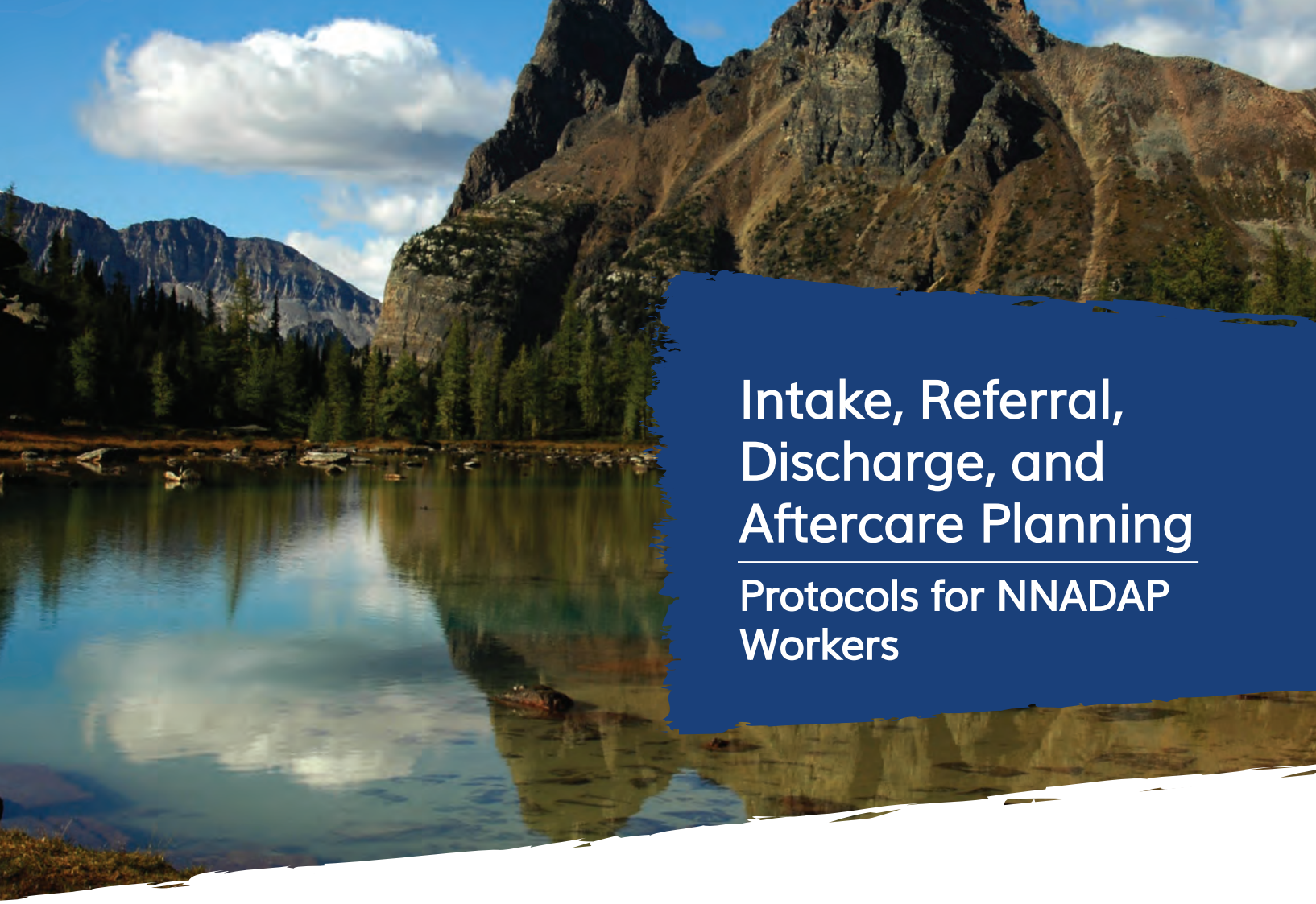


Intake, Referral, Discharge, and Aftercare Planning

Protocols for NNADAP Workers

THUNDERBIRD PARTNERSHIP FOUNDATION

TABLE OF CONTENTS

As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its operating name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

Introduction

This toolkit addresses renewal issues relevant to "Element 2: Early Identification, Brief Intervention, and Aftercare" identified in *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*.[1] NNADAP workers and regional NNADAP needs assessments have clearly stated the need for a common set of Intake, Referral, Discharge, and Aftercare Planning processes and templates to ensure clients receive appropriate, streamlined care when and where needed along their recovery journey. Both the *Honouring Our Strengths* report and the National Native Addictions Partnership Foundation's (NNAPF)* *Continuum of Care Survey* findings stress and support the need for common templates / protocols.

