Counseling Points Live!

Shedding the Label of Schizophrenia Through a Recovery Model

APNA 26th Annual Conference
A Live CE Symposium

November 8, 2012
11:45 AM – 1:15 PM
David L. Lawrence Convention Center
Ballrooms B&C
Pittsburgh, Pennsylvania

This activity is supported by an educational grant from Janssen Pharmaceuticals, Inc., administered by Janssen Scientific Affairs, LLC.

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Faculty
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Michael Rice, PhD, APRN-NP, FAAN
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Meeting Agenda

11:30-11:45 Luncheon
11:45-12:10 Current Thought in Schizophrenia Management: The Psychiatric Nurse’s Perspective
Mary Ann Nihart, MA, APRN, PMHCNS-BC, PMHNP-BC

12:10-12:35 A Recovery Model for Effective Symptomatic Self-Management in Schizophrenia
Michael Rice, PhD, APRN-NP, FAAN

12:35-1:00 Understanding the Recovered Person’s Perspective to Achieve Successful Outcomes using Non-pharmacologic and Pharmacologic Approach
Frederick J. Frese, PhD

1:00-1:15 Questions and Answers
Continuing Education Information

Target Audience
This program has been designed to meet the educational needs of psychiatric mental health nurses at all levels of practice.

Statement of Need/Program Overview
This symposium presented by the American Psychiatric Nurses Association (APNA) seeks to educate psychiatric nurses about the value and benefits of using a recovery practice approach to support persons with schizophrenia. Through this educational program, we hope to enable attendees to take a leadership role in the implementation of effective patient-centered care.

Educational Objectives
After completing this educational activity, participants should be better able to:

- Describe the paradigm shift in schizophrenia from an illness/compliance focus to a person-centered recovery model focusing on self-management
- Discuss the various stages that individuals with schizophrenia progress through as they search for a new self-identity
- Review how nurses can support individuals across all treatment settings as they transition to independent community living
- Evaluate nonpharmacologic and pharmacologic strategies, including oral and injectable antipsychotic medications, with respect to safety, efficacy, personal responsibility, and outcomes to help individuals manage symptoms of schizophrenia

Nursing Accreditation Statement
The American Psychiatric Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Credit Designation
The APNA designates this educational activity for 1.5 continuing education (CE) contact hours.

Disclosure of Conflicts of Interest
The APNA assesses conflict of interest with its instructors, planners, managers, and other individuals who are in a position to control the content of CE activities. All relevant conflicts of interest that are identified are thoroughly vetted by the APNA for fair balance, scientific objectivity of studies utilized in this activity, and patient care recommendations. The APNA is committed to providing its learners with high-quality CE activities and related materials that promote improvements or quality in health care and not a specific proprietary business interest or a commercial interest.
The faculty reported the following financial relationships or relationships to products or devices they or their spouse/life partner have with commercial interests related to the content of this CE activity:

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<tr>
<th>Name of Presenter</th>
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<tr>
<td>Mary Ann Nihart, MA, APRN, PMHCNS-BC, PMHNP-BC</td>
<td>No real or apparent conflicts of interest to report.</td>
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<td>Frederick J. Frese, PhD</td>
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<td>Michael Rice, PhD, APRN-NP, FAAN</td>
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The planners and managers, Patricia Black and Deborah Hobbs of APNA, Joe D’Onofrio and Nancy Monson of Delaware Media Group, and Mary Beth Woodin of MBK Associates, LLC, have no real or apparent conflicts of interest to report.

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The opinions expressed in this educational activity are those of the faculty and do not necessarily represent the views of The American Psychiatric Nurses Association, Delaware Media Group, or Janssen Pharmaceuticals, Inc., administered by Janssen Scientific Affairs, LLC.

Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any medications, diagnostic procedures, or treatments discussed in this publication should not be used by clinicians or other healthcare professionals without first evaluating their patients’ conditions, considering possible contraindications or risks, reviewing any applicable manufacturer’s product information, and comparing any therapeutic approach with the recommendations of other authorities.

Educational Grant

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Current Thought in Schizophrenia Management: The Psychiatric Nurse’s Perspective

Mary Ann Nihart, MA, APRN, PMHCNS-BC, PMHNP-BC

Mary Ann Nihart is a nationally known psychiatric-mental health nurse practitioner and clinical nurse specialist with recognized expertise in psychopharmacology, integration of biology into psychiatric nursing practice, and reduction of the use of seclusion and restraint. She has co-edited a psychiatric nursing textbook, lectured widely, developed curricula for schools of nursing and SAMSHA projects, and chaired conferences.

