American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

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Continuous engagement in treatment and recovery services is one of the most important aspects of addressing acute episodes of severe behavioral health problems and the ongoing disabilities associated with them. Traditionally, fragmentation in systems of care has been common, and the transition from one provider, location, or intensity of service to another has not been prioritized in treatment planning. The authors describe a set of guidelines for maintaining continuity of care that was developed by the American Association of Community Psychiatrists. These guidelines embrace a progressive conceptualization of an integrated service system. For each element of the guidelines, a sample outcome indicator is presented that could be used to measure implementation. These guidelines can be used to help form transition plans, quality improvement initiatives, and program evaluations. (*Psychiatric Services* 55:1271–1275, 2004)

A great deal has been written about the value of continuity of care and the development of "seamless" systems for persons with behavioral health disorders (1–10). We know that, in reality, many of our systems are full of seams and provide only a tenuous connection between service elements. Continuous engagement of treatment and recovery services is one of the most important aspects of addressing acute episodes of severe behavioral health problems and the ongoing disabilities associated with them. Interruption of care, for any reason, is one of the most significant obstacles to establishing a stable recovery (11–14). Continuity of care may be of particular importance to persons with substance use disorders, occurring either alone or in conjunction with another mental illness. Numerous studies have demonstrated the significance of time in treatment to favorable outcomes in substance-using populations (15–19). Also, intuition suggests that persons who have an illness will do better if they are getting help, irrespective of their involvement with substances (5). Despite these clues to the importance of maintaining continuity in services, many service systems remain fragmented; their various components have little communication with one another, and few incentives exist to change this condition (20–23).

A progressive concept of the service continuum

For the past several decades our service systems have made the transition from predominantly institutional-based care to community-based care for persons with severe behavioral health disabilities. The transition has been difficult and is not yet complete (22,24–28). Although service continuums have expanded dramatically during this period, integrating the patchwork of service elements that have developed independently from one another is often unsuccessful. The adoption of long-term planning perspectives and collaborative attitudes in administrative structures has often lagged behind the development of services. Systems often evolve in a manner that furthers their own interests rather than those of the consumers they ostensibly serve. Standard treatment programs have used a one-size-fits-all approach to treatment planning. Clients admitted to these programs are subsequently "discharged" back to the community. The responsibility for maintaining a relationship with treatment is often left to the person who is attempting to recover, despite some understanding that individuals are vulnerable to relapse in the early stages of their recovery (5,18,20). As a result, individuals are often unable to maintain stability after discharge, because they fail to make connections with the services and supports to which they are referred (13).

Clearly, much work remains to create systems that are more responsive to individual needs and the collaborative use of resources. In light of the pervasiveness of cost-conscious financing and management of health services (29,30), it is particularly important that service providers develop

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procedures to ensure smooth transitions between levels of care and various elements of the service system. The American Association of Community Psychiatrists (AACP) developed the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) (31) and the Child and Adolescent LOCUS (CALOCUS) (32) to provide a structure of service arrays of variable intensity that incorporate evolving concepts of levels of care. Rather than using traditional concepts, these documents describe overlapping and integrated levels of resource intensity, which are more conducive to providing true linkages between the phases of treatment. As progressive service arrays that are more progressive begin to evolve and incorporate structural elements that are supportive of continuity, it will be equally important to have quality processes in place to enhance their proper use. In response to these circumstances, the AACP created the guidelines to assist providers and planners in establishing standards for the management of transitions between various levels of care (33).

Critique of traditional terminology

The traditional terminology of discharge planning is counterproductive in establishing continuity of care, because it reinforces the notion of discreet, independent treatment programs that operate in a fragmented system of care. Consequently, discharge terminology implies a termination of service and responsibility rather than a transformation of service variables and a continuation of service in another setting. The terminology also implies that recovery is sufficiently established and stable, so services are no longer required. These concepts often lead to conflict between providers and the development of cracks in the service continuum through which many consumers readily fall.

Transition rather than discharge

Transition planning better captures the concept of continuing care (not aftercare) throughout the episode of illness or service need. Transition terminology implies that all providers and service systems will collaborate as specific aspects of the consumer's treatment plan change or as the consumer transitions from one provider, location, or intensity of service. Transition terminology also implies the ongoing and mutual responsibility of transition partners. Transition planning is required for a successful progression through the service continuum. In most cases the concept of a fully integrated service system remains idealistic; however, the articulation of this ideal is an important element in the reform process.