Processes and practices related to the Intake, Referral, Discharge, and Aftercare Planning act as key mechanisms that work in tandem to help clients move seamlessly through the Continuum of Care, whether seeking services in the community or more specialized services provided by treatment centres. The processes of Intake and Referral identify the issues and needs of clients and attempt to match these with the most appropriate services and supports. Discharge and Aftercare Plans serve to ensure that clients move easily from one level of service or treatment to another at the appropriate time and with the appropriate personal, social, and case management supports to successfully remain on their journey of recovery.

Intake, Referral, Discharge, and Aftercare Planning hold critical roles at different junctures within the care continuum as recognized in the *Honouring Our Strengths* Renewal Framework's "Elements of Care." The Elements of Care are defined services along a "Continuum of Care." Together, these Elements of Care represent a vision for a comprehensive and seamless Continuum of Care across the NNADAP / YSAP system.

Topics to be covered in this toolkit include:

An outline of the Continuum of Care and where Intake, Referral, Discharge, and Aftercare Planning occur along the continuum.

Overviews of:

Intake

- Tools used for Intake
- Who does Intake
- When Intake should take place

Referral

- Templates for Referral
- Who does Referrals
- System issues (e.g., external referrals, barriers, etc.)
- Criteria for Referrals to specific services

Discharge

- Templates for Discharge planning
- Who Discharges clients in the continuum
- System issues (e.g., barriers/service issues at community level, etc.)
- Criteria for Discharge to community/home

Aftercare Planning

- Templates for Aftercare
- Who offers/provides Aftercare for clients
- System issues (e.g., community capacity to provide Aftercare, lack of Aftercare plans, etc.)

Examples of comprehensive Intake and Referral templates/protocols.

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

1 Health Canada, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada* (Ottawa: Health Canada, 2011).

Objectives

The primary objective of this toolkit is to identify commonalities among NNADAP and other social / health-care partners who are involved in client Intake, Referral, Discharge, and/or Aftercare Planning within the Continuum of Care. This is in order to identify 'promising practices' to support the cross-sector collaborative development of Intake and Referral templates that will enhance and strengthen service delivery and program development at the community and treatment centre levels.

This toolkit also aims to promote and enhance the capacity of NNADAP workers to use standardized Intake / Referral and Discharge / Aftercare Planning protocols. Common Intake and Referral templates will aid in building key linkages with external social determinants of health providers who also play a key role in services for clients with substance abuse and mental health issues.

This toolkit provides an overview of what Intake, Referral, Discharge, and Aftercare Planning is in the context of working with clients with a substance abuse and/or mental health issue.

Materials

Key findings from NNAPF's *Intake, Referral and Discharge and Aftercare Planning: Literature Review and Annotated Bibliography report*:

- To provide an overview of key concepts and protocols for Intake, Referral, Discharge, and Aftercare Planning

Key findings from *NNAPF's Continuum of Care Survey*:

- To provide an overview of current issues and feedback from the field on Intake, Referral, Discharge, and Aftercare Planning

Key findings from the *Summary Findings from NNAPF's Continuum of Care Survey* report:

- To provide an overview of current issues and feedback from the field on Intake, Referral, Discharge, and Aftercare Planning

NNAPF's *Mental Health/Addictions Screening and Assessment Tools for First Nation Clients - Discussion Paper*:

- To provide a brief overview of the roles of Intake, Referral, Discharge, and Aftercare Planning in the Continuum of Care
- To provide a brief overview and demonstration of the role of screening in the Intake and Referral process

Samples of Intake and Referral templates

Samples of Discharge and Aftercare Planning templates

Recovery – What Does It Mean?

"Recovery should be viewed in the context of the entire care continuum, a process that begins at intake and referral, and whose success is dependent upon the ability of the system to respond to the treatment and support needs of clients as they progress, and sometimes relapse, on their journey to recovery."[2]

Video #1: *Christopher Kennedy Lawford's 23 year Journey of Recovery*

http://www.youtube.com/watch?v=-XxR0FnAV2s

Video #2: *What to Do About Addiction with Christopher Lawford Kennedy and Guests*

http://www.youtube.com/watch?v=hE-wGYPVuuo&feature=related

Both of these videos highlight an individual's journey towards recovery and the many obstacles and challenges that can, and often do, deter someone from staying on course to recovery. As you watch the following videos, think about how you:

- View Recovery
- Need to perform key steps to help a client move from Intake to Recovery
- Do Intake
- Do a formal Intake
- Do client Referral to NNADAP / YSAP
- Discharge clients
- Perform a client Discharge
- Provide Aftercare to clients
- Provide Aftercare Planning for clients