Ms. Nihart received the 1999 Excellence Award for Outstanding Teaching and Service at the University of California, Davis; the 2003 Nursing Excellence Award, Association of Advanced Practice Psychiatric Nurses, State of Washington, Seattle, Washington; and the 2012 American Psychiatric Nurses Association’s Psychiatric Nurse of the Year Award.

Currently, Ms. Nihart is Nurse Manager for nine outpatient mental health programs at the San Francisco Veterans Affairs Medical Center, including the Psychosocial Rehabilitation and Recovery Center, which is a program focused entirely on facilitating recovery and integrating recovery principles throughout veterans’ mental health services.

Ms. Nihart received a BSN and MA in nursing from the University of Iowa and an MA in psychology from the California School of Professional Psychology (CSPP, now Alliant International University).
Current Thought in Schizophrenia Management: The Psychiatric Nurse’s Perspective

Mary Ann Nihart, MA, APRN, PMHCNS-BC, PMHNP-BC
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San Francisco, California

Schizophrenia

• 2.4 million Americans
• ~ 1 out of every 100
• Considered chronic and disabling
• Onset of symptoms in teens
  – Later onset for women
  – Maybe other gender differences
• Direct and indirect costs of $63 billion in 2002

Diagnosis

Yesterday
• No consistent guidelines
• Poorly differentiated subtypes
• Schneiderian first-rank symptoms

Today
• Reliable tools
• Symptom dimensions, distinctive courses, patterns of treatment response, prognostic implications
Symptoms of Schizophrenia

MATRICS 7 Domains of Cognition Affected by Schizophrenia

- Working memory
- Attention/vigilance
- Verbal learning and memory
- Visual learning and memory
- Reasoning and problem-solving
- Speed of processing
- Social learning/cognition

MATRICS = Measurement and Treatment Research to Improve Cognition in Schizophrenia; http://www.matrics.ucla.edu

MATRICS: Cognitive Battery Performance in Schizophrenia

Please refer to the original source for the graphic for this slide.
Facial Emotional Recognition in Schizophrenia

Please refer to the original source for the graphic for this slide.


Cognition and Outcomes

• Best predictor of real-world function
• Cognitive function associated with:
  – Employment
  – Independent living
  – Quality of life
  – Relapse
  – Medical co-morbidities
  – Costs


Schizophrenia as a syndrome

Causation

Yesterday
- One of the most devastating mental illnesses
- Caused by bad parenting
  - Bateson’s double-bind communication theory
  - Schizophrenogenic mother/family

Today
- Neurodevelopment disorder
  - Involves specific pathways related to prefrontal cortex
  - Genetic impacts on brain development


Brain Development

- Brain's long-distance connections
  - Growth stunted and lopsided in children who develop psychosis before puberty
- Slower growth associated with poorer outcomes
- May represent “window of opportunity”


Treatments

Yesterday
- Focus on reduction of hallucinations, delusions
- Resulted in neurologic side effects, e.g., severe movement disorders

Today
- Fewer neurologic side effects
- More medical concerns
  - Diabetes, weight gain, heart disease
- Targeting cognitive deficits
- Strategies to personalize treatments

Photo credit: NIMH Child Psychiatry Division
Conventional Antipsychotics

- Psychoactive properties discovered in 1952
- Used first as a surgical anesthetic
- Numbing/sedating
- Extrapyramidal symptoms were often associated with symptom improvement
- Low vs high potency

Atypical Antipsychotics

- Aripiprazole (Abilify®)
- Asenapine (Saphris®)
- Clozapine (Clozaril®)
- Iloperidone (Fanapt®)
- Lurasidone hydrochloride (Latuda®)
- Olanzapine (Zyprexa®)*
- Olanzapine/fluoxetine (Symbbyax®)
- Paliperidone (Invega®)*
- Quetiapine (Seroquel®)
- Risperidone (Risperdal®)*
- Ziprasidone (Geodon®)*

*Oral and injectable formulations

Comparative Studies

- CATIE: US Clinical Antipsychotic Trials in Intervention Effectiveness
- CUTLASS: Cost Utility of the Latest APDs in Schizophrenia Study
- EUFEST: European First Episode Study

