A Person-Centered and Motivational Interviewing Approach to Discharge Planning

By Sarah A. Zucker, PsyD

"You cannot shame or belittle people into changing their behaviors."

– Brené Brown, (2007, p. 1)

The quote above is one of the most important philosophies regarding substance use disorder treatment. It speaks to the value of striving to treat people as autonomous and capable writers of their own stories. Applying this idea can be challenging as a clinician, especially as it pertains to something as critical as discharge planning. In the past, before I was taught how to connect motivational interviewing (MI) and discharge planning, I found discharge planning to be time-consuming, disappointing, and stressful. I also used to think MI was manipulative, inadequate, and meandering. Thankfully, personal and professional experiences led me to a new perspective. I now firmly believe that MI is a compassionate and client-affirming approach to facilitate an effective and value-driven discharge plan.

Discharge Planning

Discharge planning is one of the most important, yet often neglected, aspects in treatment. Research on the topic is also difficult regarding substance use treatment because there is not agreement on what constitutes "recovery" or a successful treatment outcome (White, 2012). Thankfully, discharge planning seems to be receiving increased attention not only in hospital health care, but also in substance use treatment.

When we fall short in residential treatment, it appears to come down to a finite amount of time and resources, which forces us to make difficult decisions about priorities. We end up trying to cram too much material into one treatment episode, not following-up appropriately, and not communicating with other providers. If you don't have the time and staff to effectively discharge plan in substance use treatment, you are doing your clients an epic disservice. We know treatment is just a blip on the radar in the journey to health, and our clients need a lot of support while they transition to their next level of care. That support comes down to a solid discharge plan to which our clients will commit.

Discharge planning is defined simply by Medicare as "[a] process used to decide what a patient needs for a smooth move from one level of care to another" (Levine, 2009). It involves continued and thorough evaluation of patients, extensive discussions with patients or their representatives and family members, in-depth planning for homecoming or transfer of care, appropriate referrals, follow-up scheduling, and ideally aftercare support (Levine, 2009). The research is clear: A good discharge plan can significantly improve health and reduce readmission rates (Wong et al., 2011). Wong et al. also found that increased readmissions were the result of sub-optimal assessment of preparedness for discharge, fractured discharge planning, break downs in communication, lack of sufficient follow-up, or some combination of these factors (2011). You can see how this specifically applies to the world of treatment since our length of stay often gets cut short by insurance denials. This uncertainty means we must implement discharge planning especially efficiently.

Why does a good discharge plan matter? Polcin, D. L., Korcha, R. A., Bond, J., and Galloway, G. (2010) studied outcomes of people residing in some form of sober living after discharge. They found that fellowship and positive social networks were strong predictors of positive outcomes. Additionally, people residing in sober living environments were able to stay stopped more successfully, regardless of many demographic factors. The positive outcomes from sober living were often maintained well after leaving the sober living. Sober living residents also showed improvements on measures of employment, psychiatric symptoms, and arrests at 12 and 18 months.

We also know that of those who do resume use, most do it in the first days and weeks following discharge (White, 2012). White (2012) also noted that treatment effects are less durable than "enduring family and social support within one's natural environment" (p. 4). With so much evidence indicating how important a good discharge plan is, it's no wonder that competent clinicians feel compelled to make one happen. I have gone wrong in the past when trying to force the "perfect" discharge plan. It can be frustrating to see a client headed for disaster after all the hard work they put into treatment. I've inadvertently alienated clients and fallen short on treatment goals when I tried to impose my will on clients. Getting attached to outcome,

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no matter how noble our intentions are, is rarely a fulfilling endeavor. Instead, we can benefit from learning how to let go of our desires and instead listen before moving forward. We also serve our clients best when we remember that our last client is not our next client, and neither client is us. Understanding this helps one to appreciate the collaborative, encouraging, strength-affirming approach of MI.

