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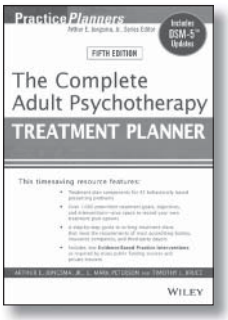

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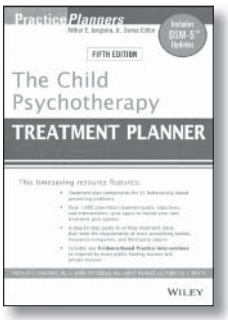

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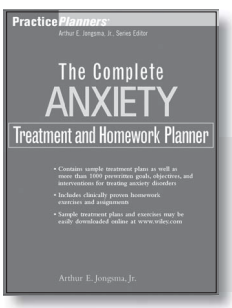

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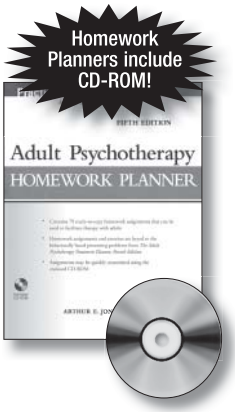

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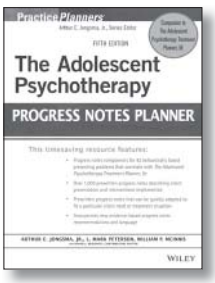

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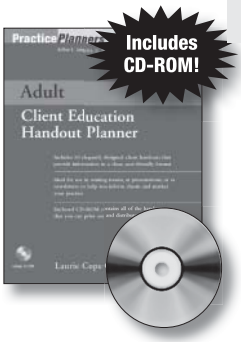

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The Intellectual and Developmental Disability Treatment Planner, with DSM-5 Updates

Kellye Slaggert

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To Jeff, Tyler, Casey, Mitchell, and Danielle for their unyielding and constant support while I spent countless hours in front of the computer. This book truly was a family effort.

—Kellye Slaggert

To all those parents and family members who have advocated for, loved, and supported their fellow family member who is developmentally disabled. They have taught us selfless service.

—Arthur E. Jongsma, Jr.

CONTENTS

PRACTICE*PLANNERS*® 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:

- Addictions
- Co-occurring disorders
- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Gays and lesbians
- Group therapy
- Juvenile justice and residential care
- Intellectual and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders

- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services
- Special education
- Speech-language pathology
- Suicide and homicide risk assessment
- Veterans and active military duty
- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***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

PREFACE

Many powerful lessons have been learned in working with clients with developmental disabilities, some lessons far more powerful than any formal education. This book is enhanced by our having learned these lessons and by our having had the privilege of working with developmentally disabled clients. It is our hope that this Planner will make a significant contribution to improving the quality and consistency of care provided to people with developmental disabilities.

Examining the needs of this population yields a vast array of abilities and needs. Each person with a developmental disability is unique. Addressing the vast range of intellectual and adaptive abilities and the interactive effect of each creates a myriad of unique combinations. This book aims for comprehensive coverage of the needs of clients with developmental disabilities in a concise manner with thorough content.

Readers should use this book guided by what is important to the individual client and his/her family, letting them pursue their own dreams and goals. Empowering the client with decision making places the agency in a position of responding to the needs of the clients. This is a major shift away from making the client fit into the system. This requires listening to the client regarding what he/she needs to have a good life. Use of treatment plan suggestions in this book should be guided by the client's vision and dreams for his/her own life.

By promoting choices, independent decision making, positive community participation, and individual competencies, agencies can lay the foundation for a person's life plan. Program goals and objectives should be client focused and crafted to ensure that activities are age appropriate, functional, and community referenced.

Skill acquisition chapters should be used as guiding points, building upon the person's strengths and existing capacities. When skill building is not feasible, supports need to be provided to the client. Support networks, resources, and personnel, both formal and informal, need to be geared toward meaningful community involvement.

As we were writing this book, a companion book was being written by David Berghuis and Arthur Jongsma, the *Severe and Persistent Mental Illness*

Treatment Planner. The authors shared ideas and insights during the development of the two manuscripts; therefore, these two books should be viewed as complementing one another. The companion books are intended to be useful to clinicians in community mental health settings or elsewhere who serve clients with developmental disabilities, severe and persistent mental illness, or both conditions.

We are deeply indebted to the people and agencies that permitted access to their libraries—Steve Goodman from the Ottawa Area Intermediate District, Al Hoogewind at Hope Network, the Pine Rest Center for Developmental Disabilities, Ottawa County Community Mental Health, and the local offices of the Association of Retarded Citizens. From each library, valuable sources of information contributing to this book were obtained.

