SUBSTANCE ABUSE AFTERCARE TREATMENT

CONTINUUM OF CARE

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SCOPE OF THE PROBLEM

1. National statistics
2. What are you seeing?

According to SAMHSA's National Survey on Drug Use and Health (NSDUH) – 2014 (PDF | 3.4 MB), about two-thirds (66.6%) of people aged 12 or older reported in 2014 that they drank alcohol in the past 12 months, with 6.4% meeting criteria for an alcohol use disorder.

Also among Americans aged 12 or older, the use of illicit drugs has increased over the last decade from 8.3% of the population using illicit drugs in the past month in 2002 to 10.2% (27 million people) in 2014. Of those, 7.1 million people met criteria for an illicit drug use disorder in the past year.

The misuse of prescription drugs is second only to marijuana as the nation's most common drug problem after alcohol and tobacco, leading to troubling increases in opioid overdoses in the past decade.

An estimated 25.2% (66.9 million) of Americans aged 12 or older were current users of a tobacco product. While tobacco use has declined since 2002 for the general population, this has not been the case for people with serious mental illness where tobacco use remains a major cause of morbidity and early death.

Additional data from SAMHSA's Behavioral Health Barometer – 2014 (PDF | 3.9 MB) show that:

•Men reported higher rates of illicit drug dependence than women, 3.8% to 1.9%.

•American Indians and Alaska Natives have the highest rates of illicit drug dependence at 6%, followed by African Americans at 3.6%.

•Asian Americans reported the lowest rate at 1%.

•About 14% of adults with illicit drug dependence reported receiving treatment in the past year, which did not vary by gender.

•Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.

•In 2012, 58.3% of people who tried alcohol for the first time were younger than 18.

•More than 50% of people aged 12 or older in 2011-2012 who used pain relievers for non-medical reasons in the past year got them from a friend or relative.

OBJECTIVES

- What is Aftercare, we will define it
- What Aftercare is not, we will discuss
- Aftercare treatment planning, we will be clear on what it should look like
- Data on Aftercare, we will learn more about how we are doing
- Aftercare resources, we will share our group ideas about what is working and discuss solutions for barriers
- Aftercare for current and future patients,

  we will discuss what it will look like

WHAT IS AFTERCARE?

- Despite the name, aftercare planning starts when referral for residential treatment begins. A **continuum of care** is our focus.
- Aftercare refers to treatment after a patient has made a transition between levels of care (i.e. from residential to outpatient treatment).
- Aftercare is a plan for the recovery person to support them in early recovery, to prevent relapse, and to help them toward their other life goals.
- Life goals, an important item to note. Why get sober? What do I get for it? My kids, a job, education, better health, financial independence, hope, calm, balance, relationships, hobbies, opportunity to give back or help. These help to sustain the person

Phil Archambault, Spiritual Advisor at NARA NW, says "10% of your recovery process occurs in residential treatment and 90% of your recovery process begins when you return home to your community".

WHAT IS AFTERCARE…

- Aftercare needs to include structure, guidance, individualized activities, interventions, and resources as created with the client, and a need for outlets for emotional, mental, spiritual, and physical well being must be included. Holistic wellness…

- Physical health issues
- Emotional health
- Mental health
- Spiritual wellness/cultural issues or needs- beyond ASAM

- Physical health- medical management, labs, patient interviews, comprehensive intakes, focused on not only chronic illnesses, urinalysis results, but diet and exercise.
- Diabetes
- Pregnancy
- Behavioral Health

- Studies on outcomes, exercise to treat depression and to reduce stress…

- How many studies does it take to convince you that moderate exercise will make you happier? If you need one more reason to start being more physically active, professors from the University of Toronto have compiled and analyzed over 26 years' worth of scientific research which concludes that even moderate levels of physical activity—like walking for 20-30 minutes a day—can ward off depression in people of all ages.

- University of Toronto PhD candidate George Mammen co-authored a review of 25 different research articles, which show that moderate exercise can prevent episodes of depression in the long term. The compilation of research is published in the October issue of the *American Journal of Preventive Medicine*.

- When thinking about our health, many times we believe ailments are either physical or mental. Emotional health, while it may sound less important, deserves just as much attention as any broken bone. Mental health and emotional health might seem very similar, when in fact they are not the same at all. A healthy state for all individuals is to find a balance between the intellectual and emotional side.