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Development of the guidelines

The guidelines were developed by the quality management committee of the AACP, consisting of psychiatrists with extensive experience working in a variety of clinical settings, predominantly in public systems of care and with multidisciplinary teams. The elements of transition planning that are identified in the guidelines were informed by clinical experience and information from behavioral health literature and were determined through committee consensus. The guidelines were distributed to providers and consumers of services for review and were revised by the committee according to feedback obtained from these groups. Although this process provides face validity, the AACP guidelines cannot be considered an evidence-based practice at this time. Existing literature is too scarce to support all the identified principles. However, we believe that data-based validation of these guidelines provides a robust agenda for future research.

The guidelines are intended to be more than a simple statement of principles. Rather, they are intended to provide a quality management framework through which systems of any type can continuously monitor and improve their processes for managing client transitions. To integrate the framework provided by the guidelines, organizations must not only endorse the underlying principles in theory but also create methods to measure their implementation. A sample outcome indicator is suggested for each of the principles that are described in this article. These indicators are provided in a generic, unquantified form. When these indicators of achievement are customized and quantified to reflect the specific circumstances of the organization, they will allow for the measurement of adherence to these principles. Although the guidelines will continue to evolve, they are useful in their present form for all elements of the service system. The guidelines can be used to develop standards for contracts by governmental agencies and other purchasers, clinical practice guidelines by regulatory agencies, program standards and quality indicators by program and quality managers, and transition plans by clinicians.

The guidelines are general principles for developing transition plans for persons who use behavioral health services while moving from one level of care to another. The guidelines offer a synopsis of elements that are common to this process, regardless of the setting or the population that is being served. Continuity of care guidelines can only offer a framework to facilitate transitions; plans that incorporate them must be adapted for each individual. The guidelines provide a template for developing standards for transitions in specific circumstances throughout a service system.

Implementation of any set of

guidelines is subject to the availability of resources. Community resources should be conceived of as an array of services and mutual supports that will operate as a unified system of care. If community resources are limited, the transition plan should reflect the most important priorities of the service user. 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 (31) or in the American Society of Addiction Medicine's *Patient Placement Criteria for Treatment of Substance-Related Disorders* (34). Only with an integrated, client-driven, community-based system of care will the ideal planning for level-of-care transitions be achieved.

Prioritization

Transition planning should begin at the time of admission to any level of care and should be part of the treatment plan. Identification of transition needs and the coordination of services required to meet them will be more urgent at intense levels of care.

Outcome indicator. Treatment plans, assessments, and progress documentation demonstrate attention to issues that are likely to be encountered during transitions to new treatment settings or providers.

Comprehensiveness

Transition plans should include all aspects of an individual's service needs. These needs typically include continuing treatment and supportive services, such as case management, child care, housing, transportation, treatment of comorbid health issues, realistic financial supports, and mutual-support networking. In some cases, interface with the legal system, child protection agencies, or family service agencies must be anticipated.

Outcome indicator. All aspects of a service user's needs, as identified in completed assessments, are adequately addressed in the transition plan

Coordination and integration

Persons in transition should not be expected to be responsible for managing complex and multifaceted aspects of their continuing care. All involved service providers should ensure that care is coordinated and integrated as part of the transition planning process. Service users with co-occurring disorders will require special attention to ensure that integrated or tightly coordinated care is in place. Whenever possible, information about the phase of treatment the client is currently completing should be provided to the agency where the client will be continuing care. Appropriate incentives for providers should be developed to achieve this objective.

Transition planning may be one of the most important determinants of outcome yet has received relatively little attention in most service systems and training programs.

Outcome indicator. Significant communication and coordination between all involved service providers are evident through service users' feedback and providers' documentation.

Continuity

All transitions should incorporate relevant elements of any preexisting treatment plan. A comprehensive treatment plan should span the entire course of an episode of illness or disability to provide a degree of continuity as transitions occur.

Outcome indicator. Treatment plans demonstrate awareness of significant aspects of previous treatment plans and build on previous treatment successes.

Service user participation

Having the service user participate in transition planning is critical to the plan's success. Efforts should be made to elicit service users' perspective on the specific difficulties that they anticipate in making the transition and their preferences for services to address these issues.

Outcome indicator. The service user's perspective on the transition and his or her preference for services is documented.

Support system involvement

Family involvement in developing the transition plan is valuable from the time of admission at any level of care. The degree of family involvement may depend on the service user's willingness to include family members in the process, but family members' involvement should be encouraged whenever possible. Other persons in the community who provide support should also be included if the client indicates a desire for their participation.

Outcome indicator. Significant members of the service user's support system are consulted in forming the transition plan, or an effort to obtain their participation is evident.

Respect for the service user's choices

Transition plans must reflect reality and address the client's needs in the most practical way possible. Planners must recognize the phase of illness 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 developed that is as inclusive of the client's wishes as possible.

