DSAMH Discharge from Services

Division of Substance Abuse and Mental Health (DSAMH)

Policy Number: DSAMH013
Date Issued: 08/14/2019
Dates Reviewed: 09/28/2022; 09/26/2023; 10/21/2024; 10/30/2025; 10/21/2026
Dates Revised: 10/03/2022; 08/30/2023; 10/16/2024; 10/15/2025; 10/07/2026
Prepared By: DSAMH Policy Committee
Applicability:

1. DSAMH-Operated Programs
2. DSAMH State Providers

Approved By: Joanna Champney, Division Director



Date Signed: October 22, 2026

I. PURPOSE

The purpose of this policy is to identify the required procedures for discharge from services delivered by DSAMH-operated and DSAMH-contracted providers.

II. POLICY STATEMENT

It is the policy of DSAMH to require that all DSAMH-contracted and DSAMH-operated service providers adhere to discharge planning standards established by the Division. This policy applies to clients who have become disconnected or disengaged from services, those who have intentionally made the decision to withdraw from services, individuals who have been discharged because goals were met, or for other reasons where continuation of services is no longer appropriate.

III. DEFINITIONS

"ACT" means Assertive Community Treatment team.

"ACT Plus" means an enhanced ACT program that allows for additional services.

"ICM" means Intensive Case Management team.

"PROMISE" means Promoting Optimal Mental Health for Individuals Through Supports and Empowerment

"Warm Hand-Off" means a transfer of care between two staff from within the same or different agencies, where the transfer occurs with the active involvement of the client and/or family. This transparent transfer of care engages clients and families in communication, allowing them to clarify or correct information or ask questions about their care. It also gives the receiving provider critical information.

IV. SCOPE

This policy applies to all DSAMH-operated and DSAMH-contracted programs.

V. PROCEDURES/RESPONSIBILITIES

A. Providers of behavioral health treatment should adhere to the following principles regarding the successful implementation of discharge and aftercare planning:
   1. Discharge planning begins at admission with the goal of stable community reintegration. This includes addressing social determinants of health that may not be directly related to behavioral health needs;
   2. Planning must be individualized, comprehensive, and coordinated with other community-based services including a warm hand-off;
   3. Clients shall be offered the opportunity to participate in the discharge planning when available;
   4. Discharge plans should include appropriate ongoing treatment and natural supports;
   5. Clients should be educated about appropriate resources based on their needs;
   6. Client should be connected to a primary care provider to monitor and address any potential or existing medical issues;
   7. Discharge planning should include plans for stable housing to prevent vulnerable clients from becoming homeless or involved in the criminal justice system, as appropriate;
   8. Discharge planning should address transportation needs to facilitate clients attending their post-discharge appointments, as appropriate;
   9. Discharges to emergency shelters should be used as a last resort, after all other options have been exhausted;
   10. Discharges to homeless programs that have 24-hour transitional programs may be made on a case-by-case basis;
   11. Discharges to independent housing and other types of supportive housing models are preferred; and
   12. Planning shall assist clients with re-entry to the community.

B. Service providers shall have a uniform, written, discharge planning process.

C. Programs shall develop discharge plans consistent with the level of care. At a minimum, documentation must include the following elements:
   1. Client's name, discharge address, and phone number;
   2. Admission and discharge dates;

3. Summary of the client's progress toward treatment plan objectives;
4. Summary of client's participation in treatment;
5. Any unresolved issues including information related to client's ongoing concerns, needs not addressed during treatment, and client's plan to address ongoing needs, including scheduled appointment times, locations, and name of providers the client is scheduled to meet with post-discharge;
6. Reason for client's discharge including whether the discharge was voluntary or involuntary; and
7. Recommendations regarding the need for additional treatment services including referrals provided.

D. If the client is able to be contacted at the time of discharge, the client shall receive written discharge documents that include the following information:
   1. A transfer summary, if transferring to another level of care, which should accompany the client to any other facility or program;
   2. The client's medications if prescribed by the discharging provider;
   3. Appointment times, locations, and name of providers the client is scheduled to meet with post-discharge;
   4. Documentation of transportation arrangements post-discharge;
   5. Contact information for other service providers the client may use to support living in the community;
   6. A list of referred and deferred goals following discharge from treatment;
   7. If required by program standards, the client's crisis plan created with the direct involvement of the client;
   8. Referrals for all aspects of treatment and care in community, including the filling of medication and information on how to access; and
   9. Assistance with ensuring client has proper identification documents needed to successfully live in the community, if required by program standards.
E. Providers discharging clients from ICM, ACT, or ACT Plus shall also complete the following steps:
   1. Coordinate discharge with the assigned PROMISE Care Manager and develop an agreed upon discharge plan.
   2. The provider shall complete and submit all required discharge documentation to the assigned PROMISE Care Manager identified in the agreed-upon discharge plan.
   3. PROMISE Care Manager shall ensure all discharge documentation is uploaded to the client's clinical record.
   4. PROMISE Care Management team shall notify the Eligibility and Enrollment Unit (EEU) of provider discharges via their internal process.
   5. A provider discharge is not a discharge from PROMISE services.

VI. POLICY LIFESPAN

This policy will be reviewed annually.

VII. REFERENCES

A. DHSS PM 66 - Discharge/Transition Practices/Guidelines

VIII. RESOURCES

A. N/A

IX. RELATED POLICIES

A. N/A