

# Relapse prevention plans and the conclusion of treatment



# Learning objectives

- Describe the importance of relapse prevention plans.
- List and describe the purpose of each section of the relapse prevention plan.



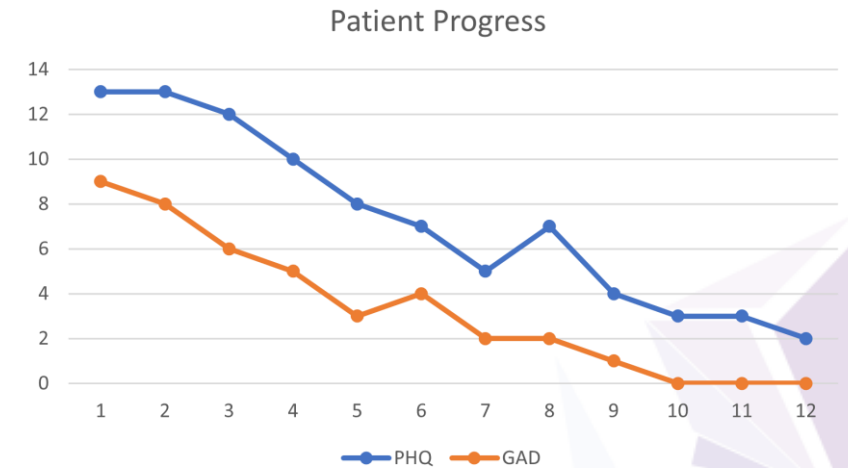
# Concluding CoCM treatment

- How team communication will occur between the patient, PCP, PC, BHCM and other stakeholders
- What documents or templates will be used
- What documentation will be included in the electronic health record and systematic case review tool
- How patients will receive a copy



# When to consider discharge

- Sustained (1-3 months) symptom reduction
  - Remission: Scores of <5 on the PHQ-9 or GAD-7
  - Response: 50% reduction of score
  - Improvement: 5-point reduction in score
- The patient has gained maximum expected benefit
- The patient has been connected to a higher level of care
- The patient chooses to end CoCM for other reasons or is lost to follow-up



# Recovery is a process

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential<sup>1</sup>
- Recovery doesn't mean cure



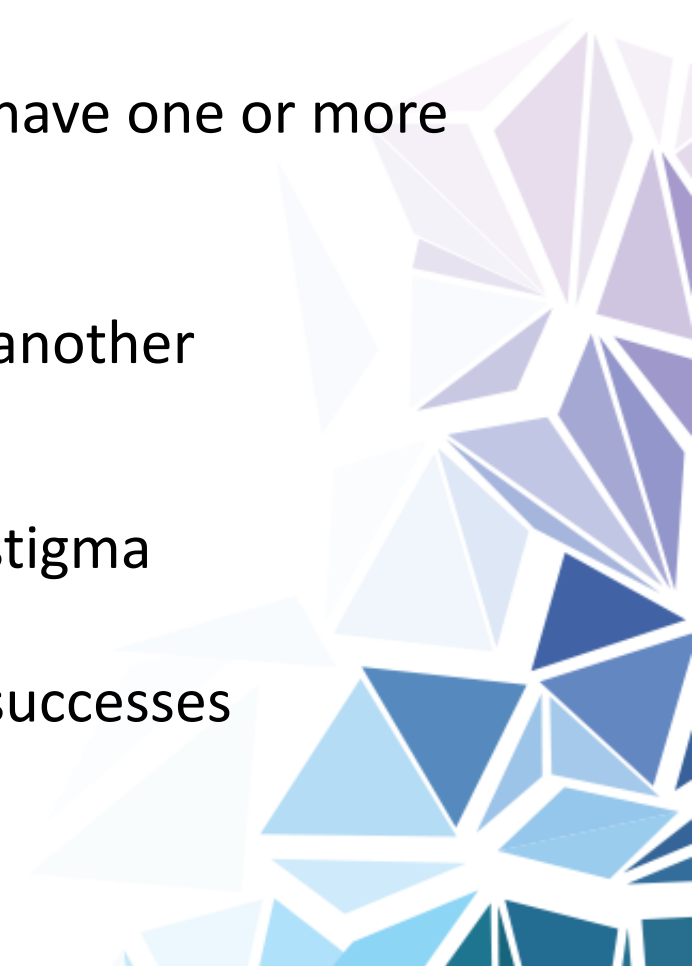
# What is relapse prevention?

