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The Social Work and Human Services Treatment Planner, with DSM-5 Updates

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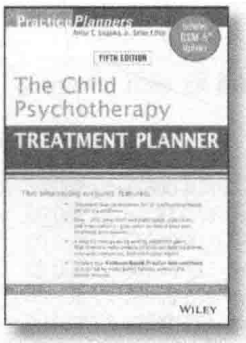

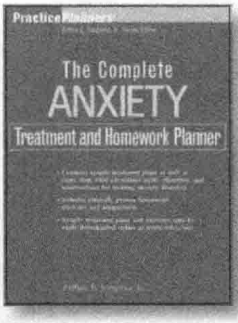

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PRACTICE*PLANNERS*® SERIES PREFACE

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:

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- Co-occurring disorders
- Behavioral medicine
- College students
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- Crisis counseling
- Early childhood education
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- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
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- Personality disorders

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- 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

To my wife, Lois Ann Wodarski.

—John S. Wodarski

To David and Emily Ann, who have contributed more to my life than I could ever express.

—Lisa Rapp-Paglicci

For my aunts, Kandy Henely and Alisa-Paris Miller, with much love and admiration.

—Catherine N. Dulmus

To Larry Slager, a compassionate social worker and a valued friend, who continues to teach me to understand and embrace human diversity.

—Arthur E. Jongsma, Jr.

INTRODUCTION

Formalized treatment planning, which began in the medical sector in the 1960s, has become an integral component of mental health service delivery in the 1990s. To meet Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and help clients qualify for third-party reimbursement, treatment plans must be specific as to goal selection, problem definition, objective specification, and intervention implementation. The treatment plan must be 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.

Although they are now a necessity, many clinicians lack formal training in the development of treatment plans. This is one area that most graduate school training programs fail to address, which often leaves the student at a disadvantage when embarking on clinical practice. The purpose of the *Social Work and Human Services Treatment Planner* is to clarify, simplify, improve, and accelerate the treatment planning process and to effectively deal with some of the hurdles that come with obtaining third-party authorization. It is also designed to serve as a framework for clinicians to follow as they plot an effective course of treatment with challenging cases.

TREATMENT PLAN UTILITY

Detailed written treatment plans can be beneficial to clients, the clinician, the treatment team, the insurance community, treatment agencies, and the overall mental health profession. The clients are served by a written plan which clearly delineates the issues that are the focus of treatment. It is very easy for both the clinician and the clients to lose sight of the issues that initially brought the clients into treatment. The treatment plan is a guide that structures the focus of the therapeutic contract and hopefully will help the clinician remain on track. Since issues can change as treatment progresses, the treatment plan must be viewed as a dynamic schematic or "road map" that can, and must, be updated to reflect any major change of problem, definition, goal, objective, or intervention. It also

serves as a tracking system for clinicians to use when attempting to explain periods of impasse during the process of treatment.

Recognizing that the plan will in most cases continue to evolve throughout the treatment process, it remains important to settle on initial treatment goals at the outset. Behaviorally based, measurable objectives clearly focus the treatment endeavor and provide a means of assessing treatment outcome. Clear objectives also allow clients to channel their efforts into specific changes that will lead to the long-term goal of conflict resolution and healthy interaction.

Clinicians are aided by treatment plans because they are forced to think analytically, and critically, about which interventions are best suited for objective attainment for their clients. In multiprovider settings, treatment plans are not only designed to help clarify objectives, but also serve the important function of delineating which clinician is responsible for what interventions. By providing a common language, the *Social Work and Human Services Treatment Planner* can ensure consistent and clear communication among members of the treatment team.

Good communication improves quality of care and mitigates risk to the clinician. Malpractice suits are unfortunately increasing in frequency, and insurance premiums are consequently soaring. The first line of defense against allegations of malpractice is a complete clinical record detailing the treatment process. A written, customized, formal treatment plan that has been reviewed and signed by the clients, coupled with problem-oriented progress notes, is a powerful defense against false claims.

Every treatment agency or institution is constantly looking for ways to increase the quality and uniformity of the documentation in the clinical record. The demand for accountability from third-party payers and health maintenance organizations (HMOs) is only increasing and is partially satisfied by a written treatment plan and complete progress notes. A standardized, written treatment plan with problem definitions, goals, objectives, and interventions in every client's file enhances that uniformity of documentation and offers a means of improving care.

Finally, the social work and human services 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 one another. The foundation of any effective treatment plan is

the data gathered in a thorough biopsychosocial assessment. As clients present themselves for treatment, the clinician must sensitively listen in order to understand the issues the client is struggling with—in terms of current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, power control, and so on. Assessment data may be gathered from a social history, physical exam, clinical interview, psychological testing inventories, or through the use of genograms. The integration of the data by the clinician or the multidisciplinary treatment team members is critical in understanding the client's issues. Once the assessment is complete, following the six steps listed here will help to ensure the development of a sound treatment plan.

