

Discharge Planning, Aftercare, and Recovery Supports

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Presenter Information



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NATIONAL
Center on
Domestic Violence, Trauma & Mental Health

US DHHS ACF FVPSA-Funded Special Issue Resource Center Dedicated to Addressing the Intersection of Domestic Violence, Trauma, Substance Use and Mental Health

- Comprehensive Array of Training & Technical Assistance Services and Resources
- Research and Evaluation
- Policy Development & Analysis
- Public Awareness

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Learning Objectives

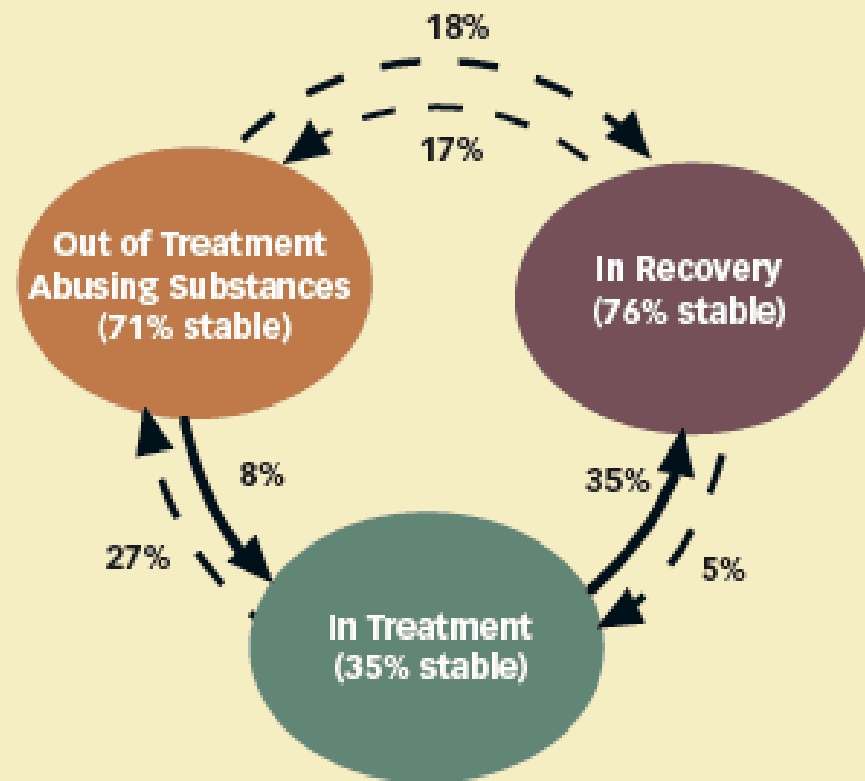
- Describe key elements of continuing recovery planning
- Identify trauma-informed discharge practices and aftercare services for individuals with substance use disorders, survivors of domestic violence and other trauma
- Become familiar with Recovery Management Checkups as a core component of aftercare services

When do you begin discharge planning?



Why are Discharge Planning & Aftercare Important?

FOR MOST PATIENTS RECOVERY IS CYCLICAL, NOT LINEAR The researchers tracked the average percentages of patients moving between points in the recovery cycle—living in the community and abusing substances, in treatment, or in recovery—each quarter during the 2-year study. The goal of the Recovery Management Checkup system is to increase treatment reentry and recovery (movement along the solid arrows).



† "Stable" indicates that patients did not transition from one point to another in the cycle.

Reprinted from *Drug and Alcohol Dependence*, Vol. 78(3): 325-338, Scott, C.K.; Dennis, M.L.; and Foss, M.A.: "Utilizing recovery management checkups to shorten the cycle of relapse, treatment reentry, and recovery," © 2005, with permission from Elsevier.

The Importance of Discharge Planning



Connection with ongoing community-based recovery support is associated with better recovery outcomes.

The Importance of Aftercare Services

Aftercare services have been found to support recovery maintenance, even services as simple as phone-based check-ins.



(McKay et al., 2005)

Combining Discharge Planning & Aftercare Services



A study found that people who participated in both community recovery support and aftercare services had better long-term recovery outcomes than those who only accessed one.

(Fiorentine & Hillhouse, 2000)

What's Our Role in Discharge Planning?