- A cognitive-behavioral approach with the goal of identifying and addressing high-risk situations for relapse and assisting individuals in maintaining desired behavioral changes
- Educates the patient about the relapse process, likelihood of relapse, and how to make it through attempts at giving up the problem behavior
- Is a personalized approach, **defined by each patient**
- Is a journey, not a destination



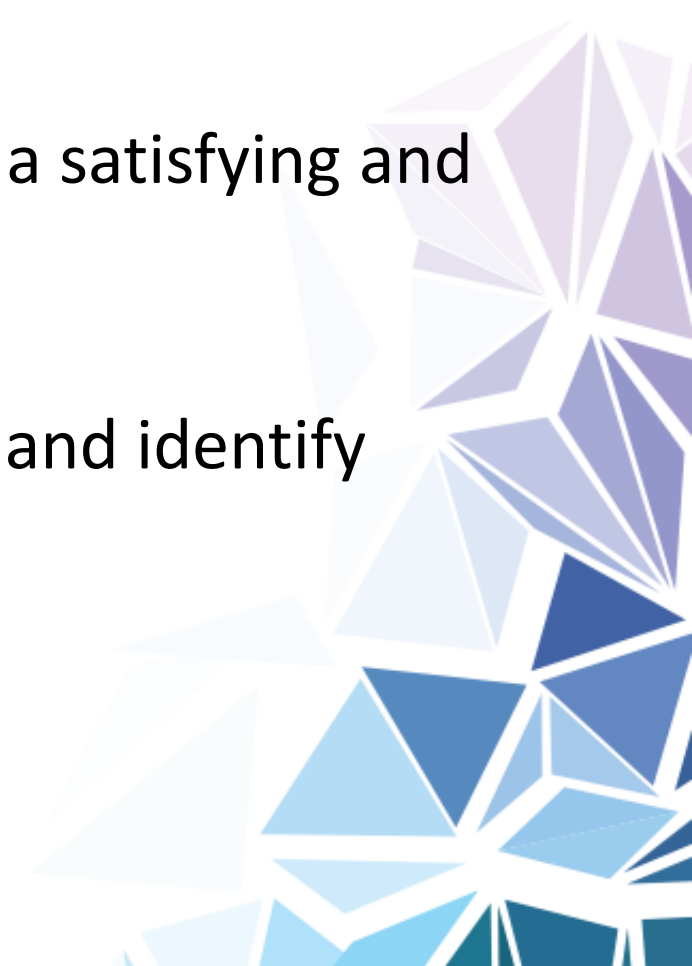
# Relapses are common

- Let your patients know that relapses can occur
- 50% of people who recover from a first episode of depression have one or more additional episodes in their lifetime<sup>2</sup>
- 80% of people with a history of two depressive episodes have another recurrence<sup>2</sup>
- It might be helpful to discuss in terms of “lapses” to minimize stigma
- Display hope, be strengths-based and remind patients of past successes



# Importance of relapse prevention planning

- Guides process, interactions, and activities throughout CoCM
- Moves the patient towards finding hope and creating a satisfying and meaningful life as defined by the patient themselves
- Encourages patients to develop essential coping skills and identify healthy relapse prevention activities





# Relapse prevention process

- Moves away from pathology, illness and symptoms to health, strengths, wellness and resiliency
- Aids in reducing the likelihood of lapse or relapse

Relapse prevention planning starts the 1<sup>st</sup> day of enrollment and is woven throughout every session

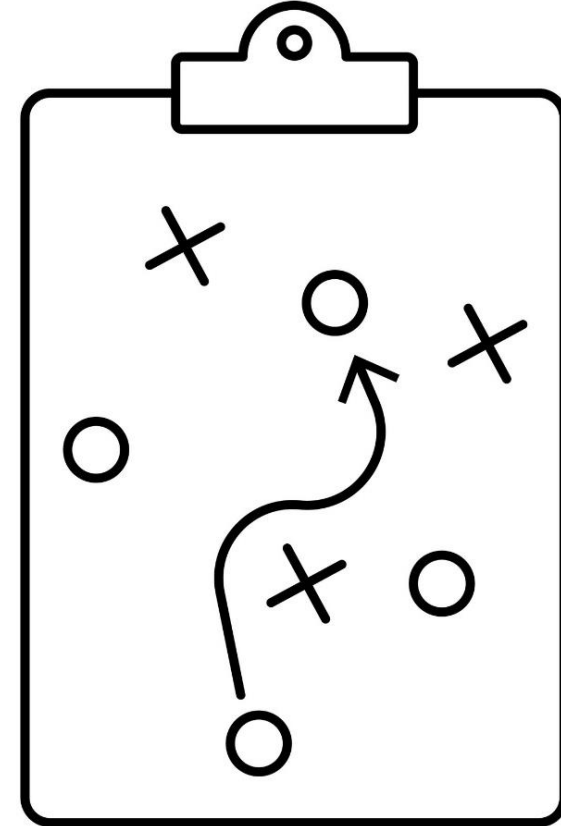
# What is a relapse prevention plan?

