QUIET GROWTH BEHAVIORAL HEALTH

TREATMENT PLAN

Quiet Growth Behavioral Health Main Campus
123 Mainstreet
Phoenix, AZ, 85355
(405) 578-5031

Plan Date: Jun 29, 2026

PATIENT IDENTIFICATION

Patient identification and plan date

First Name	Last Name	Date of Birth
George	Howard	Jul 18, 2001
MRN	**Admission Date**	**Treatment Plan Date**
MRN-00000020	Jun 30, 2026	Jun 30, 2026

PRESENTING ISSUE

Patient presenting issue with acuity level per R9-10-308.A.4.a

Primary Diagnosis (ICD-10)	F41.1 - Generalized Anxiety Disorder
Secondary / Additional Diagnoses	F32.1 - Major Depressive Disorder, Single Episode, Moderate severity, in partial remission
Chief Complaint	"I've been having panic attacks and can't sleep. I feel like I'm losing control."
Patient Goals	dfd
Acuity Level (R9-10-308.A.4.a)	High - Significant impairment, active symptoms
Acuity Level Justification	Risk level: MODERATE; Passive suicidal ideation; History of suicide attempt(s)

TREATMENT GOALS

SMART goals addressing identified problems from assessment

Functioning Score Legend (0–5)

0 — Crisis: Immediate danger, unable to function independently. 1 — Severe: Major impairment in most areas of daily living.
2 — Significant: Considerable difficulty, needs frequent support. 3 — Moderate: Some impairment, can manage with regular support.
4 — Minimal: Mild difficulty, mostly independent. 5 — No Impairment: Fully independent, functioning at expected level.

Treatment Goals #1 — Mental Health

Treatment Goal

Goal	Anxiety Symptom Reduction
Goal Details	F41.1: George experiences panic attacks, anxiety, and sleep difficulties impairing daily functioning and emotional regulation. Desired goal: George will reduce panic attack frequency to fewer than two per week and improve sleep quality within 90 days.
Baseline Score (Admission)	2
Current Score	2
Goal Status	active
Target Date	Sep 28, 2026
Objectives & Interventions	1. George will attend individual CBT sessions twice weekly to develop anxiety management and coping skills. → COUNSELING · 2× per week 2. George will participate in anxiety management and trauma-informed care group therapy weekly. → COUNSELING · 1× per week 3. George will learn and practice relaxation techniques daily during structured milieu activities. → OTHER · 7× per day

Treatment Goals #2 — Mental Health

Treatment Goal

Goal	Depression Symptom Maintenance
Goal Details	F32.1: George experiences residual depressive symptoms impairing mood stability and motivation. Desired goal: George will maintain partial remission and report mood improvement on standardized scales within 90 days.
Baseline Score (Admission)	3
Current Score	3
Goal Status	active
Target Date	Sep 28, 2026
Objectives & Interventions	1. George will engage in individual CBT sessions twice weekly to enhance coping and mood regulation. → COUNSELING · 2× per week 2. George will attend family education session within 48 hours to enhance family support. → PSYCHOEDUCATION · 1× per session 3. George will participate in trauma-informed care group weekly to support

emotional processing.
→ COUNSELING · 1× per week

Treatment Goals #3 — Medication Management

Treatment Goal

Goal	Medication Adherence and Monitoring
Goal Details	Medication Management: George experiences anxiety and depressive symptoms requiring pharmacologic treatment adherence and monitoring. Desired goal: George will adhere to prescribed sertraline regimen and report side effects or concerns within 30 days.
Baseline Score (Admission)	3
Current Score	3
Goal Status	active
Target Date	Jul 30, 2026
Objectives & Interventions	1. George will take sertraline 100mg daily as prescribed and use hydroxyzine 25mg TID PRN for anxiety as needed. → MEDICATION_MANAGEMENT · 1× per day 2. George will report any medication side effects or concerns to prescribing provider promptly. → MEDICATION_OBSERVATION · 7× per day 3. Coordinate follow-up psychiatric evaluation and medication review within one week post-discharge. → CARE_COORDINATION · 1× per week

Treatment Goals #4 — Daily Living Skills (ADLs)

Treatment Goal

Goal	Daily Activity Engagement
Goal Details	Daily Living Skills (ADLs): George experiences anxiety and mood symptoms impacting ability to engage in structured daily activities and self-care. Desired goal: George will participate in structured daily activities and practice relaxation techniques daily within 30 days.
Baseline Score (Admission)	2
Current Score	2
Goal Status	active
Target Date	Jul 30, 2026

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Objectives & Interventions	1. George will engage in structured daily milieu activities designed to promote routine and wellness. → OTHER · 7× per day 2. George will practice relaxation techniques daily to support emotional regulation and stress reduction. → COUNSELING · 7× per day

Treatment Goals #5 — Patient-Stated Goal

Treatment Goal

Goal	Patient-Stated Goal Clarification
Goal Details	Patient-Stated Goal: George states 'dfd' as a personal goal. Desired goal: George will clarify and work toward this goal with treatment team support within 30 days.
Baseline Score (Admission)	1
Current Score	1
Goal Status	active
Target Date	Jul 30, 2026
Objectives & Interventions	1. George will discuss and clarify meaning of stated goal 'dfd' during individual therapy sessions. → COUNSELING · 2× per week 2. George will identify actionable steps toward this goal with therapist assistance. → COUNSELING · 2× per week

MEDICATION PLAN

Current and prescribed medications

Current Medications	1. **Sertraline** · 100mg · Tablet · Qty: 5 · Dose: 1 · Route: By Mouth · Freq: Daily · Rx: MD John 2. **Steriline** · 300mg · Tablet · Qty: 3 · Dose: 2 · Route: By Mouth · Freq: Daily · Rx: MD John
Medication Plan Notes	No changes planned to current medications. Monitor for common side effects including sedation, gastrointestinal upset, and metabolic changes as relevant to prescribed agents. Medication review to be conducted monthly to assess efficacy and tolerability. Psychiatry consultation recommended for ongoing management and to address any emerging concerns related to the primary diagnosis.

