

PUBLICATION SERIES

PA CASSP Training and Technical Assistance Institute

WRITING EFFECTIVE TREATMENT PLANS: The Pennsylvania CASSP Model

By Marsali Hansen, Ph.D., ABPP

a CASSP technical assistance paper

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PUBLICATION SERIES

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WRITING EFFECTIVE TREATMENT PLANS The Pennsylvania CASSP Model

by Marsali Hansen, Ph.D., ABPP

Introduction

Children’s mental health service delivery has experienced a major metamorphosis during the past ten years. The introduction and implementation of the Child and Adolescent Service System Program (CASSP) has required a thorough reform of how children’s mental health services are conceptualized and delivered. The CASSP principles require a careful re-examination and re-conceptualization of the critical elements and skills required to prepare effective treatment plans. Treatment plans document the formulation of clear service planning for children being served by the mental health system. However, the children’s mental health system has changed significantly, and the CASSP principles identify critical factors that may have been overlooked in the past. The following paper provides a general framework for understanding the impact of CASSP principles on treatment plan writing, specifies necessary components of all treatment plans, and presents six areas of best practice that require careful attention.

The Principles

1. *Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child’s family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social, and physical needs of the child.*

The first CASSP principle states that services must be individualized and child-centered. Recognition of the unique qualities of children and individual differences among children is in itself a new way of doing business. Many professionals who currently work with children may have received initial training in adult mental health. Rarely are training programs based on a model of child development nor do they offer multiple classes in children’s service delivery except at the most specialized levels of training. More frequently, courses are provided in personality and abnormal psychology from an adult perspective with children added as a supplement if at all. Even when part of a curriculum focuses on children, a greater proportion focuses on adults, thereby resulting in an adult model of mental health that provides the theoretical foundation for clinical conceptualizations of the students. This first CASSP principle addresses the unique qualities of childhood and stresses that they must be included in the provision of services and documented in service plans.

In addition, this principle introduces a “strengths-based approach” and requires that strengths form the basis for all service delivery. Mental health services are traditionally deficit- and problem-oriented. Clients seek services for specific concerns and mental health professionals attempt to address them. The first CASSP principle requires mental health professionals to expand their skills to include the ability to identify and use the strengths of the child and the child’s family. Rarely are strengths included in professional training curriculum. Instead, professionals are trained to recognize and identify psychopathology. The identification and documentation of strengths

requires the use of a novel framework and new skills by professionals working with children.

Lastly, this principle stresses uniqueness. Planning for children requires creative approaches and that each plan reflect the special qualities of the individual child. Such an approach challenges the training of most professionals. Services are often justified by how positively they have affected groups of individuals: the more individuals have been affected, the more strongly the intervention is regarded and recommended. This first CASSP principle requires clinicians to expand upon their training, and incorporate individual differences into their use of validated models of service delivery. For example, participation in social skills groups has been identified as a valid method for increasing social skills for eight-year-olds. However, this CASSP principle requires that the strengths the child brings to the social skill group be incorporated into the intervention, and that the unique concerns of the individual child be addressed. Simply assigning the child to the social skill group is an insufficient intervention.

2. *Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring, and evaluation. A family may include biological, adoptive, and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation*

The second CASSP principle recognizes the expertise of the child’s family and requires that professionals do so as well. Professionals have long been trained to present themselves as experts to ensure the family follows through with treatment. This principle indelibly alters this perspective of the therapeutic relationship. The family participates as equal partners in determining the needs of the child. The principle requires the establishment of a

respectful and collaborative relationship between the family and the professional. In addition, the principle implies that the professional identify and accept the family’s definition of their own composition and who their members are. For example, aunts and uncles who are committed to the child may need to be included in all decision-making. Gone is the old adage, “the doctor knows best,” and returning is the adage, “parents know what’s best for their children.” The implementation of this principle requires the professional to document the involvement of the family throughout the treatment planning process rather than solely in the “family section” of the assessment.

3. *Whenever possible, services are delivered in the child’s home community, drawing on formal and informal resources to promote the child’s successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious, and cultural organization and other natural community support networks.*

The third principle reflects the vast changes occurring in mental health service delivery. Rarely are children hospitalized for long periods of time. Simultaneously, more and more services are being delivered in the community. The importance of the community has long been recognized in adult mental health and social psychology. Now equal importance is attributed to the community in children’s service delivery. Also mental health workers are challenged to incorporate the conceptualizations of community psychology, and expand their perceptions of their role to include interfacing with informal as well as formal community resources. The treatment plan then is expanded to include references to the community, and is written in such a way as to be applicable to community involvement in service provision.

4. *Services are planned in collaboration with all the child-serving systems involved in the child’s life. Representatives from all these*

systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

This fourth principle requires mental health providers to collaborate with other agencies who are involved with the child. The principle also implies that treatment plans be developed in the spirit of this cooperation with all agencies' goals and interventions creating a framework of coordinated services.

In the past when long-term hospitalizations were common practice, this collaboration occurred at inpatient team meetings that included such specialties as nursing, occupational therapy, physical therapy, school personnel, social work, psychology, psychiatry, and recreational therapy. The “primary therapist” might be a member of one of any number of disciplines and all members participated in the short- and long-term goals of the client. Now, however, this collaboration requires the additional effort of connecting with professionals who work at different agencies and respond to different laws (e.g., education, children and youth, juvenile justice) and different agency expectations. Such cooperation and collaboration requires additional skills from mental health professionals and a new perspective of best practice.

