Training Handout: Individual Therapist Discharge Plan Example

Purpose

This discharge plan provides an example of how an individual behavioral health therapist may formally document discharge planning for a member, using the accompanying scenario. It reflects collaborative, data-informed decision-making integrated throughout treatment.

Member Scenario

Presenting Situation

A 34-year-old woman is engaged in behavioral health treatment for co-occurring Alcohol Use Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder. She also manages diabetes through primary care.

Due to concerns related to substance use and stability, her child was removed from the home and is currently in the care of the member's mother. The member is working toward reunification while stabilizing recovery, mental health symptoms, and medical needs.

Member Status at Time of Discharge

Over the past six months, the member's treatment plan and service package were continuously reviewed and updated based on clinical progress and stability. At the time of discharge, the member demonstrates:

- One year of sobriety, with substance use disorder in remission
- Significant reduction in depression and anxiety symptoms
- Consistent use of coping skills to manage stress and emotional regulation
- Increased stability across functioning domains

Discharge Criteria Met

The member met the discharge criteria that were collaboratively established at intake. Discharge readiness was confirmed based on the following outcomes:

- Regained custody of her daughter
- Established a reliable transportation plan until she is able to drive independently
- Reduction of anxiety and depression symptoms from a reported 9/10 to approximately a 3/10 on most days

- Demonstrated consistent and effective use of coping skills to manage symptoms

These criteria were reviewed with the member and verified through clinical observation, self-report, and updated screening tools.

Provider Documentation Tip: Clearly link discharge criteria back to those identified at intake to demonstrate medical necessity resolution and continuity of care.

Service Review and Level of Care Adjustments

As the member demonstrated sustained progress and effective symptom management, services were gradually titrated to reflect her level of stability:

- Individual therapy decreased from weekly to monthly sessions
- Targeted Case Management decreased from weekly to monthly sessions

The member continued to show progress and maintained stability at this reduced level of care.

Provider Documentation Tip: Document service titration decisions and the member's response to reduced frequency to support appropriate step-down and discharge determinations.

Discharge Decision and Care Team Coordination

During a recent care team meeting, providers reviewed clinical progress, service utilization, and updated screening results. Based on this review, the care team collaboratively determined the member was appropriate for discharge.

The therapist and case manager met with the member to:

- Review treatment goals and documented progress
- Complete updated screening tools
- Update the treatment plan to reflect discharge readiness
- Collaboratively finalize the discharge plan

Provider Documentation Tip: Include screening scores, dates completed, and clinical interpretation in the discharge note when applicable.

Discharge Plan Components

Member Education

The member received education related to:

- Depression, anxiety, and alcohol use disorder
- Co-occurring disorders and how symptoms may interact

The member verbalized understanding of her primary warning signs, including:

- Increased cravings to drink
- Spending more time in bed than usual
- Persistent feelings of panic most days of the week
- Feeling overwhelmed or out of control

Provider Documentation Tip: Use the member's own language when documenting warning signs to demonstrate engagement and understanding.

Coping Skills and Self-Care Plan

The member identified and demonstrated effective self-care strategies, including:

- Use of go-to coping skills with reminders programmed in her phone
- Completion of a weekly reflective journal entry
- Daily use of a meditation app each morning to support emotional regulation

Provider Documentation Tip: Document both skill acquisition and the member's ability to independently use skills outside of sessions.

Medical and Behavioral Health Follow-Up

Post-discharge follow-up care includes:

- Psychiatric appointments every six months to evaluate ongoing need for anxiety medication
- Outreach to a therapist or case manager as needed if new concerns arise
- Primary care follow-up for diabetes management

The member demonstrated understanding of how to contact the agency, schedule appointments, and access services if needed.

Provider Documentation Tip: Clearly indicate follow-up frequency, provider type, and member understanding of access procedures.

Crisis and Safety Planning

The member was provided with:

- Agency contact information for routine concerns
- Crisis phone numbers for urgent or emergent needs

The member verbalized understanding of when and how to utilize crisis supports.

Provider Documentation Tip: Note that crisis resources were reviewed and that the member can verbalize appropriate use.

Natural and Community Supports

The member identified the following ongoing supports:

- Attendance at AA meetings twice per week
- Ongoing engagement with her sponsor
- Participation in a monthly moms' group through her church
- Support from her mother for childcare
- Assistance from two neighbors with childcare and transportation until she is able to drive again

Provider Documentation Tip: Natural supports should be named specifically to show strength-based planning and sustainability after discharge.

Relapse Prevention Plan

The relapse prevention plan was reviewed and finalized, addressing:

- Triggers and early warning signs
- Coping strategies and protective factors
- Natural, community, and professional supports

Provider Documentation Tip: Ensure relapse prevention aligns with identified diagnoses and co-occurring conditions.

Discharge Justification

Based on comprehensive clinical review, the member no longer meets medical necessity criteria for the current level of care. Discharge is clinically appropriate and supported by the following factors:

- Treatment goals identified at intake have been met or substantially achieved
- Symptoms of depression and anxiety have stabilized at a reduced and manageable level
- The member demonstrates sustained sobriety and effective relapse prevention strategies
- The member consistently utilizes coping skills and natural supports independently
- Services were successfully titrated without symptom exacerbation or functional decline
- Ongoing needs can be safely managed through natural supports, community resources, and routine outpatient medical follow-up

The member participated actively in the discharge decision-making process and agreed with the discharge plan.

Provider Documentation Tip: Clearly state why continued services are no longer medically necessary and how the member can safely maintain progress after discharge.

Discharge Summary

This discharge plan reflects a collaborative, strengths-based approach grounded in ongoing assessment and member participation. The member demonstrated readiness for discharge and the ability to maintain progress using identified skills and supports following the conclusion of services.