Step One: Problem Selection

This *Social Work and Human Services Treatment Planner* offers 32 problems to select from. Although clients may discuss a variety of issues during the assessment phase, the clinician must ferret out the most significant problems on which to focus the treatment process. Usually a primary problem will surface; secondary problems are more covert and may become evident later. Some problem issues may have to be set aside as insufficiently urgent to warrant treatment at this time. These can be identified as tertiary issues and addressed later. An effective treatment plan can only deal with a few selected problems, or treatment will lose its direction. Thus, priority schedules can and should be used within the treatment planning process.

In choosing which problems to focus on, it is important to note which problems are most acute or disruptive to a client's functioning. The 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. Obviously, this step will vary depending on the specific treatment modality the clinician chooses to employ. While some therapeutic approaches lend themselves to outlining problems and issues more clearly than others, the clinician is advised to attempt to modify these steps to accommodate the respective approach.

Step Two: Problem Definition

Each individual client uniquely reveals how a problem behaviorally manifests itself in his or her life. Therefore, each problem that is selected for treatment focus must be defined in its relation to the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those

found in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) or the *International Classification of Diseases.* The *Social Work and Human Services Treatment Planner,* following the pattern established by *DSM-5,* offers an array of behaviorally specific problem definition statements. Each of the presenting problems listed in the table of contents has several behavioral symptoms from which to choose. These prewritten definitions may also be used as models in crafting additional definitions.

Step Three: Goal Development

The next step in the treatment planning stage is to set broad goals for the resolution of the target problem. These statements need not to be crafted in measurable terms but, instead, should focus on the global, long-term outcomes of treatment. Although the *Social Work and Human Services Treatment Planner* suggests several possible goal statements for each problem, it is only necessary to select one goal for each 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. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that treatment results be measurable. As a result, the objectives presented in this *Social Work and Human Services Treatment 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 and how these objectives fit with their particular modality of therapy.

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 select as many as necessary for goal achievement. Target attainment dates should be listed for each objective. New objectives may be added to the plan as treatment progresses. When all of the necessary objectives have been achieved, the client should have resolved the target problem successfully, or at least be well en route to doing so.

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 clinician's full treatment repertoire. This *Social Work and Human Services Treatment Planner* contains interventions from a broad range of therapeutic approaches, including cognitive, dynamic, behavioral, pharmacological, systems-oriented, experiential/expressive, and solution-focused brief therapy. It should be kept in mind, however, that not all modalities of treatment adhere to treatment planning in the same way. Depending on the specific modality of treatment, the mere concept of a treatment plan at all may be incongruous with the basic tenet of the approach. Consequently, it is left to the treating clinician to chose a treatment modality that will lend itself to effective treatment planning.

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 to the criteria for diagnosis of a mental illness as described in *DSM-5*. Careful assessment of behavioral indicators facilitate a more accurate diagnosis and more effective treatment planning.

HOW TO USE THIS PLANNER

Acquiring skill in composing effective treatment plans can be a tedious and difficult process for many clinicians. The *Social Work and Human Services Treatment Planner* was developed as a tool to aid clinicians in quickly writing treatment plans that are clear, specific, and customized to the particular needs of each client. Treatment plans should be developed by moving, in turn, through each of the following steps:

1. Choose one presenting problem with the client that you have identified in the assessment process. Locate the corresponding page number for that problem in the *Social Work and Human Services Treatment Planner*'s table of contents.
2. Select two or three of the listed behavioral definitions and record them in the appropriate section on the treatment plan form.
3. Select a single long-term goal, and record it in the Goals section of the treatment plan form.
4. Review the listed objectives for this problem and select the ones clinically indicated for the client. Remember, it is recommended that at least two objectives be selected for each problem. Add a target date or the number of sessions allocated for the attainment of each objective.
5. Choose relevant interventions. The numbers of the interventions most salient to each objective are listed in parentheses following the objective statement. Feel free to choose other interventions from the list, or to add new interventions as needed in the space provided.
6. *DSM-5* diagnoses that are commonly associated with the problem are listed at the end of each chapter. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed or assign a more appropriate choice from the *DSM-5*.

   Note: To accommodate those practitioners who tend to plan treatment in terms of diagnostic labels rather than presenting problems, the appendix lists all of the *DSM-5* diagnoses that are included in the Planner, cross-referenced to the problems related to each diagnosis.

Following these steps will facilitate the development of complete, customized treatment plans ready for immediate implementation and presentation to the clients. The final plan should resemble the format of the sample plan presented at the end of this introduction.

A WORD OF CAUTION

Whether using the print Planner or the electronic version, it is critical to remember that effective treatment planning requires that each plan be tailored to the specific client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. Each client's strengths and weaknesses, unique stressors, social network, individual circumstances, and interactional patterns must be considered in developing a treatment strategy. The clinically derived statements in this Planner can be combined in thousands of permutations to develop detailed treatment plans. In addition, readers are encouraged to add their own definitions, goals, objectives, and interventions to the existing samples, particularly as they pertain to their respective mode of treatment. Clinicians are also urged to proceed with treatment planning in a manner that ensures the utmost confidentiality.