5. *Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of a particular group of people.*

Mental health professionals are now required to address the cultural strengths and needs of the specific child and the child's family and recognize the impact of these strengths and needs on service delivery. Society has become increasingly multicultural, and “one size no longer fits all.” Cultural competence has a direct impact on service delivery, and requires planning that incorporates the family as equal partners in the process. Culture has an impact on how the family defines itself, on who should be included in the assessment process, the language to be used in providing services, and the appropriateness of particular service modalities.

This fifth CASSP principle requires that multiple cultural factors be included in the formulation of services and treatment plans. Few professionals are trained to address these factors. Exploring and appropriately documenting the multiple dimensions of culture with children and families is a new and challenging task.

6. *Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.*

This sixth CASSP principle reflects the true metamorphosis of children's mental health service delivery. The strong voice of parents has been heard and children's mental health services have followed the lead of special education. “Least restrictive environments” are the preferred settings for interventions. Options for long-term hospitalization of children have been drastically reduced and communities are providing more and more services. The potential negative impact of labeling and public diagnosis is recognized as are the benefits of naturally occurring social experiences. Mental health workers are required to recognize and evaluate the potential harm as well as the benefits inherent in the services that are delivered. Children's mental health services have changed and treatment plan writing must reflect these changes.

The Concept of a Treatment Plan

Use of a treatment plan is a traditional part of mental health practice, especially in agencies. For example, a therapist providing outpatient psychotherapy to a child usually meets with the child and family to develop a treatment plan. In uncomplicated cases, the treatment plan assumes a single service (such as outpatient psychotherapy in the current example), and focuses on identifying clinical goals and objectives for the child and family. The treatment plan, in such instances, is a blueprint for clinical goal-development within a single service.

For children with complicated emotional and/or behavioral needs, more than a single agency may be involved, and more than a single mental health service may be medically necessary. The availability of EPSDT mental health services in the Commonwealth has enabled children who are eligible for medical assistance up to age 21 to receive a variety of services previously unavailable. In such cases, the treatment plan not only develops specific clinical goals and objectives; it also identifies the variety of services — mental health and other human services, and sometimes educational services — that the child needs in order to resume normalized functioning.

The treatment plan for children receiving EPSDT mental health services and for others with complex needs, therefore, serves two purposes: defining clinical goals and objectives and identifying specific services to help achieve those goals. What is called the “treatment plan” in Pennsylvania’s system of care is, in reality, a combination treatment plan/services plan.

Both the single service and the multiple service treatment plans serve as a blueprint for change and a “work plan,” identifying the strengths of the child and family and identifying areas of functioning to be addressed, desired outcomes, and interventions and services to be used to achieve desired outcomes. The treatment plan, when it is developed by the interagency team, represents a

tangible embodiment of mutual commitment among team members — the family, selected community resource persons identified by the family, and the professional members of the child’s team — to help the child. The development of the treatment plan involves the participation of the child’s family as equal partners in the process, with parental signatures on the completed document. As such, the treatment plan provides ethical justification for the entry of professionals into the lives of the child and family to provide mental health treatment for the child.

An effective treatment plan should be both informative and practical. A person reading a treatment plan should be able to grasp the major concerns and how they are being addressed. As a “work plan,” the initial treatment plan identifies the work to be done. Subsequent treatment plans must identify what is currently being done and what has recently been achieved, in addition to work and services planned for the future. By defining goals and objectives which can be monitored, the treatment plan becomes an instrument of accountability. Identified goals, objectives and outcomes can be actively tracked by the team, and modifications in treatment made as needed.

Components of All Treatment Plans

The following sections are identified as needing to be included in any documentation that serves as a plan for mental health service delivery.

Brief Description of the Child

This section was often referred to as “Identifying Data.” Our new terminology reflects the current move toward a strengths-based, respectful perspective toward children and their families. This section should include a brief description of who the child is and what progress he or she is making in treatment. The section should be limited to four to five sentences and include such material as age, ethnicity, current living arrangement, school status, recent treatment and treatment response, other system involvement, and attitude toward treatment. The section should not address mental status or diagnosis. Nor should the section address problems and concerns.

Example:

Tony is a thirteen-year-old Caucasian male living with his mother and four sisters in a three bedroom trailer. Tony is currently in the seventh grade and attends special classes for reading. Tony has been referred to counseling on multiple occasions but has yet to keep an appointment; he says, “Counseling is dumb.”

Child and Family Strengths

This section identifies the child’s and family’s strengths. Areas of strength might include **interests** (e.g., sports, music, extended family); **abilities** (art, listening skills, making new friends); **activities** (hunting, church, family reunions); and **capacities** (empathy, pride). Therapists need to be careful to avoid including “disguised weaknesses” such as “performs well if highly supervised.” Also, strengths need to be specific and unique. People reading the strengths section should be able to recognize the child and the child’s family from the description. Therapists looking to identify strengths might look toward the interests, abilities, activities, and capacities that make the individual a pleasure to work with. The strengths sections articulate and document these perceptions. A narrative example follows; however, strengths could be listed separately, in phrases rather than single words.

Example:

Tony is interested in rap music (Snoop Doggy Dog), motor cycles (Harleys) and social injustice. He relates to older adult males, and participates in activities with his sisters. He writes rap lyrics, makes friends easily (both male and female), and knows how to relate to the opposite gender. Tony’s family members look out for each other and defend each other in public. Tony’s mother is interested in her children graduating from high school.

Needs, Concerns and Problems

This section provides a specific description that identifies why the child was referred to the service and includes reasons for intervention. This section incorporates the child’s and family’s perception of the needs and concerns. Specific targets for intervention are clearly stated and needs and concerns are prioritized. The section refrains from stating the diagnosis, nor does it include a laundry list of a “multitude of sins.” The section forms the basis for the specific intervention; therefore, care needs to be taken in the choice of concerns that are presented. Irrelevant problems not related to the reason for referral and not addressed throughout the remainder of the treatment plan should be omitted and added as they arise.

