AAAP/ AACP Joint Task Force on Public Sector Interventions for Addictions

Continuity of Care Guidelines for Addictions and Co-occurring Disorders

Continuing engagement in treatment has been identified as one of the factors that is most consistently correlated with positive outcomes in addiction treatment. Treatment providers commonly observe that their clients do well while actively engaged in structured programming, but often relapse shortly after terminating their relationship with treatment. Despite these observations, the responsibility for maintaining a relationship with treatment is often left almost exclusively to the person attempting recovery. This is often the case even though these individuals are quite vulnerable to relapse in the early stages of their recovery.

This document presents general principles for developing transition plans for persons with addictions who are in treatment and are moving from one level of care to another. Clearly, the long term goal of treatment should be the establishment of stable recovery and transition out of treatment. This long term outcome can best be achieved if intermediate transitions are managed well. While transition planning must be tailored to each individuals needs, the Addiction Continuity of Care Guidelines can offer a framework for thinking about planning in a methodical and comprehensive way. They may provide a template for standard development regarding transitions in specific circumstances throughout the drug and alcohol service system.

For the purposes of this document, the term "transition" replaces the more traditional "discharge" terminology. "Transition" seems to better capture the notion of continuity of care in a seamless system of services. We recognize that the terms "discharge" and "aftercare" remain the most common terminology despite the fragmentation and the devaluation of ambulatory services that they imply. We hope this document will encourage an examination and reformulation of traditional terminology for transitions in the continuum of care.

Implementation of any set of guidelines is subject to the availability of resources and local circumstances. Community resources should be conceived of as an array of services and mutual supports which will operate as a unified system of care. If community resources are limited, the transition plan should make the most effective use of the resources that are available and reflect the most important priorities for the client in question. Realistic determinations should be made on a case by case basis. Ideally, transitions between levels of care will be based on clear criteria such as those contained in the AACP's LOCUS or ASAM's PPC-2R. Ultimately, ideal planning for level of care transitions can be achieved only through an integrated, client driven community based system of care.

Transition management is clearly a process rather than a discreet operation. The following principles for transition management are offered as elements of this process which will help to insure that service users are enabled to stay in treatment to the greatest extent possible.

Principles for Transition of Care Between Levels of Care

1. **Prioritrization:** Transition planning should begin at the time of admission to any level of care and should be a prominent part of the treatment plan. Identification of transition needs and the coordination of services required to meet them will be most urgent and have greatest importance at the most intense levels of care.

2. **Client Involvement**: The client's wishes with regard to continuing care must be factored heavily into a transition plan. A plan that the client is not invested in is one that is not likely to succeed. While the service user's judgment may be questioned in the early stages of recovery, if the client cannot be persuaded and convinced of the wisdom of plans which do not coincide with their own thinking, efforts must be made to develop as constructive a plan as possible that takes into account the wishes and perceived needs of the client. Plans should focus on the service user's unique circumstances and should acknowledge and use their identified strengths.

3. **Co-Morbidity:** A significant percentage of individuals in addiction treatment settings have co-morbid psychiatric or medical conditions which require continuing care, but transition plans do not usually address these issues adequately. All addiction programs should develop policies for transition planning regarding psychiatric and medical illnesses that incorporate the principles listed here. Transition plans should routinely strive for *integrated* treatment of psychiatric and additive disorders and *collaborative* treatment of medical and addictive disorders for individuals with co-occurring disorders. Provisions should be made to ensure continuity even in the event of relapse, and to facilitate access to dual recovery peer supports.

4. **Comprehensiveness:** Transition plans should include all aspects of an individual's service needs. This type of comprehensive planning has not always been a part of traditional approaches to addiction treatment. Referral to treatment services alone have frequently been considered to be sufficient. Although substance use programs have traditionally not been funded as generously as mental health services, a multidimensional view of client needs must be considered and a full array of supportive services should be available to transition planners. These would typically include services such as case management, child care, residential stabilization, treatment of co-morbid issues of mental or physical health, realistic financial supports, and mutual support networking (such as twelve step programs). In some cases interface with the legal system or child protection/family service agencies will be required.

5. **Collaboration:** Coordination of and collaboration between elements of the service system which are involved with the client on either side of the transition should occur as part of the treatment plan such that a sense of continuity is achieved while the transition evolves. It is helpful to think of a transition team when developing a transition plan, and this coordination must be elevated in status to an essential aspect of the transition plan, rather than an afterthought. Short of this, information regarding the most recent

treatment experience should be provided to the agency where the client will be continuing care. Appropriate incentives for providers are an essential consideration in efforts to achieve these objectives.

