy state (mentally).”
- “Experiencing another episode - not desirable.”
- “Relapse would be a re-occurrence of psychosis symptoms – hearing voices, getting paranoid.”
- “Being mentally unstable again – experiencing symptoms as originally experienced.”
- “Different severities – anything from a blip to full blown syndrome.” (wife)
- “Not to get really sick again and end up in hospital.”
Birchwood Insight Scale

Insight following recovery

Please read the following statements carefully and then tick the box which best applies to you:

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Some of my symptoms were made in my mind</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. I have always been mentally well</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. I did not need medication</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. My stay in hospital was necessary</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. The doctor was right in prescribing medication for me</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. I did not need to be seen by a doctor or psychiatrist</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. If someone said I had a nervous or a mental illness, they would be right</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. None of the unusual things I experienced were due to an illness</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Insight Scale (Birchwood)

- N = 14
- Full insight = 6
- Good insight = 6
- Limited insight = 2
<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Full adherence</td>
<td>Takes all medications as prescribed</td>
</tr>
<tr>
<td>3</td>
<td>Good adherence</td>
<td>Takes medications regularly but misses a dose once or twice per month</td>
</tr>
<tr>
<td>2</td>
<td>Moderate adherence</td>
<td>Takes prescribed medications most of the time but misses a dose once or twice per week</td>
</tr>
<tr>
<td>1</td>
<td>Poor adherence</td>
<td>Misses prescribed medications at least 3 times per week or takes lower dosage than prescribed</td>
</tr>
<tr>
<td>0</td>
<td>Non-Adherent</td>
<td>Does not take the prescribed medications</td>
</tr>
</tbody>
</table>
Medication Adherence Scale

- N = 14
- Full adherence = 9
- Good adherence = 4
- Moderate adherence = 1
Timing

- After partnership meeting
- After good symptom remission
- When clients start talking about stopping their medications
- Preparing for graduation from the program
Summary of Results (2nd pilot)

- There was consistency among clients in their understanding of ‘relapse’ as a return of symptoms.
- Insight generally: full or good
- Medication adherence: full to good
- Timing: optimal time still to be determined
Future Directions

- RPP will be used with all clients in fulfillment of the Ontario EPI Standards
- RPP will be included in the Quality Assurance plan (in process)
- Explore electronic options for RPP (e.g., interactive website, smart phone app)
Acknowledgements

- Thanks to the RPP working group:
- Dr Suzanne Archie
- Allison Henderson: OT
- Dr Stephanie McDermid-Vaz
- Kevin Tregunno: Peer Support Worker
- Sarah Wallace: Program Evaluator
Contact Information

- Cleghorn Program
- Tel: 905 540 6586
- Fax: 905 525 2805
- Email: hhobbs@stjoes.ca or eward@stjoes.ca
Literature Review

Keyword search: Relapse Prevention, Early Intervention Psychosis


