

Leaving inpatient rehab can bring relief, hope, and a surprising amount of uncertainty. The structured environment is ending, but recovery continues in the routines, relationships, and decisions of everyday life. A good **transition home** plan helps bridge that gap. It turns “keep getting support” into specific next steps: who to contact, when the next appointment is, how to get there, and what to do when a difficult evening arrives.

Discharge planning should begin before the day you leave. You do not need every detail of the future figured out. You do need a workable first plan, a few backup options, and names and numbers you can use. This guide explains what to include, with attention to continuity of care, transportation, living arrangements, and common challenges in the first days at home.

What a transition home plan is—and what it is not

A transition plan is a practical handoff from residential treatment to the next phase of care. It should connect the work done in rehab with the support available after discharge. That may include outpatient therapy, medication follow-up, peer or recovery meetings, case management, primary care, or another level of treatment recommended by your care team.

It is not simply a list of referrals. A list that says “find a therapist” leaves you to make calls, compare availability, arrange transportation, and solve problems while adjusting to home. A stronger plan identifies the next action, the person responsible for it, and what happens if the first option is unavailable.

Programs differ in what they provide. Ask your treatment team which arrangements they can make directly and which you or your support person will need to handle. For example, Aura Recovery Center’s website, aurarecoverycenter.com, can be one place to review program information and contact options. Confirm details with the provider rather than relying on a webpage to answer questions about your individual discharge needs.

1. Put continuity of care on the calendar

The most important question to answer before discharge is: **What is the next appointment, and how will I get there?** Whenever possible, schedule the first follow-up visit before leaving inpatient care. Write down the date, time, provider or clinic, address or video link, and phone number. If the appointment is not booked yet, record who will call, by what date, and what to do if there is no response.

Continuity of care may involve several providers. Your discharge plan should make clear which person is responsible for each part of care and how information will be shared—with your permission. Common follow-up needs include:

- Appointments with a therapist, counselor, or outpatient treatment program.
- Medication management, including how and when prescriptions will be refilled.
- Primary care or specialist visits for ongoing health needs.
- Peer support, recovery meetings, or other community-based support.
- Case management for housing, benefits, work, education, or other practical concerns.

Ask the residential team to send relevant records or a discharge summary to the next provider, following the required consent process. If you take medication, make sure you understand the instructions, have enough medication to bridge the time until follow-up, and know whom to call with questions. Do not change or stop medication without guidance from a qualified clinician.

For veterans, the U.S. Department of Veterans Affairs provides information about residential mental health services on its VA Mental Health Residential Rehabilitation page. Veterans and family members can use it as a starting point for learning about VA residential programs and services. Eligibility, availability, and next steps depend on individual circumstances, so contact the VA or your care team to confirm what applies.

2. Make transportation and living arrangements realistic

A follow-up appointment is only useful if you can get to it. Include a **transportation plan** for the first appointment and for recurring care. “I’ll figure out a ride” is not a plan. Specify the driver, transit route, ride service, pickup time, cost, and a backup. If the appointment is by video, check that you have a private place, a working device, and a reliable internet connection.

Need Plan to write down Backup question First follow-up visit Date, time, address or link, contact number Who will you call if the provider cancels? Transportation Driver or route, departure time, fare or cost What is the second way to get there? Medication Prescription, pharmacy, refill date, prescriber Who can help if the pharmacy cannot fill it? Living arrangements Address, household expectations, safe contacts Where can you go if the arrangement becomes unsafe?

Living arrangements deserve direct discussion. Consider whether the home is stable, whether people there will respect your recovery boundaries, and whether substances or other triggers are present. If you will be staying with family or friends, agree on practical details: where you will sleep, how long the arrangement is expected to last, how household concerns will be raised, and who to contact if conflict escalates.

Family involvement can help when it is wanted and appropriate, but it should not be assumed. Ask the person leaving treatment whom they want involved and what information they consent to share. A support person can offer a specific ride, help make a call, or join a planning conversation—without being made responsible for managing someone else’s recovery.