Example:

Tony was referred to treatment to help increase his school attendance. Tony is frequently truant and in danger of failing. Tony’s mother is also concerned that Tony doesn’t come home in the evenings until after midnight. Tony expresses no interest in school and feels school activities aren’t relevant to him.

Progress Update and Review of Treatment Plan

Following the initial treatment plan, each subsequent treatment plan needs to describe the child’s overall progress and review the goals and objectives of the prior treatment plan, identifying those and objectives attained, those not attained, and those still in progress. On the basis of this review, a new treatment plan, with appropriate goals, objectives and services, can be developed.

Review of a previous treatment plan can occur in a separate section, or can be integrated into the delineation of current goals and objectives. Either way, the discussion of progress enables the individuals providing the service to modify the child’s treatment so that it continues to be current and individualized.

Statement of Goals and Objectives

A goal is a global statement that reflects a positive resolution to the identified need or problem, indicates the specific area of functioning to be addressed, and includes an outcome measure or expectation. An objective (short-term goal) is similar to and directly related to a specified goal but highly specific and reflecting small attainable

increments, developmentally appropriate, reflective of cultural strengths, and clearly incorporating the desires of the child, family and youth.

For example a goal might be the completion of seventh grade. The objectives could include attendance in class, completion of homework, appropriate classroom behavior, and passing tests. Critical components of goals and objectives are that both the child and family want the goal/objective attained and the goal/objective must be stated in positive terms (it is impossible to attain a “not” such as “not be confused”). In addition, the goal or objective must be measurable, attainable, observable, and capable of being evaluated. Goals and objectives must clearly relate to the needs and priorities agreed upon by the team and identified in the treatment plan.

Examples of Objectives (see Figure 1):

- *Tony acquires three new friends his age.*
- *Tony comes home by curfew on weekends.*
- *Tony shares his interest in music with his mother once a week.*

Figure 1
OBJECTIVES: MEASURABLE AND OBSERVABLE

Characteristics of Quality Objectives

- The child or child’s family wants it to happen
Example: Tony acquires three new friends his age.
Not: Joey attends therapy (the child may or may not want to attend therapy, particularly on a sunny day in the summer; going to therapy is a “method of intervention,” not a goal)
- The objective goal is stated in positive terms.
Example: Tony comes home by curfew on weekends.
Not: Tony quits hanging out all night.
- The objective can be measured, observed or concretely described.
Example: Tony tells his mother where he will be and when he will be home Saturday night.
Not: Tony improves communication.
- The objective is achievable; the objective is broken down into smaller, incremental tasks.
Example: Tony is home by 10 p.m. on Friday nights.

Not: Tony comes home at night.

- The objective can be accomplished within a short-term, identifiable period.

Example: Tony identifies three friends his age interested in his music.

Not: Tony joins a band and goes on tour.

- The objective can be easily understood.

Example: Tony shares his interest in music with his mother once a week.

Not: Tony communicates better.

- The objective uses a strengths-based approach.

Example: Tony writes his feelings oin rap lyrics to share with his mother.

Not: Tony talks about his feelings with his therapist (Tony denies the need for treatment.).

- The objective has one expected outcome per goal/objective.

Example: Tony increases his number of friends his age from zero to three.

Not: Tony makes more friends and likes school.

- The objective is appropriate to the child’s developmental level.

Example: Tony talks to his mother about his sisters.

Not: Tony talks to his mother about his girlfriends.

- The objective is appropriate.

Example: Tony shares his rap music with his mother.

Not: Tony shares his rap music with his English teachers.

- The objective is child-focused and related to the intervention.

Example: Tony discusses his plans for an afterschool rap group with his therapist.

Not: The therapist will talk to Tony about his own experience in Los Angeles.

Reasons Why Objectives Should Be Measurable and Observable

- Measurable objectives ensure that each child has an individualized treatment plan.
- Measurable objectives convey to all persons working with the child the same expectation and approach to the behavior being changed.
- Measurable objectives determine what treatment is being carried out and its effectiveness in working with the child.
- Measurable objectives determine the success of the interventions.

Methods/Interventions

The method and intervention section are descriptive statements of treatment that specify who, what, where, and how often, in observable terms. Staff, child, and family responsibilities and activities are clearly stated and the identified strengths are used to obtain the objectives. The method and intervention section is individualized

and specific to the child, members of the child’s family and community. The identification of modalities to be used in treatment (e.g., individual

therapy, family therapy, behavioral specialist services, etc.) does not constitute a method. It is important to specify the functions or actions of the staff member. The family’s cultural values and strengths are also carefully incorporated into the formulation and documentation of the intervention.

Example:

The therapist will meet with Tony and members of Tony’s family to formulate a list of locations where Tony will be after 10 p.m. Tony and his family will meet for a weekly problem-solving session to discuss how to keep Tony safe at night.

Target Date

In addition to establishing a target date for completion of the goals and objectives, the treatment plan ought to include plans for tapering off and eventually discontinuing mental health services.

