Use of Simulated Multidisciplinary Treatment Teams and Client Actors to Teach Case Conceptualization and Treatment Planning Skills

Cynthia J. Osborn, Erin P. Dean, & Megan L. Petruzzi

The authors describe instructional methods used to teach comprehensive and individualized case conceptualization and treatment planning in a graduate-level Advanced Counseling Procedures course. Students participate in a theory-driven, simulated multidisciplinary treatment team and meet with recruited client actors to bring "to life" the process of integrating multiple clinical perspectives into a cohesive service plan for a client. Feedback from students and recommendations for course enhancement are provided.

Comprehensive, individualized case conceptualization can be easily overlooked in favor of expedient diagnostic categorization to manage large client caseloads. Faced with restrictions on resources and the demand of funding sources to provide clients with immediate services, counselors may use standardized clinical profiling to expedite the process of care. This lack of individualized care has been identified as a failure of the community mental health movement in the United States today (Hadley, Turk, Vasko, & McGurrin, 1997). Mumma (2001) identified such practice as highlighting a difference between nomothetic-aggregate and intraindividual-idio­graphic approaches: The former uses structure and quantification to capture common characteristics among persons designated within a particular group; the latter isolates and exposes the unique or idiosyncratic characteristics of an individual.

The idiographic approach to case conceptualization is emphasized in a graduate-level Advanced Counseling Procedures course in an effort to teach students the process of constructing individualized and realistic treatment plans for clients. Experiential methods used to accomplish this task are (a) assignment of students to simulated multidisciplinary treatment teams, with each team responsible for devising a comprehensive case conceptualization and treatment plan for an assigned and shared client and (b) recruitment of actors to portray the client (hereinafter referred to as client actors) in the assigned cases and to meet with their respective treatment teams on three occasions during the semester.

Cynthia J. Osborn, Erin P. Dean, and Megan L. Petruzzi, Counseling and Human Development Services Program, Kent State University. Correspondence concerning this article should be addressed to Cynthia J. Osborn, 310 White Hall, Kent State University, PO Box 5190, Kent, OH 44242-0001 (e-mail: cosborn@kent.edu).
This article presents case conceptualization as the necessary first step in personalized treatment planning and provides a rationale for the multidisciplinary treatment team as the preferred (and increasingly standard) format for the planning of treatment. We also describe the use of client actors who meet with treatment teams during class time to bring the written client case "to life." Students' evaluations of instructional methods and the Simulated Treatment Team Project are provided, and recommendations are presented for continued improvement of course design.

Comprehensive Case Conceptualization

Case conceptualization is the counselor's intentional, focused, and ongoing effort to understand a particular client case. It precedes and makes possible individualized treatment planning (Mumma, 2001; Persons, Davidson, & Tompkins, 2001) and involves the systematic interpretation of all information obtained about a client in order to propose a course of action in counseling that is relevant and feasible for that client. This is consistent with the former U.S. Surgeon General's pronouncement that "[t]o be effective, the diagnosis and treatment of mental illness must be tailored to all characteristics that shape a person's image and identity" (Satcher, 2000, p. 13). Indeed, the more that is known about a client, the more likely that an individualized treatment plan can be constructed (Radwin, 1995).

Often referred to as "case formulation," this counselor activity is intended to generate hypotheses that summarize and explain the nature and etiology of a client's presenting issues, including how such problems fit together and are maintained (Brems, 2000; Eells, 1997; Mumma, 2001; Weerasekera, 1993; Woody, Detwiler-Bedell, Teachman, & O'Hearn, 2003). Several authors (e.g., Berman, 1997; Bieling & Kuyken, 2003; Murdock, 1991) have recommended that case conceptualization be theoretically driven, which challenges clinicians to intentionally integrate theory and practice and avoid what Persons et al. (2001) referred to as "hit-or-miss decision-making" (p. 26).

Multidisciplinary Treatment Teams

Multidisciplinary treatment teams are quickly becoming a standard model for health care services in the United States. Schmitt (2001) explained this trend as a response to a managed care system that requires comprehensive, coordinated, and integrated care. Cordess (1996) added that with the development of mental health subspecialties, it has become "increasingly unrealistic" (p. 97) for any single clinician to know all the relevant information or provide all the necessary care for a particular client. For persons with multiple and complex needs (e.g., co-occurring mental illness/substance use disorders, eating disorders), a team-based approach is indicated (Hadley et
al., 1997; Munetz, Birnbaum, & Wyzik, 1993; Roesler, Gavin, & Brenner, 1995; Weiner, 1999) and has become the dominant organizational model of treatment (Mueser, Noordsy, Drake, & Fox, 2003).

