

# *Guideline Six*

**A strategy for relapse prevention and treatment resistance should be implemented.**

## Background

The avoidance of early relapse is crucial, as frequent, or long untreated episodes of psychosis increase the risk of further relapse. The presence of more than one relapse and residual symptom in the first two years is a major prognostic factor in its own right. Relapse risk has also been linked to acute and chronic stress (Kuipers and Bebbington, 1994).

## Requirements

### ***Relapse Prevention***

1. Clients and families should be informed about the risk for relapse and how they can help to reduce this.
2. Relapse risk assessment should form part of the ongoing assessment process and embrace:
  - **Vulnerability: untreated psychosis, previous exacerbations**
  - **Prophylaxis: utility of and adherence to medication regimes**
  - **Stressors: both acute (life changes, cannabis abuse) and long-term (intrafamilial stress, unstable life patterns)**
3. An individualised, shared and documented relapse prevention plan should be developed and rehearsed with the client and social network (see Tool Kit). This should include:
  - **Individualised signs of relapse ('relapse signature')**

- **Development and rehearsal of a linked 'relapse drill', involving, where appropriate, targeted and time limited neuroleptic medication.**
  - **An active relapse monitoring procedure.**
4. The experience of relapse/exacerbation should be viewed as an opportunity to review the relapse signature and operation of the relapse prevention procedure.

### **Treatment Resistance**

1. The continued experience of psychotic symptoms within 6 months of first treatment suggests that such symptoms are likely to continue (Lieberman et al, 1993). The review at this point should declare the presence of drug resistant symptoms and determine an appropriate strategy (see [Tool Kit](#)).
2. The trial use of atypical antipsychotics such as Clozapine should be considered. The combinations of cognitive therapy with medication has also shown considerable promise for drug resistant symptoms (Garety et al, 1997) and should be considered.
3. Teaching clients and carers how to deal with and cope with such symptoms to minimise distress may be required (Tarrier et al, 1998).

### Getting it right....

**Simon has a 2 year history of psychotic illness. After two lengthy hospital admissions under section he is now agreeing to try medication and to accept follow-up from the CPN team. His medication has helped with sleep, concentration and clarity of thought but he remains low in mood poorly motivated and finds it difficult to mix socially. Using early signs monitoring and family support, Simon is learning to recognise his symptoms of relapse. He agreed to attend a day unit informally when he felt depressed and was able to share his worries with the CPN. His admissions and relapses have reduced.**

### Where things can go wrong....

**John was discharged after a 12-week hospital admission with hypomania to his parents home. He had previously been living alone. He was to be followed up by another team but the referral letter was not written until 4 weeks after discharge. Whilst on the way, John had indicated his reluctance to adhere to medication and, in fact, did not obtain a repeat prescription. His parents were worried about what to do in the event of deterioration. Lost time, he left home and caught a train when acutely disturbed prior to his admission and the family were worried that police will have to be involved again.**

## *Ask Yourself.....*

**Does the family/client/keyworker/GP know what to do (in writing) with clear practical steps to take, if things go wrong, including:**

- Advice on medication adjustment to manage over the weekend and at night, to defuse an escalating crisis?
- A clear plan to access respite/day/inpatient care?
- A clear plan to access out-of-hours support?
- A clear plan of who to contact in the absence of a named worker?
- Does the letter/summary to the GP contain the above information in a clear form?
- Is there a service response time standard which is audited?

National Service Framework Links: Standards 4 and 5 repeatedly require clarity about action to be taken in a crisis and for this to be shared between client, carer and professional.