- Some areas of mental and emotional health overlap. Processing and reasoning are two very important parts of our personality that also carry over into mental health. A strong sense of reasoning is required to make sure we aren't losing control over our emotions or becoming unstable. Our decisions on how to react to various scenarios must also be processed very carefully to avoid anxiety or overreacting. If we lack a balance between processing and reasoning, we put our health in a very unstable state and may experience disorientation and issues with functioning efficiently.

- To help distinguish between mental and emotional health, it may help to define each. Mental health involves cognitive thinking and harnessing one's attention to stay focused. This involves processing information, storing it in memory, and understanding this new information. Like stated above, mental health also includes properly exercising reason and processing any learned information. On the other hand, emotional health involves expressing one's emotions appropriately. Mental health requires managing emotional actions and gauging the appropriate reactions to situations. This prevents unnecessary and unhealthy stress, which if severe enough can lead to depression.
- Yerkes-Dodson Human Performance Curve

- Mental and emotional health, while separate in their own ways, are both necessary and work together cohesively. As human beings with hundreds of thoughts and emotions running through us constantly, we make many choices based on feelings. Many of our feelings are created through cognitive reasoning and processing the situation at hand. These two separate, yet complimentary realms of health work together to ensure our overall health is up to par and we efficiently communicate and interact with others.

Spiritual health= What is it? Is it the first thing to go in addiction as always stated in recovery circles?

- Spirituality. Is addiction a spiritual problem? To think about this we first have to define the word, "spirituality." This turns out to be surprisingly hard to do. A search reveals that up to about 70 years ago, the terms spirituality and religion were almost synonymous. But since then, "spirituality" has also been used to refer to a feeling or belief in the oneness between an individual and the universe, being in touch with one's soul or inner self, and even simply a sense of personal well-being. None of these newer meanings has a specific reference to a deity or to religion.

- So, is addiction a spiritual problem? If "spiritual" is used in the original sense as "religious" then the answer is certainly no. Addiction is not a failure of religious devotion. There is also no reason to think of addiction as a disconnection between an individual and the universe, or any other New Age ideas such as working for social change or channeling contact with spirits. Since addiction is a psychological symptom, it probably could be loosely described as being out of touch with one's inner self, in the sense that there are unconscious elements in every emotional symptom. But calling addiction a spiritual problem on this basis would mean saying that every aspect of emotional distress was a "spiritual" problem. That would add nothing to our understanding or treatment and would actually interfere with trying to figure out the specific emotional factors within people that produce this behavior.

- *The Heart of Addiction: A New Approach to Understanding and Managing Alcoholism and Other Addictive Behaviors*
  Lance Dodes M.D., former professor of Psychiatry Harvard Medical School.

CULTURAL RELEVANCE

- Cultural resources and needs for the client
- Identity and Connection
- Engagement in practices
- Introduction to practices

What do you have to add on this topic?

PREVALENCE OF CO-OCCURRING DISORDER

45% of people with addiction have a co-occurring disorder

According to the *National Survey on Drug Use and Health, 2010*.

Co-occurring mental health conditions and substance use disorders affect nearly 8.9 million Americans each year. Of those only 7.4% receive appropriate treatment, with the vast majority bounced among treatment systems with different and opposing treatment structures.

CO-OCCURRING PATIENT NEEDS

- Few drug treatment centers specialize in treating complex co-occurring disorders. Nationally, research continues to reveal that people with co-occurring disorders need a specialized form of treatment, referred to as integrated services or dual diagnosis treatment.

- Mental health treatment and addiction treatment have historically and continue to be separated systems of care. While many research studies have been performed on mental health and addictions separately, it has only been within recent years that studies have emerged on people who struggle with both conditions in tandem. This emerging research identifies that traditional separated systems of care not only alienate the consumer from treatment, but they also result in much poorer outcomes that those experienced by people with single disorders. More surprising, we are now learning from these studies that programs predominantly designed to treat a specific disorder are actually only capable of treating the minority of those in need.

- In fact, up to 65.5% of people with a substance dependence disorder had at least one mental disorder and 51% of people with a mental disorder had at least one substance abuse disorder.
- We are also increasingly learning that these poorer outcomes result as much from these separate and contradictory systems of care as from the diagnoses themselves with people who have co-occurring conditions comprising the majority of the 10 percent of people using over 70 percent of the nation's healthcare resources. There are now more than 14 million people in the U.S. with co-occurring substance abuse and mental health disorders.