- A relapse prevention plan is a written document that helps patients outline their risk factors for relapse, coping skills and support networks
- A tool to remind patients to continue doing the things that make them feel better, assess their own symptoms and warning signs and know when to ask for help



# Other names for relapse prevention plans

- Resiliency plan
- Mental health maintenance plan
- Relapse recovery plan
- Wellness plan



# Self-management plans vs. relapse prevention plans

## Self management plans

- Where the patient started their CoCM journey
- Goals or destination of what they wanted to achieve
- Tools to reach their goals

## Relapse prevention plans

- Gains they want to maintain
- Tools to maintain progress
- Plan for maintaining
- One type of self-management plan



# Framing the discussion

## **Positive framework**

- Progress
- This is a journey
- Recurrence is normal so let's plan for it

## **Patient involvement**

- Elicit input from the patient
- Reflect what the patient has noted as helpful over the course of treatment

## **Empowerment**

- Symptom recognition
- Highlight what has worked
- Having a plan to get support

# Motivational interviewing summary

## Core skills: OARS

- Open questions
- Affirmation
- Reflection
- Summary

## Guiding principles

- Resist the fixing reflex
- Understand the patient's motivation
- Listen with empathy
- Empower the patient

## Four processes

- Engaging
- Evoking
- Focusing
- Planning

# Sections of a relapse prevention plan

1. I will keep, share and review my plan
2. Maintenance medications
3. Things I do to prevent symptoms from returning
4. Personal warning signs
5. Things I can do when I notice my warning signs
6. Return to services plan



# 1. I will keep, share and review my plan

Discuss with patients:

- Where they will keep the plan
- Who they will share the plan with
- How often they will review the plan

## **My Relapse Prevention Plan**

**Name:** Jamal Brown

**Date:** March 3, 2023

### **I will keep my plan:**

At my desk and a picture on my phone

### **I will share my plan with:**

My mom and coach Diaz

### **I will review my plan:**

Every six weeks



## 2. Maintenance medications

- List the name of each psychotropic medication, number of tablets, and dose.
- Discuss how the patient can obtain medication refills when needed

### **My Relapse Prevention Plan**

#### **Maintenance Medications**

Example: <Medication name>; <number of> tablet(s) of <dose> mg. Take at least until <date>

1. Fluoxetine; 1 tablet(s) of 20mg. Take at least until discussing with Dr. Kalarin.

Call your treating provider or behavioral health care manager with any questions or if you are thinking about stopping a medication (see contact information below).

### 3. Things I do to prevent symptoms from returning

- Have the patient identify healthy lifestyle activities they can continue doing
- By this point in treatment these should not be new activities they have never tried

#### **My Relapse Prevention Plan**

##### **Things I do to prevent symptoms from returning:**

- Walk around the block every morning
- Sleep at least seven hours each night
- Spend time with my little brother Reggie once per week

# Putting it together sections 1-3

1. I will keep, share and review my plan
2. Maintenance medications
3. Things I do to prevent symptoms from returning



## 4. Personal warning signs

- Warning signs are clues that your patient is on a relapse path
- Once recognized, this path can be halted and a return to healthy behaviors can occur

### **My Relapse Prevention Plan**

#### **Personal Warning Signs**

- Not responding to messages
- Skipping medication doses
- Not eating for a few days
- Arguing with my grandma
- My PHQ-9 score is 10 or higher and/or my GAD-7 score is 10 or higher.

