Why Write a Treatment Plan?

What is a treatment plan?

A treatment plan is a tool used in therapy that outlines specific goals and objectives, as well as ways to measure progress towards them. It specifies which treatment interventions will be used and the responsibilities of both the patient and therapist. In other words, a treatment plan presents a guide for therapy with a beginning, middle, and end. A good treatment plan should be tailored to fit the patient's presenting problem(s) and his/her individual needs.

One main objective of a treatment plan is to guide the course of therapy and select treatment interventions. Having a treatment plan allows you to make positive changes with purpose, attention, and direction. A focused treatment plan can help patients get better sooner! When developing a treatment plan, keep the following pointers in mind:

- Diagnosis and case conceptualization determine treatment interventions
- Treatment interventions should be tied to specific goals and objectives
- Goals and objectives form the basis for measuring treatment progress

A treatment plan documents the intent and goals of treatment in the medical record.

Documenting a treatment plan is a major source of communication between the patient and therapist, as well as other interested parties (e.g., other treating providers, payers, etc.). Other providers collaborating on the patient's case can easily determine the purpose and goals of current treatment when there is a well-documented treatment plan in the patient's medical record. This is especially helpful for multidisciplinary collaboration. In addition, future providers can review treatment records to determine the content and course of past treatment, which can help guide future treatment and avoid repeating unsuccessful treatment interventions. Moreover, the plan allows for continuity of care for patients who relocate to another duty station in the middle of an evidence-based psychotherapy (EBP) or other treatment.

A treatment plan defines criteria for treatment completion.

Since the treatment plan is a written plan created collaboratively by the patient and the therapist, it serves as a guide for how therapy should proceed to address the patient's unique needs based on clinical presentation and noted concerns. It is essential for effective treatment. Criteria for termination are established at the onset of treatment. Well-defined goals and objectives help to assess when the patient is ready to end treatment.

Treatment plans do the following:

- Outline specific symptoms to be addressed
- Define interventions to be utilized
- Outline desired outcomes and termination criteria
- Set the stage for successful treatment and future termination of care