Providers play a key role in preparing individuals for discharge through:

- individualized planning
- linking to community resources
- facilitating transitions
- actively supporting early engagement in community-based recovery support

Best Practices in Discharge Planning

- Start Early
- Ongoing Planning
- Continuing Recovery Planning
- Continuity of Care



Start Early

Begin
discharge
planning
during
intake

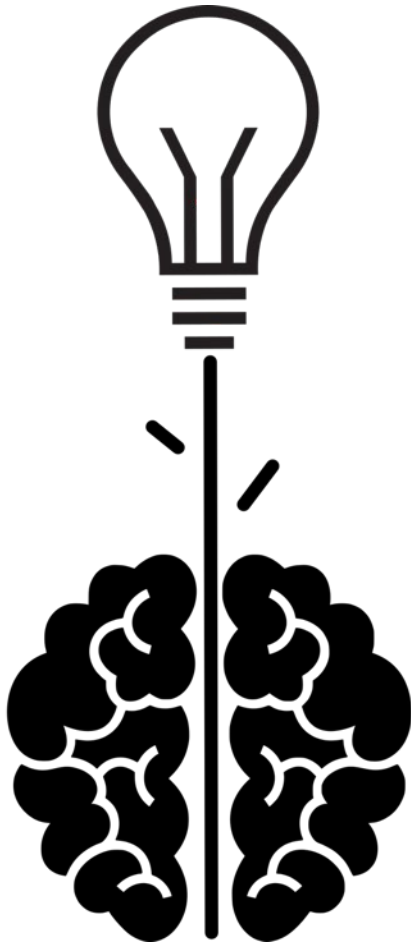


Start Early 2

How will we know when treatment (or the level of care) is complete?

- Indicators are defined collaboratively and mutually understandable.
- What are the data sources for these indicators?

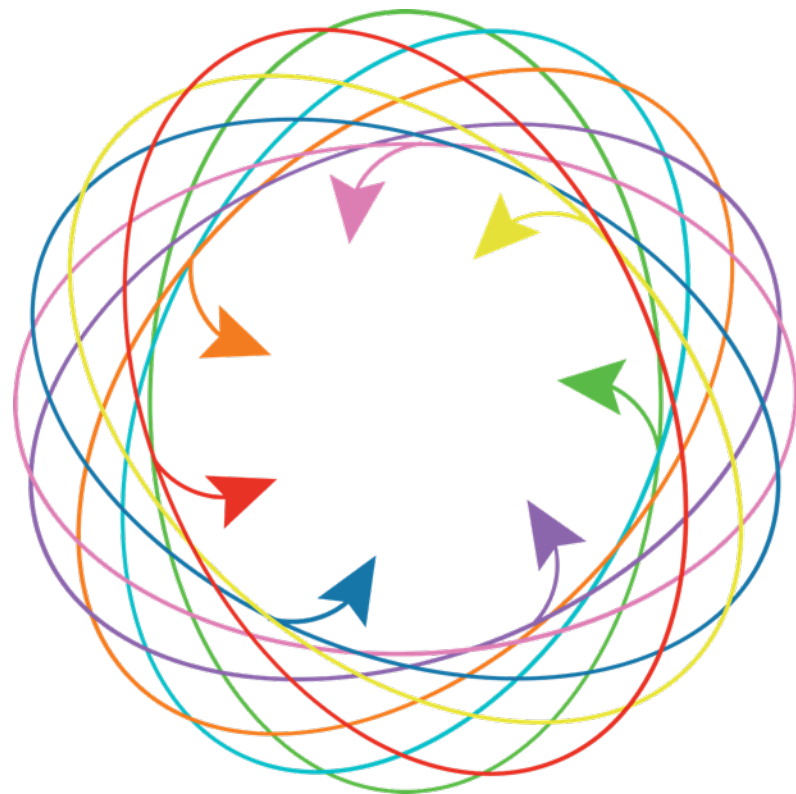
Start Early 3



Supports transparency, consistency, and predictability, while supporting autonomy within services - all essential aspects of trauma-informed approaches

Ongoing Planning

- Identify needed resources and facilitate access to potential community resources/partners early in the process
- Continue reviewing and updating as needs emerge and evolve



Who is Involved in Discharge Planning?