Outcome indicator. Transition plans will reflect the preferences of the service user even when his or her choices do not coincide with those of the service provider.

Cultural sensitivity

Transitions should be managed in a culturally sensitive manner. In the

broadest sense, an individual's beliefs, customs, and social context must be considered when planning transitions.

Outcome indicator. Cultural issues that are relevant to the transitions are identified and addressed in the transition plan

Prevention

Plans for making a transition from highly structured settings to loosely structured settings should include comprehensive relapse prevention plans that recognize early warning signs. Strategies should be identified that help the consumer avoid reinitiating old, dysfunctional patterns of behavior. For example, financial supports should be administered in a manner that promotes a healthy lifestyle.

Outcome indicator. Early warning signs and factors that contribute to the exacerbation of illness or disability are identified, and transition plans include strategies that minimize their impact.

Access to resources

The transition plan should be designed to maximize the resources that are available to the client for continuing care. Planning should foster self-reliance, although significant support may be required during the client's early stages of recovery.

Outcome indicator. Resources necessary to support the service user during the transition are identified, and arrangements that meet those needs are documented.

Gradual transitions

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

Outcome indicator. Opportunities to expose clients to transitions before the referring entities end their involvement are available and used.

Designation of responsibility

Systems should develop clear protocols that delineate responsibility for the care of clients during transition periods. In most cases, some elements of mutual responsibility between the referring and receiving entities should exist. Concurrent responsibilities are more likely to ensure a smooth transition and continuity of services between levels of care. Reimbursement arrangements should incentivize transition processes that incorporate concurrent responsibilities where appropriate, such as ensuring the service user's awareness of location, time, and contact person for the next scheduled treatment session. The transition plan should ensure that the service user has access to a sufficient quantity of prescribed medication to allow for uninterrupted use between physician contacts. The plan should also guarantee that the service user is aware of whom to contact if the original transition plan needs to be altered, if difficulties arise with obtaining or using medication during the transition period, or if difficulties arise with any other aspect of required services. Finally, the plan should ensure that the service user is aware of the tracking plan and the process that will be initiated to re-engage the service user if unplanned alterations in the plan occur.

Outcome indicator. Contacts are clearly identified during the transition period, and the service user is well informed and able to follow the instructions provided.

Accountability

A mechanism for monitoring outcomes of transition plans and identifying opportunities to improve the process should be in place. This mechanism should identify appropriate quality indicators that can be easily measured with realistic benchmarks. The mechanism should also be able to establish corrective action plans for systems that are unable to meet those quality indicators. In addition, the transition plan should be able to document that all the responsibilities delineated above occurred within appropriate time frames. Furthermore, all stakeholders in the system, including the service user, should have oversight of the quality management process. Finally, standards that have been established should be incorporated into contracts with managed care organizations to ensure proper incentives in reimbursement.

Outcome indicator. A comprehensive process for improving quality is in place.

Special needs

Transition plans must recognize the needs of special populations, including persons with addictions, children and adolescents, older adults, women, and criminal offenders. Incorporating resources to address the needs of these populations is an essential element of successful planning.

Outcome indicator. The transition plan facilitates the recognition of special needs and resources and the processes useful in addressing them.

Conclusions

Transition planning may be one of the most important determinants of outcome; yet it is an aspect of care that has received relatively little attention in most service systems and training programs. Even in social work, which has carried the bulk of responsibility for developing transition plans, exposure to transition planning in most training programs has been limited primarily to field placement. Thus transition planning has been most heavily influenced by prevailing practices. Resource use has also been an issue that has limited comprehensive approaches to transition planning. The emphasis for the past several years has been on short-term savings. Therefore, investments in the types of collaborative and comprehensive planning described in this article are often discouraged, despite the likelihood that such an investment would pay dividends in the long term by reducing recidivism and the use of costly services.

Lack of resources often creates significant barriers to implementing many of these guidelines. To realize the full potential of the resources available, significant system changes must occur. Changes would include financing that is more flexible, delegation of resource management to clinical continuum managers, and clinical systems built around ideas such as those outlined in this article. These changes would allow clinical interventions to build on one another.

As noted earlier, although these guidelines represent expert consensus and, as such, have strong face validity, more research is needed to solidly establish these guidelines as evidence-based practices. Significant

opportunities exist to examine these practices and their impact on clinical outcomes, functional status, quality of life, and cost savings.

For the present, these guidelines are offered as a simple set of standards through which systems can measure the status of their current practices to monitor and improve the quality of transition management for the people they serve. ♦

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