Signatures

All treatment needs to clearly identify each participant by name and role, and each participant should sign and date the treatment plan. All parents

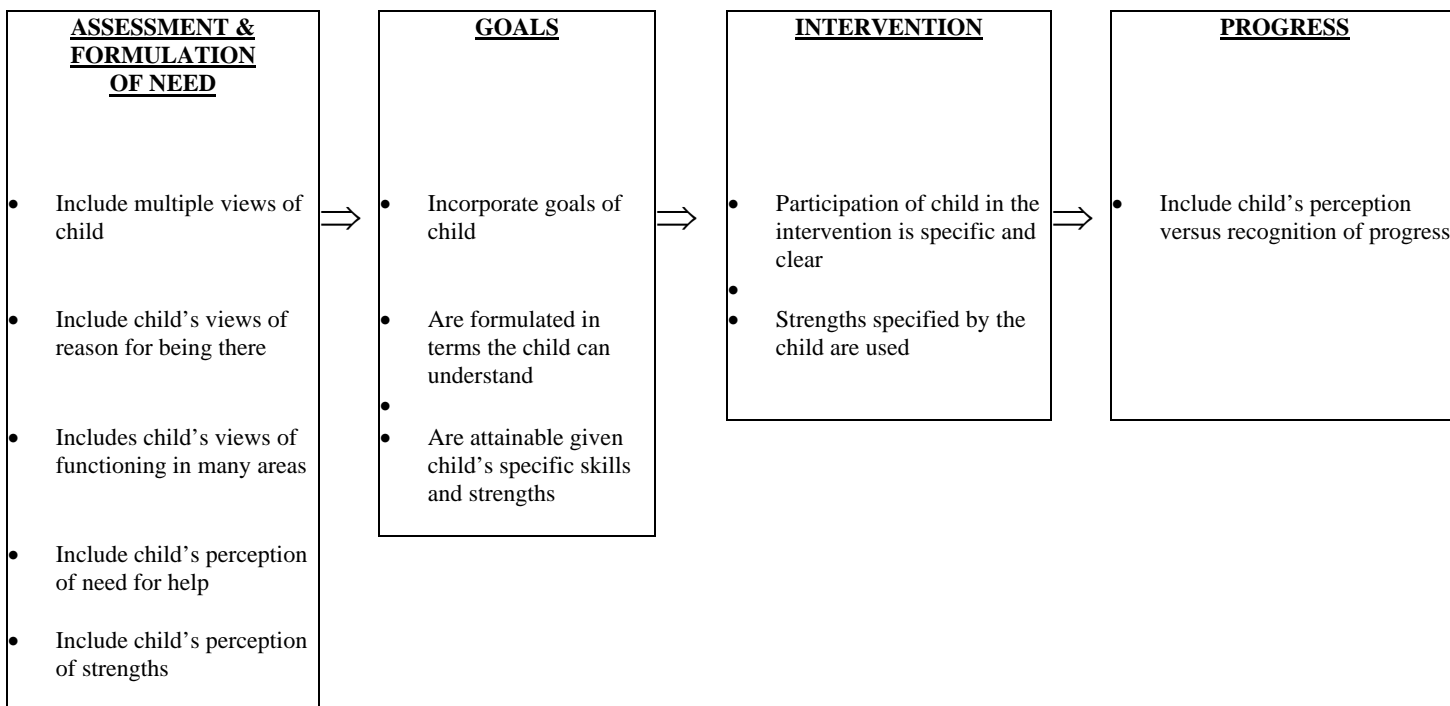
should be encouraged to sign (required for a child under age 14). Children should also be encouraged to sign (required for a child age 14 and older).

Specific Issues in Writing Effective Treatment Plans

1. Plans Need to Be Individualized

The first CASSP principle clearly states that treatment plans need to be individualized and child-centered. Effective treatment plans refer to the child and members of the child’s family by name rather than by role. The name that is chosen is the preferred name of the person. However, the given name should be stated first in the “brief description section,” with the preferred name immediately following. The child’s involvement in the treatment plan should be documented throughout the treatment planning process (see Figure 2).

Figure 2:
DOCUMENTATION OF “INDIVIDUALIZED”: Congruency and Continuity



All components should be age-appropriate and provide evidence of the uniqueness of the individual. Attention to the child’s culture should also be evident throughout the treatment plan (see Figure 3). See also Appendix 1, which is designed to assist professionals in evaluating the quality of their treatment plans along this dimension.

2. Families Should Be Involved as Partners

The second CASSP principle states that the approach to the family should also be individualized and the family’s involvement should be documented throughout the treatment plan (see Figure 4). The treatment plan should specify who is in the family and how the family defines itself. The treatment plan should also address characteristics of the specific culture including values, strengths and language. Specific suggestions regarding working with parents are noted in Appendix 2.