## 5. Things I can do when I notice my warning signs

- Patients should create a menu of options they can do:
  - By themselves or with others
  - During the day and at night
  - In public or private spaces

### **My Relapse Prevention Plan**

#### **Things I can do when I notice my warning signs**

- Journaling
- Mindfulness exercises
- Progressive relaxation

## 6. Return to services plan

- What would have to happen to re-engage in services
- How would they have to feel to contact services
- Who would patient contact

### **My Relapse Prevention Plan**

#### **If symptoms return, contact:**

Treating Provider: Dr. Kalarin

Phone Number: 555-555-5555

Behavioral Health Care Manager: Alex Kosciuszko

Phone Number: 123-456-7890

#### **Next Appointment**

Date: September 5, 2023

Time: 4:00pm

Location: Greenway Clinic

# Putting it together sections 4-6

- 4) Personal warning signs
- 5) Things I can do when I notice my warning signs
- 6) Return to services plan



# Resources

- [My Relapse Prevention Plan Template](#)
- [Relapse Prevention Plan Patient Letter](#)





# References

1. Substance Abuse and Mental Health Services Administration. (2023, August 11). Recovery and recovery support. Find Help. <https://www.samhsa.gov/find-help/recovery#:~:text=SAMHSA's%20working%20definition%20of%20recovery,to%20reach%20their%20full%20potential>
2. Burcusa SL, Iacono WG. Risk for recurrence in depression. *Clin Psychol Rev.* 2007;27(8):959-985. doi:10.1016/j.cpr.2007.02.005



# Additional support from PRISM

## Advanced training

- <https://micmt-cares.org/upcoming-trainings>
  - Implementing Collaborative Care with Perinatal Patients
  - Implementing Collaborative Care with Adolescent and Pediatric Patients
  - Treating Substance Use in Collaborative Care Settings

## Upcoming webinars

- <https://micmt-cares.org/events?type%5B4639%5D=4639>

## BHCM monthly discussion group

- 3rd Thursday of the month from 12:00pm–1:00pm ET

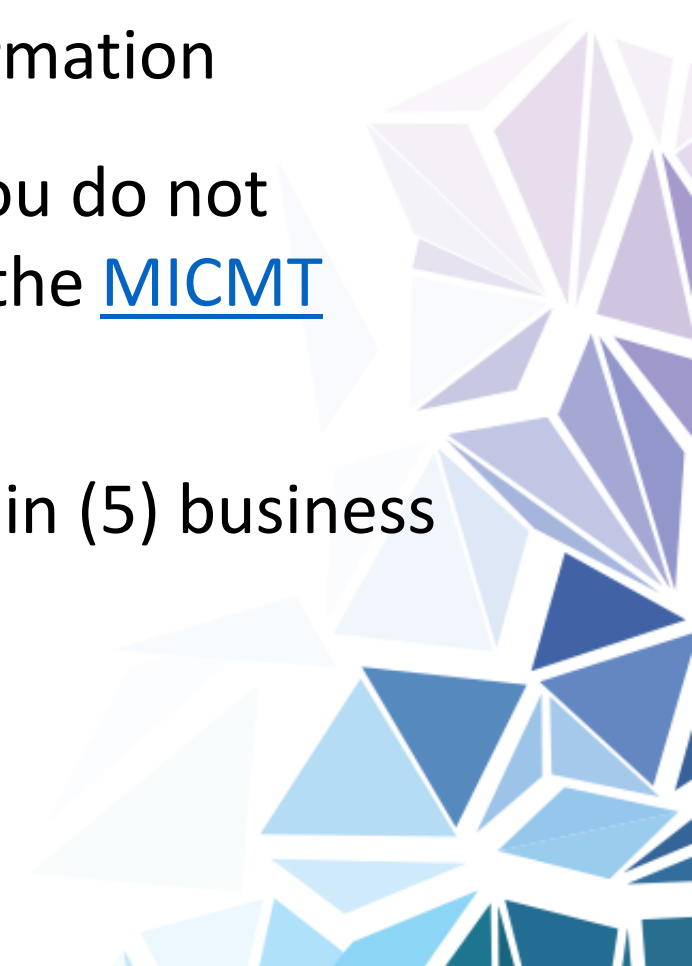
## Ongoing implementation support

- Discuss scheduling with your Implementation Specialist



# CE reminders

- **Following the course completion**, you will receive an e-mail from the Michigan Institute for Care Management and Transformation
- Please allow up to 24 hours to receive the e-mail. If you do not receive within 24 hours, please submit an inquiry via the [MICMT contact form](#).
- Please follow the link to complete the evaluation within (5) business days for each session you attend to earn credit.



# Contact us

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