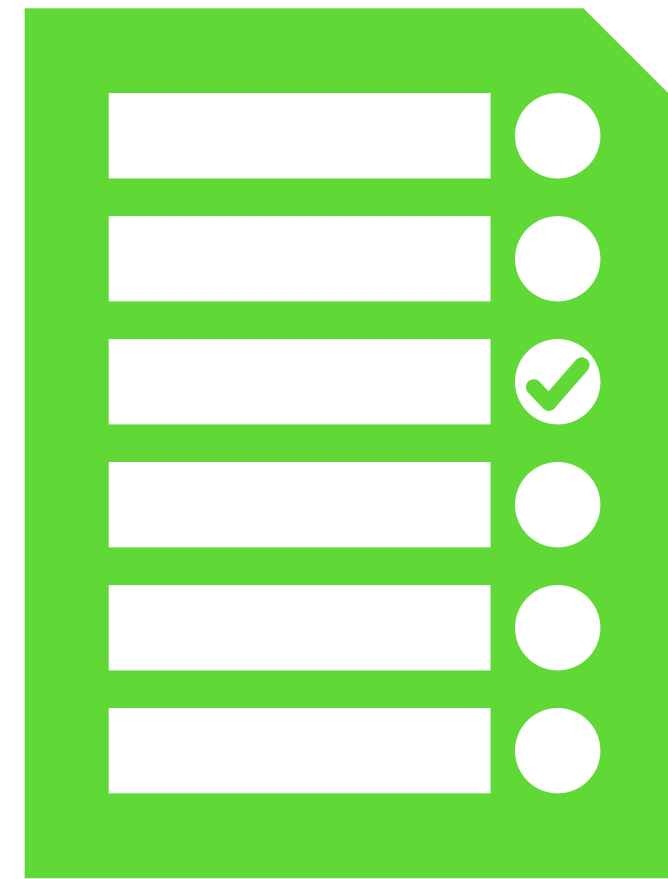


From
Hearing
Needs



To
Developing
A Plan

Treatment Planning

Fall 2025 SOWK 581 - Week 07

Jacob Campbell, Ph.D. LICSW

Week Seven Plan

Agenda

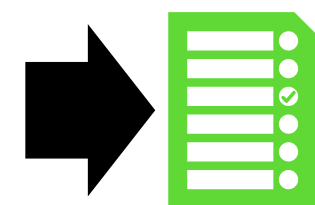
Week Seven Activities

Basics of Service Plan
Creation

Example of a Treatment
Plan

Learning Objectives

- Develop an understanding of how a treatment plan is used in practice
- Identify the components of a treatment plan and learn from a practical example



be working on your
biopsychosocial
assessment

Read

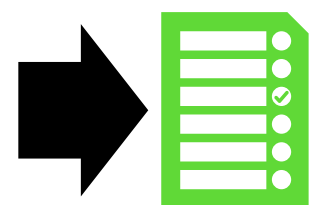
- Mancini (2021) *Person-Centered Treatment Planning*
- Reamer (2005) *Documentation in Social Work: Evolving Ethical and Risk-Management Standards*
- Bodek (2010) *Standards for Clinical Documentation and Record Keeping*
- Cameron and Turtle-Song (2002) *Learning to Write Case Notes Using the SOAP Format*

Write

5 Replies

- Reflecting on Week Seven's Content
- Developing a SMAARRT Goal
- Write a SOAP Note
- AI and Other New Technologies in Clinical Documentation
- Ethical Dilemmas in Documentation

Complete midcourse feedback



Jacob Campbell, Ph.D. LICSW at Heritage University

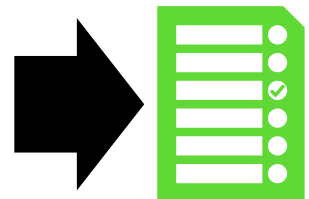
Week 07 Activities

Fall 2015 SCW 131

Creating the Service Plan

Things To Consider

- Involving the client and the family
- Using the assessment
- Strengths
- Barriers
- Client voice

