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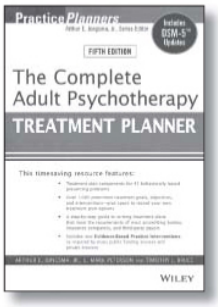

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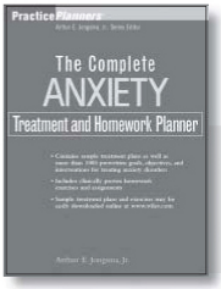

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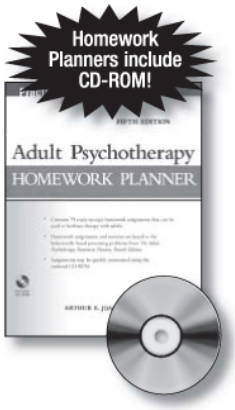

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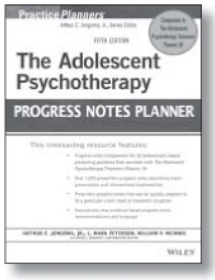

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Practice*Planners*®

Arthur E. Jongsma, Jr., Series Editor

The Juvenile Justice and Residential Care Treatment Planner, with DSM-5 Updates

William P. McInnis

Wanda D. Dennis

Michell A. Myers

Kathleen O'Connell Sullivan

Arthur E. Jongsma, Jr.

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To my wife Lynn for her constant love and support.

—William P. McInnis, Psy.D.

To my niece Amanda and nephews David, Darius, Zelma, and Adri.

—Wanda D. Dennis, Ph.D.

To my sister who made it normal for me to dream.

—Michell A. Myers, Ph.D.

To my newborn son Patrick Connell for waiting until my writing was complete to make his grand entrance.

—Kathleen O'Connell Sullivan, Psy.D.

To my colleague, Bill McInnis, for his loyalty, support, and insightful professionalism.

—Arthur E. Jongsma, Jr., Ph.D.

PRACTICEPLANNERS® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books in the Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice*Planners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner, Child Psychotherapy Treatment Planner*, and Adolescent Psychotherapy Treatment Planner, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

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- Juvenile justice and residential care
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- Neuropsychology
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- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook,* contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

ACKNOWLEDGMENTS

We would like to start by thanking Art Jongsma for involving us in this project. It has certainly been a tremendous learning experience. We would like to express our appreciation to several important people who helped to make *The Juvenile Justice and Residential Care Treatment Planner* a reality. We'd like to acknowledge the contributions of Sue Rhoda, who provided word processing skills on the initial stages of this project. To Jen Byrne, Dr. Jongsma's project manager, for her attention to detail; to our editors at John Wiley & Sons for their support and to the many colleagues who contributed clinical wisdom and helpful references. We would also like to express our gratitude to our families and friends.

BILL, WANDA, KATE, AND MICHELL

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WANDA D. DENNIS, PH.D.

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MICHELL A. MYERS, PH.D.

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KATHLEEN O'CONNELL SULLIVAN, PSY.D.

I would like to thank my wife, Lynn, for her continued love and support. I also thank my three children, Breanne, Kelsey, and Andrew, for the love and laughter that they bring into my life.

WILLIAM P. MCINNIS, PSY.D.

I dedicate this book to the administrative, clinical, and youth care staff at Wedgwood Christian Youth and Family Services. They provide deeply caring psychological services to adolescents who have been repeatedly abused, neglected, and/or abandoned by adults who were supposed to care. Blessed are the merciful.

ARTHUR E. JONGSMA, JR.

INTRODUCTION

PLANNER FOCUS

This year marks the 102nd anniversary year of the juvenile court in the United States. Guided by the spirit of the American Child Guidance movement, juvenile court judges sought professional assistance in understanding the mental health problems of children who appeared before the court. In 1909, William Healy established the Juvenile Psychoanalytic Institute, later renamed the Institute of Juvenile Research. The purpose of the Institute was to evaluate and diagnose children seen by the juvenile court. As time passed, the value of mental health professionals became more apparent, and an increasing number of clinics servicing the juvenile justice system were established. Today, the juvenile court's reliance on mental health professionals is stronger than ever. An important development has been the centralization of mental health services. Some assessment centers like Juvenile Assessment Centers (JAC), Target Cities or Treatment Alternatives for Safe Communities (TASC) provide a single point of entry for assessment and provisions for comprehensive services.

