HEALTHWEST

Practice Guideline

No. 12-013

Prepared by:

Effective: June 3, 2009
Revised: April 10, 2018

Approved by:

Subject: Relapse Prevention and Wellness Planning after Psychiatric Admission

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Julia Rupp
Executive Director

I. PRACTICE GUIDELINE

Relapse Prevention and Wellness Planning after Psychiatric Admission.

II. PURPOSE

To enable the Agency to provide consistent and effective treatment to individuals receiving services. Relapse Prevention and Wellness Recovery Support Services include activities to develop and implement or treatments applied in advance to:

a. Prevent future symptoms of and promote recovery for mental illness and/or substance use disorders

b. Reduce the adverse health impacts related to mental illness, substance abuse, and related traumatic experiences

c. Build on, and/or maintain wellness skills learned in medical, behavioral health, and related trauma treatment and allied recovery support services

d. Link to other services that promote recovery and wellness, which are considered relapse prevention and wellness recovery support activities

III. APPLICATION

This practice guideline applies to all HealthWest employees and contract providers.

IV. PROTOCOL

A. Adults Receiving HealthWest Services

1. Initial notification of hospitalization of an individual receiving HealthWest services.

a. The Adult/Youth Assessment and Stabilization Team will notify the HealthWest Primary Worker and/or their Supervisor on the same day or by the next business day via e-mail or in person, when an individual is hospitalized <u>who HealthWest is financially responsible for</u>.

b. The Hospital Liaison will notify the Primary Worker for individuals receiving Medicare when notified by the treating facility.

2. The HealthWest Primary Worker will contact the individual in the hospital within 24 hours of the notification of hospitalization, except on weekends and Holidays. For an individual receiving only HealthWest Outpatient services, the hospital liaison will provide the intervention.

   a. Consult with the individual and review the admission and the individual's wishes, plan of care, and discharge.

   b. Consult with the hospital staff (social worker) regarding the plan of care and discharge, and encourage attendance of the individual receiving services at the hospital team meeting.

      i. Provide the Psychiatric Hospital a copy of the last prescriber's note, the medication sheet listing the current medications, and guardianship information (when applicable).

      ii. The treating HealthWest prescriber will consult with hospital prescriber whenever there are medication questions.

      iii. Baseline of the individual receiving services and expectations of treatment.

      iv. For individuals with Developmental Disabilities, provide the hospital a completed Hospital Briefing Sheet (Form M180 – Attachment #1).

   c. When discharge is imminent, the Primary Worker will be in close contact with the hospital staff for discharge planning.

3. All hospitalized individuals will be seen by a HealthWest worker within seven calendar days after discharge excluding Holidays.

   a. If the individual receiving services is scheduled to be discharged to Brinks, the HealthWest Primary Worker will help facilitate the discharge. For individuals receiving outpatient treatment only, the Primary Worker will work in tandem with the Hospital Liaison to facilitate the discharge.

   b. If the individual receiving services is scheduled to be discharged to their residence, the HealthWest Primary Worker, (except for Outpatient Services), and Peer Support Specialist (when available), will meet with the individual and discuss wellness planning including but not limited to:

      i. Review what has been learned from this hospitalization.

ii. Wellness Recovery Action Planning

iii. Identification of personal relapse prevention needs, triggers and warning signs

iv. Development of self-assessment tools and strategies and crisis safety plans to address recovery, relapse prevention, and wellness needs

v. Identification of respite programs and other resources to support recovery and wellness

vi. Shared decision-making (Advanced Directive for Mental Health Care (Attachment #2)

vii. Positive coping strategies

viii. Relapse contingency planning

ix. Recovery management

x. Lifestyle change reinforcement that includes stress management, relaxation techniques, assertiveness training, spiritual practices, and conflict resolution.

xi. Relapse prevention and wellness support activities that include advocacy and facilitation supports. Participation in mutual aid groups such as Narcotics Anonymous (NA and Alcoholics Anonymous AA) or in other mutual self-help activities and programs.

c. If the individual receiving services was discharged to Brinks, the above documentation will occur prior to the individual's discharge from Brinks.

d. For individuals receiving Outpatient Services, the Outpatient Therapist will review the above and document the discussion at the first post-discharge therapy session.

4. The HealthWest Primary Worker will schedule a minimum of weekly contacts for the first month following hospital discharge and review status of the plan and adjust the plan as necessary.