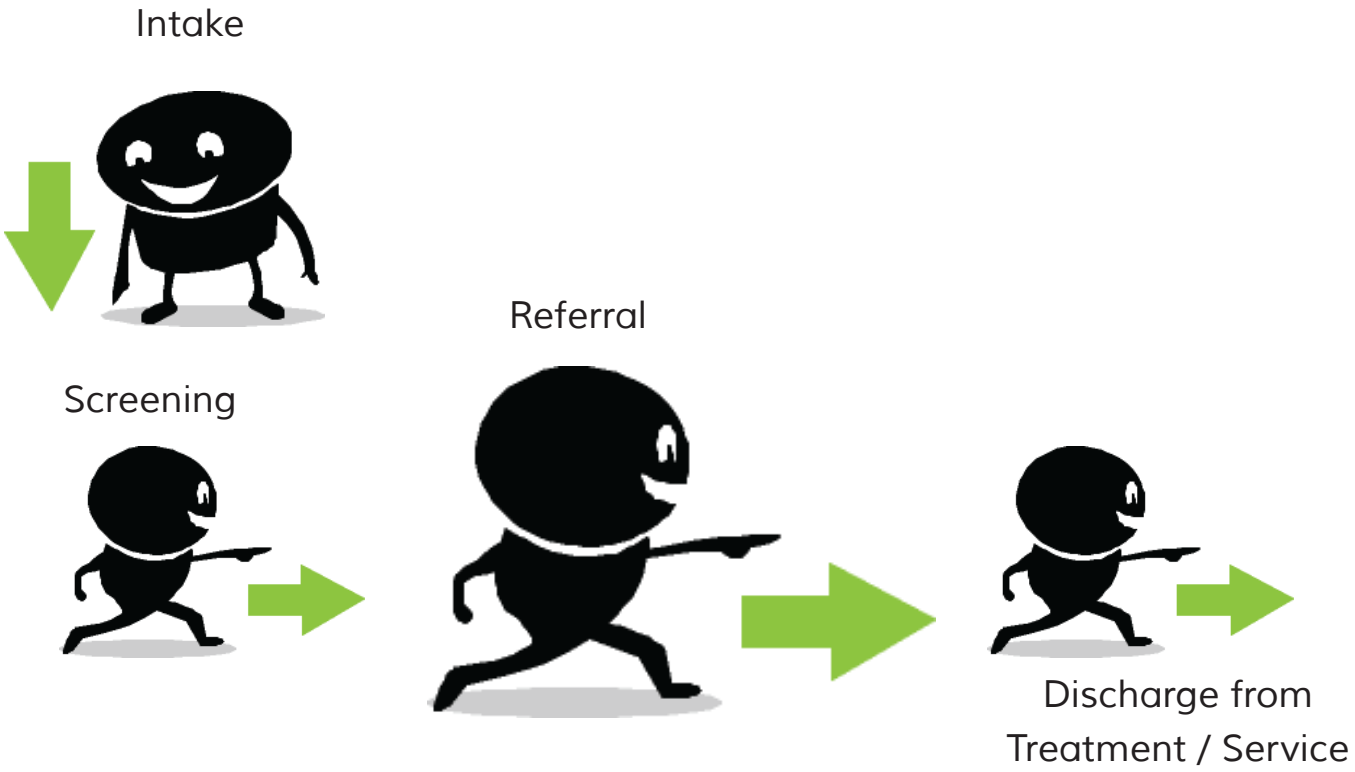
After viewing the video clips, ask yourself the following questions:

- Who are the key players in someone's recovery journey?
- Why do so many people not seek help for their substance abuse problem?
- What do you see as the barriers in your practice / work environment that may prevent some clients from coming to your service for help?
- Who are the other service providers (health, social, etc.) in your community that perform or provide Intake,
- Referral, and Aftercare services / supports to clients with an addiction or related mental health issue?

2 NNAPF's *Intake, Referral and Discharge and Aftercare Planning Literature Review* report.

The Continuum of Care

The following diagram depicts a simplified flow of care and the key steps that a client takes along their services and treatment path with NNADAP:



As a client moves from initial contact with service through each phase of service/treatment, think about how many specific service providers are involved in the client's journey.

Ask yourself at how many stages does a client provide information to someone – information on their substance abuse issue and history; family issues; mental health issues; abuse; intergenerational trauma; etc.

