TREATMENT PLANNING STEP BY STEP

Once you have completed your **Initial Assessments** (parent interview, teacher interview and classroom/playground observation) and filled out your **Behavioral Health Assessment** (BHA), and have had about 4 meetings with your client, you are ready to formulate a **Treatment Plan**. Here are the steps:

- ❑ **List all Presenting Problems**

  Create a "laundry list" of the problems and/or symptoms that your client is experiencing. These may include behaviors, feelings, thoughts, life events, cultural experiences, family systems features, etc.

- ❑ **Write a Problem Statement**

  From your list of problems, select **one** problem that will be the focus of therapy. Although several problems may exist, they should be *prioritized* so that services will help the client most effectively. Problem areas should be expressed in *behavioral* terms. (see examples)

  In choosing a *single* problem to focus on, consider whether there is a "lynchpin" problem which must be tackled before any other issue or symptom can be addressed. Also consider the length of treatment. In the case of school clients, for example, you might choose to treat a problem that can be expected to change within the 12 week treatment period.

  Problems are evidenced by *signs* (what you see) and *symptoms* (what the patient reports). A problem statement on the treatment plan should be followed by *specific physical, emotional, or behavioral evidence that the problem actually exists*. List the problem, add "as evidenced by" or "as indicated by," and then describe the concrete evidence you see that tells you that the problem exists.

- ❑ **Determine the Problem Domain** – **IFAS Category** and give it a severity rating. Choose only ONE problem domain that matches your problem statement.

- ❑ **Write a Treatment Goal –** What is the client's (or the parents'/teacher's) **desired outcome**? Develop a goal that you feel could possibly be accomplished within 3 months, and write it as a *measurable* goal. This will give both you and your client something tangible to shoot for! What will your client be able to do or experience as a result of your work together? How will you know that your goal has been reached?

- ❑ **Create 2 to 3 Objectives –** these objectives will be steps along the way to your treatment goal. They may describe skills that your client needs, therapeutic/relational experiences they need to have, or feelings they need to approach.

- ❑ **Generate Strategies (Interventions)**

  For each objective, write brief statements of the types of strategies you propose to use in treatment. These are your interventions, the *experiences* that you provide for your client that help them to meet the treatment objectives.

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- ❑ **Strengths, Resources and Sources of Support**

  Its very important to focus on your client's strengths and resources, with an eye to enhancing and developing their inner and outer assets. You will want to revisit this list, and perhaps add to it, as therapy progresses.

- ❑ **Human Diversity Considerations**

  Here is where you write about your client's unique cultural milieu and your mutual understanding of how these factors will influence your work together. How are you different, and what are the potential blind spots you will need to be vigilant for? How will you address these differences? How will you enhance your knowledge and understanding of your client's world view, cultural, religious, gender and other perspectives?

- ❑ **Case Conceptualization**

  Your case conceptualization is a hypothesis about the causes and maintaining influences of your client's psychological, interpersonal and/or behavioral problems. You write this as a brief narrative that describes how your client's symptoms, history and current circumstances make sense to you, given your particular theoretical lens. Your conceptualization is also what guides your objectives and your interventions.

- ❑ **Diagnosis**

  Determining a DSM 5 Diagnosis for your client can be a good learning tool. However, please do not enter a DSM Diagnosis into Clinic Tracker: it seems to create all kinds of confusing pop-ups and often prevents me from signing notes.

  IMPORTANT NOTE: As a policy, we do not share our diagnoses – or ideas *about* diagnosis -- with school-based clients or their parents, teachers, or school staff under any circumstances. We have chosen this policy in order to avoid the misunderstandings, anxiety and negative reactions that often result.

Remember that a treatment plan is a fluid document – and is likely to change and grow as you get to know your client and their inner world. At any point in time, you will be working on (educated) hunches and hypotheses that help to guide your work.

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