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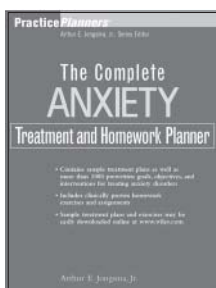
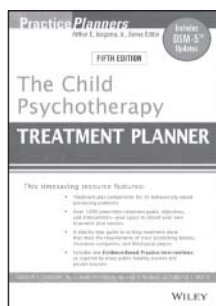
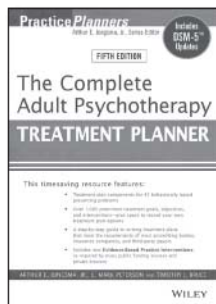
WILLIAM P. McINNIS, WANDA D. DENNIS, MICHELL A. MYERS,
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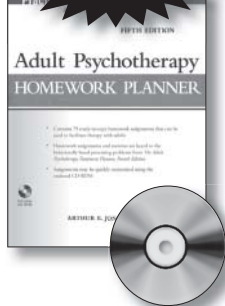
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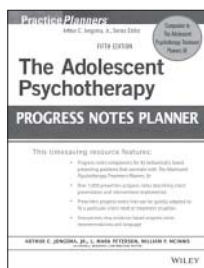
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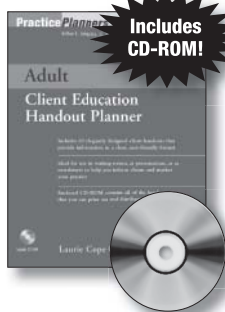


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PracticePlanners®

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.

WILEY

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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.*

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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 *PracticePlanners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The *PracticePlanners*® 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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- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
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- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders

- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
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- 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

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.

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WANDA D. DENNIS, PH.D.

Participating in this project would not have been possible without the love and support of my husband Pierre, my mother Albertha Myers, my father Ernest Myers, and a host of family and friends. And I can't forget the patience of my son Micah. A special thanks to Vetta Sanders Thompson, Ph.D., for her professional guidance and advice.

MICHELL A. MYERS, PH.D.

I would like to thank my husband Joe Sullivan for his boundless patience,

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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

2 THE JUVENILE JUSTICE AND RESIDENTIAL CARE TREATMENT PLANNER

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.

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

Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. *The Juvenile Justice and Residential Care Treatment Planner* contains interventions from a broad range of therapeutic approaches, including cognitive, dynamic, behavioral, multisystemic, pharmacologic, family-oriented, and client-centered therapy. Other interventions may be written by the provider to reflect his/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 the 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 are arranged under each problem for which they are appropriate as assigned reading for clients. When a book 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).

A list of reference resources is also provided for the professional provider in Appendix C. These books are meant to elaborate on the methods suggested in some of the chapters.

Assigning an intervention to a specific provider is most relevant if the patient is being treated by a team 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 require that the responsible provider's name be stipulated for every intervention.

Step Six: Diagnosis Determination

The determination of an appropriate 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 with 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 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 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 patient 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 Juvenile Justice and Residential Care 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. Choose one presenting problem (Step One) that you have identified through your assessment process. Locate the corresponding page number for that problem in the Planner's table of contents.
2. Select two or more 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 problem is not

listed. (Note that while our design for treatment planning is vertical, it will work equally well on plan forms formatted horizontally.)

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. 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 that are related to each objective in the parentheses following the objective statement. However, 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 will have to 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 a client who has this problem. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed or assign a more appropriate choice from the *DSM-5* (Step Six).
7. To accommodate those practitioners who tend to plan treatment in terms of diagnostic labels rather than presenting problems, Appendix B lists all of 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 their 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 on the facing page.

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 individual'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 judgment, clinicians can easily select the statements that are appropriate for the individuals whom 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 Juvenile Justice and Residential Care 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: PROBATION NONCOMPLIANCE

- Definitions:** Failure to obey court-ordered probationary requirements and directives.
Disobedience of reasonable directions of the caregiver.
- Goals:** Comply with all probationary directives.
Comply with the rules and expectations in the home, school, work setting, and in the community on a consistent basis.

Short-Term Objectives

1. Complete psychological testing to identify factors that may contribute to probation noncompliance. (1, 2)
2. Identify obstacles to complying with the recommendations and/or requirements of the juvenile justice system. (3)

Therapeutic Interventions

1. Arrange for psychological testing of the client to assess current cognitive, social, and emotional factors that contribute to noncompliant behavior.
2. Provide feedback to the client and his/her caregiver, juvenile justice officials, and relevant school personnel regarding the assessment results and recommendations.
3. Assist the client in identifying situations or personal problems that interfere with his/her compliance with the terms of probation (e.g., family conflict, peer pressure, unresolved grief, academic skills deficits, etc.).

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3. Implement a constructive problem-solving approach to obstacles to probation noncompliance. (4)
4. Verbalize an awareness of how probation noncompliance impacts family members and self. (5, 6)
5. The caregiver learns and implements appropriate and effective parenting techniques and disciplinary strategies. (7, 8, 9)
4. Teach the client problem-solving techniques (e.g., define the problem, brainstorm possible solutions, list pros and cons of each possible solution, implement action, evaluate outcome, etc.) that can be applied to personal problems that interfere with his/her probation noncompliance.
5. Discuss the negative consequences for the client from his/her noncompliant behaviors (e.g., more restrictive settings, tether, tighter curfews, etc.) and the positive consequences that arise from compliant behavior (e.g., terminating probation, increased independence, less restrictive curfew, etc.).
6. Assist the client in identifying the short- and long-term consequences of violating probation for family members (e.g., prolonged involvement with legal system, disappointment and resentment, loss of trust, etc.).
7. Recommend that the caregiver read books on effective parenting and limit setting (e.g., *The New Dare to Discipline* by Dobson; *Parents, Teens, and Boundaries* by

Bluestain; *Toughlove* by York, York, and Wachtel; or *Parents and Adolescents* by Patterson and Forgatch).

8. Teach the caregiver how to implement effective parenting techniques and disciplinary strategies including natural and logical consequences.
9. Confront the caregiver's tendency to respond to the client's behavioral problems in an overly punitive or over-protective and lax manner.

Diagnosis: Oppositional Defiant Disorder F913

ACADEMIC UNDERACHIEVEMENT/ LEARNING DISABILITIES

BEHAVIORAL DEFINITIONS

1. Reading achievement, as measured by individually administered, standardized tests of reading recognition or comprehension, is significantly below the expected level, given the client's chronological age, grade, and measured intelligence.
2. Mathematical ability, as measured by individually administered, standardized tests, is significantly below the expected level, given the client's chronological age, grade, and measured intelligence.
3. Written language skills, as measured by individually administered, standardized tests, are significantly below the expected level given the client's chronological age, grade, and measured intelligence.
4. History of academic performance that is below the expected level, given the client's measured intelligence or performance on standardized achievement tests.
5. Repeated failure to complete school or homework assignments on time.
6. Poor organization or study skills.
7. Frequent tendency to postpone doing homework assignments in favor of engaging in recreational, leisure, or social activities.
8. Recurrent pattern of engaging in acting-out, oppositional, disruptive, and negative attention-seeking behaviors when encountering frustration in learning.
9. Low frustration tolerance as manifested by tendency to give up easily when encountering difficulty with schoolwork.
10. Excessive anxiety that interferes with performance during tests and ability to complete schoolwork in a timely manner.
11. Feelings of depression, insecurity, and low self-esteem that interfere with learning and academic progress.