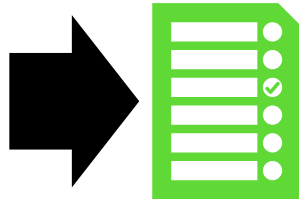


TREATMENT PLAN

Client Name:		DOB:		CID:		Assigned Clinician:	
Funding Source:	Choose an item.	Provider One #:		DSHS CLID:		Type of Plan:	Choose an item.
Date of Plan:		Click here to enter a date.		Review Due:		Click here to enter a date.	
LOC	LRA	Admitting DX Date	Change in DX Date	Change in DX Date	Change in DX Date	Change in DX Date	
??	Y/N?	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	
Axis I:							
Axis II:							
Axis III:							
Axis IV:							
Axis V:							
CURRENT SUPPORTS							
Name			Relationship		Role in Treatment		ROI
							Click here to enter a date.
							Click here to enter a date.
							Click here to enter a date.
							Click here to enter a date.
GOAL							
Goal: (Client Voice)							
Problem Need/Barriers: (Client Voice)							
Strengths: (Client Voice)							
Treatment Modalities/Interventions/Supports utilized in treatment (Plan to be reflected in notes)							
<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Therapeutic Psychoeducation <input type="checkbox"/> Brief Intervention <input type="checkbox"/> Crisis Services <input type="checkbox"/> Family Treatment <input type="checkbox"/> Group Treatment <input type="checkbox"/> Medication Management/Monitoring <input type="checkbox"/> Special Population Evaluation <input type="checkbox"/> Stabilization Services <input type="checkbox"/> Case Management <input type="checkbox"/> Medical Coordination <input type="checkbox"/> Other.							
Client Measurable Goal		Client will identify, learn and practice 2-3 coping skills for management with BLANK symptoms related to STATED GOAL in the next 6 months.					
Client will be utilizing the use of informal and formal supports listed above in their recovery plan. Client and provider will work together to tie strengths and the use of supports to assist in working towards the client stated goal and coordinating their care with the listed supports.							

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Funding Source:	Choose an item.	Provider One #:		DSHS CLID:		Type of Plan:	Choose an item.
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TREATMENT PLAN

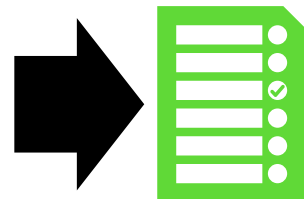
Client Name:		DOB:		CID:		Assigned Clinician:	
Funding Source:	Choose an item.	Provider One #:		DSHS CLID:		Type of Plan:	Choose an item.

LRA Start Date:Click here to enter a date.		LRA CLIENTS		Length of LRA:Choose an item.	
<p>LRA clients receive services at least weekly for the first 14 days, monthly for the next 90-180 days unless otherwise specified by physician</p> <p>Reviews occur monthly for first 90 days and 180 days to determine release from continuation of the involuntary treatment order</p> <p>Service provider is to maintain contact with CRU when client misses appointments or if there are other concerns</p>		Identify Condition of LRA:			
Plan for Transition to Voluntary Treatment:					

TREATMENT PLAN

Client Name:		DOB:		CID:		Assigned Clinician:	
Funding Source:	Choose an item.	Provider One #:		DSHS CLID:		Type of Plan:	Choose an item.

Date of Plan:	Click here to enter a date.	Review Due:	Click here to enter a date.
<p>By signing this document, I acknowledge and agree that I have actively participated in and contributed to the planning of my treatment as stated in this document as described above. I understand that by not signing this agreement to treatment that this is a refusal of the plan that was co-created and I may contact Omsbud at 1-800-795-9269 to file a grievance.</p>			
<i>Client Signature</i>	<i>Date</i>	<i>Guardian/Responsible Party Signature</i>	<i>Date</i>
<i>Clinician Signature</i>	<i>Date</i>	<i>Clinical Supervisor Signature</i>	<i>Date</i>
<i>Signature/Relationship to Client</i>	<i>Date</i>	<i>Signature/Relationship to Client</i>	<i>Date</i>

[illegible]

TREATMENT PLAN

Client Name:		DOB:		CID:		Assigned Clinician:	
Funding Source:	Choose an item.	Provider One #:		DSHS CLID:		Type of Plan:	Choose an item.

GOAL REVIEW			
Date of Plan:		Click here to enter a date.	
Review Due:		Click here to enter a date.	
Goal: (Client Voice)			
Treatment Modalities/Interventions/Supports utilized in treatment (Plan to be reflected in notes)			
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DISCUSSION WITH CLIENT:			
REVIEW OF EFFECTIVENESS OF PLAN:			
ASSESSMENT OF LEVEL OF CARE:			
GOAL REVIEW			
Date of Plan:		Click here to enter a date.	
Review Due:		Click here to enter a date.	
Goal: (Client Voice)			
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DISCUSSION WITH CLIENT:			
REVIEW OF EFFECTIVENESS OF PLAN:			
ASSESSMENT OF LEVEL OF CARE:			