Figure 3
DOCUMENTATION OF CULTURAL COMPETENCE: Congruency and Continuity

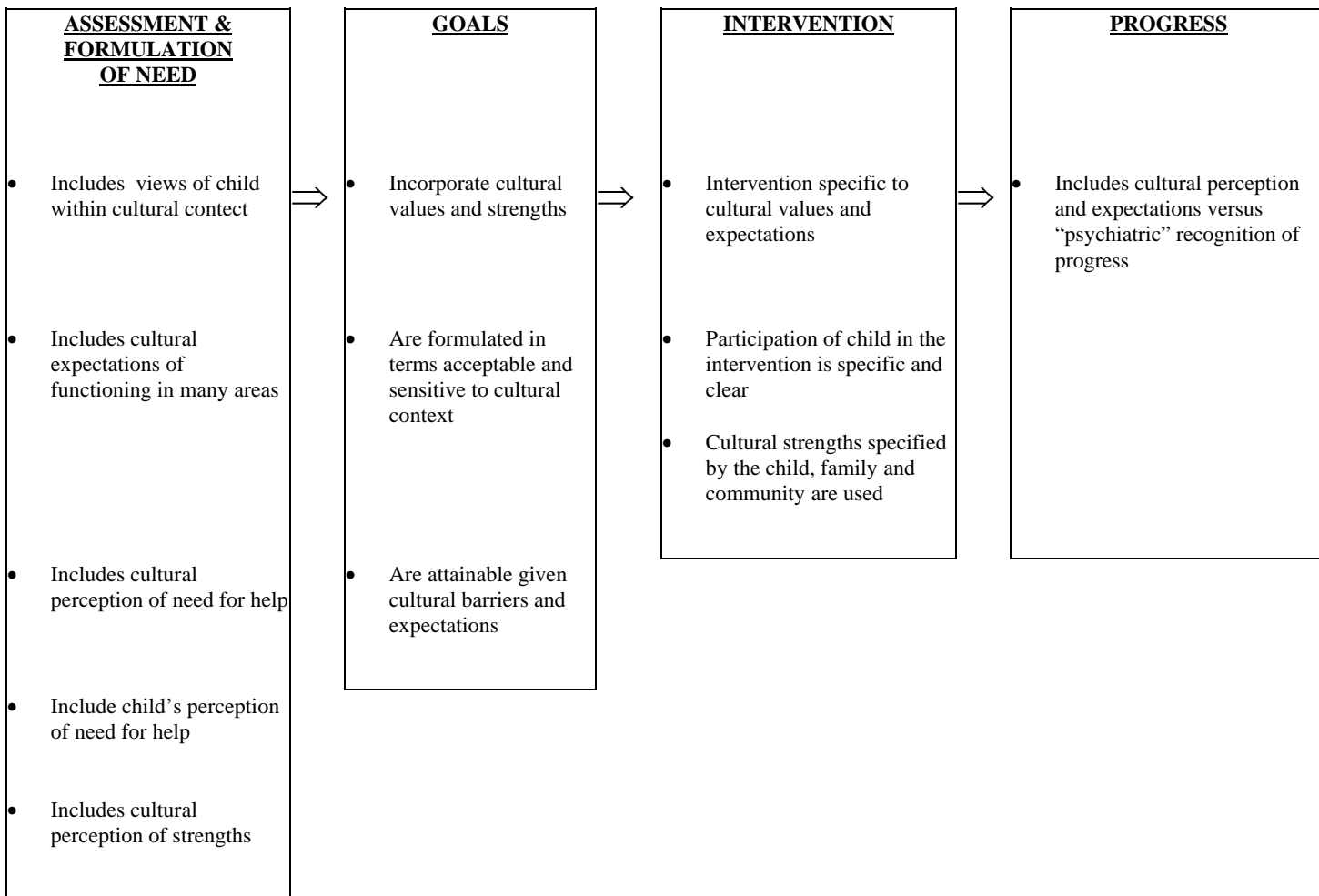
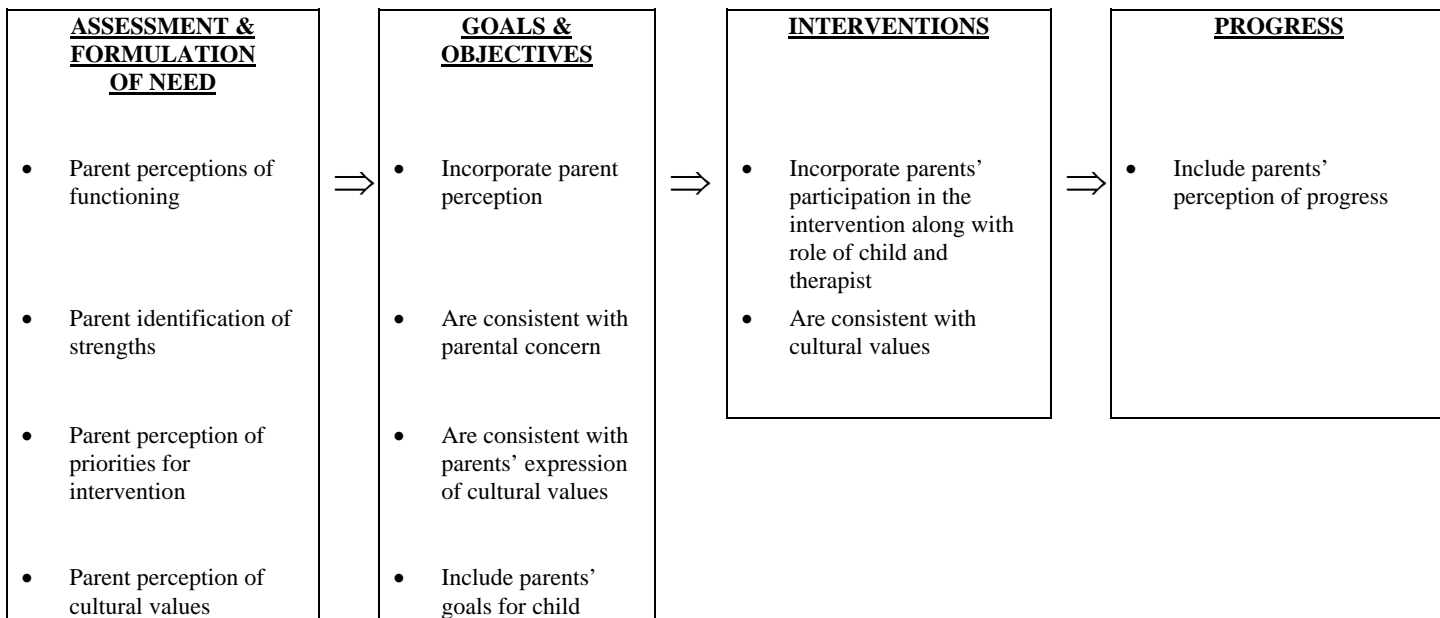


Figure 4
DOCUMENTATION OF PARENT PARTNERSHIP: Congruency and Continuity



3. Plans Should Be Strengths-Based

Treatment plans need to incorporate the strengths of the child and the child's family. Interventions based on strengths are effective. Clinicians often identify the strengths and incorporate them into their interventions. However, mental health workers need to document this process in both the goal/objective and methods sections.

