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BRADFORD M. BOGUE, ANJALI NANDI, AND ARTHUR E. JONGSMA, JR.

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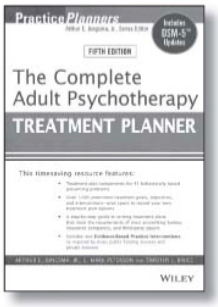


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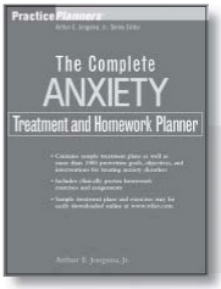


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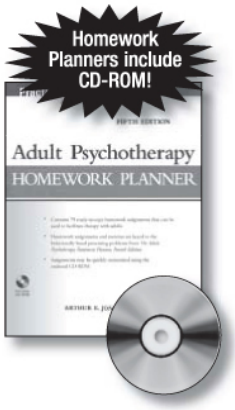


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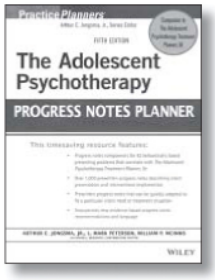


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**Arthur E. Jongsma, Jr., Series Editor**

# The Probation and Parole Treatment Planner, with DSM-5 Updates

***Brad M. Bogue***

***Anjali Nandi***

***Arthur E. Jongsma, Jr.***

WILEY

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To my wife, Andrea, my daughter, Beccah and my son, Sam, for their continuous ability to make my life meaningful and wonderful

—B.M.B.

To Elbert Gibford, my husband, my best friend, my source of endless love and support; to my family, Margaret Fraser, Jennifer Nandi, Sanjay Nandi, and Aarathi Bhat for their unconditional love; and, to my father for being here in spirit

—A.N.

To Beccah Bogue, one of God's marvelous lights, strong then weak, now becoming strong again and looking for her perfect place to shine. Watch for her brightness. It will not be denied.

—A.E.J.

# 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
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- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
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- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
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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.

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- ***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*

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hanging on and creating a gift to your profession—*The Probation and Parole Treatment Planner*.

# INTRODUCTION

Gradually, since the early 1960s, formalized treatment planning has become a vital aspect of the healthcare 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 to 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. With the advent of managed care in the 1980s, treatment planning became even more important. Managed care systems *insisted* that clinicians move rapidly from problem assessment to 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 specifically address presenting problems, behaviorally-defined symptoms, treatment goals and objectives, and interventions. Treatment plans must be individualized to meet the client's needs and goals, and the observable objectives must set milestones that can be used to chart the client's progress. Pressure from third-party payers, accrediting agencies, and other outside parties has 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. This book will clarify, simplify, and accelerate the treatment planning process.

# PLANNER FOCUS

*The Probation and Parole Treatment Planner* is written for practitioners in the field of corrections and related treatment areas (addictions, domestic violence, sex offender treatment, etc.). It serves as a guide with a comprehensive menu of case plan ingredients from which the officer or clinician may select offender objectives and/or practitioner interventions for addressing the criminogenic needs of offenders on their caseloads. Appropriate offender assessment to determine actuarial risk (for recidivism) and to identify each offender's most prominent criminogenic needs is a critical function that must precede the case planning protocols elaborated in this text.

The field of community corrections (e.g., probation, parole, residential halfway houses, day reporting) is dynamic and complex, involving a number of different *critical event cycles* within any agency. Research in the past 10 to 15 years, sometimes referred to as “What Works,” highlights the significance of effective intervention strategies in terms of potential reductions in recidivism and criminal victimization. As policy-makers listen to their constituencies on the one hand and their analysts and researchers on the other, the “What Works” literature and evidence has become a driving force for reengineering community corrections to have a greater accountability and emphasis on outcomes. This trend plays a significant role in shaping the demand for more efficient and effective offender case plans.

Case plans, long considered the linchpins for accountability in case management, have languished for 20 years, not evolving in corrections until recently. Given the advent of so-called third-generation risk/need offender assessment tools (LSI-R; Compas, etc.), the means for identifying offender criminogenic needs now mandates case plans that are tailored to these same critical factors. The chapters in

the *Planner* can each be logically subsumed or identified with the primary dynamic risk factors (e.g., antisocial peers, antisocial values, dysfunctional family relations, substance abuse, and self-control deficits) that have the most research evidence as being criminogenic. Therefore, the *Planner* should readily serve as a bridge between the offender needs identified in assessment and individualized plans of action to address those specific (and criminogenic) needs. This linkage is crucial for operationalizing the need and responsivity principles described throughout the "What Works" literature.