AFTERCARE IS NOT

- Aftercare is not simply a 1:1 session once a month after treatment, or sending a client to a group once a week for a month.
- It is a level-of-care stair step process. Gold standard is IOP 4 times per week, managed by a counselor or case manager to track progress, and collect urine analysis for accurate accountability. With best practice model and peer support. Does it exist?
- IOP, OP, AA, Tx, rinse repeat
- If a client relapses in aftercare, it is not time to go straight back to residential treatment automatically. Relapse or a lapse in sobriety could be a learning tool to examine relapse, review triggers and re-assess the support system.

WHAT DO RELAPSE NUMBERS MEAN?

- Looking for answers to this question, *TIME* writer David Sheff, who almost lost his son to drug addiction, spoke to Joseph A. Califano, Jr., former Secretary of Health, Education, and Welfare and founder of the National Center on Addiction and Substance. Califano who told Sheff, "The therapeutic community claims a 30% success rate, but they only count people who complete the treatment programs." Califano adds that the other 70-80 percent have dropped out of care contact by the 3-6 month marker.

- Sheff points to outdated philosophies and one-size-fits-all programs as reasons for the ineffectiveness of so many programs. The successful approaches, in Sheff's assessment, "don't rely on best guesses or tradition." Sheff sees hope in treatments that are "evidence-based treatments (EBTs)" and facilities that emphasize research-based therapies, such as Cognitive Behavioral Therapy, Motivational Interviewing, and Contingency Management, in addition to medication.

- **Drug overdoses have become the number one cause of injury-related death in the United States, killing an average of 44,000 people every year, according to Medscape.**

  The Centers for Disease Control estimate that 114 people die a day because of drugs (*TIME* magazine offers a much higher estimate), and 6,748 will be sent to hospital emergency rooms for treatment. While addiction and substance abuse are undoubtedly major problems in the US, a survey conducted by the Substance Abuse and Mental Health Services Administration found that as many as 90 percent of people who most need drug rehab do not receive it. With such a desperate need for solutions, what results can be expected from treatment? What are rehab success rates and statistics?

BARRIERS TO EFFECTIVE AFTERCARE

- Lack of understanding of addiction as a process, disease, ongoing issue beyond residential care
- **By the patient**
    - Client is over confident "I'll never drink/drug again".
        - Client may be going to treatment to avoid legal issues, or to appease the family
        - **By the family**
    - "You said that inpatient treatment was the best option, didn't you fix them?" If we can just get him to treatment, she is pregnant, etc. This is also a break for the family, the community.
    - Behaviors in the family that are cues for relapse (i.e. Holidays, family social drinking, etc.)
- **By providers**
    - Not aware of risks in plans
        - Some meetings are used to score drugs- reality focus
        - Not understanding the patient's needs and not getting buy in
        - Urinalysis (UA), Urine Drug Screens results are effective

BARRIERS TO EFFECTIVE CARE 2

- Early Recovery and Relapse Prevention Challenges
  - Risks are often minimized,
  - “I’ll stay sober if you stay sober”.
  - White knuckle sobriety- holding on too tight to sobriety
  - Recovery burnout- overdoing it, school, work, groups, IOP
- Co-Occurring conditions
  - Untreated Depression, Bipolar DO, Anxiety, etc.
  - Untreated Diabetes, high blood pressure, lungs, heart problems
- Reluctance to engage in sober activities.
  - Stigma of “addict” label.
  - Fear of the unknown
  - Boredom
  - Cannot relax, cannot sleep

WHEN DOES AFTERCARE BEGIN?

- Aftercare begins upon the referral to inpatient treatment
  - Why so soon?
    - It is the first few months after treatment that are the most dangerous time because this is when the risk of relapse is highest.
    - An aftercare treatment plan, including support services in the community, is developed with patient, residential counselor and outpatient Tribal counselor. Possibly family.
    - Allows providers the opportunity to work to create a supportive environment upon the patient's return.
    - It is an opportunity to explore and assess the impact of resources in the community where the member will return.

WHO IS INVOLVED IN AFTERCARE PLANNING?

- Patient
- Patient's family
- Outpatient/Referring Therapist
- Inpatient Therapist & Other Providers
- Spiritual or Cultural Support
- Peer support
- Anyone else?