Although treatment team practice originated in the medical profession and psychiatrists continue to be regarded as treatment team leaders (Rodenhauser, 1996), Munich (2000) has observed that today's multidisciplinary treatment team "more truly integrates its members with defined areas of responsibility and expertise and operates on a broadly functional rather than a narrowly medical or hierarchical basis" (p. 488). Counselors, therefore, have a unique opportunity to become prominent members of treatment teams. Counselor preparation programs, however, do not emphasize interdisciplinary collaboration, and students are not "provided with skills to work in collaborative teams comprised of varying professions" (Bemak, 1998, p. 282). Greater attention needs to be given, therefore, to familiarizing students with their future role as members and leaders of multidisciplinary treatment teams (Hoge, Jacobs, Belitsky, & Migdole, 2002). Without such emphasis during formal training, counselor credibility may be jeopardized (Seligman & Ceo, 1996).

Use of Client Actors

Historically, medicine has used client/patient actors more consistently in its formal training programs than have the other helping professions. Often referred to as "standardized patients," these persons are recruited to interact "live" with medical students and residents to assist in their instruction and evaluation (McNaughton, Tiberius, & Hodges, 1999; Rosenbaum & Kreiter, 2002; Taverner, Dodding, & White, 2000; Walsh, Sanson-Fisher, Low, & Roche, 1999; Woodward, 1998). Simulated clients/patients have also been used in nursing education (Nehring, Ellis, & Lashley, 2001), psychology training (Bögels, 1994; Lane, 2000; Pomerantz, 2003), counselor education (Anderson, Gundersen, Banken, Halvorson, & Schmutte, 1989; Fall & Levitov, 2002; Levitov, Fall, & Jennings, 1999), and teaching programs for a variety of disciplines (e.g., occupational/physical therapy and social work; Woodward, 1998). Students have reported an overall appreciation for the "real-life" experience of such exercises (Pomerantz, 2003), which have been enhanced by the use of believable actors who provide instructive feedback (Anderson et al., 1989). In addition, the use of client actors has demonstrated increased accuracy of (Bögels, 1994) and confidence in (Rosenbaum & Kreiter, 2002) student interviewers' clinical skills.

Simulated patients or client actors have been recruited in a variety of ways. Training programs have used professional actors (McNaughton et al., 1999); drama/theater students (Fall & Levitov, 2002; Lane, 2000; Levitov et al., 1999; Pomerantz, 2003); undergraduate psychology students (Anderson et al., 1989); psychiatric
nurses (Bögels, 1994); and "friends, relatives, and neighbors of university faculty and staff, along with some members of the university community" (Woodward, 1998, p. 134). Recruitment incentives have included money (Fall & Levitov, 2002; Lane, 2000; McNaughton et al., 1999; Woodward, 1998) and academic credit (Pomerantz, 2003). Simulated patients have also reported additional motivations for participation, including personal enjoyment, increasing acting skills, contributing to the professional development of students, and personal enrichment (Lane, 2000; McNaughton et al., 1999).

An additional positive outcome for individuals serving in the client role has been a "greater understanding of and empathy toward people with psychosocial problems" (Woodward, 1998, p. 144; see also Anderson et al., 1989). It is for this specific reason—the belief that their use of empathic skills accentuates an authentic portrayal of clients—that advanced counseling students and counseling program alumni are recruited as client actors for the Simulated Treatment Team Project. Of the approximately 15 client actors recruited for the Advanced Counseling Procedures course, the majority have been advanced counseling students (n = 4) and program alumni (n = 7) who have conveyed a sense of gratitude for the opportunity to help out fellow students or "give back" to their alma mater. (The remaining client actors who have been recruited have been faculty and doctoral students from related programs and a friend of one of the co-instructors for the class.)

Overview of the Simulated Treatment Team Project

Students typically take the elective Advanced Counseling Procedures course immediately before or concurrently with their internship experience. The major course assignment is the construction of a comprehensive treatment plan based on participation on a simulated multidisciplinary treatment team. This assignment has three facets of delivery, with the latter two representing a collaborative group effort: (a) preparation and submission of a written and theoretically informed client case conceptualization paper (individual student project; see Appendix A); (b) preparation and submission of a written treatment plan, which includes a theoretically integrated case conceptualization (group project; see Appendix B); and (c) in-class group presentation of the collective treatment plan, depicting a 30- to 45-minute treatment team meeting.

