Relapse Prevention Planning
(Maintenance Planning)
Care of Mental, Physical, and Substance use Syndromes

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Learning Objectives

• Define what it means to be in remission from each of the targeted conditions in COMPASS

• Describe the components of relapse prevention for each

• Explain and demonstrate the use of the maintenance plan
Relapse Prevention Planning

Active Engagement Phase
1st and 2nd Contact

Active Management Phase
Weekly contacts in the first month
Every other week over the next 2-3 months

Active Transition Phase
Frequency gradually extended
Average duration 5-18 weeks

Maintenance Phase
(Relapse Prevention)
Monthly to every 3 months
Average duration 6-12 months
Tying Everything Together

Motivational Interviewing

Behavioral Activation
(patient’s specific, attainable goals/activities)

Relapse Prevention
Maintenance Plan Components – Depression and Medical Conditions

- Steps to keep myself on track
- Personal Warning Signs
- How to Minimize Stress
- Other Treatments
- Contact/Appointment information
**Maintenance Medications**
The following is a list of all of the medications and dosages that I am currently taking:

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<thead>
<tr>
<th>Med Name</th>
<th>Dosage</th>
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I will continue to take my medications as they are prescribed. If I begin to think I can stop taking any of them, I will contact my Primary Care Provider to discuss this. I know that stopping any of my medications on my own can cause problems and that some may need stopped slowly.

**Other Treatments and Self-management Supports**
I will continue to participate in any other treatments or activities that I am currently involved in. These may include Specialized Treatment, Community Support or other activities that help me keep my new lifestyle. I plan to continue:

1. 
2. 
3. 
**My Warning Signs**

I understand that there may be times when I feel stressed or upset and going back to the way I was may seem tempting.  
My personal triggers are:

1. 
2. 
3. 

---

**My Steps to Keep Myself on Track**

1. 
2. 
3. 

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**Contact/Appointment information**

Primary Care Provider: ________________________________
Tel. No. ________________________________

Next appointment:

Date: ____________________ Time: ____________________

Integration Specialist: ________________________________
Tel. No. ________________________________

Next appointment:

Date: ____________________ Time: ____________________

I will bring my plan with me to my next appointment to talk about how I am doing and any changes I need to make. I will call my Primary Care Provider or Integration Specialist if my symptoms return or if I have any problems with my plan.
Maintenance Planning Per Condition

• Review progress
• Review risk factors
• Review rationale for continuing treatment
• Reinforce patient’s autonomy and motivations
• Discuss early warning signs; long-term treatment
• Develop maintenance plan with patient
• Reminder of how CM and PCP can be reached
• Discuss future follow-up contacts (PHQ-9s, PCP visits)

Leading up to session, prepare patient for transition and emphasize healthy changes
Depression at Target

• When?
  – PHQ-9 < 5 for 3 consecutive months
  – See guidelines for tapering off meds etc.

• Goals
  – Maintain remission of depression symptoms
  – Minimize stress
  – Continue self-monitoring, pleasant activities
  – Continue healthy lifestyle

• Next Contacts
  – Monthly for 6-12 months (telephone contacts, maintenance groups)
**Diabetes and CVD at Target**

- **When?**
  - Lab values maintained for 3 months (SBP, HbA1C, LDL)
  - ✓ Goal level TBD per patient by PCP

- **Goals**
  - Maintain adherence to medications
  - Self-Monitor (SBP, HbA1c)
  - Continue healthy lifestyle

- **Next Contact**
  - 2 to 3 months, then every 3 to 4
Preventing Depression Relapse

• Risk for relapse is high
  – 20-85% in the first 6 months following remission
• Treat aggressively early
• Many patients are willing to accept (and stop!) at response
• Patient education is critical – this process takes time and most people need at least one treatment adjustment
Depression Maintenance Planning

- Talk through skills learned so far to identify depression triggers for early detection
- Schedule future follow up appointments with PCP
- Have patient “read back” their medication plan discussed with PCP
- Prepare patient for 6- and 12-month PHQ-9 follow ups
- Re-enroll patient if PHQ-9 if ≥ 10
Video
Maintenance Planning

http://uwaims.org/files/videos/relapseprevention.html
Role Play
Practice creating a maintenance plan
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THANK YOU