5. The HealthWest treatment team will review the individual's relapse and discuss "promoting treatment adherence" options within one month of community discharge. (Attachment #3)

B. Youth Receiving HealthWest Services

1. Initial notification of hospitalization of a youth receiving HealthWest services.

a. The Adult Assessment and Stabilization staff or Utilization Management (UM) staff will notify the HealthWest Primary Worker and/or supervisor when a youth is hospitalized.

b. UM will provide contact information to the hospital staff regarding HealthWest services, including a copy of the last prescriber's note, the medication sheet listing the current medications, and name and contact information for primary HealthWest staff (therapist and/or Case Manager).

2. The Primary HealthWest staff (therapist and/or Case Manager) will provide relevant information to hospital staff as needed.

3. UM will collaborate with hospital staff and request the primary therapist to be involved as possible (conference call or pre/post meeting consultation) to address treatment needs, plan for discharge, coordinate with youth's parent/ guardian as needed.

4. At time of discharge, UM staff will direct the aftercare plan.

   a. Schedule appointment for the youth receiving services with HealthWest Primary Worker within 7 days, and with Prescriber within 30 days.

   b. Assure that 30 days of medication has been prescribed before discharge.

   c. Request discharge instructions and Physician's Discharge Summary be faxed to Youth Services within 24 hours.

   d. Notify the HealthWest Primary Worker of the date of discharge and therapy recommendations or name and contact information for hospital primary therapist.

5. The HealthWest Primary Worker will schedule weekly contacts for the first month following hospital discharge, and meet with the youth receiving services and parent/guardian at first session to discuss Youth Crisis Plan, including:

   a. Review the issues/warning signs/relapse signs that led to hospitalization.

   b. Review coping skills and resources to prevent relapse.

   c. Review medication needs, questions, and adherence issues.

   d. Review emergency contact procedures.

6. The Primary worker will schedule, within one month from discharge, a team meeting with therapist, HealthWest, Nurse, Prescriber, the youth receiving services, and parent/guardian to discuss ongoing treatment needs and prevention of relapse.

C. Expected Outcomes may include the following:

a. Continued length of abstinence from substances

b. Improved bio-psychosocial health

c. Increased ability to identify and manage high-risk situations that could lead to relapse

d. Increased ability to be proactive regarding relapse prevention and wellness recovery planning including the ability to identify warning signs and triggers and to adhere to self-defined goals and strategies to maintain abstinence and wellness achievements

e. A reduction in mental illness and/or substance use disorder services as individuals assume responsibility for their own wellness and recovery stability, manage and reduce their symptoms through varied self-help techniques and initiate the support of a network of peer, indigenous community and professional supports

f. Increase in stable housing and employment

g. Increased linkages made to other recovery and wellness support services

h. Increased overall quality of life

V. REFERENCES

A. CARF
B. SAMHSA Recovery Support Services: Relapse Prevention/Wellness Recovery Support
C. Attachment #1 - Form M180 – Hospital Briefing
D. Attachment #2 - Advance Directive from http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_41752---,00.html

/ab

Case Number: ________________

HEALTHWEST

Hospital Briefing

(231) 724-1222

Date: ____________________ Name: ____________________
HealthWest Contact Person (Clinical Information/Discharges): ____________________
HealthWest Contact Phone #: ____________________
Guardian (Consent for Treatment): ____________________ Guardian Phone #: ____________________
Residence: ____________________ Residence Phone #: ____________________
Home Manager (Caregiver Information): ____________________
Diagnosis: ____________________
Allergies: ____________________

The following information is being provided to you in order to assist with an orderly transfer of information on this consumer.

- **BEHAVIORAL ISSUES:**

  - ☐ No behavioral issues
  - ☐ Will require 1-on-1 staff
  - ☐ May require a PRN medication for behaviors
  - ☐ Other – Describe behaviors:
  - ☐ They have significant behavioral issues
  - ☐ May be a danger to self/others
  - ☐ May bite/hit/spit at staff or visitors

- **Behavioral skills that may help when they are upset:**

- **ADAPTIVE SKILLS:**

  - ☐ Can do most daily living skills independently
  - ☐ Needs hands-on assistance with most ADLs
  - ☐ Other – Describe:
  - ☐ Needs verbal prompting to complete most tasks
  - ☐ Totally dependent on staff

- **VISION/HEARING/SPEECH:**

  - ☐ Is fully verbal
  - ☐ Can report pain and needs accurately
  - ☐ Can understand sign language
  - ☐ Cannot understand verbal communication
  - ☐ Is legally/totally blind
  - ☐ Uses hearing aids
  - ☐ Uses a communication device
  - ☐ Other – Describe:
  - ☐ Can make wants and needs known
  - ☐ Problem reporting needs accurately and clearly
  - ☐ Is not verbal
  - ☐ Responds to facial expression, tone, and tenor of voices
  - ☐ Hard of hearing
  - ☐ Uses sign language
  - ☐ Wears glasses