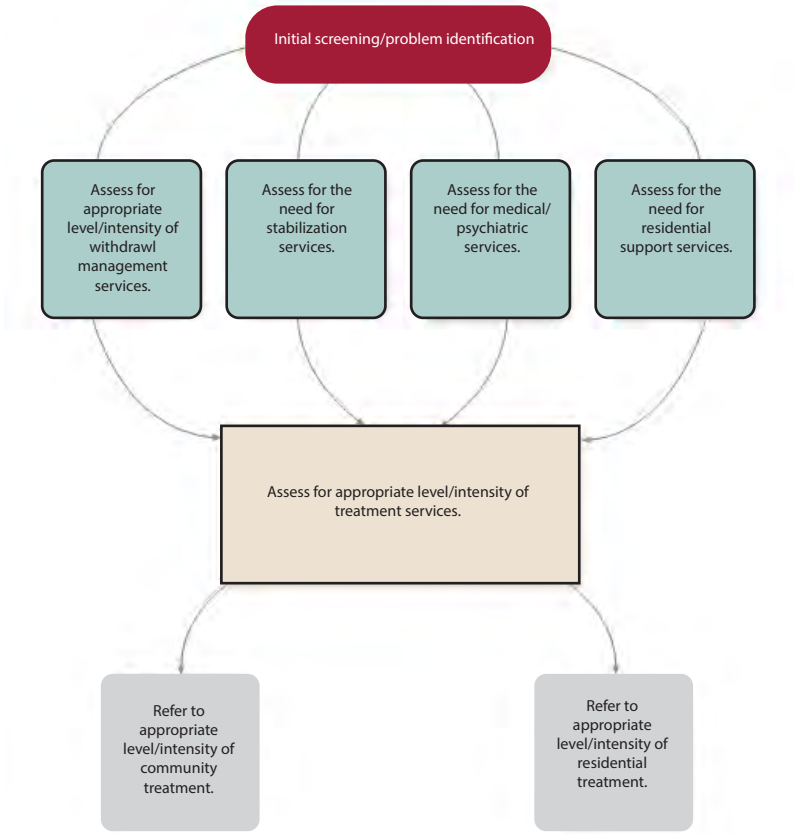
The goal of standardized Intake and Referral protocols is to ensure that clients tell their story to a minimal number of people in the most comprehensive and concise manner. The client's information is collected, reviewed with the client and a referral is made to the most appropriate service that meets the needs of the client – needs that are identified at Intake.

Discharge and Aftercare Planning protocols are dependent upon the collection and review of accurate, needs-based information gathered at Intake, used at Referral and determined throughout assessment and treatment.

Decision Trees

Decision Trees are another way to contextualize where Intake, Referral, Discharge, and Aftercare fit in the Continuum of Care. The first diagram below is an Admission Decision Tree created by the Centre for Addiction and Mental Health (CAMH). It shows the key questions a counsellor needs to ask at screening before referring a client on to treatment:

Admission decision tree



Questions to ask:

- What are the key questions you need to know / ask a client before you can refer them?
- Do you use a similar process for screening and determining the type of service / treatment provider your client needs?
- What would you need to do in your practice to develop an Intake Decision Tree?
- What other services or supports in your community are or should be involved in the Intake, Screening, and Referral process?
- What are your biggest barriers when you are performing Intake, Screening, and Referral?

What is Intake?

Intake is the process of information exchange, triage, and engagement initiated upon formal contact with the client.

The key objectives of Intake are to:

- Determine the appropriateness of the provided Addiction Services to meet identified needs of the client
- Promote client engagement
- Provide relevant information and client education
- Identify and refer to appropriate services, programs, and agencies
- Determine assignment of priority level
- Determine the need for further assessment
- Establish a baseline of specific problem areas that can be used during treatment to evaluate a client's progress

Questions to ask:

- Who does Intake for clients with an addiction problem in your community?
- How would you do an Intake process for a client who presents to your service with an addiction AND mental health issue?
- To what service provider would you refer a client with an addiction AND mental health issue?
- Do you have an appropriate community-based service provider for referrals for clients with an addiction or an addiction AND mental health issue?
- If not, where are clients referred?
- Do you use a formal Intake form?

What is Referral?

Referral is the identification of the needs of the client that cannot be met by the counselor or agency and helping the client to utilize the support systems and community resources available. Referral is closely related to case management when integrated into the initial and ongoing treatment plan. Referral should also include aftercare or discharge referrals that take into account the Continuum of Care.

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resource to meet client needs
- Explain in clear and specific language the necessity for and process or referral to increase the likelihood of client understanding and follow-through
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

The following are best practice guidelines for competency in performing Referral:

- The counselor must be familiar with community resources (alcohol, drug, and others) and be aware of the features and limitations of each service.
- The counselor must be able to demonstrate a working knowledge of the referral process, including the confidentiality requirements.

The following outline key criteria for conducting referrals:

1) Identify need(s) and/or problem(s) that the service / department / program / counselor cannot meet
2) Explain the rationale for the referral with the client
3) Match client needs and/or problems to appropriate resources
4) Adhere to applicable laws, regulations, and program policies and procedures related to the protection of the client's confidentiality
5) Assist the client in utilizing the support systems and community resources available

Case Noting and Record Keeping

Case Noting is the ongoing process of client bio-psycho-social assessment and is the record of treatment provided. It includes recording data, issues addressed, treatment received, ongoing assessment, treatment plan, and goals of treatment. It may take the form of initial, progress, and closure notes.