Photo credit: ©Panamsky/Dreamstime.com
Comparative Findings

• Limited data and mixed results suggest second-generation antipsychotics are more effective than first-generation agents
• Strongest differences seen in side-effect profiles
  • Most pronounced difference is that second-generation antipsychotics cause fewer extrapyramidal motor symptoms
• Outcomes and health care system utilization examined in only single studies with no differences seen

www.effectivehealthcare.ahrq.gov/reports/final.cfm

Compliance vs Adherence

Yesterday
• Paternalistic, controlling, sedating

Today
• High rates of discontinuation
  • CATIE: As high as 74%
• Personalized
• Driven by self-determination and choice


Elyn Saks: TED Lecture 2012

• “I am very pro-psychiatry and anti-force”
• “We need to stop criminalizing mental illness”
• “Stigma detours people from getting care”
• “We need to figure out what gets people to want treatment”

Photo credit: ©Chris Fourie/Dreamstime.com
Outcomes

Yesterday
• In 1971, 433,000 people were institutionalized

Today
• Identifying “prodromal” factors that may be predictive in up to 80% of youth at risk
• Awareness of childhood onset is increasing
• Brain cell growth may predict outcomes in children who develop psychosis before puberty


Today’s Focus
• Move to psychiatric rehabilitation and recovery
• Cognitive assessment and enhancement
• Peer-led interventions and support
• Community integration

Recovery After an Initial Schizophrenia Episode

Goal:
• NIMH research project designed to fundamentally change the trajectory and prognosis of schizophrenia through coordinated and aggressive treatment in the earliest stages of illness

RAISE is designed to:
• Reduce the likelihood of long-term disability
• Increase productive, independent lives
• Reduce the financial impact on the public systems

Recovery After an Initial Schizophrenia Episode

Two Research Teams:
• Feinstein Institute for Medical Research
• Research Foundation for Mental Hygiene at Columbia University


Tomorrow

• Improved metabolic outcomes in youth
• Prevention focused on diagnosis prior to first psychotic episode
• Interventions to prevent deterioration
• Decreased incidence of co-morbid disorders such as smoking
• Epigenetic changes may be controlled or reversed
Bibliography


A Recovery Model for Effective Symptomatic Self-Management in Schizophrenia

Michael Rice, PhD, APRN-NP, FAA

Michael Rice is a Professor of Psychiatric Mental Health at the College of Nursing, University of Nebraska Medical Center in Omaha. He is also the Associate Director of the Behavioral Health Education Center of Nebraska (BHECN), an annually funded state legislative earmark of $1.5 million dollars to support the recruitment, retention, and competency of the Nebraska behavioral health workforce by providing education and training in evidence-based practice, interprofessional collaboration, and use of behavioral telehealth service to expand outreach and serve the people of Nebraska.

Dr. Rice attended the University of Arizona, where he was an individually funded NRSA predoctoral instrumentation fellow. He earned his master’s degree in psychiatric mental health nursing from the University of Nebraska Medical Center and his baccalaureate degree from Mount Marty College, in Yankton, South Dakota.

Dr. Rice is a licensed psychiatric APRN and has been board-certified by the American Nurses Credentialing Center since 1995. He is active in the American Psychiatric Nurses Association in the areas of national board certification and test development. Dr. Rice has taught psychiatric mental health nursing at the undergraduate, masters, and doctorate of nursing practice levels, including psychotherapy/counseling; assessment, diagnosis, and treatment of medical differential and co-morbid conditions in psychiatric presentations; and neuropsychopharmacology.

Dr. Rice has a long history of maintaining an active practice. He has practiced at Langley Porter Psychiatric Hospital and Clinics at the University of California, San Francisco; as Assistant to the Chairman and Director of the Acute Care Treatment Team at Kino Community Hospital, in Tucson, Arizona; in private practice as a psychiatric ARNP in rural and medically underserved Steven’s County, Washington; and at Arizona State University Health Clinics and in an Assertive Community Treatment Program.
A Recovery Model for Effective Symptomatic Self-Management in Schizophrenia

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Professor
College of Nursing
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Omaha, Nebraska

Recovery From Schizophrenia

- Harding et al (1987) reported individuals in recovery
- Deegan (1988) reported a personal journey of recovery
- Mismatch of medical\disease model
- Outcomes in conflict with established treatment

Medical Model of Recovery

- Recovery is:
  - Elimination or reduction of symptoms
  - Return to premorbid levels of function\(^1\)
- For a 2-year period within normal limits:
  - No symptomatology
  - Participating in work or school
  - Living independently
  - Maintaining social relationships\(^2\)

Current Medical Definition

“…as a state of improvements in core signs and symptoms to the extent that any remaining symptoms are of such low intensity that they no longer interfere significantly with behavior and are below the threshold typically utilized in justifying an initial diagnosis of schizophrenia.”