This is a chance to rally support formally and possibly informally

ASSESSMENT PROCESS

- **5 Pillars Of An Aftercare Program**
- **1. Coping Strategies** how to deal with the emotional and social triggers
- **2. Relapse Prevention** Planning for prevention of relapses is the key to sustaining long-term recovery.
- **3. Goals** In an aftercare program, one of the most important pillars is the opportunity to receive education assistance or vocational training.
- **4. Continued Therapy** These therapy sessions will help you build communication, establish and respect boundaries, and set goals for the future.
- **5. Establishing A Sober Life** Your aftercare program should show you how to develop sober activities and relationships for your new life

TREATMENT PLANNING/REFERRAL PROCESS

- I. outpatient SA counseling plus AA/other
- II. intensive o/p plus AA/other
- III. residential Tx plus aftercare (one of the afore-named)
- IV. intensive medical management

WHEN HOME IS NOT THE BEST PLACE TO RETURN TO

- Limited resources- more specifically limited therapy access, limited jobs, limited healthcare, and possibly limited finances-poverty, or sober social support
- Toxic environment- conflict, gangs, domestic violence
- Ease of return to established patterns

HOW TO ADDRESS LIMITED RESOURCES

- Use of technology
  - Sober apps
  - Telehealth
- Scheduling
  - Daily, weekly, monthly
- Sober contacts
- Creative, individualized activities.
  - Sports, hobbies, fitness, etc.

ASSESSING SUCCESS

- Old school beliefs
  - “He didn’t make it, treatment didn’t work.”
  - “They haven’t suffered enough, or hit bottom yet.”
- Harm reduction- 6 beers instead of a case a day, no drinking while driving, Marijuana card for pain with no more use of alcohol or Meth?
- Measures that can be used to monitor progress
  - Quantitative: # of days sober, graduation, completes probation, etc.
  - Qualitative: Reports feeling happier, increased motivation, family notices increased frustration tolerance, positive reactions to change.

Follow Up and Follow Through

Some programs are sending out letters, 10 years ago this was not being done widely. Gold standard, it gets results. What are your no show rates??

Org chart of your organization needs to include:

- Intake admission counselor
- Counselor to review progress
- Case manager to see them through levels of care
- Aftercare dedicated counselor
- IOP to refer to
- Outpatient for step down to
- Choose a treatment modality with groups and individual for Matrix, White Bison, CBT, DBT for example
- Providers need to be on the same page