- Person accessing services
- Their safe social supports (as defined by AND if desired by the person)
- Treatment team

Elements of Successful Discharge Planning

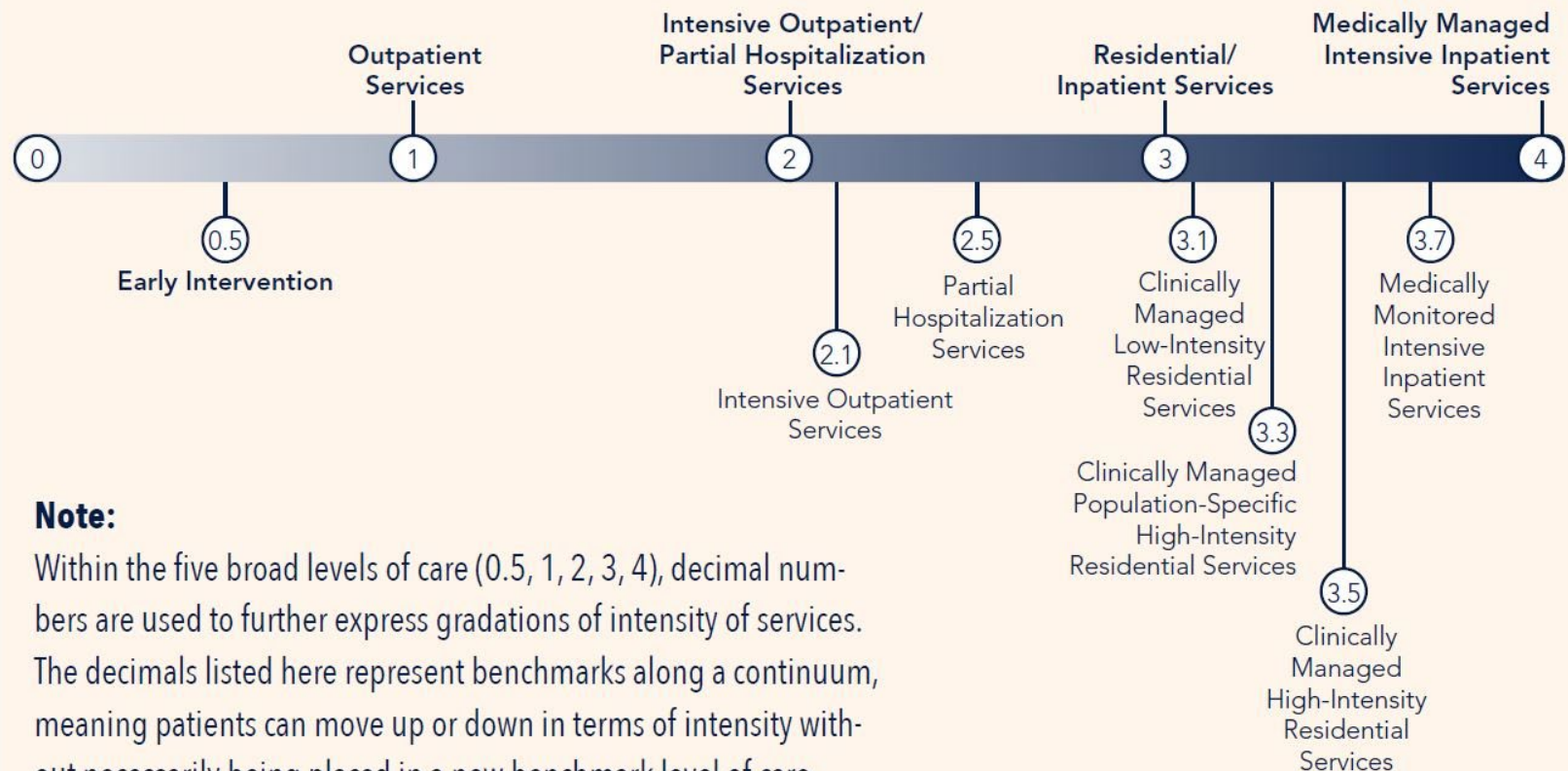


- Individualized
- Comprehensive
- Puts together a well-coordinated system of continuous support
- Access to community resources
- Community reintegration
- “...practical and realistic and maximize available community resources for the benefit of the client.”
- Continuing recovery planning