Motivational Interviewing (MI)

In balancing out our desire to meet treatment goals, we should keep in mind that a favorable evaluation of treatment near the time of discharge has a significant positive correlation with use improvement results (Zhang, Gerstain, & Friedmann, 2008). Also relevant is that many people have more than one treatment episode, and sometimes we are planting seeds rather than making the sweeping changes we'd hope for. Making treatment a space that clients will want to return to if needed is crucial. An MI approach takes all of this into consideration.

We are taught in graduate school to listen, affirm, reflect, interpret, and support. These are important strategies, but we do not always know where we are going. In recovery fellowships, we are taught to share experience, strength, and hope and tell it like it is. The former can lack direction, and the latter can feel simplistic and sanctimonious at times. It was not until a post-doctoral position that I realized that MI is a beautiful melding of these components. It uses a "guiding" style, which is perfectly between following and directing (Miller & Rolnick, 2013). Research shows that a client's motivation for change is significantly influenced by the therapist's relational style (Norcross, 2002), and a therapist's behavior can even "determine a client's noncompliance with change suggestions." (Lundahl & Burke, 2009, p. 1233). Hence, your helpful suggestions could be in vain if your delivery is ineffective or off-putting. Also important is that in MI, the clinician does less than half of the talking (Miller & Rolnick, 2013). Instead, he or she focuses on listening, asking open-ended questions, affirming, reflecting, and summarizing. The spirit of MI is one of partnership, acceptance, compassion, and evocation. MI is a "collaborative conversation, never a lecture or monologue" about change (Miller & Rolnick, 2013, p. 372).

MI started as a more compassionate intervention for substance use disorders, especially alcohol use disorder, and was shown to promote "positive behavioral change" (Motivational Interviewing, 2017). Lundhal et al. (2013) reported in their meta-analysis: "The central implication of our findings is that MI can profitably be delivered by a range of professionals with a minimum investment of time in medical care settings in a variety of formats and time frames for patients of different ages, genders, and ethnicities. Our review suggests medical providers can use MI to help patients exercise more, lose weight, lower HIV viral load, blood pressure and cholesterol, reduce problematic substance use (perhaps even more effectively than in non-medical settings), and boost self-efficacy in their ability to make health-related behavioral changes" (p. 166).

SAMHSA's National Registry of Evidence-based Programs and Practices review found that MI also helps people with problem gambling, increases compliance with various health-related recommendations, and aids people facing academic concerns (Motivational Interviewing, 2017). It is reported that it may be especially helpful for clients who are reluctant to seek treatment (Motivational Interviewing, 2017). Also noted is that it has shown to help those with eating disorders, especially when combined with other treatments (Motivational Interviewing, 2017). MI has also been shown to be effective in engaging clients with mood, anxiety, and psychotic disorders (Romano & Peters, 2015).

For our purposes, MI includes attuning to natural language about change in all conversations with our clients throughout treatment and seeing how we can use our clients' own words and underlying values to increase commitment to a healthy and effective discharge plan. MI is best used when our clients are ambivalent or torn between making a change and sustaining a behavior. It can be used in short bursts throughout treatment anytime sustain talk arises in order to help the client. MI is special because we can have difficult conversations without putting our clients on the defense. It allows the clients to have and express their understandably mixed feelings (ambivalence) about making big decisions regarding discharge, while gently guiding them to act in accordance with their value of recovery. (Even the most hesitant client has typically come to treatment by making a choice, so there is almost always a kernel of underlying motivation.) MI posits that arguments for healthy change are already within us, which is in contrast to previous notions about people presenting to treatment.

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Below are some client-centered and MI-congruent suggestions for discharge planning in substance use treatment.