Special thanks goes to the individuals who offered insightful suggestions from their respective specialties—Dale Drooger, Karen Becker, and Susan Karpinski from Ottawa County Community Mental Health.

We are grateful to Jen Byrne for her assistance and support with preparing the manuscript and her patience and flexibility with some of the technical difficulties encountered during the scope of this book. She organized the innumerable details that are part of a completed manuscript.

David Berghuis and his wife Barbara, both community mental health professionals, spent numerous hours in reviewing chapters, improving wording, and offering critical review and helpful suggestions to enhance the contents of the chapters. Their fresh and objective ideas, coupled with their years of experience in working with clients with developmental disabilities, aided in bringing this book to completion. We would also like to recognize the able leadership of our editor at John Wiley & Sons, Kelly Franklin. She has worked tirelessly to make the Practice Planners a high-quality and successful series. Thank you again, Kelly.

Finally, at the completion of this project, we take time out to thank those who have granted us the time to spend writing, our spouses Jeff Slaggert and Judy Jongsma. Your support was invaluable.

—Arthur E. Jongsma, Jr.
—Kellye Slaggert

The Intellectual and Developmental Disability Treatment Planner, with DSM-5 Updates

INTRODUCTION

Since the 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. To achieve accreditation, most treatment providers 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 and third-party payers were uncertain about the direction of mental health treatment. Goals were vague, objectives were nonexistent, and interventions were not specific to individual clients. Outcome data were not measurable, and neither the treatment provider nor the client know 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. Medicaid managed care plans now require person-centered planning. Professional staff assist in the planning and delivery of treatment along with the planning and delivery of support systems needed by clients. Treatment and support provided must be designed to promote maximal independence, community involvement, and quality of life. This is a departure from Medicaid requirements and other regulatory standards of the past, which governed the treatment process each client received. 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 client'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.

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 mental health 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 provider and client to lose sight of what the issues were that brought the client to seek services. The treatment plan is a guide that clarifies and structures the focus of the treatment needs. Since issues can change as clinical services progress, 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.

Treatment plans for clients with developmental disabilities should be person centered. The person-centered planning process dictates that the client directs the planning process with a focus on what he/she wants and needs. This necessitates facilitating a support system for the client to live successfully in the community. This is different from the traditional treatment modality, which states that the client has a problem and will get better with treatment. A person experiencing developmental disabilities has a condition that requires support and assistance from others to live independently. The developmental disability cannot be cured with treatments.

Clients and clinicians benefit from the treatment plan, which forces both to think about clinical service outcomes. Behaviorally stated, measurable objectives clearly focus the treatment endeavor. Clients clearly understand the purpose of clinical services. Clear objectives also allow the client and care providers to channel their efforts into specific changes that will lead to the long-term goal of increased independence in identified areas. Both client and clinician 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 client. The formalized plan guides the treatment process. The clinician must give advance attention to the particular approaches and techniques that will form the basis for the interventions.

Clinicians benefit from clear documentation of treatment because it provides a measure of added protection from possible client litigation. Malpractice suits are increasing in frequency, and insurance premiums are soaring. The

first line of defense against allegations of malpractice 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 identified needs 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 client treatment used to be the only source of interaction between providers; often, therapeutic conclusions or assignment were not recorded. Now, a thorough treatment plan stipulates in writing the details of objectives and the varied interventions (pharmacological, milieu, group therapy, family therapy, recreational, individual therapy, and so on) 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 discharge 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 mental health 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 to document that interventions 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. The foundation of any effective treatment plan is the data gathered in a comprehensive assessment. As the client presents himself or herself for services, the clinician must sensitively listen in order to understand the client's needs, desires, 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, physical exam, clinical interview, psychological testing, behavioral analysis, or contact with the client's significant others. 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 needs. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

Step One: Need Selection

This Planner presents 28 common habilitative and mental health needs of persons with developmental disabilities. It is important to start with a thorough review of all the client's records followed by obtaining the client's and caretaker's view of his or her needs and long-term goals. The clinician must ferret out the most significant needs on which to focus the treatment process. Usually a *primary* need will surface, and *secondary* needs may also be evident. Some *other* needs may have to be set aside as insufficiently urgent to require treatment at this time. An effective treatment plan can only deal with a few selected needs, or clinical services will lose their direction.

As the clinical needs become clear to the clinician or the treatment team, it is important to include opinions from the client as to his or her prioritization of issues for which services are 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 or her greatest needs.

