Treatment Plan Template and Tips

- PRIOR to writing up your treatment plan, schedule a session with guardians and/or client to discuss treatment planning, treatment goals, your approach to therapy and what therapy tends to look like (**See attached description from Therapist Aid**). Make sure that you have a corresponding Comp. Community Support note for this.
- Treatment plans are updated every 6 months. The first plan is the "Initial" (click corresponding button). For subsequent 6-month reviews, you will click the "Review" button. If you need to make any corrections outside of the 6-month review, that will be an "Update."
- When entering plan END date, the easiest thing to do is google "what is 180 days from today," then plug in that date. I always do the plan start time as 12:00am and the plan end time as 11:59pm – that's just a personal preference.
- STRENGTHS: These are protective factors, values and traits that the family and client have that allow them to thrive and/or participate meaningful in therapy. E.g. Client has attuned and committed parents who co-parent effectively. Client is able to accept care and support from family and community members. Client is willing and motivated to participate in therapy. Client is connected to his community – attends church regularly and participates in extracurricular activities. Client is able to makes friends easily and is currently in a supportive, age-appropriate romantic relationship.
- CHALLENGES: These are risk factors or circumstances/symptoms that may inhibit progress in therapy or exacerbate current symptom presentation. E.g. Client has a tumultuous relationship with foster parents, who are not supportive of gender identity. Client uses substances. Guardians use substances. Client is often isolated, and has few community or familial connections. Client is skeptical of therapy and is hesitant to engage.
- DISCHARGE PLANNING: this is a cut & paste most often: "Client will discharge from services once treatment goals are met and/or client/family feel as though client has adequate coping skills to manage symptoms and life transitions."

Problem: This should be very short and reflect the primary working diagnosis. E.g (for a client diagnosed with depressive disorder, unspecified) *Client experiences symptoms of depression including sadness, loneliness, thoughts/feelings of being a burden on her parents, thoughts of suicide, self-harm, and feelings of guilt related to a peer's death* (this can be directly lifted from the client's initial assessment – but you don't need to add everything; you can summarize). Even if the client has multiple diagnoses, the identified "problem" should ONLY be those symptoms that you are treating in therapy. For example, if the client also has an autism spectrum disorder, but is receiving occupational therapy from another community provider, this would not be included in your treatment plan.

Goal: Client's depressive symptoms will reduce in frequency and intensity to manageable levels, improving functioning at school, in the community and at home.

- **SMART** [objectives] use 5 criteria to help guide the process of setting an effective [objective]. These criteria include: *Specific, Measurable, Achievable, Relevant, and Time-Bound.*

Objective 1: All adults and supports in client's life will be in contact at least 1x/month for the next 6 months in order to coordinate care across all life domains

Objective 2: Client will engage in exploration of emotional experience, ultimately being able to identify [you can add a number here] core emotions, and explore at least three contributing factors/triggers to depression, as reported by client, caregivers, school staff and providers, within the next 6 months.

Objective 3: Client will implement and practice new coping skills in 3 out of every 5 instances [or 75% of the time] so that she is able to manage depression as reported by client, caregivers, school staff and providers, within the next 6 months.

Objective 4: Client will engage in medication management services at least 1x/month (or as needed) in order to mitigate symptoms of depression for the next 6 months. [only use this objective if client is enrolled in medication management services].

Other Possible Objectives: Supportive adults will increase understanding of the client's depression, its causes, and treatment strategies by 50%, over the next 6 months.

Client will attend at least 2 pro-social activities/events per week for the next 6 months.

Interventions:

COMPREHENSIVE COMMUNITY SUPPORT: This therapist will maintain open and consistent communication with identified adults, medical staff, and school staff to coordinate and ensure Client's needs are understood and met; psychoeducation materials will be provided as necessary.

FAMILY: This therapist will support Client's guardian(s) in increasing attachment and closeness, identifying helpful communication patterns, setting boundaries/limits, and allowing opportunity to express feelings; psychoeducation materials will be provided as necessary.

INDIVIDUAL/GROUP: This therapist will actively build/maintain the level of trust with client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance in order to support her in increasing her ability to identify and express emotions and concerns.

INDIVIDUAL/GROUP: Therapist will utilize CBT, DBT, strength-based, art therapy interventions, and mindfulness-based techniques to assist Client in developing healthy coping and cognitive patterns about self, others, and the world that serve to alleviate depressive symptoms.

INDIVIDUAL/GROUP: This therapist will assist Client in identifying triggers to his depression, as well as current unmet emotional needs; Therapist will work with Client to develop communication skills needed to express these needs to safe supports around him.

FSS: Family Support Specialist (FSS) will engage client in his home, school, and other community environments with solution-focused and strengths-based interactions (modeling, role-playing, behavior rehearsal) for the purposes of reinforcing treatment goals, e.g. increasing his self-awareness and ability to manage mood/behavior in various settings.

MEDICATION MANAGEMENT: Treatment team will collaborate regarding client's presenting mental health needs, symptoms and response to medication management; client will take medications as prescribed and attend scheduled follow-up appointments; psychoeducation materials will be provided as necessary.

- AFTER you complete and sign your treatment plan/review, schedule another session with family/client to discuss this treatment plan and offer them a copy of the plan. Due to Telehealth, I have been obtaining a "verbal signature" on the treatment plan (I just write "obtained signature verbally" on such and such date on the appropriate signature line. **See Treatment plan Signature Page attached.** Once you get signature, then scan/email form to Admin and they will upload to client's ECR. Make sure that you have a corresponding Comp. Community Support note for this.