Early in the semester, the course instructor divides the class into groups of three or four students, giving consideration to diverse representation (e.g., gender, race/ethnicity, master's-level or doctoral student), consistent with Grant's (1999) recommendations for culturally sensitive treatment teams. Each group, referred to as a treat-
ment team, is assigned a different client case, which consists of a one- to two-page written description of a client's demographics and a brief history of presenting concerns. Case descriptions are of actual clients (with names and other identifying information altered to ensure confidentiality) and reflect the characteristics of the client actor who will portray the client described in the written case.

Each member of a treatment team selects a theoretical perspective from which to view the team's assigned client and prepares a separate written case conceptualization. Students are provided with a list of approximately 10 counseling theories and are instructed that each member of their treatment team should select a different theory. Therefore, three or four different counseling theories are represented on each counseling team. This theoretical mixture serves to simulate the likely experience of a multidisciplinary treatment team, because members tend to have different perceptions of a client based on their varied training, disciplines, and professional roles (e.g., medicine, psychology, social work).

Once students become acquainted with their assigned written client case, client actors meet with their respective treatment teams during the latter part of class time. Before their meeting, the client actors are provided with the same written description of the case as the treatment team members receive. An effort is made to match, as much as possible, client actors with demographics of the written client cases. Client actors meet with their respective treatment teams for three separate, 30-minute sessions during the semester. These meetings take place in the counseling program's on-site clinical laboratory and counseling center, and all sessions are videotaped, as is consistent with the practice of others who use a similar training format (Bögels, 1994; Fall & Levitov, 2002; Lane, 2000; Pomerantz, 2003). The instructor observes interactions via live remote feed on the premises and meets with team members after each session to process the interactions and provide assistance in client conceptualization and treatment planning (as recommended by Lane, 2000). Students are encouraged to review videotaped sessions as they construct their collective treatment plan.

To help students prepare for their interactions with the client actors and to provide a model case conceptualization and treatment plan, a written client case of "Michael" is distributed to all of the students prior to the teams' initial meetings with their assigned client actor. Discussion about Michael's case focuses on factors that must be considered in a comprehensive conceptualization and a preliminary treatment plan (including specific goals and objectives). These factors are discussed with the entire class over several class sessions. During this process, an actor portraying Michael visits the class on two occasions. On these occasions, the instructor models an assessment interview with Michael and invites students to
ask Michael questions or provide comments. After Michael's second class visit, the instructor prepares and distributes a written case conceptualization and preliminary treatment plan, based on an existential perspective, which serves as a model for students in preparing their theory-guided individual and group written assignments.

The first treatment team meeting with the client actors allows students to become acquainted with their respective client. Occasional discrepancies between the written case and the portrayal by the actor (e.g., actor appearing younger than reported age) are not attributed to "poor acting." Rather, such discrepancies are presented as exemplifying actual clinical practice, wherein information about clients from various sources (e.g., self- and/or collateral report, medical records) is not always clear. During the first meeting, members of the treatment team are encouraged to interact with their client from their selected theoretical frame of reference in order to gain a fuller appreciation of the client (see Weiner, 1999). This session is an opportunity for the members of the treatment team to formulate a comprehensive picture of their client. Obtaining such a comprehensive picture is consistent with an idiographic approach and is the first step of individualized treatment planning.

The second treatment team meeting with the client actors is typically scheduled 3 to 4 weeks after the first session so that team members have time to discuss their initial clinical impressions, review the videotape, and deliberate about a preliminary treatment plan. This second meeting with each team's respective client actor serves as an occasion for members to present their proposed treatment plan to the client actor and solicit feedback from him or her about the plan's feasibility. This meeting is designed as a "validity check" for team members, allowing them to determine whether their perceptions reflect a feasible treatment plan that is acceptable to the client. In addition, any noted discrepancies or unanswered questions can be addressed. After meeting twice with the same client actor, students are required to submit a written, comprehensive client case conceptualization. Because this assignment is an individual student project, the student’s selected counseling theory is intended to guide the composition of the case conceptualization.