(Baron et al., 2008)

Discharge Planning: Considerations by Level of Care

REFLECTING A CONTINUUM OF CARE



Note:

Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

Discharge Planning: Withdrawal Management (WM)

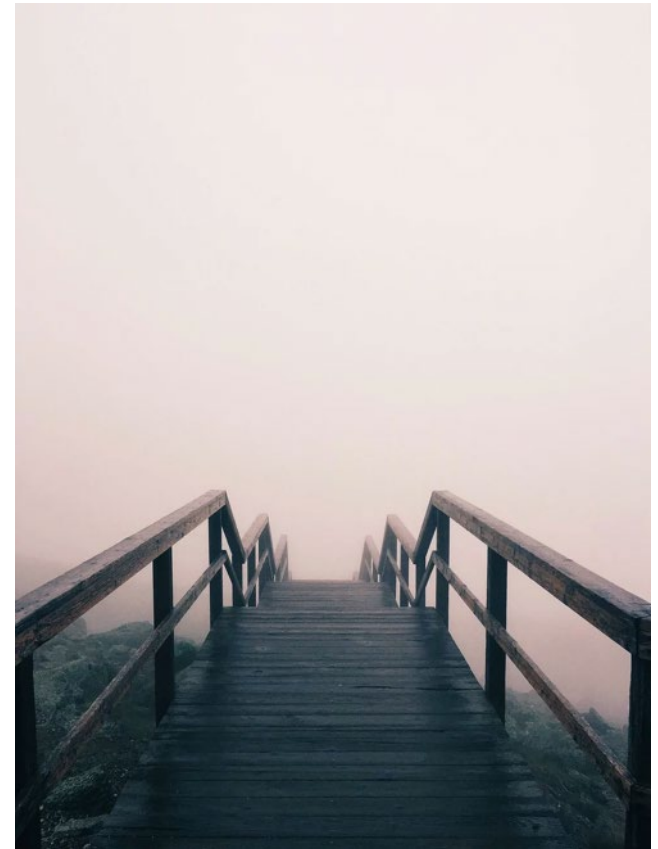
- WM is available at every level of care (WM alone is not considered treatment)
- Ongoing recovery support is critical for those completing WM services
- WM-alone for opioids (without stabilization and linkage to ongoing MAT) has been found to be increase risk of fatal overdose (Strang et al. 2003)
- Overdose prevention education and naloxone
- Promising practices: bridge MAT clinics, recovery coaching/peer-based support, warm handoffs, seamless care coordination across settings (services follow the person)

Detox & Discharge: Fred's Story



Discharge Planning: Inpatient/Residential to Outpatient

- Safety needs
- Engagement in step-down outpatient care
- Housing and vocational support
- Recovery support network
- Recovery support for family
- Community reintegration



Supportive Discharge Plan: Marcy's Story



Continuing Recovery Planning (CRP)

- Flows from dynamic treatment planning
- Main goals of Continuing Recovery Planning:
 - Maintain treatment gains
 - Support greater life goals/needs
 - Recovery capital (both internal and external resources)
 - Aftercare planning

CRP: Maintain Treatment Gains

- Individualized coping toolbox (cravings/cues)
- Anticipating situations that present a high risk to recovery gains, including strategies to
 - avoid and/or prevent
 - escape
 - cope
 - engage recovery supports
- Recovery setback response plan

Sample: CRP for Risk-to-Recovery Situations

If I encounter a high-risk situation:

- I will leave the situation and/or environment.
- I will put off the decision to use for 15 minutes. I will remember that most cravings are time-limited and I can ride it out.
- I will recognize my thoughts as thoughts, not absolute facts. Do I really need to use? Not likely. I will remind myself that my only true needs are for air, water, food, and shelter.
- I will think of something unrelated to using.
- I will remind myself of my successes to this point.
- I will call my list of emergency numbers.