For example, a parent who regularly brings a child to treatment is demonstrating a strength: a capacity to follow through with treatment and an interest in obtaining help for their child. The therapist is likely to rely on this strength in the formulation of the intervention including counting on the parent to bring the child to treatment, and the therapist may actually look forward to encountering this dedicated parent. Such strengths, however, need to be documented and incorporated into objectives and interventions.

Strengths are also demonstrations of adequate functioning or developing coping skills

under adverse conditions. For example, children performing at grade level and living in poverty are demonstrating significant strengths. Developmentally appropriate behavior is an often overlooked area of strength in children that can be readily incorporated into goals, objectives and interventions. Specific suggestions for questions that elicit strengths are provided in Appendix 3 with examples of potential strengths in Appendix 4.

4. Objectives and Methods Should Be Measurable

Objectives and methods sections need to be written in a manner that can be implemented by professionals who read them. Objectives and methods are written in clear and specific terms. Progress towards goals need to be measurable if goals are to be attainable. As stated earlier, goals are global statements and objectives are specific, short-term goals. Objectives, therefore, identify how goals can be attained. Characteristics of quality goals are incorporated into the chart that follows (see Figure 1: “Objectives: Measurable and

Observable”). Appendix 5 provides further examples.

Methods specify the intervention needed to assist in meeting the goals and objectives. Methods need to clearly identify the activities to be performed by the child or youth, the involvement of the parents and/or family in the intervention, and the actions to be performed by the professional. As noted, methods of intervention that incorporate and specify the strengths of the child or youth and the members of the child’s family are more likely to be effective than those that do not. In addition, interventions that incorporate natural supports from the child’s and family’s environment are more likely to result in long-term progress.

All methods need to be selected and based on an individualized, comprehensive assessment of the child’s and the family’s needs and strengths. Only methods that are appropriate for the child, the family, and the targeted objectives have any chance of being effective. The methods must be described in a clear and detailed way so they can be implemented as designed. That is, no method, no matter how appropriate, will be effective if it is too vaguely stated to be accurately and consistently implemented. (See Appendix 6 for a list of common problems encountered in writing methods sections.)

5. Plans Should Be Congruent and Consistent

Treatment plans need to be written with consistency. Goals need to address the most important needs and concerns of the family. Identified objectives need to be significantly linked to the goals. The methods/interventions section should identify the specific roles and activities of involved professionals and the family, not just the modalities and specific services, and link these activities to the goals and objectives. Methods need to specify the linkages with naturally occurring supports within the child’s community. Specific services should be selected that actually help achieve the desired goals. The content of all components flow logically, incorporating consistent strengths and cultural factors throughout (see Figures 5 and 6). Finally, ongoing communication and collaboration among all those involved in creating the treatment plan are essential so that the treatment plan and the evaluation are congruent with each other, targeting appropriate concerns and treatment approaches. Appendix 7 identifies some specific pitfalls inherent in writing all treatment plans.

Figure 5
DOCUMENTATION I

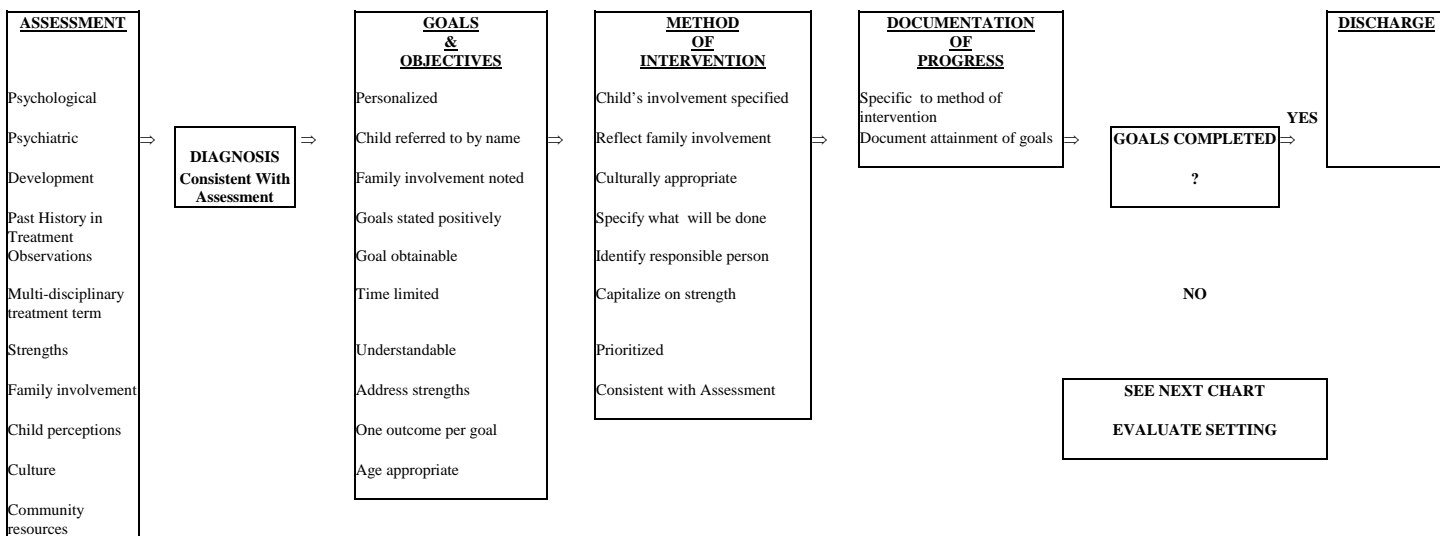
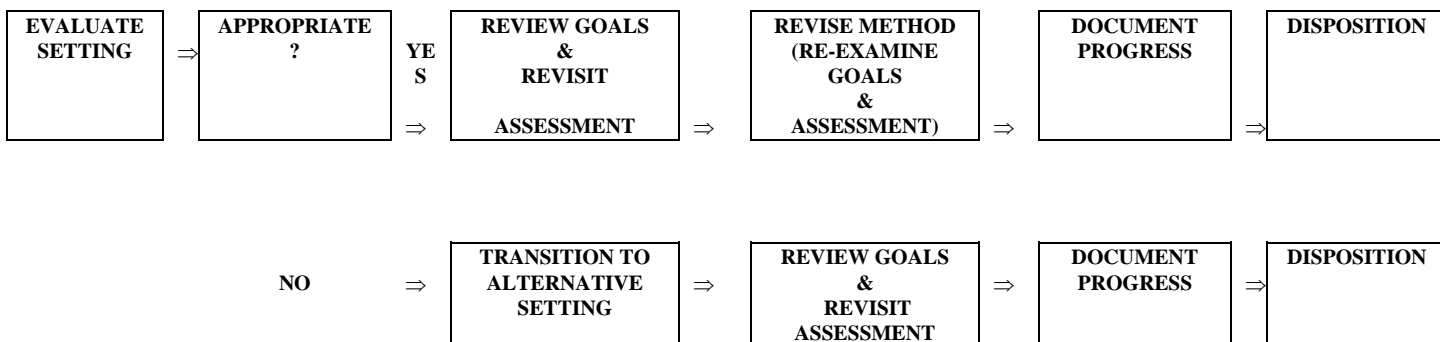