SUICIDE-RELATED INFORMATION

Required if patient has suicide history or ideation per R9-10-308.A.4.c (references R9-10-307.A.11)

☑ Patient has history of suicide attempt or exhibits suicidal ideation

Suicide Assessment Date	Current Suicide Risk Level
Jan 7, 2026	Moderate Risk

Suicide Assessment Summary	George has a history of one suicide attempt occurring in August 2023, with the most recent attempt dated 08/01/2023. Currently, George reports passive suicidal ideation without a plan or intent, resulting in an overall moderate risk level. Contributing risk factors include the previous suicide attempt, while no recent loss, family history, substance use, or access to means were identified. Protective factors include family support, though George is not currently engaged in treatment and lacks future orientation.
Safety Plan	George is advised to monitor warning signs including increased feelings of hopelessness, withdrawal from family and social activities, and intensifying suicidal thoughts. To manage distress, George should engage in coping strategies such as reaching out to their spouse, mother, or AA sponsor for support. It is important that George restricts access to any lethal means to reduce risk. George is encouraged to initiate and maintain engagement in treatment services promptly. In case of escalating risk or crisis, George should contact their mental health provider or emergency services immediately. This plan aims to reduce suicide risk by leveraging protective factors and available support while promoting timely professional intervention.
Means Restriction Counseling	Lethal means restriction has been addressed with George as indicated by the intake assessment. Counseling focused on safe storage of medications and removal of potentially harmful items from the home environment. It is recommended that George continue to maintain these safety measures and involve their spouse/partner in ongoing monitoring to reduce risk.

CRISIS PLAN

Emergency contacts and crisis management

Warning Signs	Warning signs that may indicate a crisis is developing for George include increased expressions of suicidal thoughts or verbalizations without a clear plan, withdrawal from family or social supports despite previous family engagement, noticeable decline in participation or engagement in treatment activities, emergence of hopelessness or negative future-oriented statements, sudden changes in mood such as increased irritability or sadness, difficulty concentrating or increased rumination on self-harm, and any new onset of substance use behaviors or cravings if applicable, including associating with peers who use substances.
Coping Strategies	1. Utilize regular phone or in-person check-ins with the spouse, mother, or AA sponsor to maintain connection and receive emotional support during moments of distress. 2. Engage in daily spiritual or religious practices such as prayer or meditation to foster inner calm and reinforce resilience.

	3. Develop a personalized list of grounding techniques, such as deep breathing or sensory focus exercises, to use when experiencing overwhelming symptoms. 4. Identify and plan for high-risk situations by creating a step-by-step action plan, including reaching out to the support system or attending a recovery meeting if cravings or urges arise.
Support Contacts	Spouse: emotional and practical support Mother: emotional support AA Sponsor: emotional and recovery support

Crisis Hotline Number
988 (Suicide & Crisis Lifeline)

Emergency Contact	John Johnson (spouse) (602) 555-0124

PLAN REVIEW SCHEDULE

Review schedule per R9-10-308.A.4.e (minimum every 30 days per R9-10-308.C)

Review Frequency
Every 30 days (minimum required)

Next Plan Review Date
Jul 30, 2026

DISCHARGE PLANNING

Include if discharge planning is already determined per R9-10-308.A.4.f

☑ Discharge planning has been initiated

Anticipated Discharge Timeframe
60-90 days

Target Discharge Date
Sep 28, 2026

Discharge Criteria	1. Demonstrate 14 consecutive days of abstinence from all substances as verified by negative urine drug screens. 2. Maintain stable mood and behavior with no acute psychiatric symptoms requiring residential intervention for at least 7 days. 3. Complete all prescribed medication regimens with adherence confirmed by nursing staff. 4. Participate in and actively engage in at least 3 relapse prevention sessions or groups. 5. Develop and demonstrate a comprehensive aftercare plan including outpatient therapy and support group attendance.

Anticipated Step-Down Level of Care
Intensive Outpatient Program (IOP) — 3+ days/week

Aftercare Recommendations	Recommend outpatient cognitive-behavioral therapy twice weekly for 12 weeks. Schedule medication management follow-up with psychiatrist every 4 weeks. Encourage attendance at Alcoholics Anonymous meetings at least three times per week. Refer to community-based relapse prevention program with weekly sessions. Connect with local family support services for spouse and mother involvement.

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PATIENT PARTICIPATION

Documentation of patient/representative participation in treatment planning

☑ Participation in treatment planning requested from patient/representative

SIGNATURES

PATIENT SIGNATURE *

Patient acknowledgment of participation in treatment planning.



GEORGE HOWARD *Jun 30, 2026 8:13 AM UTC-7*

✓ *Electronically signed*

BEHAVIORAL HEALTH PROFESSIONAL SIGNATURE *

Signature of the Behavioral Health Professional.



SOFIA BROOKS, LCSW *Jun 30, 2026 8:13 AM UTC-7*

✓ *Electronically signed*

ELECTRONIC SIGNATURE VERIFICATION

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