Mental health treatment plan

Fictional completed example: TP-01

1. Assessment and priorities

Client identifier, setting and plan dates

TP-01: Riley, adult outpatient mental health. Initial plan: November 9, 2026. Review addendum: December 7, 2026; initial objectives retained below.

Clinician, role and assessment source

Morgan, licensed clinical social worker. Signed assessment TP-A01, November 9, and Riley's account of the preceding week.

Assessed concerns, diagnosis or formulation, and functional impact

TP-A01 documents major depressive disorder, low energy and withdrawal from usual activities. Riley reports preparing an evening meal on 1 of 5 weekdays during November 2-6 and no chosen social contact during November 2-8. These are self-reported activity counts, not a symptom scale.

Client priority and longer-term goal

Riley: 'I want evenings to feel manageable and to stop losing touch with people.' Shared goal: rebuild a workable evening routine and regular contact with people Riley chooses.

Strengths, preferences and access needs

Riley can prepare familiar meals and has a cousin they would like to contact. Prefers a paper activity record, individual sessions and appointments before work. The cousin is a potential personal support, not a clinician contact or confirmed participant.

Participation, choices and areas of disagreement

On November 9, Riley chose meal preparation and social contact as initial targets. Riley declined group treatment at this stage; Morgan recorded the preference and agreed to revisit options if requested. Riley received a plain-language copy of the plan.

Mental health treatment plan

Fictional completed example: TP-01

2. Objectives and planned work

Objective 1: baseline, target, timeframe and evidence source

Baseline: evening meal prepared on 1 of 5 weekdays, November 2-6, by Riley's report. Target: prepare a chosen simple evening meal on at least 3 of 5 weekdays in each of two consecutive weeks by December 7. Riley will mark completed days on paper; Morgan will review counts and barriers in sessions.

Objective 2: baseline, target, timeframe and evidence source

Baseline: no chosen social contact during November 2-8, by Riley's report. Target: initiate a chosen call, message or in-person conversation on at least 2 days per week for two consecutive weeks by December 7. Count days with contact, not the number of messages; Riley's record is the source.

Clinician interventions, rationale, provider and planned service schedule

Initial agreement, November 9: Morgan and Riley agree to four weekly 45-minute individual sessions using behavioral activation and collaborative problem-solving. Morgan will help select manageable activities, examine barriers and review the activity record against both objectives. The schedule is a plan; completed sessions are recorded separately.

Client actions, barriers and agreed support

Riley will choose simple meals and preferred contacts, then mark activity days. Variable work finishing times may interfere with evening plans. At the November 23 review, Riley and Morgan agree to select meals earlier in the day and choose contact times after checking that week's work schedule.

Coordination, permissions, task owners and status

No external referral is agreed in this plan. Riley has not authorized clinician contact with the cousin. If another service is proposed, Morgan will record consent, the referral owner and whether the receiving service has accepted it.

Safety assessment, response plan and earlier-review route

Safety assessment and individualized response instructions are in TP-A01 and TP-S01. Morgan and Riley reviewed the contact steps on November 9. Riley has the service's daytime and after-hours routes; changes in safety or ability to manage prompt reassessment through those routes. No risk rating is inferred from the activity counts.

Mental health treatment plan

Fictional completed example: TP-01

3. Review, decisions and agreement

Review dates, responsible clinician and information to bring

Morgan owns the interim review on November 23 and target-date review on December 7. Riley will bring the paper record. Compare the same activity definitions and date windows, ask about functioning and experience, and reassess needs sooner if circumstances change.

Review findings: source, dates, objective status and client view

November 23: Riley's record shows meal preparation on 2/5 weekdays and social contact on 1 day in each of the two preceding weeks; both targets remain in progress. December 7: meals reached 3/5 weekdays in each of the last two weeks, meeting Objective 1. Social contact occurred on 1 day, then 2 days, so Objective 2 is partly met. Riley says evenings feel more manageable but maintaining contact still takes effort.

Decision, rationale, changes and next checkpoint

December 7: Maintain the meal routine and continue work on social contact. Preserve Objective 2's original December 7 result; revise its target date to December 21, keeping the two-consecutive-week target. Morgan and Riley agree to two additional weekly 45-minute individual sessions on December 14 and 21, using behavioral activation and collaborative problem-solving for Objective 2. Riley will continue the chosen activities and paper record between visits. Both sessions are booked; the December 21 session includes the objective review and reassessment of the approach. These are planned sessions, not evidence of delivery.

Transition or discharge criteria and outstanding needs

Discuss reducing or ending this course of care when the agreed functional gains are sustained, Riley can use the chosen strategies, and reassessment supports a transition. Meeting the meal objective alone does not complete the broader treatment goal. Social contact and ongoing symptom/function review remain active.

Agreement, copy provided and clinician authentication

Riley agrees with the December 7 revision and receives the updated paper copy. Morgan records the review addendum with date, time and professional role in the clinical record.