If the planned home is not stable or safe, raise that before discharge. Ask your case manager or treatment team to discuss alternatives such as recovery housing, temporary accommodation, or local housing resources. Confirm eligibility, costs, availability, and move-in dates rather than relying on a referral alone.

3. Build routines for triggers and hard evenings

Home can bring back familiar routines, relationships, and stressors. A plan for triggers should be specific and personal. Talk with your counselor about situations that tend to raise risk—such as conflict, loneliness, access to substances, certain places, pain, boredom, or contact with particular people. The goal is not to promise that difficult feelings will not happen. It is to decide what you can do when they do.

For each likely trigger, write down a first action and a person or service to contact. For example: “If I feel overwhelmed after work, I will leave the room, call my peer support contact, and go to the evening meeting at 7 p.m.” Make sure the plan includes options you can use outside office hours. If you are experiencing a medical emergency or immediate danger, contact local emergency services.

[first week after rehab tips](#)

Evenings can be especially challenging because structure and staff support may suddenly be less available. A simple evening routine might include a meal, a scheduled check-in, a recovery activity, and a consistent bedtime. Keep it realistic: a few predictable steps are more useful than a packed schedule that is hard to maintain.

Try a simple three-step plan

1. **Notice:** Name what is happening—such as an urge, anxious thought, argument, or feeling of isolation.
2. **Take one planned action:** Use a coping skill, change your surroundings, attend a meeting, or contact someone you have chosen.
3. **Get more help if needed:** Contact your clinician, crisis resource, or emergency service based on the level of risk.

Put key numbers where they are easy to find, not only in an email or a phone contact list you may not be able to access. Include your outpatient provider, pharmacy, chosen support contacts, and relevant crisis or emergency resources. Ask your care team to help identify the right services for your location and circumstances.

A practical discharge checklist

Before leaving, review these items with your discharge coordinator, case manager, or another member of the care team:



- The next appointment is booked—or there is a named person and deadline for booking it.

- You have the provider's name, phone number, address or video instructions, and appointment time.
- You know how you will get to care and what your backup transportation option is.
- You understand your medication instructions, have access to prescribed medication, and know who handles refills.
- Your living arrangements are confirmed, including a backup plan if the home is not workable.
- You have identified likely triggers and written down actions for difficult moments, including evenings.
- You know how to reach after-hours help and what to do in an emergency.
- You know which records or information will be shared with your next providers and have discussed consent.

News and information sources may discuss treatment and recovery at a broad level, but a general article cannot determine what services are available in your area or what is right for you. If you read coverage from outlets such as Israel National News, treat it as general information—not a substitute for an individualized discharge conversation with your clinical team.

What to do if the appointment falls through

Plans can change: a clinic may have no openings, an appointment may be canceled, or transportation may fail. Decide in advance how you will respond instead of treating a setback as the end of the plan.

1. **Call the provider or clinic promptly.** Ask for the earliest available appointment, a cancellation list, and any short-term option they recommend. Write down the name of the person you spoke with and the date.
2. **Contact the discharge coordinator or referring clinician.** Tell them what fell through and ask which alternate provider or service they recommend. If your medication supply or safety is at risk, say that clearly.
3. **Use the backup you prepared.** Arrange alternate transportation, contact the next provider on your list, or use the appropriate after-hours or urgent service. Keep working toward a replacement appointment with a date and contact name.

If you need to call multiple providers, make a short list with the organization, phone number, date called, result, and next step. This prevents repeated guesswork and helps a case manager see what still needs attention.

The first weeks are for adjustment, not perfection

A strong transition home plan gives you structure without pretending that every day will go as expected. It connects residential treatment to the next provider, turns transportation and living arrangements into concrete decisions, and makes room for the triggers and quiet evenings that can catch people off guard.

Before discharge, ask for a brief review of the plan with the people who will use it. Read it back: the next appointment, the ride, where you will stay, the evening routine, and who to call if something changes. If any step has no date, name, or phone number, ask how it will be completed. The goal is a workable start at home—and a clear path to the next source of care.