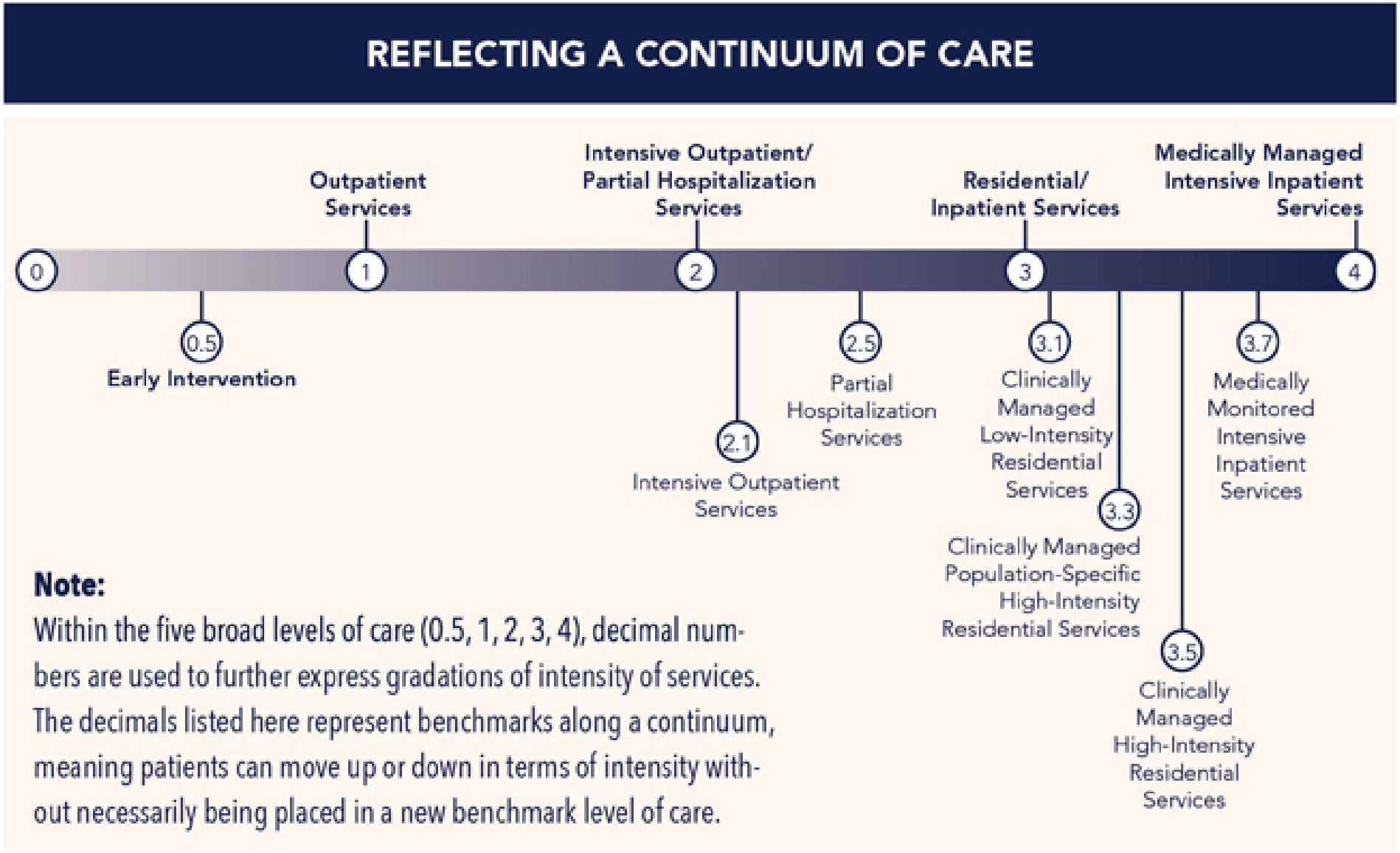
DIMENSIONS OF ASSESSMENT

https://www.asam.org/asam-home-page

At a Glance: The Six Dimensions of Multidimensional Assessment	
ASAM's criteria uses six dimensions to create holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:	
Dimension 1	**Acute Intoxication and/or Withdrawal Potential** Exploring an individual's past and current experiences of substance use and withdrawal
Dimension 2	**Biomedical Conditions and Complications** Exploring an individual's health history and current physical condition
Dimension 3	**Emotional, Behavioral, or Cognitive Conditions and Complications** Exploring an individual's thoughts, emotions, and mental health issues
Dimension 4	**Readiness to Change** Exploring an individual's readiness and interest in changing
Dimension 5	**Relapse, Continued Use, or Continued Problem Potential** Exploring an individual's unique relationship with relapse or continued use or problems
Dimension 6	**Recovery/Living Environment** Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Figure 1. ASAM's Six Dimensions of Multidimensional Assessment

PLACEMENT OPTIONS



DATA ON QUALITY OF AFTERCARE AND RELAPSE RATE

- What is the standard rehab success rate?
- There is no standard definition of rehab, so there is no standardized way to measure the success of addiction centers. Many base their success rates on unreliable metrics, such as:
- Completion of the program
- Sobriety rates immediately after treatment
- Client interviews
- Internal studies
- A better approach involves judging the actual quality of care a facility provides, both during and after the formal treatment period.

-American Addiction Centers

PHOENIX AREA AFTERCARE DATA ANALYSIS

2016-2017 & 2017- 2018

- Please see your handout for a discussion on aftercare tracking, and what it could look like for your community

Aftercare Data Analysis (6/27/2017-5/11/18)							
Patient Discharge Counts in 6/27/2017 and 5/11/2018							
Patient Discharge Year	Count Of Patients						
2018	53						
Total	53						
Count Of After Care treatment Scheduled by Intervals							
Year	30 Days	60 Days	90 Days	6 Months	9 Months	12 Months	Grand Total
2018	45	42	41	27	17	0	172
Grand Total	45	42	41	27	17	0	172
Count of scheduled follow-up by status							
Client Contact Status	30 Days	60 Days	90 Days	6 Months	9 Months	12 Months	Grand Total
No Status	24	23	26	16	10		99
Compliant	15	10	4	1			30
Discharge AMA/ASA		1					1
Discharge Deceased							0
Discharge Moved out of area	2	2	1				5
Discharge Successful			1				1
Discharge Went to prison		1					1
Inactive		3	7	10	7		27
No Contact							0
Non-Compliant	3	1	1				5
Previous-Discharged							0
Discharged from AFT / OPT	1	1	1				3
Grand Total	45	42	41	27	17	0	172