Consumer View

• Personal process and personal outcomes
  – Internal experience
  – External goals
• Personal benchmarks for symptomatic and functional improvement
  – Internal symptoms
  – External functioning

Consumer View

• Internal conditions
  – Beliefs and attitudes
• External conditions
  – Based on beliefs and attitudes
  – A positive culture of healing-oriented service

Internal Conditions

- **Purpose**
  - Sense of internal goals and direction

- **Sense of empowerment**
  - Offsets powerlessness and dependence associated with traditional mental health care

- **Sense of social connection**
  - Re-establishing social connections with others

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External Conditions

- Care experiences, policies, and practices leading to recovery, including:
  - Human rights
    - Combatting stigma/discrimination
  - A positive value of healing
    - A culture that fosters growth, respect, and hope

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Recovery: SAMHSA 2012

*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*

Recovery emerges from hope:
– Hope is the catalyst of the recovery process

Recovery is person-driven:
– Self-determination and self-direction

Recovery occurs via many pathways:
– Individuals are unique
– Setbacks are natural
– Foster resilience and abstinence

Recovery is holistic:
– Mind, body, spirit, and community
– Integrated and coordinated services

Recovery is supported by peers/allies:
– Mutual support/mutual aid groups
– Peer-operated supports and services

Recovery is supported through relationship and social networks:
– Presence of people who believe in recovery
– Family members, peers, providers, faith groups, community members form support networks

Recovery is culturally-based:
– Cultural values, traditions, beliefs are important
– Keys to determining a person’s unique pathway to recovery
SAMHSA Guiding Principles

- **Recovery involves addressing trauma:**
  - Fostering physical/emotional safety and trust
  - Promote choice, empowerment, and collaboration
- **Recovery involves individual, family, and community strengths and responsibility:**
  - Communities have responsibilities to address discrimination and foster social inclusion and recovery

**SAMHSA Guiding Principles**

*Recovery is based on respect:*
Protecting rights and eliminating discrimination

**Five Gold Standards of Recovery**

- Hope
- Self-esteem
- Empowerment
- Self-responsibility
- Meaningful role in life

Redefine Treatment

Redefine treatment goals and personalize:
- Set attainable goals
- Reduce medication side effects
- Limit symptom control
- Target psychological and social problems
- Focus on best quality of life


Standards of Recovery Care Services

- Consists of recovery-oriented services
- Services fostering hope
- Encourage internal empowerment through inclusion of the consumer as a partner with mutual respect
- Consistent evaluation of fidelity between services and consumer goals


Standards of Recovery Care Services

- Rebuild self-image and discover keys to well-being and health maintenance
- Use personal narratives – Marked with reduction in negative symptoms
- Peer support

Standards of Recovery Care Services

- Focus on increasing consumers' abilities
- Foster coping with life's challenges
- Facilitate services leading to recovery
- Enhance and encourage building resilience
  - Not just managing symptoms

Outcome Goals

- Describe acceptance
- Control over illness
- Identify activities that help
- Focus on collaborative treatment experiences


Standards of Care: Assessment

Person-centered Assessment

- Meaning of illness to self and community
- Trauma - empowerment
- Self-esteem – self-responsibility – self-control of symptoms
- Hope – knowledge
Standards of Care: Assessment

- Meaningful role in life – purpose
- Consumers’ resilience
  - Co-morbid medical conditions
- Personal strengths
  - Education
  - Employment history
- Kin/community supports

Standards of Care: Assessment

- Coping strategies for life’s challenges
  - Substance abuse
  - Kin, religious, family support

Standards of Care: Intervention

*Person-centered Plan*

- Literacy on knowledge of illness
- Engagement with team for responsibility and enhanced self-management of symptoms
- Peer support and therapy to address meaning of illness and offer hope
Standards of Care: Intervention