Figure 6
DOCUMENTATION II: Continuation of Treatment, Non-Completion of Goals



6. Service Selection Promotes Desired Outcomes

In order to promote the desired outcomes, it is important to keep in mind the potential purposes of mental health services:

- to address critical needs, problems and concerns;
- to promote the child’s adaptive functioning and development in multiple life domains;

- to support caretakers, reinforcing competence and offering new learning and skill acquisition; and
- to promote the self-sufficiency of the child and family.

For services to promote the desired outcomes, they must emerge from a careful discussion of overall treatment strategies, following clarification of needs, goals and objectives.

Professional services should be complemented by community-based services and resources and by a commitment to further explore

these possibilities. Efforts should be made to provide the appropriate quantity of the right service(s) in an individualized way, as discussed already. Criteria for monitoring and tapering services should be developed so that the individualization process can continue over time.

Summary

The current paper presents a model for incorporating CASSP principles into writing effective treatment plans. Components needed in all treatment plans are identified and described (see Appendix 8 for Definitions). Specific concerns are raised by the CASSP principles. These concerns include the need for individualized and child-centered documentation, evidence of parental participation throughout the treatment plan, the

recognition of and incorporation of strengths and cultural factors, and the identification of and incorporation of the child’s and family’s strengths into the methods for intervention.

Best practice approaches are presented for writing measurable and observable goals and objectives, specific child and family centered methods of intervention, and consistent and congruent documents. Figures and Appendices provide additional material to assist the practitioner and the supervisor in evaluating treatment plans. Lastly, Appendices 9 to 11 provide sample treatment plan forms for agencies and individuals that incorporate the areas specified in this paper.

Marsali Hansen, Ph.D., ABPP has been the Director of the Pennsylvania CASSP Training and Technical Assistance Institute since 1997. Before becoming director, she was the curriculum development specialist. She is also the author of several books and numerous articles, and previously taught psychology to counseling students and special education teachers at Indiana University of Pennsylvania. She holds a Ph.D. in psychology from the Peabody College of Vanderbilt University, Nashville, Tennessee. This paper is based on the curriculum developed by a statewide workgroup for a series of regional trainings sponsored by the PA CASSP Training Institute on writing effective treatment plans. The curriculum was first developed in 1995 and continues to be offered periodically as part of the Institute’s regular training schedule.

October 1996

APPENDIX 1

INDIVIDUALIZED TREATMENT PLANS

A. How the person is identified

1. Always describe the person by name.
2. Present the name respectfully with the initial name as the formal version, followed by the “preferred” version when appropriate.

EXAMPLE: James (“Jimmy”) Wilson

SAMPLES:

“the child”	Sharon
“the teen”	Bill
“the parents”	Mr. and Mrs. Jones
“the kid”	Sean

B. Objectives are personalized and ones that reflect the input of John, Philip, Susan.

SAMPLES

“The Ten Most” (goals children would never think of):

10. “Improve grade level”
9. “Quit complaining”
8. “Improve appearance”
7. “Quit disrupting the class”
6. “Improve attitude”
5. “Keep room clean”
4. “Do the dishes”
3. “Improve peer relationships”
2. “Spend less time on the telephone”
1. “Improve sibling relationships”

C. Children’s involvement is to be specified in the “method” of intervention.

Example: Hillary will discuss with her therapist how she responded to hostile situations during the week.

D. Children’s perceptions and involvement are identifiable in the discharge goals.

Not:

Richard is ready to be discharged when *all goals are met*.

Richard is ready to be discharged *when significant progress is made*.

Better:

Richard is ready to be discharged when he has made two friends and kept them both for three months.