Treatment teams meet with their assigned client actors for a third and final time during the last class session of the semester, after the treatment plan has been submitted to the instructor and presented in class. This final meeting is a review, feedback, and debriefing session for both the members of the treatment team and the client actors. The client actor is instructed to arrive "out of role" (i.e., as him- or herself) and share with team members his or her experiences as the client and of interacting with the team, a process that is similar to the process described by other instruc-
tors and researchers (e.g., Bögels, 1994; Fall & Levitov, 2002; Rosenbaum & Kreiter, 2002). Actors are provided with reflective questions (e.g., "What were your impressions of the client you portrayed?" and "What would have been helpful for you to have heard from team members?") prior to their arrival as a way of organizing the feedback they provide. Team members typically regard such feedback as valid, given their realization that the client actor has a graduate degree in counseling, may now have a counselor license, or may be a doctoral student or faculty member in counseling or a related discipline.

In-class presentations by the treatment teams are intended to display the team's theoretically integrated conceptualization of (i.e., how they integrated the three or four different theories represented on each team into one case conceptualization) and recommendations for their assigned client for an initial 8-week treatment period. Treatment team members are instructed to interact during the presentation in order to demonstrate a treatment team meeting that includes presenting the client case, describing the client from each theoretical perspective represented on the team, and deliberating about appropriate treatment. The team's recommended and written treatment plan is distributed to all the students in the class, and after the presentation, all students are encouraged to ask questions and provide comments.

Grading for the individual case conceptualization assignment is based on a clear and consistent articulation of the selected theory; justification made for its use, or "fit," with the assigned client case; and infusion of the theory throughout the case conceptualization (e.g., attention to theory-specific language). Grading criteria for the written treatment plan (group project) include a clear integration of the theories represented on the team; consistency between the integrated case conceptualization and eventual treatment plan (i.e., coherence; Lueger, 2002); and clear, specific, and justifiable clinical interventions using information obtained from both the written client case and the client actor. Grading for the in-class presentation by the treatment team is based on a clear and well-organized oral presentation and the participation of all team members.

Student Perceptions and Evaluations

Approximately 124 master's-degree and doctoral students have participated in the Simulated Treatment Team Project over the past 5 years. Students' reactions to and evaluations of the project are based on anonymous Student Evaluation of Instruction (SEI) forms (i.e., formal course evaluations completed by 86% of students) administered on the last day of class without the instructor in the classroom, according to university policy. Of the 53 students who have provided a narrative response to the open-ended SEI question regarding as-
pects of the course that were most successful, 25 (47%) specifically made reference to the treatment team project. These students indicated that the most beneficial aspect of the treatment team project was the theoretically informed approach to case conceptualization and treatment planning. One student commented, "This project allowed me the opportunity to study and apply one particular counseling theory in depth. Because of this, I feel confident that I could use the ideas behind my chosen theory with future clients." Another student indicated, "having to use and defend one theory . . . helped reinforce how to use it" that represented a "good review." These evaluations mirror more global perspectives about the course that focused on the intentional integration of theory and practice. One student offered, "[The course] pulled together a lot of concepts, ideas, etc., from all previous counseling classes: counseling theories, diagnosis, treatment, etc. Very helpful. Should be a requirement." This was echoed in two additional evaluations: "[The course] tied all of my previous course work together. I now feel more prepared to enter the field" and "It was rewarding finally being able to integrate much of the information learned in the program up to this point."

Students also identified working as a member of a simulated multidisciplinary treatment team as another beneficial aspect of the overall treatment team project, which one student regarded as "an excellent, relevant use of cooperative learning." Working as a group for the sake of a client seems to have enhanced certain students' conceptualization of and appreciation for that client. One student indicated, "Talking about a client with a team gave me a better understanding of the whole client," which supports one of Crepeau's (1994) stated benefits of the treatment team. "Learning/practicing to integrate my views with others" was valued by at least one student and reinforced by another who said, "I liked that we all had differing views, but came together for the good of the client." Although several students commiserated about the difficulties of working as a group, one likened this experience to real life: "It taught [me] how conflicting views need to be worked out so that the client receives the full benefit of the team approach. It gave me practice and it also taught me how to negotiate with others for the benefit of the client."