- **EATING/DIETARY:**

☐ Diabetic
☐ Wears dentures/partial
☐ General diet
☐ Ground meat diet
☐ Thickened liquids
☐ Requires supervision due to food stuffing
☐ Low calorie snacks only
☐ Other – Describe:
☐ Food allergies
☐ Choking risk
☐ Pureed diet
☐ Chopped diet
☐ Is fed by staff
☐ Foods must be prepared by staff (cutting food, removing lids, etc.)
☐ Will steal or take others' food/drink

- **AMBULATION:**

☐ Is independent
☐ Uses a walker
☐ Nonweightbearing
☐ Other – Describe:
☐ Needs hands-on assist or standby assist for walking
☐ Uses a wheelchair for distance

- **TOILETING:**

☐ Independent
☐ Needs reminders
☐ Wears adult undergarments and needs assistance
☐ Other – Describe:
☐ Needs verbal prompting for thoroughness
☐ On toileting schedule every ________ hours
☐ Prone to UTIs

- **Likes/dislikes/ways to divert their attention**:

- **How to know when they are in pain**:

- **How to know when they are feeling better**:

- **How do they take their medications**:

MICHIGAN
ADVANCE DIRECTIVE
FOR MENTAL HEALTH CARE

I, ___________________________________, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _______________________________, my _________________,
(Insert name of patient advocate) (Spouse, child, friend …)

living at ____,
(Address of patient advocate)
telephone number ____________________, as my patient advocate.

If my first choice cannot serve, I designate _________________________,
(Insert name of patient advocate)
my_________________, living at____ (Spouse, child, friend …) (Address of patient advocate)
_________________________, telephone number ____________________, as my patient advocate.

GENERAL POWERS

My patient advocate can only make decisions for me if a physician and a mental health professional determine I cannot give informed consent for mental health care. OPTIONAL: I can choose the physician and mental health professional by filling in the two names and telephone numbers here:

____
____

My patient advocate must sign an acceptance before he or she can act for me the first time. I have talked over this appointment with the individuals I have chosen as patient advocate.

In making decisions, my patient advocate shall try to follow my wishes, whether I have talked about them or written them in this document or any other document.

I give my patient advocate power to agree to or refuse treatment as set forth below, and to pay for such services with my funds.

The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right. To grant such access, I appoint this individual as my "personal representative," as defined in the privacy provisions of the Health Insurance Portability and Accountability Act, and as my "authorized representative," as defined in the Michigan Medical Records Access Act.

SPECIFIC POWERS AND PREFERENCES

Following is a list of types of treatment. I can choose one or more. By writing **YES** next to a number, I give my patient advocate power to consent to that type of treatment. By writing **NO** next to a number, my patient advocate cannot consent to that treatment.

If I want, I can write my preferences for each power I give my patient advocate.

1. _______ Outpatient therapy. If I need outpatient therapy, I prefer it to be provided by ____.

2. _______ My admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital. If I need to be hospitalized, I prefer the following hospital: ____.

3. _______ My admission to a hospital to receive inpatient mental health services. If I need to be hospitalized, I prefer the following hospital: ____.

4. If I need to be hospitalized, I prefer ______________________________to take me to the hospital.

5. _______ psychotropic medication (psychiatric medicine). I prefer to receive the following medication or medications:

_____________________________ ________________________________

_____________________________ ________________________________

I **do not** want to receive the following medication or medications:

_____________________________ ________________________________

because ____

6. _______ electro-convulsive therapy (ECT). I want the maximum number of treatments to be ___________.

7._______ placement in a group residence

8. _______ seclusion and restraints

9. Additional wishes: (optional)

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REVOCATION

(Initial one statement)

______ I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

______ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

LIABILITY

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: ____

Signed: ____
(Your signature)

____
(Address)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

______________________ ____

(Print name) (Signature of witness)

____

(Address)

______________________ ____

(Print name) (Signature of witness)

____

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's mental health.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(4) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests.

(5) The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

(6) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(7) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(8) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(9) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, ______________________________________, understand the above
(Name of patient advocate)
conditions, and I accept the designation as patient advocate or successor patient advocate for ____, who signed an
(Name of patient)
advance directive for mental health care on the following date: ____.

Dated: ____

Signed: ____
(Signature of patient advocate or successor patient advocate)