HEALTHWEST

Practice Guideline

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Prepared by:

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Subject: Relapse Prevention and Wellness Planning after Psychiatric Admission

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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 who HealthWest is financially responsible for.

b. This is documented within the electronic health record via a Pre-Admission Screening. The information will also be entered into our Monitor Inpatient and CRU Placements queue. UM is responsible for monitoring this queue and completing the Continued Stay Review documents as necessary, authorizing the stay as they go.

c. 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 HealthWest Crisis Residential, Utilization Management 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. UM also schedules the post hospital appointment with the primary clinician. This is noted in the Follow-up section of the End of

Episode Continued Stay Review and removes it from the Monitor Inpatient and CRU Queue. .

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

   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.

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

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