The advent of *The Juvenile Justice and Residential Care Treatment Planner* is a continuation of Wiley's Practice Planners, which are designed to provide specialized resources for professionals. To enhance the treatment resources for children and adolescents, Wiley's first step was to create a treatment planner that addressed the unique mental health needs of children and adolescents. *The Juvenile Justice and Residential Care Treatment Planner* enhances this effort by expanding on the resources

available to address the treatment concerns specifically relative to children and adolescents who are involved in the legal system. *The Juvenile Justice and Residential Care Treatment Planner* blends mental health and legal concerns in a variety of ways. Chapters that highlight traditional mental health diagnoses incorporate important matters relative to delinquency within the behavioral definitions, objectives, and treatment interventions. In addition, other chapters focus primarily on delinquent activities and highlight specific mental health concerns that may need to be addressed.

The Juvenile Justice and Residential Care Treatment Planner was developed to assist professionals (e.g., probation officers, case managers, therapists, etc.) who are working with youth in the juvenile justice system. However, this book is equally suited to assist professionals who work with clients in outpatient or residential settings who engage in delinquent behavior even though the client may not be formally charged or involved with the legal system. At times, professionals who use the Planner may discover the close relationship that exists between mental health concerns and the acting- out behaviors that come to the attention of the juvenile court. Many young people who interface with the juvenile court have mental health diagnoses; thus, there is overlap when considering treatment options for this population and other youth with mental health diagnoses. It is hoped that the uniqueness of this Planner will illustrate how the juvenile court client frequently requires specific interventions.

An additional goal of *The Juvenile Justice and Residential Care Treatment Planner* is to assist professionals in collaborating with one another to provide comprehensive services to this client population. It suggests a spectrum of services that may be necessary to address the needs of youth who are committing delinquent acts and who may

also be involved with the juvenile court. In this way, *The Juvenile Justice and Residential Care Treatment Planner* provides a variety of professionals with useful information to inform and advance treatment decisions.

HISTORICAL BACKGROUND

Since the early 1960s, formalized treatment planning has gradually become a vital aspect of the entire health care delivery system, whether it is treatment related to physical health, mental health, child welfare, or substance abuse. What started in the medical sector in the 1960s spread into the mental health sector in the 1970s as clinics, psychiatric hospitals, agencies, and so on began to seek accreditation from bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to qualify for third-party reimbursements. For most treatment providers to achieve accreditation, they had to begin developing and strengthening their documentation skills in the area of treatment planning. Previously, most mental health and substance abuse treatment providers had, at best, a bare-bones plan that looked similar for most of the individuals they treated. As a result, clients were uncertain as to what they were trying to attain in mental health treatment. Goals were vague, objectives were nonexistent, and interventions were applied equally to all clients. Outcome data were not measurable, and neither the treatment provider nor the client knew exactly when treatment was complete. The initial development of rudimentary treatment plans made inroads toward addressing some of these issues.

With the advent of managed care in the 1980s, treatment planning has taken on even more importance. Managed care systems *insist* that clinicians move rapidly from assessment of the problem to the formulation and implementation of the treatment plan. The goal of most

managed care companies is to expedite the treatment process by prompting the client and treatment provider to focus on identifying and changing behavioral problems as quickly as possible. Treatment plans must be specific as to the problems and interventions, individualized to meet the client's needs and goals, and measurable in terms of setting milestones that can be used to chart the patient's progress. Pressure from third- party payers, accrediting agencies, and other outside parties has therefore increased the need for clinicians to produce effective, high- quality treatment plans in a short time frame. However, many mental health providers have little experience in treatment plan development. Our purpose in writing this book is to clarify, simplify, and accelerate the treatment planning process for youth involved in the juvenile justice system.

TREATMENT PLAN UTILITY

Detailed written treatment plans can benefit not only the client, therapist, treatment team, insurance community, and treatment agency, but also the overall psychotherapy profession. The client is served by a written plan because it stipulates the issues that are the focus of the treatment process. It is very easy for both the provider and the client to lose sight of what the issues were that brought the patient into therapy. The treatment plan is a guide that structures the focus of the therapeutic contract. Since issues can change as therapy progresses, the treatment plan must be viewed as a dynamic document that can and must be updated to reflect any major change of problem, definition, goal, objective, or intervention.

Clients and therapists benefit from the treatment plan, which forces both to think about therapy outcomes. Behaviorally stated, measurable objectives clearly focus the treatment endeavor. Clients no longer have to wonder what

therapy is trying to accomplish. Clear objectives also allow the patient to channel effort into specific changes that will lead to the long- term goal of problem resolution. Therapy is no longer a vague contract to just talk honestly and openly about emotions and cognitions until the client feels better. Both the client and the therapist are concentrating on specifically stated objectives using specific interventions.

Providers are aided by treatment plans because they are forced to think analytically and critically about therapeutic interventions that are best suited for objective attainment for the patient. Therapists were traditionally trained to "follow the patient," but now a formalized plan is the guide to the treatment process. The therapist must give advance attention to the technique, approach, assignment, or cathartic target that will form the basis for interventions.