Several students have indicated that the comprehensive and idiosyncratic case conceptualization assignment may be too ambitious and "exhaustive" and, therefore, not feasible in real-world clinical practice. This highlights the competing tasks of comprehensiveness and immediacy that Eells (1997) identified as one of several tensions inherent in case formulation. One student argued, "although it's a great idea to take the time to understand EVERYTHING about a client, how realistic this is in an agency is beyond me." During one final class session, however, several students defended the thorough approach
by defining comprehensive case conceptualization as the "nuts and bolts" of good treatment planning. "You can't learn to read unless you've learned the alphabet," it was explained, "and comprehensive case conceptualization is like learning the alphabet." What may seem unnecessarily ambitious for some, therefore, may be the result of learning a language that may not be the dominant language spoken in agencies encumbered with temporal and financial restraints and pressures to demonstrate immediate client outcomes.

Since the introduction of client actors to the treatment team project 2½ years ago, students have voiced their appreciation for the opportunity to interact with "actual clients" who "gave 'real' feel to the project." Words such as "'real life' experience" and "actual treatment plan" used in student course evaluations to describe the benefits of the activity indicate that students value the attention given to a well-designed simulation that closely resembles a practice environment in which they will soon be working. In addition, knowing that the majority of client actors are trained as counselors and are currently practicing has given greater legitimacy to the exercise; that is, students know they will receive feedback from the client actor about the diagnosis assigned and the treatment recommended based on the client actor's own clinical training and practice.

**Recommendations for Course Improvement**

One recommendation for improving the course is to implement a more structured mechanism for assessing student learning outcomes, as other instructors and researchers have done to assess the influence of simulated patients (Bögels, 1994; Rosenbaum & Kreiter, 2002; Taverner et al., 2000). Another recommendation is to track the impact on students of participation on a simulated treatment team throughout the semester. This approach would provide formative feedback that might capture data regarding process that is not reflected in or accounted for by students' course evaluations. This might resemble Falvey, Bray, and Hebert's (2003) "thinking aloud" process-tracing strategy used to assess clinicians' judgment strategies.

A third, and related, recommendation is to have students construct two or three "mini" treatment plans for their treatment team's assigned client in preparation for the final collective treatment plan due at the end of the semester. This would give students additional practice in writing goals and objectives and would provide them with formative feedback from the instructor.

Three specific recommendations have been identified for the continued use of client actors. First, McNaughton et al. (1999) discussed that some amount of financial reimbursement would be regarded "not only as well-deserved remuneration for a difficult job, but also,
just as importantly, as a symbol of recognition" (p. 138). This may entail simple reimbursement for mileage or a modest stipend (Fall & Levitov, 2002) for three visits and might address Pomerantz’s (2003) concern that “if the actors simply volunteer, there is the risk that they may drop out or attend sporadically because there is no formal commitment to the project” (p. 364).

A second recommendation entails providing client actors with time to rehearse their roles and early feedback about their portrayal to ensure credibility (Anderson et al., 1989). In this regard, Woodward (1998) described the formal training she provided to simulated patients in light of necessary improvisation and interaction with student interviewers. Specifically, assuming the role of a client and being interviewed are not only about acting or performing; they entail assuming the identity of a person experiencing mental/emotional disturbances and being able to consistently maintain this identity while being interviewed by a group of counseling students.

A final recommendation, based on research conducted with simulated patients (McNaughton et al., 1999; Woodward, 1998), is that client actors have the opportunity to debrief and process their experience with course instructors after their interactions with the treatment team. Debriefing and processing will not only assist in their moving in and out of role, they represent a more structured and systematic means of assessing the impact of portraying a client, both positive (e.g., increased empathy) and negative (e.g., emotionally upsetting).

**Conclusion**

Participation in a Simulated Treatment Team Project for the purpose of constructing a comprehensive case conceptualization and treatment plan is intended to prepare counseling students for their inevitable role as members and leaders of treatment teams in various settings. This project also requires students to synthesize what may often be vast amounts of information about a client into a meaningful and helpful depiction of the client. Essential aspects of the project also include the routine task of writing individualized treatment plans and understanding the meaning of clinical practice intentionally informed by counseling theory. These learning objectives are not only consistent with accreditation and ethical standards of the counseling profession, they are commensurate with standards of practice in today’s mental health care system.

In the Introduction to the 2001 Standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the statement that “Counselor Education programs prepare students to be effective in a dynamic world and profession” (p. 55). Providing students with the opportunity to experience membership on a simulated multidisciplinary treatment team seems to address
most, if not all, of the common CACREP core curricular areas and to prepare students to work collaboratively with professionals from a variety of disciplines. Although not representing a professional counseling perspective, Hanson and Sheridan (1997) noted that graduate training programs need to "clearly acknowledge and aggressively prepare students" for "typical managed care procedures" (p. 237), including preparing treatment plans and, one might add, working on multidisciplinary treatment teams.