(NIAAA, 2003)

Sample: Recovery Setback Response Plan

1. Get rid of the substance(s).
2. Get away from the place where I used.
3. Read this aloud: One use or even one day of use does not have to result in a relapse. I will not give in to feelings of guilt or shame because I know these feelings will pass in time. I can get through this.
4. Call a recovery support for help.
5. I will examine this use with my counselor (or Recovery Coach or sponsor), identify cues and my reaction to them. I will update my plan so that I will be able to cope with a similar situation in the future.

**REMEMBER: THIS IS ONLY A TEMPORARY
DETOUR ON THE ROAD OF RECOVERY**

(NIAAA, 2003)

CRP: Greater Life Goals / Needs

- What's most important for the individual, what are their greater life goals?
- How does continuing recovery fit in with their greater life goals?
- What remaining needs exist and how can we plan for them?
- What specific actions are needed in order to satisfy any court/legal mandates? (if applicable)

CRP: Recovery Capital

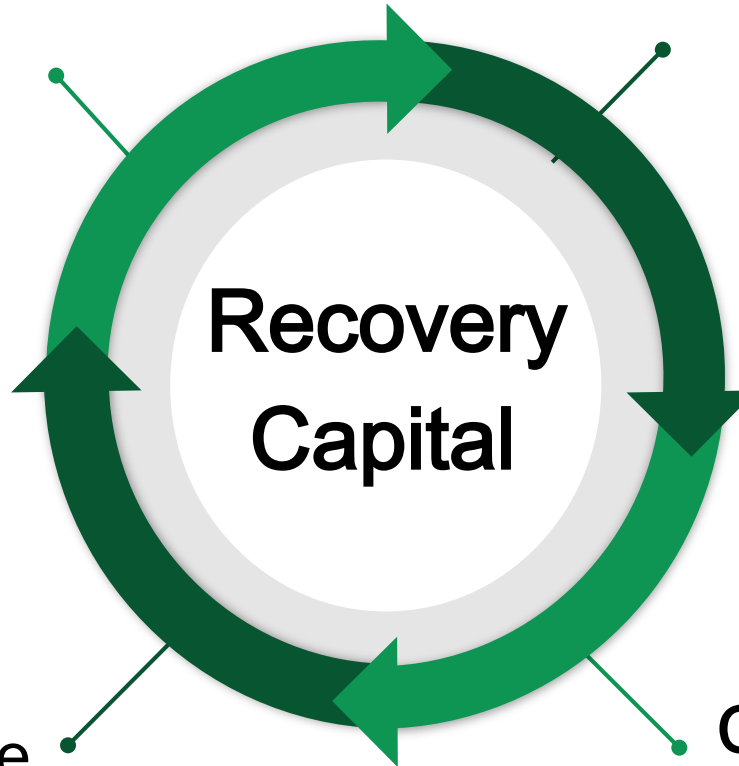
- The collection of internal and external supports a person can access that aid in the journey of recovery (White & Cloud, 2008)
- Community-based support resources
- Recovery-oriented social supports
- Core values, and how they fit in with experience of recovery and recovery goals

HUMAN

Skills,
education,
self-efficacy,
hopefulness,
personal
values

SOCIAL

Family, intimate
relationships,
kinship, social
supports



PHYSICAL

Physical health,
safe shelter,
basic needs,
financial
resources

COMMUNITY

Anti-stigma,
recovery role
models, peer-led
support groups

(White & Cloud, 2008)

CRP: Aftercare Planning

- How can the treatment provider support the individual's continuing recovery and pursuit of greater life goals?
- What aftercare services are available?
- How would the individual like to incorporate available aftercare services into their overall continuing recovery plan?

Challenges in Discharge Planning



- Increased anxiety about end of treatment
- Difficulty anticipating post-treatment needs
- Lack of community resources
- Lack of established protocols and training

How Can Organizations Support Effective Discharge Planning?