The report and record keeping function is extremely important as it can:

- Benefit the counselor by documenting the client's progress in achieving their goals
- Facilitate adequate communication between coworkers and service providers
- Be valuable to other programs that may provide services to the client at a later date
- If properly performed, enhance the client's treatment experience

Key criteria for Case Noting and Record Keeping include:

- Prepare reports / case notes and relevant records integrating available information to facilitate Continuum of Care
- Chart pertinent ongoing information about the client
- Utilize relevant information from written documents for client care

Key objectives for Case Noting and Record Keeping are to:

1) Provide accountability
2) Provide a record of client progress relating to treatment / care goals (i.e., physical, psychological health, employability, etc.)
3) Assist in an organized and thoughtful approach to the implementation of treatment / care recommendations

Client Records

The client record serves as a case management tool and documents a comprehensive assessment, care / treatment plan, and care / treatment response of the client. It serves to evaluate the program appropriateness and effectiveness for meeting the client's needs. The client record is also necessary for consistent communication and as a legal document.

The key objective is to provide a standardized individual record system that begins upon referral and is inclusive of all relevant information and services provided.

A standard client record includes the following:

- Identification / demographic data (age, sex, date of birth, etc.)
- Consent for services
- Confidentiality contract
- Screening / Intake
- Assessment (where completed)

- Case care / treatment plan
- Case notes
- Progress update
- Discharge summary
- Consent to release / obtain information
- Referral form
- Drug screen information / Medication lists
- The date the file was opened and the date the file was closed
- The identity of the author and a signature page

Pre-Discharge Protocols

Pre-Discharge Protocols ensure that clients are prepared for re-entry back into the community, maintaining their aftercare, and preventing / addressing relapses. The key elements of a Pre-Discharge Protocol are:

- Discussion of post-treatment issues and discharge planning should begin early in treatment and focus on the ability of the client to maintain abstinence in his/her own personal environment following transition and re-entry back into the community.

- Relapse prevention issues should be identified and relapse programming should be initiated no later than halfway through treatment.

- The client should be assisted by the primary therapist in identifying potentially dangerous (to sobriety) situations, circumstances, states of mind, and other warning signs of relapse as well as resources that will support his/her sobriety and recovery.

- A viable relapse prevention plan or plan of action should be developed which will outline potential strategies for coping or dealing with thoughts or urges to return to use. It should address what to do in the event that a "slip" or relapse does occur.

- Helping the client to remain actively engaged in the recovery process should be a high priority.

- Prior to discharge, the client should also be fully informed of the purpose and importance of aftercare in the overall Continuum of Care and maintenance of sobriety.

- The client should also be encouraged to attend and participate in some aftercare groups prior to discharge.

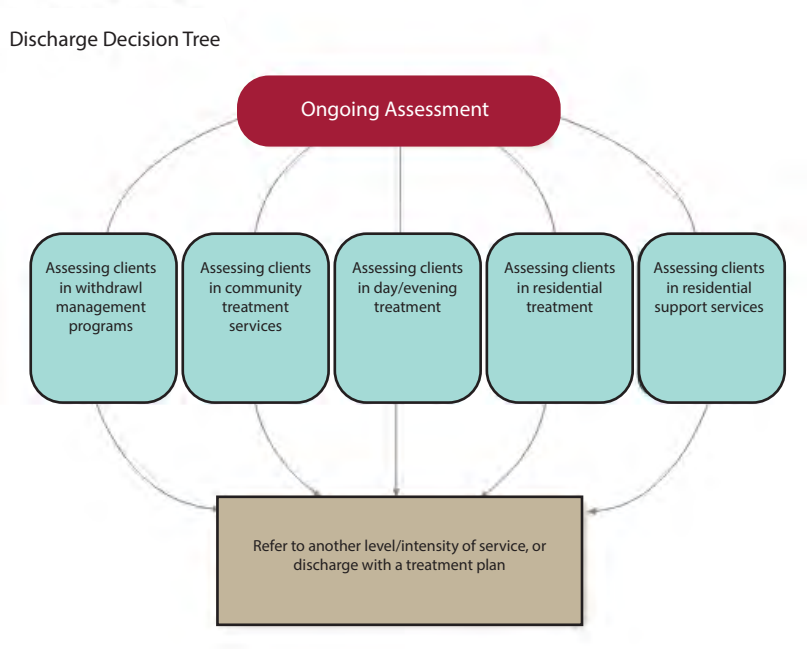
- The aftercare coordinator or person responsible for aftercare should orient the client to the goals, objectives, activities, and expectations of aftercare and follow-up.