Many of the case plan short-term objectives in each of the problem-oriented *Planner* chapters are commonly found in a variety of cognitive behavioral skills training curriculum and adhere to cognitive behavioral training paradigms. Cognitive behavioral interventions are clearly indicated in the research as the preferred treatment strategy when working with corrections populations. This book emphasizes the suggestion of interventions that involve skill training with directed practice.

We assume that the monitoring and necessary surveillance of the client will be driven by the policies in each agency. Nevertheless, it is our recommendation that monitoring and necessary surveillance correspond to the risk principle, which is to provide services in proportion to risk levels: the greater the risk, the greater the level of surveillance services. Treatment or case plans for the client developed from this book should be consistent with the needs principle; that is, the provider must target those criminogenic need areas of the client with a sequential plan of treatment action. *The Probation and Parole Treatment Planner* is an ambitious guide for developing individual offender action plans in accordance with current research and demonstrated effectiveness.

# USING QUANTIFIABLE LANGUAGE IN TREATMENT PLANS

Appendix A contains the Criminal Peers chapter, which has been revised using more measurable, quantifiable language than in previous editions. In today's clinical-economic marketplaces of both managed care/third-party payors and accrediting bodies—JCAHO, NCQA, and CARF—there is an increased emphasis on behaviorally observable and/or quantifiable aspects of treatment plans. One reason for this is a general and national movement toward shorter inpatient stays (public and private hospitals and residential facilities) and briefer managed outpatient treatment, with the focus on specific symptom resolution. If you are experiencing such pressure, you may need to alter our *Treatment Planner* observable behavioral criteria into language that is more measurable and quantifiable.

Clinicians may want to look for the opportunity to craft measurable/quantifiable aspects of the patient's behaviors into their treatment plans. You may introduce measurability at the symptomatic level (e.g., behavioral definitions) and/or at the treatment outcome level (e.g., short-term objectives). Behavioral definition terms such as *repeated, frequent, tendency, pattern consistent, excessive, high-level, persistent, displays, heightened, recurrent,* and the like, and even words like *verbalizes, displays, demonstrates, refuses, unable, avoids, seeks, difficulty, increasing,* or *declining* can have frequencies or circumstances added to quantify the item. For example, the definition item “Verbalizes having suicidal ideation” can be made more quantifiably measurable by changing it to “Verbalizes having suicidal ideation once to twice daily for the past two weeks.”

Clinicians may add aspects of severity to symptom definition statements, in addition to frequency, to introduce greater measurability. For example, “Verbalizes having sad thoughts four to five times daily for the past two weeks and, on a scale from 1 to 10 (10 being the worst), were judged to be at an 8.” Or, alternatively, the clinician may list quantified psychometric data as a criterion measure, such as scores from symptoms screening instruments such as the BPRS, BDI, Ham-D, BSI, SCL-90-R, or GAF, to reduce subjectivity.

The short-term objective language found in the *Treatment Planner* can also be modified to follow the more quantified approach; thus, “Engage in physical and recreational activities that reflect increased energy and interest” becomes “Engage in physical and recreational activities within one week's time (by 1/20/2004).” Also, “Verbally express an understanding of the relationship between depressed mood and repression of sadness and anger” becomes “Verbally express an understanding of the relationship between depressed mood and repression of sadness and anger (by 1/18/2004).” A sample treatment plan containing quantified language is located at the end of this Introduction. This “Sample Quantitative Treatment Plan” exactly mirrors the “Sample Standard Treatment Plan” in terms of the items that have been selected from the “Criminal Peers” chapter.

# DEVELOPING A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on one another much like constructing a house. The foundation of any effective treatment plan is the gathering of data in a thorough biopsychosocial assessment. As the client presents himself or 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, physical exam, clinical interview, psychological testing, or contact with a 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 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, the clinician must focus the treatment process on the most significant problems. Usually a *primary* problem will surface, and *secondary* problems may also be evident. *Other* problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can deal only with a few selected problems or the treatment will lose its direction. This *Planner* offers 30 problems that you can use 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 about his or 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 or her greatest needs.

## STEP TWO: PROBLEM DEFINITION

Each individual client presents with unique nuances about how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition on how it is evidenced in that particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *Diagnostic and Statistical Manual (DSM)* or the *International Classification of Diseases (ICD)*. The *Planner,* following the pattern established by *DSM-5,* offers behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize one of the 30 presenting problems.

## STEP THREE: GOAL DEVELOPMENT

The next step in treatment plan development is to set broad goals for the resolution of the target problem. Although not crafted in measurable terms, these statements are 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 only one statement 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. Accrediting agencies, HMOs, and managed care organizations insist on measurable psychological treatment outcomes. The objectives presented in this *Planner* are designed to meet this demand for accountability. Alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment concerning the appropriateness of objectives 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, 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 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 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.