- Written discharge planning protocol
- Standardized discharge planning forms
- Training for all staff involved in discharge planning
- Review upcoming discharges and discharge plans in clinical staffing
- Cultivate community resources
- Routine review of clinical records to provide coaching and feedback for staff
- Routine review of protocols to improve their effectiveness
- Collect/analyze follow-up data

(Baron et al., 2008)



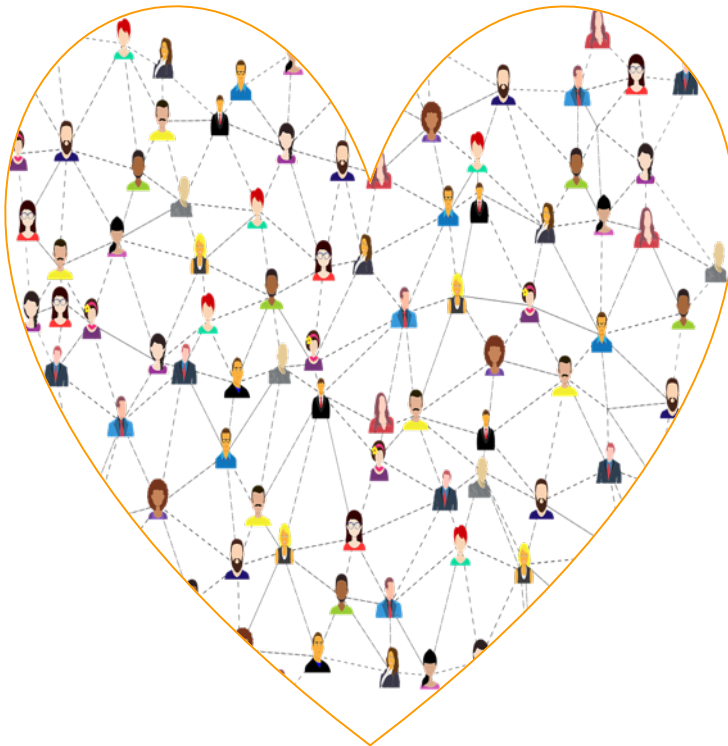
Pause -
please return in
5 minutes

Continuity of care

- Community-Based Support
- Resource connection & gradual transitions
- Aftercare services



Community-Based Supports



- Mutual aid resources
- Recovery Community Organizations
- Family, friends, and other natural supports
- Community-based providers

Resource Connection



1. Assessing and anticipating post-treatment needs
2. Cultivating resources
3. Gradual transitions

Gradual Transitions: Medication-Assisted Treatment

1. Strong linkages with community-based MAT providers
2. Well-coordinated transitions
3. Collaborative aftercare planning
4. Early re-engagement in higher level of care (if needed)

What is Aftercare?

- Follows the end of treatment - ideally, when a person is ready to independently implement their continuing recovery plan
- Can occur in a variety of settings
- Includes an array of services



(CSAT/SAMHSA TIP 27, 2000)

What kind of aftercare services does your program offer?



Aftercare Services

- Alumni Community
- Recovery Support Services
- Recovery Coaching & Peer-Based Support
- Recovery Management Checkups