Clinicians benefit from clear documentation of treatment because it provides a measure of added protection from possible patient litigation. Malpractice suits are increasing in frequency, and insurance premiums are soaring. The first line of defense against allegations is a complete clinical record detailing the treatment process. A written, individualized, formal treatment plan that is the guideline for the therapeutic process, that has been reviewed and signed by the client, and that is coupled with problem-oriented progress notes is a powerful defense against exaggerated or false claims.

A well- crafted treatment plan that clearly stipulates presenting problems and intervention strategies facilitates the treatment process carried out by team members in inpatient, residential, or intensive outpatient settings. Good communication between team members about what approach is being implemented and who is responsible for which intervention is critical. Team meetings to discuss

patient treatment used to be the only source of interaction between providers; often, therapeutic conclusions or assignments were not recorded. Now, a thorough treatment plan stipulates in writing the details of objectives and the varied interventions (e.g., pharmacologic, milieu, group therapy, didactic, recreational, individual therapy, etc.) and who will implement them.

Every treatment agency or institution is constantly looking for ways to increase the quality and uniformity of the documentation in the clinical record. A standardized, written treatment plan with problem definitions, goals, objectives, and interventions in every client's file enhances that uniformity of documentation. This uniformity eases the task of record reviewers inside and outside the agency. Outside reviewers, such as JCAHO, insist on documentation that clearly outlines assessment, treatment, progress, and termination status.

The demand for accountability from third- party payers and health maintenance organizations (HMOs) is partially satisfied by a written treatment plan and complete progress notes. More and more managed care systems are demanding a structured therapeutic contract that has measurable objectives and explicit interventions. Clinicians cannot avoid this move toward being accountable to those outside the treatment process.

The psychotherapy profession stands to benefit from the use of more precise, measurable objectives to evaluate success in mental health treatment. With the advent of detailed treatment plans, outcome data can be more easily collected for interventions that are effective in achieving specific goals.

HOW TO DEVELOP A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on each other, much like constructing a house. The foundation of any effective treatment plan is the data gathered in a thorough biopsychosocial assessment. As the client presents himself/herself for treatment, the clinician must sensitively listen to and understand what the client struggles with in terms of family- of- origin issues, current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, self- esteem, and so on. Assessment data may be gathered from a social history, legal file physical exam, clinical interview, psychological testing, or contact with a client's guardian, social service worker, and/or probation officer. The integration of the data by the clinician or the multidisciplinary treatment team members is critical for understanding the client, as is an awareness of the basis of the client's struggle. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

Step One: Problem Selection

Although the client may discuss a variety of issues during the assessment and court orders may request specific services, the clinician must ferret out the most significant problems on which to focus the treatment process. Usually a *primary* problem will surface, and *secondary* problems may also be evident. Some *other* problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems; otherwise, treatment will lose its direction. *The Juvenile Justice and Residential Care Treatment Planner* offers 32 problems from which to select

those that most accurately represent your client's presenting issues.

As the problems to be selected become clear to the clinician or the treatment team, it is important to include opinions from the client as to his/her prioritization of issues for which help is being sought. A client's motivation to participate in and cooperate with the treatment process depends, to some extent, on the degree to which treatment addresses his/her greatest needs.

Step Two: Problem Definition

Each individual client presents with unique nuances as to how a problem behaviorally reveals itself in his/her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes, such as those found in the *Diagnostic and Statistical Manual* or the *International Classification of Diseases*. The Planner, following the pattern established by *DSM-5*™, offers such behaviorally specific definition statements from which to choose or from which to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize 1 of the 32 presenting problems.

Step Three: Goal Development

The next step in treatment plan development is that of setting broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long- term goals that indicate a desired positive outcome to the treatment procedures. The Planner suggests several possible goal statements for each

problem, but one statement is all that is required in a treatment plan.

Step Four: Objective Construction

In contrast to long- term goals, objectives must be stated in behaviorally measurable language. It must be clear when the client has achieved the established objectives; therefore, vague, subjective objectives are not acceptable. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that psychological treatment outcome be measurable. The objectives presented in this Planner are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment as to which objectives are most appropriate for a given client.

Each objective should be developed as a step toward attaining the broad treatment goal. In essence, objectives can be thought of as a series of steps that, when completed, will result in the achievement of the long- term goal. There should be at least two objectives for each problem, but the clinician may construct as many as are necessary for goal achievement. Target attainment dates should be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all of the necessary objectives have been achieved, the client should have resolved the target problem successfully.

Step Five: Intervention Creation

Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does