It also seems that constructing comprehensive and individualized case conceptualizations and treatment plans is an ethical responsibility. In a review of the American Counseling Association's (1995) Code of Ethics and Standards of Practice, several ethical codes address this clinical practice. These include Section A.1.c., Counseling Plans, which indicates that "Counselors and their clients work jointly in devising integrated, individual counseling plans," and Section E.5.a., Proper Diagnosis, which states that "Counselors take special care to provide proper diagnosis of mental disorders." Furthermore, Section E.5.b., Cultural Sensitivity, is upheld when treatment team members inquire about and prioritize their assigned client's culture and cultural identity in formulating their collective treatment plan.

Counseling students, their current and future clients, and the counseling profession are all well served when counseling programs offer educational experiences designed to effectively prepare students for the challenging work of counseling in today's multidisciplinary mental health field. Although subject to ongoing revision and improvement, the experiential activities and student projects offered in the Advanced Counseling Procedures course represent a noteworthy effort in preparing students for such practice.

References


APPENDIX A

**Case Conceptualization Format**

Client Name
Date of Birth
Admission/Assessment Date
Name(s) of Professional Conducting Assessment

**Noteworthy/Identifying Client Characteristics (e.g., age, sex, race/ethnicity, marital status)

**Presenting Complaint (client report for seeking counseling now; list in order of priority)

Referral Source(s) (include title, position, address, and phone number, if applicable)

**Client’s Stated Goal(s) for Counseling (list in order of priority/importance for client)

**Client Strengths/Resources (based on client report and/or clinical impressions; e.g., past accomplishments, motivational level, current sources of support)

**Client Liabilities (based on client report and/or clinical impressions; i.e., client characteristics and contextual factors that may prevent or impede realization of client/counseling goals)

Multiaxial Diagnosis (including client report of medications on Axis III; for all listings on Axis III, need to specify “per client report” if no medical documentation from physician on hand; infuse theory in the writing of Axis IV)

**Integrative Interpretation (summary of client information/case and clinician’s integration and interpretation of all relevant information, informed by selected theoretical orientation and utilizing counselor impressions [including assessment of client stage of change])

** = sections in which to deliberately infuse and integrate selected counseling theory
APPENDIX B
Treatment Plan Format

1. Primary and/or Immediate Client Need(s)
   a. Specify Primary and/or Immediate Client Need(s)/Issue(s) (e.g., client or other [from client] safety; related directly to multiaxial diagnosis)
   b. Intended or Necessary Outcome (i.e., description of client status as result of helpful or “effective” involvement in clinical services)
   c. Clinical/Counseling Interventions (action to be taken by clinical staff to assist in meeting outcome; give careful attention to how each intervention will be measured, i.e., how will you know when each intervention has been fulfilled or accomplished?)
   d. Client Implementation or Demonstration (action to be taken by client to assist in meeting outcome; give careful attention to how each implementation will be measured, i.e., how will you know when each client implementation has been fulfilled or accomplished?)
      • note Location (in-patient, out-patient) and Format (group, individual, and/or family) of services provided, as well as Professionals (e.g., physician, psychiatrist, case manager, vocational counselor) Providing Services

2. Additional and Related Client Need(s)/Issue(s): (enumerate each, in order of priority)
   • for each need listed hereafter, specify Intended or Necessary Outcome, Clinical/ Counseling Interventions, and Client Implementation or Demonstration
   • note Location (in-patient [medical], residential [non-medical], or out-patient) and Format (group, individual, couple, and/or family) of services provided, as well as Professionals (e.g., physician, psychiatrist, case manager, vocational counselor) Providing Services

3. Recommended/Predicted Length, Duration, and Pace/Frequency (weekly? twice weekly? monthly?) of Counseling Services, and Date when Treatment Plan will be Reviewed (duration of current treatment plan, when it will need to be updated)

4. Prognosis (clinical impressions indicating likelihood of accomplishing goals and objectives identified in treatment plan in specified length/time frame of counseling): Excellent, Very Good, Good, Fair, Poor, or Guarded

5. Professionals Contributing to Treatment Plan (print names, provide signatures, and indicate respective counseling theoretical orientations represented on treatment team)