Standard Treatment Plan Guidelines

Psychology Treatment and Diagnostics Board

Professional Standards for Mental Health Treatment Planning

I. Overview and Purpose

This document establishes standardized guidelines for developing, implementing, and monitoring psychological treatment plans. All mental health professionals must adhere to these standards to ensure quality, consistency, and ethical treatment delivery.

> **Required Components:** Every treatment plan must include all sections outlined in this document. Incomplete treatment plans may not be implemented without supervisor approval.

II. Treatment Plan Structure

A. Client Information Header

```
Client Name: _________________ Date of Birth: ________ ID#: ________
Primary Therapist: _________________ Supervisor: _________________ Date
Created: ________ Review Date: ________ Next Update: ________
Insurance/Payment: _________________ Emergency Contact: _________________
```

B. Assessment Summary

- **Presenting Problem:** Clear, objective description of client's primary concerns
- **Diagnostic Formulation:** DSM-5 diagnosis with specifiers and severity ratings
- **Risk Assessment:** Suicide, homicide, and safety risk evaluation
- **Functional Assessment:** Current level of functioning across domains
- **Strengths and Resources:** Client assets, support systems, and protective factors

C. Treatment Goals

SMART Goals Criteria:

- **Specific:** Clearly defined behavioral outcomes
- **Measurable:** Quantifiable progress indicators
- **Achievable:** Realistic given client's current functioning
- **Relevant:** Directly addresses presenting problems
- **Time-bound:** Specific target dates for achievement

Goal Categories:

- **Long-term Goals:** Major treatment outcomes (6-12 months)
- **Short-term Objectives:** Stepping stones to long-term goals (2-8 weeks)
- **Session Goals:** Weekly therapeutic targets

III. Intervention Strategies

A. Primary Treatment Modalities

- **Evidence-Based Approaches:** Must cite research support for chosen interventions
- **Theoretical Orientation:** Clear rationale for treatment approach
- **Frequency and Duration:** Session schedule and estimated treatment length
- **Treatment Setting:** Individual, group, family, or combination

B. Specific Interventions

```
Intervention 1: _________________ Target Symptoms: _________________
Implementation Method: _________________ Expected Outcome:
_________________ Timeline: _________________ Intervention 2:
_________________ Target Symptoms: _________________ Implementation
Method: _________________ Expected Outcome: _________________ Timeline:
_________________
```

C. Adjunctive Services

- Psychiatric consultation and medication management
- Case management and social services
- Medical evaluations and coordination
- Educational or vocational support
- Family therapy or couples counseling

IV. Progress Monitoring

A. Measurement Tools

- **Standardized Assessments:** Use validated instruments (PHQ-9, GAD-7, etc.)
- **Behavioral Observations:** Objective tracking of target behaviors
- **Self-Report Measures:** Client's subjective experience and ratings
- **Functional Indicators:** Work, school, relationship, and daily living metrics

B. Review Schedule

Mandatory Review Intervals:

- Initial review: 2-4 weeks after treatment initiation
- Regular reviews: Every 4-6 weeks during active treatment
- Crisis reviews: Within 24-48 hours of significant events
- Insurance reviews: As required by payer guidelines
- Discharge planning: 2-4 weeks before anticipated termination

V. Documentation Requirements

A. Session Notes

- **SOAP Format:** Subjective, Objective, Assessment, Plan
- **Progress Documentation:** Movement toward goals and objectives
- **Intervention Records:** Techniques used and client response
- **Risk Updates:** Any changes in safety or risk factors

B. Treatment Plan Updates

```
Update Date: _________ Updated By: _________________ Changes Made: ☐
Goals modified ☐ Interventions changed ☐ Frequency adjusted ☐ Diagnosis
updated ☐ Risk level changed ☐ Discharge planning Rationale for
Changes: ____________________________________________________
_____________________________________________ Client Agreement: ☐
Yes ☐ No Signature: _________________
```

VI. Ethical and Legal Considerations

A. Informed Consent

- Treatment goals and methods clearly explained
- Risks and benefits discussed
- Alternative treatments presented
- Confidentiality limits outlined
- Client rights and responsibilities reviewed

B. Confidentiality and Privacy

- **HIPAA Compliance:** All documentation must meet privacy standards
- **Mandated Reporting:** Clear procedures for duty to warn/protect
- **Record Security:** Secure storage and access controls
- **Information Sharing:** Written consent required for releases

C. Cultural Competency

- Cultural formulation included in assessment
- Culturally adapted interventions when appropriate
- Language and communication preferences considered
- Religious and spiritual factors addressed as relevant

VII. Quality Assurance

A. Supervision Requirements

- **Weekly Supervision:** All treatment plans reviewed by licensed supervisor
- **Case Consultation:** Complex cases require team input
- **Peer Review:** Regular case presentations and feedback
- **Outcome Monitoring:** Systematic tracking of treatment effectiveness

B. Continuing Education

- Annual training on evidence-based practices
- Updates on diagnostic criteria changes
- Ethical and legal requirement updates
- Cultural competency enhancement

VIII. Discharge Planning

A. Criteria for Discharge

- Treatment goals substantially achieved
- Symptom reduction to manageable levels
- Improved functional capacity
- Client-initiated termination with safety planning
- Transfer to different level of care

B. Discharge Summary Requirements

```
DISCHARGE SUMMARY Client: _________________ Discharge Date: _________
Treatment Duration: _________ (from _________ to _________) Total
Sessions: _________ Primary Therapist: _________________ TREATMENT
SUMMARY: Initial Presentation: _____________________________ Goals
Achieved: _____________________________________ Remaining Concerns:
_____________________________ FINAL DIAGNOSIS:
_____________________________________ FUNCTIONAL STATUS:
_____________________________ RECOMMENDATIONS: ☐ No further
treatment needed ☐ Maintenance sessions recommended ☐ Referral to:
_____________________________________ ☐ Crisis plan established Follow-
up Contact: _________________
```

IX. Emergency Procedures

A. Crisis Intervention

- **Immediate Safety:** Assess and ensure client safety
- **Risk Mitigation:** Implement protective measures
- **Support Activation:** Engage family/support systems
- **Professional Consultation:** Contact supervisors and colleagues
- **Documentation:** Detailed crisis notes and actions taken

B. Treatment Plan Modifications

Crisis situations may require immediate treatment plan adjustments. Emergency modifications must be documented within 24 hours and reviewed with supervision within 72 hours.

> **Compliance Note:** These guidelines must be followed for all treatment planning activities. Deviations require documented justification and supervisor approval. Regular audits will ensure adherence to these standards.