Count of After Care Appts/By Intervals							
Individual Counselling	30 Days	60 Days	90 Days	6 Months	9 Months	12 Months	Total
No	4	7	4	0			15
Yes	17	9	4	1			31
Total	21	16	8	1			46
Group Counselling							
No	19	14	7	1			41
Yes	2	2	1	0			5
Total	21	16	8	1			46
IOP							
No	20	16	8	1			45
Yes	1	0	0	0			1
Total	21	16	8	1			46
Other Services							
No	18	14	8	1			41
Yes	3	2	0	0			5
Total	21	16	8	1			46

Count of After Care Appts/By Intervals							
Client Relapsed							
No	20	14	7	1			42
Yes	1	2	1	0			4
Total	21	16	8	1			46
Client Drug Use							
No	21	16	8	1			46
Yes	0	0	0	0			0
Total	21	16	8	1			46
Alcohol Use							
No	21	16	8	1			46
Yes	0	0	0	0			0
Total	21	16	8	1			46
Other Use							
No	21	16	8	1			46
Yes	0	0	0	0			0
Total	21	16	8	1			46
Support Meetings							
No	15	11	7	1			34
Yes	6	5	1	0			12
Total	21	16	8	1			46
Client Work/School							
No	18	14	7	1			40
Yes	3	2	1	0			6
Total	21	16	8	1			46
Patient New Legal Charge							
No	20	16	8	1			45
Yes	1	0	0	0			1
Total	21	16	8	1			46

Determining Successful Rehab

- With all this in mind, how can – and should – rehab programs be evaluated? Treatment centers should be judged on the quality of the care they provide, even after treatment, not merely the quantity of clients they see. What former clients have to say, via personal recommendations and testimonials, can say much more about a facility than an impressive but ill-defined “90 percent success rate.”
- To that effect, a treatment center that invests in continuing care is likely the kind of place that would truly have its clients’ best interests at heart. Continuing care can be:
- Encouraging clients to attend treatment for longer periods of time
- Helping clients to cultivate roots in an ongoing or long-term support community

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- Facilitating aftercare support, as an extension of the formalized treatment offered by the facility
- Providing education and resources to clients' family members
- Offering different treatment dynamics: individual therapy, group therapy, family therapy sessions, etc.
- Of course, one of the best ways to determine the potential success of a program offered by a treatment center is to ask questions. A center that cannot satisfactorily answer inquiries about how its success rates are calculated (Is it the number of people who merely begin a program? Complete a program? Participate in aftercare?) may not be of the best quality.

-American Addiction Centers

SUPPORT GROUPS 12 STEP

The benefits of 12-step recovery programs include:

The opportunity to connect with other recovering addicts at free meetings and events around the world

Access to motivational speakers and literature to help you reach your recovery goals

Practical guidelines and strategies for coping with the daily challenges of addiction

The guidance of a sponsor who can lead you through the 12 steps, providing strength and motivation

SUPPORT GROUPS- 12 STEP 2

- From the day you decide to seek help for addiction until long after you graduate, 12-step programs offer experience, strength and hope. Many aftercare programs, most notably Alcoholics Anonymous, use the 12-step program structure as a means of staying clean and moving forward. These 12 steps are not for everyone; however, for millions of people around the world, the guiding principles of peer group interaction and “giving into a higher power” have provided relief and accountability for those in recovery.

RELAPSE PREVENTION

Addiction specialists now recognize that relapse is a hallmark symptom of addiction. If you have a co-occurring disorder like depression, anxiety or post-traumatic stress disorder, the temptation to revert to substance abuse to manage your symptoms is even stronger. The primary goal of aftercare is to prevent a relapse into drug or alcohol use. By providing continuing counseling, group sessions and other schedule meetings, aftercare programs provide an extra level of accountability that helps insure that the individual has not fallen back on old habit.

Alcohol Research & Health identifies the following components of an effective relapse prevention program:

Learning about your triggers. There are a lot of environmental, social and psychological factors that can trigger substance abuse. An episode of depression, a flashback to an abusive situation, a conflict in your marriage or a stressful public event may drive you to turn back to drugs or alcohol. As part of relapse prevention, you should learn how to identify these stressors.