6. **Continuum of Responsibility:** Systems should develop clear protocols delineating responsibility for care of clients in transition periods. In most cases responsibilities should incorporate redundancies between the referring and receiving agencies. These concurrent responsibilities will be more likely to ensure a smooth transition and prevent some of the discontinuations commonly observed in systems which do not contain overlaps between levels of care. Reimbursement arrangements should incentivize processes which incorporate concurrent responsibilities where appropriate, for the following transitions functions:
   - Client demonstrates awareness of location, time, and contact person for next scheduled treatment session
   - Client has access to prescribed medication and a sufficient quantity is available to allow uninterrupted use between physician contacts.
   - Client is aware of the person(s) to contact should there be any difficulties with either obtaining or using medication during the transition period or with any other aspects of required services.
   - Client is aware of contact person for arranging alterations in the original discharge plan should such changes become necessary.
   - Client is aware of tracking plan and the process that will be initiated to re-engage him/her should unplanned alterations in the plan occur.

7. **Continuity:** Transitions, either upward or downward in the continuum of services, should incorporate relevant elements of any preexisting treatment plan. Treatment plans should be relevant to the entire course of an episode of illness/disability so that they can provide a degree of continuity in the context of change if properly elaborated and utilized.

8. **Support System Involvement:** The degree of family involvement will generally be dictated by the client's and the family's willingness to engage in the process. Efforts to obtain this participation should be a priority of the transition team as family members often play a critical role in the addiction drama. Other persons providing support in the community, such as a PCP or spiritual advisor, should be included as well if a client indicates a desire for their participation. Consensus on the plan will increase the likelihood that the various participants will maintain a commitment to the process.

9. **Relapse Prevention Strategies:** Discharge planning from residential settings to community settings should include comprehensive relapse prevention planning. Strategies to avoid re-initiating old, dysfunctional patterns of behavior should be identified as well as available community supports and treatment programming. Financial supports should be arranged in such a manner as to avoid undue pressure to misuse funds in destructive ways.

10. **Pragmatism:** Transition/Discharge plans must reflect reality and address client needs in the most practical way possible. This will require recognition of the phase of illness and/or recovery of the client for which services are being planned. In many cases, clients may choose to leave treatment early or they may have had marginal investment in the service they are departing from. Regardless of the circumstances of their departure or the likelihood of their continuing in treatment, a comprehensive plan should be elaborated in a manner which is as inclusive of client wishes as possible. The overall goal in many instances will be to minimize the potential for harmful outcomes. This objective may be particularly relevant to working with persons who have disabling mental disorders.

11. **Maximize Resources:** Transitions have frequently required that clients return to situations in which their basic needs are not adequately met. The transition/discharge plan should be designed to maximize the resources available to the client for continuing care. This includes efforts to secure benefits for which the client is eligible with the active participation of the client. Planning should foster self reliance while recognizing that significant support may be required in the early stages of recovery. Distinctions between enabling interventions and necessary supports should be consistently drawn and frequently scrutinized, but with a realization that an overly rigid, withholding approach is often counterproductive. This latter point is particularly relevant to work with persons who have co-occurring mental disorders.

12. **Confidentiality:** Information sharing should occur only in the context of client consent. Statutory requirements for confidential treatment of information related to addiction treatment are well understood by most clinicians, but clear consideration of these requirements with the client is important, and may assist the in the establishment of trust in the transition planning process.

13. **Cultural Sensitivity:** Transitions should be managed in a culturally sensitive manner. Considering this in its broadest sense, an individual's beliefs, customs, and social context must be considered when making transitions upward (to more intensive levels of service) or downward (to less intensive levels of service).

14. **Timing:** Whenever possible, transitions should take place gradually, titrated according to an individual's ability to adapt to changing roles and expectations.

15. A mechanism for monitoring outcomes of transition plans and identifying opportunities to improve the process should be in place.

    - Appropriate quality indicators should be established with realistic benchmarks which can be easily measured.
    - A mechanism for establishing corrective action plans for systems unable to meet those expectations should be elaborated.
    - Documentation should clearly indicate that all responsibilities delineated above occur and that they do so within appropriate time frames
    - Oversight of the quality management process should include all stakeholders in the system, including persons in recovery.

- Standards established should be incorporated into contracts with Managed Care Organizations to assure proper incentives in reimbursement

Co-Occurring Psychiatric Disorders

There has been growing recognition that the majority of persons with substance use disorders suffer from concurrent psychiatric disorders. Substance use treatment programs must develop proficiency in assessing and treating these problems, just as mental health programs must be proficient in addressing substance use issues. Likewise, the transition plan must reflect the importance of addressing both illnesses adequately. The principles provided above will apply well to persons will Co-Occurring disorders, but when developing a service plan, additional issues may need to be considered:

- These clients may require additional supports to engage with the treatment process beyond restrictive settings.
- Medication management is a significant concern when planning transitions, both in terms of continuity and with regard to acceptability of the plan.
- Harm reduction approaches will generally be preferable to a take it or leave it approach. Adopting this perspective may provide a basis for engagement and eventual investment in a change process.
- Unique mutual support programs may be needed to address the issues relevant to the dual recovery client.
- Services must meet client needs rather than attempting to make clients fit into pre-existing programming.