Alumni Community



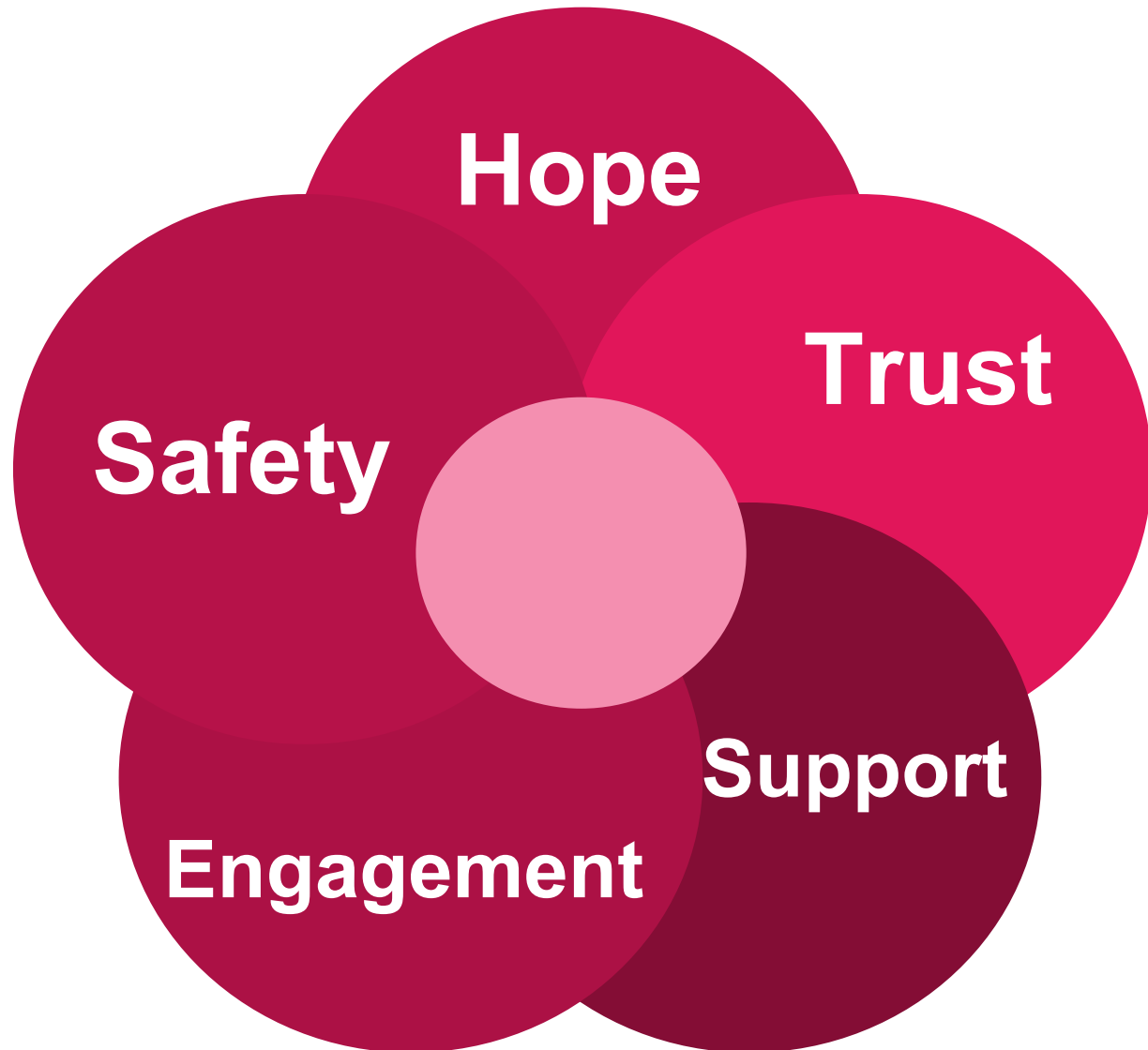
- Alumni group
- Recovery celebrations
- Alumni family events

What is included in Recovery Support Services?

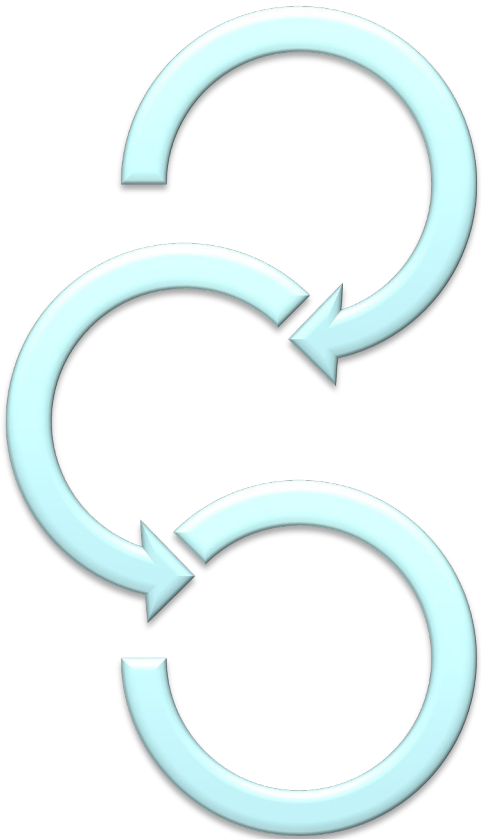
- Vocational support
- Resource advocacy
- Service coordination and linkage
- Outreach
- Housing assistance and services
- Child care
- Transportation support
- Family, parent, child development support
- Peer-to-peer services, mentoring, and coaching
- Mutual aid groups
- Life skills support
- Community building
- Continuing recovery support

(CSAT/SAMHSA, 2008)

Healing is Relational: Peer-Based Recovery Support



Recovery Management Checkups (RMC)