Coping with stressors and cravings. After graduating from rehab, you'll be faced with a lot of situations that you may not have considered during treatment. Getting a new job, starting a new relationship or moving to a new home may leave you in an emotionally vulnerable state. Counseling sessions and support groups can help you cope with these high-risk situations.

***Thinking through the outcome of a relapse*.** Many recovering addicts go back to drugs or alcohol with the expectations that these chemicals will make them feel better. In fact, drinking and drugging usually result in unpleasant or dangerous outcomes, such as an overdose, emergent medical treatment, loss of a relationship or incarceration. A relapse prevention plan teaches participants to evaluate the potential outcome of a slip before taking that first drink or picking up drugs.

***Keeping a lapse from turning into a relapse*.** A minor slip doesn't have to turn into a major relapse if you seek help immediately and take steps to get back to your program. Because the chances of relapse are so high, it's important to learn how to cope with the occasional slip if it does occur.

FAMILY INVOLVEMENT AND SUPPORT

- Aftercare programs help provide support and instruction for the family members of recovering addicts. Many times there is still a great deal of tension between the individual and the family, caused by events that occurred during the period of drug use. Other times, the individual is struggling to blend back into a "normal life" which is causing stress for the family. In both these cases, aftercare programs provide counseling and advice for the family to help get them through this difficult time.
- Aftercare services for family members may include:
- One-on-one counseling sessions for partners, spouses or children
- Group therapy meetings for family members
- Educational programs to provide information on the nature of addiction and mental illness
- 12-step programs like Al-Anon or Nar-Anon for the family members of recovering addicts
- Addiction and mental illness can create financial instability in a household as well as emotional conflict. Some families may need assistance with practical needs like job placement, nutritional counseling, childcare or transportation. Others may require education to prevent the younger family members from falling into substance abuse. Creating a healthy home environment for all members of the household is one of the crucial objectives of family aftercare.

TRANSITIONAL PROGRAMS

- After being discharged from an inpatient treatment facility, many individuals with a Dual Diagnosis find that they can make a more comfortable transition if they spend time in a sober living home. These communities offer a structured, secure environment to residents who want to concentrate on their recovery without the temptations and stressors of the outside world. During the aftercare period, a transitional residential community can provide:
- An environment free from drugs or alcohol
- An affordable living situation for recovering addicts who are searching for employment
- Emotional support and encouragement from fellow residents who understand the challenges of Dual Diagnosis recovery
- House meetings to reinforce a sense of fellowship and community
- Transitional communities are less structured than most addiction treatment centers, yet they offer enough supervision to provide a sense of safety for those who still feel too new in sobriety to face the pressures of daily life. Residents are expected to adhere to house curfews, attend household meetings and participate in chores. They are also expected to contribute to the house expenses by paying rent or by doing jobs in the community in exchange for their living expenses

SMART GOALS

- The November 1981 issue of *Management Review* contained a paper by George T. Doran called *There's a **S.M.A.R.T.** way to write management's goals and objectives*.[1][3] It discussed the importance of objectives and the difficulty of setting them.
- ***Specific*** – target a specific area for improvement.
- ***Measurable*** – quantify or at least suggest an indicator of progress.
- ***Assignable*** – specify who will do it.
- ***Realistic*** – state what results can realistically be achieved, given available resources.
- ***Time-related*** – specify when the result(s) can be achieved.

FOCUS GROUP DISCUSSION- TIME ALLOWING

WHAT ARE THE SUBSTANCE ABUSE CHALLENGES THAT YOU ARE SEEING IN YOUR COMMUNITY?

WHAT IS WORKING IN YOUR COMMUNITY FOR AFTERCARE?

WHAT ARE THE NEEDS FOR YOUR COMMUNITY FOR AFTERCARE?

HOW CAN WE WORK TOGETHER TO CREATE A BETTER CONTINUUM OF CARE?

SUMMARY

- What is Aftercare, we did define it
- What Aftercare is not, we discussed it
- Aftercare treatment planning, we are clear on what it should include
- Data on Aftercare, we must generate the data ourselves
- Aftercare resources, we have solutions to barriers that we can pursue
- Aftercare development, we engaged in a focus group identifying needs/what is effective
- Aftercare for current and future patients,

  we discussed what it will look like

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THANK YOU!