- Therapy with trauma reduction fostering empowerment
- Peer support and therapy to address meaning of illness and offer hope
- Supportive therapy and engagement for self-esteem, responsibility, and management

Standards of Care: Intervention

- Define a role and purpose in life
- Facilitate and refer for co-morbid medical conditions
- Enhance personal strengths
- Educate
- Build on personal strengths in occupational therapy

Standards of Care: Intervention

- Coping strategies for life’s challenges
  - Enhance resilience and coping skills
- Substance abuse
- Kin, religious, family support
- Family/community support sessions
Standards of Care: Intervention

- Coping with stigma
  - Personal and family
  - Community interactions
- Peers, friends, and family support
- Community support and engagement
  - Employment services

Recovery-Based Outcomes

- Assertive Community Treatment (ACT) versus standard care improved:
  - Symptoms ($P < 0.01$)
  - Global functioning ($P < 0.05$)
  - Quality of life ($P < 0.05$)


Recovery-Based Outcomes: ACT

- Higher employment ($P = 0.001$)
- Living independently ($P = 0.007$)
- Medication adherence ($P < 0.001$)
- Lower persistent substance misuse ($P = 0.027$)
- Significantly lower inpatient costs than standard care

Peer Support Services

- Improve engagement in treatment
- Some support for reduced hospitalizations

Standards of Care: Fidelity

- Periodic fidelity assessment of services
- Highlight gaps in service model for improvement
- Maintain quality of services
- Identify most effective interventions

Care Management Tools

- ACT Fidelity Checklist¹
- BE SMART Trauma Wellness²
- Moller-Murphy Symptoms Management Scale³
- Nursing-Oriented Practices⁴
- Interprofessional Teamwork⁵
- Teamwork in Assertive Community Treatment⁶


Photo credit: ©Mauricio Jordan De Souza Coelho/Dreamstime.com
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Understanding the Recovered Person’s Perspective to Achieve Successful Outcomes Using Nonpharmacologic and Pharmacologic Approaches

Frederick J. Frese, PhD

Frederick J. Frese is a psychologist with more than 40 years of experience working with persons with serious mental illness. Since retiring from the Ohio mental health system, where he served as Director of Psychology at Western Reserve Psychiatric Hospital for 15 years, he has coordinated the Summit County Recovery Project, which serves consumers in the Akron area.

Dr. Frese is an Associate Professor of Psychiatry at the Northeast Ohio University College of Medicine. A graduate of Tulane University, he majored in psychology. Following his graduation, he served as an officer in the Marine Corps in Japan during the Vietnam War. Later, while working as a guard officer for the nuclear weapons arsenal at the Naval Air Station in Jacksonville, Florida, Dr. Frese experienced his first schizophrenic break. For the next 10 years he was in and out of mental hospitals, often on secure wards. Despite his disability, he was able to earn a degree from the American Graduate School of International Management in Phoenix, Arizona, and masters and doctorate degrees in psychology from Ohio University.

Dr. Frese has been active as a consumer/provider and advocate in the mental health movement. He is on the Board of Trustees for the Treatment Advocacy Center and the National Institute for the Severely Handicapped (NISH) in Washington, D.C. He founded the Community and State Hospital Section of the American Psychological Association (APA), where he is currently part of the Task Force for the Seriously Mentally Ill/Emotionally Disturbed. In 1999, he received the Hildreth Award, the APA’s highest honor, for distinguished service in public service psychology. He is a past-president of the National Mental Health Consumers Association. He is also on the Board of Scientific Advisors for Schizophrenia Bulletin. In the past, he has served on the boards of the National Alliance on Mental Illness (NAMI), the American Occupational Therapy Association, and the Ohio Psychological Association. He has also worked as a consultant to the National Institute for Mental Health and the Veterans Administration.

Dr. Frese is the editor of The Role of Organized Psychology in Treatment of the Seriously Mentally Ill, published by Jossey-Bass in the winter of 2000. He is the author of numerous articles and book chapters, and lectures widely around the United States and Canada. Dr. Frese has been featured on CNN and World News Tonight with Peter Jennings, as well as in The Chicago Tribune and The Wall Street Journal, and in the video I’m Still Here: The Truth About Schizophrenia.

Dr. Frese is married and the father of four grown children.
Understanding the Recovered Person’s Perspective to Achieve Successful Outcomes Using Nonpharmacologic and Pharmacologic Approaches

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