Relapse Prevention Webinar Agenda

- By the end of the webinar you will be able to
  - Describe what a RPP is
  - Discuss its importance in Collaborative Care
  - Compare common and best practices in ending treatment
  - Plan for using the concepts of RPP throughout treatment
  - Plan for discussion of how to use PCC, CBO and/or family in RPP process
  - Know how to complete the form

What Is It?

- Plan to empower patient in lifelong self care
- Prevent recurrence of depression and/or help patient know when to seek help

Terminology

- Concept used in substance abuse treatment
  - Acknowledges recurrence is common
  - Best plans made BEFORE recurrence

How This Fits for Depression

- Depression recurrence is common

How This Fits for Depression

- Least able to plan well when depressed
- Works well with behavioral model of treatment
- Empowers patient and family
  - Remind what worked to reduce depression so they can take action sooner
  - Identify need for help sooner

Relapse Prevention Planning

**Why Is It Important?**
- Ending well is as important as starting well
- Is a way to taper down treatment contacts and allow patients a chance to use skills on own
  - Empowers patients and families
- Usual termination discussion is often about process/loss
  - RPP is strength-based patient empowerment/self management

**Common Practice: Open-Ended Termination**
- Some primary care BH programs
  - Open-ended, indeterminate
  - No criteria for when to consider termination
    - Patients can always benefit from more
    - Reinforcing to keep seeing patients who are better
    - May prefer long-term, in-depth practice
  - Minimizes access and reach, maximizes depth
    - Small # of patients get in-depth service
    - Many who need help missed, waiting list
    - Some patients don’t want in-depth therapy

**Common Practice: Predetermined**
- Some primary care BH programs
  - Predetermined length
    - e.g. 6 sessions, 12 weeks
  - Rigid termination criteria regardless of outcomes
    - Most criteria allow 1 treatment course
    - 50-70% need at least 1 change in treatment
    - Each treatment change gets 20% of patients better
  - Maximizes access, sacrifices depth
    - Large # get one course of treatment
    - Patients (50-70%) don’t get depth they need

**Best Practice: Driven by Treatment Outcome**
- Research evidence supports
  - Middle ground
    - Neither open-ended nor predetermined
  - Clear criteria for measuring treatment outcome
    - Most common: 50% decrease or remission
    - Alternate: 5 point decrease in PHQ-9 or GAD-7
  - Use treatment outcome to determine length
    - Avg duration of evidence-based CC: 6 months
    - Allows for more than 1 course of treatment
    - Recognize when referral to specialty care best

**Collaborative Care: Typical Contact Frequency**
- Active Treatment
  - Initial 3-6 months or until patient improved
  - Typically ~2 contacts per month
    - Unless psychotherapy part of tx plan
    - Mix of phone and in-person works best
- Monitoring after RPP
  - 1 contact per month
    - After 50% decrease in PHQ-9/GAD-7 (or similar) achieved
    - Monitor for ~3 months to ensure patient stable

**How It Works**
- Strengthens
  - Self-efficacy
  - Outcome expectancies
  - Coping
- Adherence to medications
- Adherence to other interventions
  - e.g. behavioral activation, PST, CBT, other strategies they learned during treatment
- Family can be engaged to support plan
Relapse Prevention Planning

Phases of the Relapse Prevention Plan

- **Start on Monitoring and Maintenance**
  - Transition from active treatment
  - Begins termination process

- **Throughout Treatment**
  - Part of patient education
  - Work on plan throughout treatment

- **Termination Session**
  - Caps treatment
  - Provides a structure for final session

Throughout Treatment

- Use PHQ-9 to monitor symptoms
- Support medication adherence (if part of treatment plan)
- Reinforce coping strategies (e.g. pleasant activities, behavioral activation, PST)
- Empower patient to actively participate in treatment monitoring
- Involve family when appropriate

Helping Patients Adjust to Ending Treatment

- Discuss treatment timeline and structure from beginning
- Use PHQ-9 graph to help them see progress
- Work with patient to find other sources of support and identify effective coping skills
- Give specific end date (when appropriate)
  - E.g. two more sessions, spread sessions out more and more

Start of Maintenance/Monitoring Phase – Do RPP on CMTS

- Facilitates transition from active phase
  - Provides structure for step-down
  - Gives patient concrete plan
- Follow patient with monthly (brief) contacts for about 3 months
  - Usually by phone
  - Can be in person
  - Could be in a maintenance group
- If patient drops out of treatment then plan is in place

Termination Session

- Facilitates termination session - review of plan
  - Provides structure for session
    - Helpful for both patient, family and provider
  - Creates concrete plan for patient self-management
  - Reminds patient of progress made
  - Develops concrete plan for self-care and self-monitoring symptoms
  - Clear plan for what to do if symptoms return
    - Mitigate fear of termination

CMTS Relapse Prevention Plan
**Family-Centered RPP**

- Respect patient’s autonomy and preferences for family involvement.
- Elicit a discussion about the ways in which family involvement has helped the patient achieve remission.
- RPP can be formulated and discussed with family member present.
- Specific roles for family in RPP can be negotiated (e.g., encouraging pleasant activities, supporting medication management, assistance in reviewing and identifying personal warning signs, encouraging or helping the patient to discuss progress or recurrence of symptoms with his PCP).