- Examine your own countertransference and notice sources of discomfort. Your journey is not your client's journey. Having personal experience with addiction and treatment can be very helpful to our clients, but it can also do them a disservice when we are overly identified with our path to recovery. Recovery means many different things to many different people, and we should let our clients' definitions guide us. They will know if their plan is working or not, and we will be there for them if things go astray.
- Utilizing an MI-style does not mean that you cannot give blunt, honest feedback. This may apply if you notice problems in a discharge plan and want to express concern. That's a very important part of our job. Being directive, at the right time and in the right manner, is inherent in MI. Being direct involves asking for permission, offering feedback, and giving non-judgmental observations. It may look like this: "Can I give you some feedback? I'm very concerned because you're returning to your apartment with your roommate who uses. You've also expressed that you want to stay sober no matter what. Can we make sure you're thinking this through?" An MI-consistent format for doing this is asking an open-ended question, making a brief statement, and then asking another open-ended question. Lastly, we must be prepared for our clients to say "no" when asked if we can provide feedback. (I have not had this happen because just asking permission has proven disarming, but if someone said no, I would ask to revisit the topic at a later time or just accept the "no" and affirm the client for being assertive. You can always look for an opening later, but chances are the rapport needs work.)
- Everyone, from the outreach team to the resident assistants, are part of treatment. Every staff member can act in the spirit of MI and influence a solid discharge plan in their own appropriate way. All staff members can be trained in an MI-consistent, respectful approach, which facilitates an atmosphere of warmth and openness. The clients spend a lot more time with the resident assistant staff and the nurses than they do with the therapists (even though we see our clients for four hours or more of therapy per day), and they are invaluable members of the treatment team.
- Individualize all discharge plans and respect cultural considerations. A good discharge plan does nothing for your client if they do not plan to follow through on it. Our clients are not "just" substance users – they have various identities that intersect to create their unique place in the world. Clinicians, especially clinicians with various privileges, should always consider how being marginalized and discriminated against has affected clients. Socioeconomic status should be factored into discharge planning, and financial considerations should be strongly considered. Clients should not have to go broke to remain sober. Therefore, we do the best that we can within the confines of reality when it comes to discharge planning. We also best serve our clients when we have a keen understanding of their barriers to change.
- Affirm strengths. Too many times, a client walks through the door crestfallen after resuming substance use. They consider their previous period of sobriety an abject failure because it was not perfect and infinite. Anytime clients are more functional, more content, healthier, and living how they wish to be living, we can see strength. So much had to go right for the client to maintain a period of abstinence or reduced use, and there is much to affirm about returning to treatment after a lapse. We try to encourage clients to see things in shades of grey and we want them to be able to identify what they did right after previous treatment episodes. This also allows them space to see where they fell short and what needs to be different this time in order to maintain their recovery. Clients will need to draw on an internal reservoir of strength when making tough decisions after discharge, and authentic affirmations during treatment can build resilience. Recovery and addiction is more fluid than previously thought, so we can serve our clients by honoring their progress, not perfection.
- The language you use matters. MI does not label clients as "in denial" or "oppositional." It looks at client "resistance" within the context of the therapist putting the client on the defense via their confrontational delivery. A client-centered approach advocates for person-first, professional language. Labeling clients as "addicts" or "alcoholics" or "substance abusers" can force an unwanted label on a client. Clients should be given the opportunity to self-identify. Just as we no longer call people with Borderline Personality Disorder "Borderlines," we can use person-first language by referring to our clients as people "with substance use disorders" or "ineffective behaviors." Destigmatizing our clients helps them in the larger community and lends validity to the idea that a substance use disorder is a condition someone has, not what they are. Using professional language is important not only in front of clients and in the community, but also amongst colleagues in private meetings.
- Practice good self-care. Sometimes I think we forget just how hard it is to be new in recovery. Our clients need our compassion, knowledge, and unconditional positive regard. We highlight the importance of self-care to our clients, and we often neglect ourselves. This leads to decreased empathic bandwidth. Discharge planning and investing in our clients is inherently stressful, and consulting and supporting one another is imperative to doing good work. Don't neglect your own therapy or fellowships. We need a lot of our own support in order to avoid burnout.

Finally, it really helps to continue your education and keep up with current research. Be curious. We needn't be afraid of change and what works will prove itself over time. If we all work collaboratively, we can add to the legitimacy of our field, continue to improve our interventions, and be of maximum service.

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