By the time the client completes primary treatment, he/she should have the opportunity to:

- Develop a basic understanding of the dynamics of relapse
- Identify internal and external triggers that can potentially lead to thoughts or urges to use substances or drink alcohol
- Identify and develop appropriate internal and external resources and support systems
- Develop strategies and a plan for coping with threatening situations and circumstances (internal and external)
- Develop a relapse prevention plan and an intervention plan in the event that a "slip" or relapse should occur
- Gain an understanding of the importance of aftercare within the overall Continuum of Care and be introduced to an aftercare group

What is Discharge (Transition Planning)?

Clients should be frequently assessed at each stage of treatment in order to determine their need for other services and their readiness to move along the Continuum of Care. Using a Decision Tree can help determine when a client should move to another service and/or when they are ready to be discharged. CAMH's Discharge Decision Tree below is an example that demonstrates how Discharge Planning fits in the Continuum of Care and the key questions that need to be asked before a client is discharged:



The individual receiving service must participate in creating a plan for his/her return to the community. The intent of Discharge planning is to ensure that each client's transition back to the community is adequately supported.

Key Criteria for Discharge/Transition Planning:

- Work on the transition plan begins early in the individual's stay at the residential facility and is a collaborative process between the individual receiving service, residential staff, the appropriate community-based resource(s), and (where appropriate) the individual's circle of support (e.g., family, friends, and/or supportive others).
- The transition plan reflects the individual's successes, preferences, and ongoing goals and addresses any concerns she or he may have about returning to the community.
- The plan may deal with any or all of the following elements as appropriate to each client's situation:
  - Ongoing substance use treatment and support
  - Mental health
  - Life skills
  - Relationship with family
  - Personal and social supports (including community groups)
  - Connection to a family doctor
  - Spiritual and cultural practices and preferences
  - Education and/or vocational training
  - Housing
  - Employment
  - Recreational interests (e.g., arts, sports, social activities)
  - Safety from violence and abuse
  - Parenting skills

Developing a Discharge Protocol

Work with a colleague or your program staff to review the following recommendations that support effective discharge planning procedures. Use these recommendations as well as the ones in the "Elements of Successful Discharge Planning" section below to develop a draft Discharge Protocol. In developing your protocol, your group needs to ask and address the following:

1. If you don't already have a Discharge Protocol: Establish a discharge planning work group that is reflective of the various programs / services provided by your agency. This work group will:
   - Develop a uniform discharge planning process for individuals leaving your system of care.
   - Establish a written Discharge Protocol for discharge planning that includes the use of discharge forms.

2. If you already have a written Discharge Protocol: Revisit your discharge and aftercare policy and procedures to assess whether they are appropriate for individuals who are homeless or at risk of becoming homeless.
   - Example: Does the plan include linkages to appropriate housing and other community-based care?

3. Provide training to all staff involved in discharge planning to ensure some degree of uniformity in the implementation of your written Discharge Protocol.
   - If resources allow, evaluate whether staff are following protocol and adhering to written guidelines.

4. Determine who is in your wide network of "care providers" – to whom do you typically discharge and/or refer your clients?

5. Determine whether members of your network of "care providers" have policy and procedures for accepting discharges that are consistent with your discharge policy and procedures.

6. If resources allow, collect data on outcomes of your discharge procedures. This will help you to assess whether the goal / purpose of your discharge procedure is being accomplished.

Elements of Successful Discharge Planning

The following is a comprehensive list of Discharge and Aftercare Plan elements compiled from the available literature:

- Discharge planning must be tailored for different needs of different clients; it is important to create an Individual Service / Treatment Plan.
- Discharge planning needs to be comprehensive – all of the client's needs across multiple health systems should be addressed in the Discharge Plan.
- Discharge planning must create a system that is continuous and coordinated.
- Discharge planning for clients who abuse substances must include appropriate treatment as such clients are more at risk for homelessness and criminalization.
- "Next step" resources are central to Discharge planning; Discharge planning is illusory without these resources.
- The lack of good Discharge planning is often related to lack of appropriate options.
- Discharge Plans must be practical and realistic and maximize available community resources for the benefit of the client.

Questions to be asked:

Have you had any training in the area of Intake, Referral, Discharge, or Aftercare Planning?

Does your organization / program have a Discharge Planning Model?

What should an ideal Discharge Planning include?

What are the key questions, information pieces, client outcome information, etc.?

Who should be Involved / included in a client's Discharge Planning process?

Discharge Planning Model

Both mental health and substance abuse treatment staff should have initial training, cross-training, and on-the-job supervision to adequately meet the needs of clients with co-occurring disorders.

Staff in substance abuse treatment settings should have training in the following areas:

- Recognize and understand the symptoms of the various mental disorders
- Understand the relationship between different mental symptoms, drugs of choice, and treatment history
- Individualize and modify approaches to meet the needs of specific clients and achieve treatment goals
- Access services from multiple systems and negotiate integrated treatment plans

Staff working in mental health settings, should have training that includes knowledge development on:

- Basic definitions of substance abuse and addiction
- Common signs and symptoms of drug abuse and/or addiction to substances
- Understanding the interaction and potential side effects associated with commonly prescribed mental health medications and commonly abused drugs and/or substances
- The role of self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, etc.