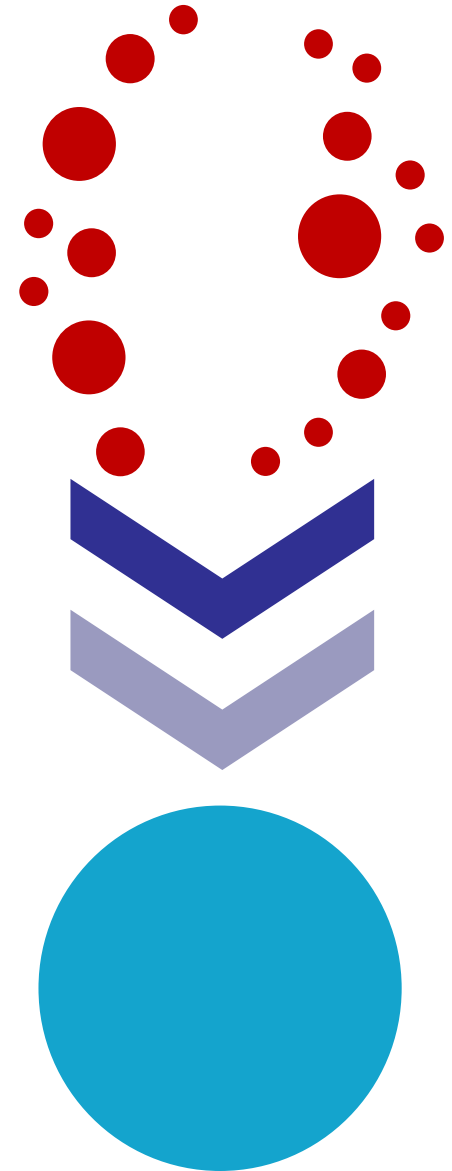
- Emerged out of the understanding of substance use disorders as sharing many similarities with other chronic health conditions
- Follow-up support and early re-engagement are standardized practices in managing other chronic health conditions

RMC: Core Components

- Quarterly check-in's
- Motivational enhancement techniques to:
 - Provide personalized feedback
 - Help resolve ambivalence about substance use
 - Treatment linkage, engagement, and retention

(Scott et al., 2013)

Recovery Management Checkups assertively support long-term recovery by not relying on the assumption that people will/can notice the early symptoms of a substance use disorder and reach out if treatment is needed.



(Scott & Dennis, 2009)

Challenges in Providing Aftercare Services



- Funding and reimbursement
- Geographic service areas
- High caseloads
- Disengagement

Funding and Reimbursement

Most sources of funding and reimbursement do not yet pay for aftercare services, despite their potential cost-effectiveness and high return on investment.



Geographic Service Areas



- Support connection to local resources
- Collaboratively create a clear follow-up plan
- Phone and telehealth

High Caseloads

- Support a culture of mutual aid and alumni community
- Collaborate with Recovery Community Organizations
- Offer group-based aftercare services



Supporting Women in After-Care Services

- Help address barriers
 - resource advocacy, flexible scheduling, in-home services
- Women-only gender-responsive services
- Case management support, especially for those who experience concerns related to housing and/or parenting
- Peer-based programming
- Coordinating mom's services with children's services

(Coughey et al., 1998; SAMHSA TIP 51, 2009)

What Can We Do? Next Steps

- Establish a discharge planning protocol and train all staff involved in discharge planning
- Begin discharge and aftercare planning at intake
- Use clinical staffing and supervision to review upcoming discharges and discharge plans
- Nurture peer support and alumni community
- Expand after-care offerings and follow-up
- Implement Recovery Management Checkups
- Connect with local recovery community organizations
- Create linkage agreements with community resources

Resources

- Faces and Voices of Recovery (Recovery Community Organizations and Mutual Aid):
<https://facesandvoicesofrecovery.org/>
- SAMHSA's Treatment Locator:
<https://findtreatment.samhsa.gov/>
- Florida Coalition Against Domestic Violence:
<https://www.fcadv.org/>
- Florida Association of Recovery Residences:
<https://farronline.org/>
- Florida Division of Vocational Rehabilitation:
<http://www.rehabworks.org/>

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Thank You!



Question & Answer

