**Client Treatment Plan**

The Client Treatment Plan is a primary way of involving clients in their own care. The development of the treatment plan is an interactive process between the client and the treatment team. It is designed to establish the client’s treatment goals, develop a set of objectives to help realize these goals, and reach agreement on the services we will provide. Program goals should be consistent with the client’s/family’s goals as well as the diagnosis and assessment. The treatment plan must include documentation of the client’s participation in the development of, and agreement with the plan.

**Client Participation**

Client participation in the formulation of the treatment plan is documented by obtaining the signature of the client/parent/guardian, providing a copy of the plan to the client/family member, OR by documenting in a progress note how the client/parent/guardian participated in developing and approving the treatment plan.

It is not sufficient to write on the plan or in a progress note that the client missed the appointment or could not be reached; this does not describe the client’s participation.

It must be documented that a copy of the plan was offered to the client and if the client accepted or declined the copy. Offering a copy of the plan to the client/family member is an important acknowledgment of the client’s involvement in the development of the client plan, and demonstrates the clinician’s commitment to involving clients/families as full participants in their own recovery process.

**Treatment Plans must be written in the client’s preferred language.** If the preferred language is not English, the treatment plan must be translated into English as well.

**The 10 elements required by the current MHP & SUD/ODS Contract with DHCS:**

1. Statement of the problem to be addressed;

2. An expected frequency for each proposed intervention;

3. An expected duration for each proposed intervention and target dates;

4. Adequate documentation that the client was offered a copy of the plan;

5. Observable and measurable goals and objectives

6. Provider’s signature with Degree/License or job title on the Plan;

7. Specific behavioral interventions (description) for each proposed service;

8. All interventions that were actually delivered to the client;

9. Timely completion according to the MHP’s own documentation standards;

10. Documentation that the client participated in and agreed to the plan;

11. Date of the provider’s signature on the plan (i.e., date completed).

**Client Treatment Plan Elements**

**CLIENT’S OVERALL GOAL/DESIRED OUTCOME - The client’s desired outcome from successful treatment.**

This is the reason the client is seeking treatment. Overall goals are broad life goals, such as returning to work or graduating from high school, that reflect the client’s intent and interests. The overall goal should be clear to the client and the treatment team, and it should reflect the client’s preferences and strengths. These goals have a special place in a system committed to recovery – they should speak to the client’s ability to manage or recover from his/her illness and to achieve major developmental milestones.

**DIAGNOSIS/RECOVERY BARRIER/PROBLEM – *Primary Diagnosis’ signs/symptoms/impairments, and other barriers/challenges/problems****.* Describes the behavioral health symptoms and impairments that are the focus of treatment.

**GOAL –The removal or reduction of the problem.**

The goal addresses the problem. The goal is the development of new skills/behaviors and the reduction, stabilization or removal of the barrier/problem. Individual goals address the barriers that prevent clients from reaching overall goals. They are generally related to important areas of functioning - affected by the client’s mental health condition - such as living situation, daily activities, school, work, social support, legal issues, safety, physical health, substance abuse and psychiatric symptoms. The treatment plan must clearly document how a particular goal reflects the client’s mental health condition. Goals must relate to the diagnosis and case formulation and be specific and observable.

**OBJECTIVE(S) – What the client will do.**

This is a breakdown of the goal. It may include specific skills the client will master and/or steps or tasks the client will complete to accomplish the goal. Objectives should be specific, observable or quantifiable, and related to the assessment and diagnosis. A simple mnemonic that may be helpful when working with the client to develop program objectives is SMART (Simple, Measurable, Accurate, Realistic, Time-bound).

**INTERVENTION(S) – The specific services that staff will provide.**

These are all of the service types that will be utilized in treatment (e.g., Medication Support, Family Therapy, Individual Therapy, Group Therapy...etc.)List all that apply.

Interventions describe actions to be taken by the provider (i.e. services or service modality) to assist clients in achieving their goals. Every planned intervention (such as individual therapy, family therapy) must be listed. An intervention added in the course of treatment must be written and dated on the plan.

**DURATION OF INTERVENTION -**This time frame is a prediction of how long the intervention will be needed; it is the total expected timespan of the service.