**Practical Strategies for Involving Family in RPP**

- Elicit patient preference for family and negotiate involvement in RPP beforehand.
- Fill out RPP with family present and engaged in plan development.
- Be specific about family role(s) in RPP.
- Give copy of RPP and PHQ-9 to both patient and family member.

**Patient-Specific Issues**

- Discuss patients who are in remission or improved to a level where we expect they are going to stay.
- Discuss how long patient needs to stay on meds.
- Discuss how patient will stay involved with CBO, PCP, and family.

**Clinic-Specific Issues: Workflow for RPP**

- Each PCC and CBO team needs a general plan of its own for RPP.
- Who will do RPP? Will it always be the same system? Or will patient issues as well as support systems involved change this?
- How will you get needed information?
- Will patient stay involved with CBO? How will this be reinforced?
- Which team will do the F/U for the three months?
- How will patient reengage in care?
- What will be the role of family in preventing relapse? If family has been involved, will you create a plan with family member there? If family was not involved, will you consider involving them?
Relapse Prevention Planning

**How-To Complete: Medications (if part of treatment)**
- Discuss dose and length of time to stay on meds with PCP and/or psych consultant, reinforce with patient
  - If meds entered into registry, most current regimen will auto-fill
  - If meds not already in registry, can be added for relapse prevention plan
- Review rationale for staying on meds and for discussing any change with PCP before making a change
- Review how to handle refills, questions about meds

**How-To Complete: Warning Signs**
- Ask patient to identify their personal signs/symptoms
- Review initial PHQ-9 for symptoms
  - Especially if patient is having trouble remembering
- Help patient recall behaviors you know they had in the beginning of treatment
  - E.g. not getting dressed, not contacting friends

**Healthy Behaviors**
- Review strategies that improved mood
  - Daily activities, social activities, pleasant activities
  - Exercise
- Review experimental process
  - When you feel down, do something
  - How did it work?
- If PST part of treatment
  - Review & reinforce PST strategies
- Be detailed!

**Other Activities**
- Stay with CBO? How often to go?
- Review referrals (if any)
- Discuss when to go see their provider again

**Poor Sample Relapse Prevention Plan**
- Medications:
  - Prozac 20 mgs every AM
- Warning signs of depression returning:
  - Down, depressed or hopeless
  - Little interest or pleasure in doing things
- Healthy behaviors:
  - Exercise
  - Spend time with friends
- Contact your PCP if you are having problems

**“HEALTHY” Relapse Prevention Plan**
- Medications:
  - Prozac 20 mgs every AM. Remain on the medications for at least 6 months. Call the pharmacy for refills and contact PCP if you run out of refills. Talk to your PCP before stopping
- Warning signs of depression returning:
  - Spending more time in bed, especially in the afternoon
  - Not returning friends’ phone calls
  - Low energy; walking less often
  - Lack of interest; turning down invitations
  - Attending Serving Seniors (CBO) less often
Sample Relapse Prevention Plan

- **Healthy Behaviors:**
  - Go to lunch at Serving Seniors M/W/F and go to bingo once a week
  - Walk 2 times a week with neighbor in the morning
  - Go to book club monthly/read daily in afternoon for 15 minutes
  - Deep breathing daily at 8AM
  - Know that when I am feeling down that it is a message that something is bothering me. Get active and/or do PST
- **Contact your PCP or [your name and number] if these symptoms persist and your healthy behaviors aren’t enough. If you are having a crisis please call [provide crisis line].**

Sample Relapse Prevention Plan Including Family

- **Medications:**
  - Prozac 20 mgs every AM. Remain on the medications for at least 6 months. Call the pharmacy for refills and contact PCP if you run out of refills. Talk to wife and PCP before stopping
  - Wife can assist with pill box, reminders to take medication, and discussion with PCP
- **Healthy Behaviors:**
  - Walk 2 times a week with wife in the morning
  - Deep breathing daily at 8AM together with wife
  - Know that when I am feeling down that it is a message that something is bothering me. Get active and/or do PST

Distributing the Plan

- **Use registry to do the plan**
  - Can be done in person or on the phone
- **Give copy to patient (and family)**
  - Mail or hand it to patient
- **Discuss plan for patient to regularly review RPP**
- **Attach or copy/paste into EHR for PCP**
- **PCP/CBO/family needs to reinforce plan ongoing; talk to family about how they will do this**

Checklist

- Explained why a relapse prevention plan is helpful. Discussed these points:
  - Help patient watch for return of depression symptoms
  - Clarify how long to stay on medications (if used)
  - Outline helpful things to keep doing
- Discussed medications with patient (if patient is taking them)
- Reviewed signs/signals that patient is feeling down or getting depressed
- Worked with patient to make a list of behaviors that helped him/her improve his/her mood
- Asked patient to figure out when he/she will review this
- **Explanation Process**
  - Asked patient if he/she had any questions
  - Used easy to understand language
  - Was empathic
  - Stance was collaborative, not didactic

Discussion

- **What about patients who have fluctuations in PHQ-9 scores?**
- **What about patients who don’t want to end treatment?**
- **What if I am worried about the patient?**
- **How do I get the information on medications?**
- **What if they don’t know warning signs?**
Next Step: Case Call, April 20, 2016, 12-1pm PDT
Care Managers should come prepared to discuss a specific case involving relapse prevention planning.

Next Step: Case Review

Thank You!