Discharge Planning Forms

Working with colleagues and/or external provider representatives, identify if you are using the following discharge forms:

- ☐ Reason for client's discharge
- ☐ Mental health / substance abuse treatment and service needs at discharge
- ☐ Services provided to client while in the care of discharge entity / agency
- ☐ Primary or significant problems / issues identified during treatment stay
- ☐ Assessment of client's level of functioning
- ☐ Referrals provided for ongoing mental health and/or substance abuse treatment
- ☐ Referrals provided for "recovery support" type of services
- ☐ Primary agency to which individual is being discharged to
- ☐ Other information related to client / patient achievement of treatment goals / outcomes

What is Aftercare Planning?

Aftercare Planning ensures that clients getting ready to leave treatment are connected with the community-based supports and services identified in their Discharge / Transition Plan. The intent of Aftercare Planning is to ensure that clients experience a seamless transition from treatment to the community and are supported in the community in order to continue building on the progress they made during their treatment stay.

Aftercare Planning Elements

• The treatment centre / program actively supports the client in maintaining or establishing relationships with the substance use service providers that they will be working with when they return to the community.

• The treatment centre / program actively supports the client in making contact with other health / social service agencies and community organizations (e.g., primary care, housing, child care, employment services and support groups) as needed.

• The treatment centre / program refers clients to other services as required.

• The follow-up / Aftercare Plan is reviewed with the community counseling / NNADAP worker.

• Support is provided to family members, as indicated and where possible.

• Clients are supported through teaching such things as coping strategies, relapse prevention strategies, and health / self-care practices (e.g., exercise, good nutrition, regular sleep).

• All client records will have a follow-up / Aftercare Plan attached.

• Follow-up / Aftercare Plans are monitored and revised a minimum of every three months or as required.

Best Practice Guidelines for Aftercare

The available literature defines addiction as a chronic disorder. This means that multiple relapses are common for individuals with a substance abuse problem, especially during stabilization and early recovery periods. The following is a "best practice" guiding principles checklist to reference when clients are returning to the community for aftercare services / supports:

- ☐ A compatible treatment philosophy exists across all levels of care.
- ☐ Aftercare has objective and articulated goals.
- ☐ Aftercare incorporates motivational enhancement strategies that parallel stages of recovery.
- ☐ Aftercare services are provided for at least a year post-discharge. Six to nine months post-discharge is considered to be the most critical period for relapse.
- ☐ Adequate frequency of contact with professional services is maintained to maximize outcomes.
- ☐ Aftercare fosters and helps develop a positive support network for clients.
- ☐ Aftercare encourages and/or supports self-help involvement.
- ☐ Aftercare includes an ongoing and multi-dimensional assessment process.
- ☐ The frequency and intensity of individualized services is determined based on high-risk relapse factors.
- ☐ Aftercare includes transitional management to bridge the gap for clients during periods of transition.
- ☐ Aftercare services should include consideration of:
  - ☐ Housing
  - ☐ Job
  - ☐ Transportation
  - ☐ Childcare
- ☐ Aftercare is capable of outreach and provision of services in order to maintain the engagement of clients who might drop out prematurely.

Aftercare has monitoring strategies:

- ☐ Drug testing
- ☐ Case management
- ☐ Home visits
- ☐ Telephone calls
- ☐ Other: _____

Please watch the following video clips:

Video #3: *Ledghill Recovery and Treatment Centre's Aftercare Treatment Program*

http://www.youtube.com/watch?v=Mm4qWIZqCao

This video highlights Ledgehill Recovery and Treatment Centre's aftercare program that provides a successful bridge between addiction and recovery (sobriety). After watching the video, answer the following questions:

Why is Aftercare so important to recovery?

Why is Aftercare often "overlooked" in the treatment process?

What are some examples given of Aftercare programming at the facility?

Video #4: *Addiction Recovery Aftercare from talkdavid.com*

http://www.youtube.com/watch?v=mKBnF4KxzRk

Note the role of Aftercare in client recovery and the role of the Addiction Worker / Counsellor as it is defined in the video. After watching the video, answer the following questions:

Why do so many clients "fall off the recovery wagon"?

When should Aftercare planning begin?

What is the role of the Treatment Centre worker in a client's Aftercare Planning?

What should an Aftercare Plan include?

What are some different forms of Aftercare?

How long can Aftercare last?