Step Two: Need Definition

Each individual client presents with unique nuances as to how clinical needs behaviorally reveal themselves in his or her life. Therefore, each problem that is selected for a psychological treatment focus requires a specific definition about how it is evidenced in the particular client. The clinically based needs chapters have *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) criteria associated with the client's signs and symptoms of mental illness. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-5* or the *International Classification of Diseases.* (However, note that some third-party payers may require that the presenting medical diagnosis remain the primary diagnosis of record). This Planner, following the pattern established by *DSM-5,* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.

Step Three: Goal Development

The next step in treatment plan development is that of setting broad goals for the procurement of identified needs. 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. This Planner suggests several possible goal statements associated with each chapter, but one statement is usually 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 mental health 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 identified needs. 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 may be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all the necessary objectives have been achieved, the client should have demonstrated progress with skill deficits or improvements in Axis I symptomatology.

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 not accomplish the objective after the initial intervention, extended time frames or new interventions should be added to the plan.

Interventions should be selected on the basis of the client's needs and desires and the treatment provider's full therapeutic repertoire. This Planner contains interventions from a broad range of therapeutic approaches, including

cognitive, dynamic, behavioral, pharmacologic, family-oriented, and solution-focused brief therapy. The underlying focus across the range of interventions centers on helping clients obtain maximal independence and functioning. Other interventions may be written by the provider to reflect his or her own training and experience. The addition of new problems, definitions, goals, objectives, and interventions to those found in the Planner is encouraged because doing so adds to the database for future reference and use.

Some suggested interventions listed in this Planner refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. The books, videos, and skill-promoting aides are arranged under each chapter for which they are appropriate as assigned reading or viewing for clients. When a bibliotherapy source is used as part of an intervention plan, it should be reviewed with the client after it is read, enhancing the application of the content of the book to the specific client's circumstances. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Books* (1994) by Santrock, Minnett, and Campbell (available from The Guilford Press, New York). The Internet is also a rich source for locating information and self-help books, especially for recent publications (e.g., www.amazon.com or www.barnesandnoble.com).

Assigning an intervention to a specific provider is most relevant if the client is being treated by a multidisciplinary team (e.g., nurse, physical therapist, occupational therapist, psychologist, and psychiatrist) in an inpatient, residential, or intensive outpatient setting. Within these settings, personnel other than the primary clinician may be responsible for implementing a specific intervention. Review agencies may require that the responsible provider's name be stipulated for every intervention.

Step Six: Diagnosis Determination

The determination of an appropriate psychological diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents to the criteria for diagnosis of a mental illness condition as described in *DSM-5*. The issue of differential diagnosis is admittedly a difficult one that research has shown to have rather low interrater reliability. Psychologists have also been trained to think more in terms of maladaptive behavior than in terms of disease labels. In spite of these factors, diagnosis is a reality that

exists in the world of mental health care, and it is a necessity for third-party reimbursement. (However, recently, managed care agencies are more interested in behavioral indices that are exhibited by the client than in the actual diagnosis.) It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis. An accurate assessment of behavioral indicators will also contribute to more effective treatment planning.

HOW TO USE THIS PLANNER

Our experience has taught us that learning the skills of effective treatment plan writing can be a tedious and difficult process for many clinicians. It is more stressful to try to develop this expertise when under the pressure of increased client load and short time frames placed on clinicians today by managed care systems. The documentation demands can be overwhelming when we must move quickly from assessment to treatment plan to progress notes. In the process, we must be very specific about how and when objectives can be achieved, and how progress is exhibited in each client. *The Intellectual and Developmental Disability Treatment Planner* was developed as a tool to aid clinicians in writing a treatment plan in a rapid manner that is clear, specific, and highly individualized according to the following progression:

1. Based on referral information, caregiver insight, and client self-reporting, identify the client's clinical/habilitative need (Step One). Locate the corresponding page number for that problem (or a closely related problem) in the Planner's table of contents.
2. Select two or three of the listed behavioral definitions (Step Two) and record them in the appropriate section on your treatment plan form. Feel free to add your own defining statement if you determine that your client's behavioral manifestation of the identified clinical/habilitative need is not listed.
3. Select a single long-term goal (Step Three) and again write the selection, exactly as it is written in the Planner or in some appropriately modified form, in the corresponding area of your own form.
4. Review the listed objectives for this problem and select the ones that you judge to be clinically indicated for your client (Step Four). Remember, it is recommended that you select at least two objectives

for each problem. You may add a target date or the number of sessions allocated for the attainment of each objective.