Maximizing Aftercare Outcomes

The following are key elements needed to maximize Aftercare outcomes:

- Treatment Centre / Clinical Services
  - Staff should be familiar with ongoing risk and motivational assessment / crisis / situational management. They should be familiar with motivational strategies and know how to provide support and encouragement as needed.
  - Services should include individual and group therapy as well as relapse prevention strategies to provide clients with recovery training and teach relapse prevention skills.
  - Clinical services should be variable and of sufficient intensity, frequency, and duration to identify and address transitional and high risk relapse factors that may threaten the client's recovery and the program's outcomes.
  - Following primary treatment, clients should have varying levels of readiness to implement their recovery programs in the community.

- Case Management Services: Clients may have several needs which, if not addressed, can lead to early drop-out or may place the client at risk of relapse. These needs include (but are not limited to):
  - Wraparound services (job, housing, employment, transportation, childcare, etc.)
  - Advocacy for the client through school, employment, and criminal justice contacts (where and as appropriate)
  - Healthcare access for medical, dental, mental health, and other services
  - Pharmacotherapy / medication management
  - Good working relationships with legal system and other referral sources

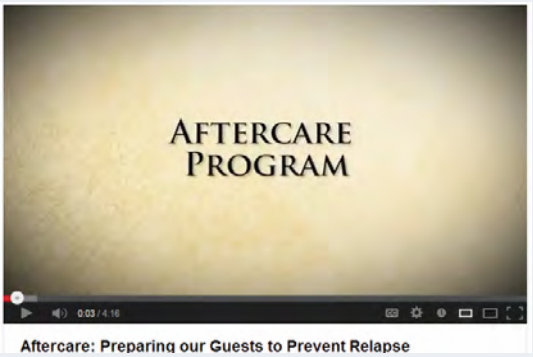
- Outreach
  - Aftercare should be capable of outreach and provision of services in settings other than traditional clinic settings in order to keep the engagement of clients who might drop-out prematurely.
  - Aftercare programs should be capable of providing services and support in whatever settings will encourage the most involvement (including home). The goal is to maintain contact.

- Post-Discharge Support
  - Monitoring Strategies such as drug testing, home visits, and follow-up phone calls should be utilized. The goal is frequent contacts with the client for the first six to nine months.
  - Twelve-Step Programs or similar groups that encourage some type of involvement in self-help activities.
  - Linkage with Senior Peers should be provided. This involves the client having a connection with or support from peers with advanced recovery.

Please watch the following video clips:

As you watch the following video clip, note how Aftercare is delivered by the program and how Aftercare has benefited the program's clients.

Video #5: Aftercare: *Preparing our Guests to Prevent Relapse*



http://www.youtube.com/watch?v=Qgkb8zz5fv0

Please answer the following questions after watching the video:

Why does relapse occur?

How does Duffy's Rehab provide relapse prevention?

Do you provide relapse prevention?

How does Duffy's Rehab assist their clients through Aftercare Planning?

What are some relapse triggers that clients should be aware of before leaving treatment?

How important do you think Aftercare Planning is for your clients?

Development Exercise

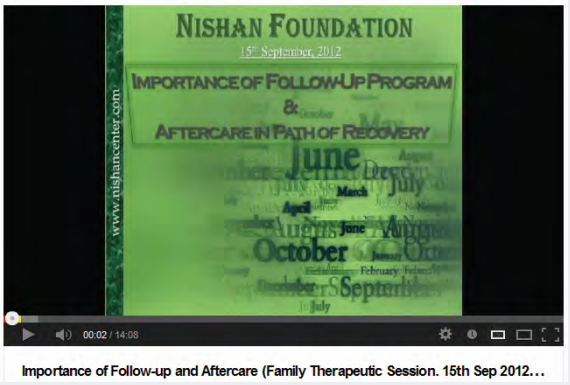
The following video clips will help to further your knowledge base on Intake, Referral, Discharge, and Aftercare Planning. Once you have watched the video clips, hold a meeting with colleagues / staff / department members and discuss the following:

- Are there any elements or pieces of the Continuum of Care missing from your program?
- Does your program provide relapse prevention counseling / services?
- How many clients (that you know of) have returned from treatment without a formal Aftercare Plan?
- How did you help these clients?
- What other service providers in your community provide Aftercare?
- What is your relationship with these service providers? Do you have any formal agreements or joint programs with them?

Video #6: *Accurately Responding to Process Items: Plan of Care Synopsis (M2250)*

http://www.youtube.com/watch?v=H7mdobdIXr4

Video #7: *Importance of Follow-up and Aftercare (Family Therapeutic Session. 15th Sep 2012) Nishan Foundation*



http://www.youtube.com/watch?v=rCleV4OJnvg

Video #8: *Addiction & Recovery: Action With Purpose*

http://www.youtube.com/watch?v=l-o0Lf7mMoE

Video #9: *Addiction & Recovery: Do the Next Right Thing*

http://www.youtube.com/watch?v=zarvAMMSrC0&feature=relmfu


THUNDERBIRD PARTNERSHIP FOUNDATION