5. Choose relevant interventions (Step Five). The Planner offers suggested interventions related to each objective in the parentheses following the objective statement. But do not limit yourself to those interventions. The entire list is eclectic and may offer options that are more tailored to your theoretical approach or preferred way of working with clients. Also, just as with definitions, goals, and objectives, there is space allowed for you to enter your own interventions into the Planner. This allows you to refer to these entries when you create a plan around this problem in the future. You may assign responsibility to a specific person for implementation of each intervention if the treatment is being carried out by a multidisciplinary team.
6. Several *DSM-5* diagnoses are listed at the end of each chapter that are commonly associated with clients who have this type of problem. These diagnoses are meant to be suggestions for clinical consideration. Select a listed diagnosis or assign a more appropriate choice from the *DSM-5* (Step Six).

   Note: To accommodate those practitioners who tend to plan treatment in terms of diagnostic labels rather than presenting problems, Appendix B lists all the *DSM-5* diagnoses that have been presented in the various presenting problem chapters as suggestions for consideration. Each diagnosis is followed by the presenting problem that has been associated with that diagnosis. The provider may look up the presenting problems for a selected diagnosis to review definitions, goals, objectives, and interventions that may be appropriate for clients with that diagnosis.

Congratulations! You should now have a complete, individualized treatment plan that is ready for immediate implementation and presentation to the client. It should resemble the format of the sample plan presented at the end of this introduction.

A FINAL NOTE

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The indi-

vidual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns *must* be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgement, clinicians can easily select the statements that are appropriate for the individuals they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. It is our hope that *The Intellectual and Developmental Disability Treatment Planner* will promote effective, creative, treatment planning—a process that will ultimately benefit the client, clinician, and mental health community.

SAMPLE TREATMENT PLAN

Problem: SOCIAL SKILLS

Definitions: Strained interpersonal relationships resulting from inappropriate or exaggerated emotional responses.
Lack of skills to be assertive in making peer choices to avoid problem social situations.

Goals: Learn and implement social skills that allow for controlled, appropriate expression of emotions.

Short-Term Objectives	Therapeutic Interventions
1. Participate in an assessment of social skills.	1. Arrange for an assessment of the client's social skills to establish a baseline of the client's ability and to gain insight into his/her strengths and weaknesses. 2. Ask family members or care givers to complete the Social Performance Survey Schedule (Matson, Helsel, Bellack, and Sanatore) prior to and after treatment. 3. Provide direct feedback to the client, family members, and caregivers on the results of an assessment.
2. Adhere to training recommenda-	1. Obtain consensus from the

(Continued)

tions made from social skills evaluation.	client, family members, school officials, and caregivers re-garding suitable social skills training programs or interventions that build on the client's strengths and compensate for his/her weaknesses; make referral to the selected program.
3. Maximize social skills acquisition by participating in social skills training exercises.	1. Encourage parents, caregivers, and teachers to model social skills that the client can imitate. 2. Develop a specific plan regarding social skills to be taught, modalities to be used, and the number of sessions needed.
4. Implement basic social interaction skills.	1. Present social skills of benefit to the client (e.g., basic conversational skills, self-assertion, honesty, truthfulness, and how to handle teasing), identifying critical components, while providing positive and negative role-playing to the client for each skill; reward progress using a predetermined schedule of reinforcement. 2. Assess the client's comprehension of presented skills by requesting that he/she verbalize or role-play social skills. 3. Assess the client's ability to conform his/her behavior to acquired knowledge of social skills through spontaneous role-playing, self-reports, and reports from caregivers or supervisors.
5. Identify labels for and trigger events of strong emotions.	1. Teach the client about the different emotions and how to identify the triggering event of an emotion (e.g., "I am angry

(Continued)

	because I was not considered for a job"). 2. Request that the client identify his/her own problematic emotions and the situations that elicit those problematic emotions.
6. Demonstrate the ability to control and express strong emotions in a socially acceptable manner.	1. Assist the client in listing potential rewards that can be used to reinforce behavioral progress in social skills training. 2. Assist the client in identifying healthy ways to control and express problematic emotions, role-playing his/her identified strategies. Utilize role-reversal techniques to teach the impact of his/her negative behavior on others. 3. Provide the client with a written or pictorial form of his/her problematic emotions, triggers, and healthy responses so this can be referred to in the future.

DIAGNOSIS

F84.0	Autism spectrum disorder
F71	Moderate Intellectual Disability

Note: The numbers in parentheses accompanying the short-term objectives in each chapter correspond to the list of suggested therapeutic interventions in that chapter. Each objective has specific interventions that have been designed to assist the client in attaining that objective. Clinical judgment should determine the exact intervention to be used, including any outside of those suggested.