APPENDIX 2

**PARENTS INVOLVED NETWORK
1211 Chestnut St., Philadelphia, PA 19107
(215) 751-1800; 1-800-688-4226**

Tips for Parent/Professional Collaboration

- Do call the parents by their name, for example, Mr. and Mrs. Jones.
 - Not “mom” or “dad.”
 - Not by their first names unless asked to do so.
- Do write parents’ names in the treatment plan, not “mom” or “dad.” If you want to refer to the role, write the mother/father.
- Do refer to the child/children involved by their names, followed by the name of their disorder.
 - For example, John who has ADHD, not the ADHD kid” or not the client.
- Do imagine this is your own child.
 - Think about the language and tone you would like to read about your own child.
 - Think about this plan as something you would feel comfortable using with another agency/provider in relation to your own child.
- Do remember families are people, not “cases” or “clients.”
- Do remember to schedule appointments at mutually convenient times.
- Do remember each family is unique with its own culture and values.
- Do remember to focus on strengths.
- Do remember that treatment goals are the family’s choices.
- Do remember that families have the right to make decisions that might be different from the ones you might make.
- Do remember that partnership means working with the family, not “taking over,” or “rescuing.”

Checklist for Effective Parent/Professional Collaboration

- Have I put myself in the parents/place and mentally reversed roles to consider how I would feel as the parent of a child with an emotional handicap?
- Do I see the child/adolescent in more than one dimension, looking beyond the diagnosis or handicap?
- Am I able to keep in mind that the child/adolescent is a person whom the parent loves?
- Do I really believe that parents are equal to me as a professional and, in fact, are experts on their child?
- Do I judge the child/adolescent in terms of her/his progress and communicate hope to the parent by doing so?
- Do I consistently value the comments and insights of the child’s parents and make use of their reservoir of knowledge about the child’s total needs and activities?
- Do I listen to the child/adolescent’s parents, communicating with words, eye contact and posture that I respect and value their insights?
- Do I ask questions of parents, listen to their answers and respond to them?
- Do I work to create an environment in which parents are comfortable enough to speak and interact?
- Am I informed about the individual child’s case before the appointment or group session, placing equal value on the parents’ time with my own time?
- Do I speak plainly, avoiding the jargon of medicine, sociology, psychology or social work?
- Do I distinguish between fact and opinion when I discuss a child’s problems and potential with a parent?
- Do I make every effort to steer parents toward solutions and resources, providing both written and oral evaluations and explanations as well as brochures about potential services, other supportive arrangements and financial aid?
- At the request of parents, am I an active part of their information and referral network, expending time and energy to provide functional contacts to points in the service system and to parent support networks?
- Do I express hope to parents through my attitude and my words, avoiding absolutes like “always” and “never”?
- Do I see as my goal for interactions with parents the mutual understanding of a problem so that we can take action as a team to alleviate the problem?
- Do I make appointments and provide services at times and in places which are convenient for the family?

- Do I actively involve the parents of each child in the establishment of a plan of action or treatment and continually review, evaluate and revise the plan for parents?
- When I make a commitment of action to the family, do I follow through and complete that commitment?
- Do I obtain and share information from other appropriate professionals to insure that services are not duplicated and that families do not expend unnecessary energy searching for providers and services?

Excerpted from an adapted article in *Social Work*, July-August 1987, Volume 32, Number 4, by Rosemary Alexander and Patricia Tompkins-McGill, entitled, “Notes to the Experts from the Parents of a Handicapped Child.” Families as Allies Project, Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and their Families, Portland State University, Portland, OR 97207.

APPENDIX 3

STRENGTHS

Questions that help identify strengths:

- What are some interests of the child/youth?
- When given a choice what does he or she like to do?
- What does the family do together?
- Who other than the parent takes an interest in the child?
- What skills or abilities does he or she have?
- What object or action gives the child comfort or support?
- What community supports exists for the child and family (social/recreational, church, service)?
- What interpersonal skills is the child demonstrating in areas other than the one of present concern? (after school, with siblings, with extended family members, with grandparents, with pets, in solitary activity, alone with a parent)
- When given a choice, who does the child spend time with?
- What religious or cultural value (practice) provides support to the child or child’s family?

Examples of Strengths:

Interests:

Music, sports, pets, Nintendo, computers

Choices:

Talking on the phone, playing with the dog, going anywhere with Dad, baby-sitting

Family Activities:

Church, Friday night videos, going to grandmothers, going hunting, watching football

Other persons who are interested:

Uncle, older brother, neighbor family, grandparents, religious leader

Abilities:

Compassion for animals, creative problem solving, appreciation for older adults

Object of Comfort or support:

Music, the cat, older sister

Community Supports:

Church choir, the hunting lodge

APPENDIX 4

STRENGTHS

Questionable

Better

nice smile

engaging and contagious smile

attractive

demonstrates care in appearance

sociable

makes friends easily

good attitude

enthusiastic, optimistic outlook on life

intelligent

expresses a quick wit and problem solving skills

likes music

listens to music when experiencing stress

religious

family participates in regular church activities

active in school

participates in extra curricular activities including sports, band, and ski club

supportive relatives

uncle helps with homework and provides support when needed

ethnic pride

speaks proudly of Latino heritage; expresses interest in African American heroes

APPENDIX 5

OBJECTIVES

Questionable

Better

improves self esteem

is able to discuss self in positive ways

develops independence

can complete his daily chores without help from parent

reduces depression

can talk to peers without crying and verbalizing negative self comments

socializes more

initiates and carries on conversation with at least two persons daily

improves peer relationships

can manage interpersonal conflicts without use of offensive comments

stops hitting

expresses anger and frustration verbally

stops interrupting

allows others to complete their comments before responding

improve negative attitude

greet people with pleasant gestures or remarks

stops badmouthing

expresses concerns without the use of negative or derogatory comments

APPENDIX 6

PITFALLS IN WRITING THE METHODS SECTION OF THE TREATMENT PLAN

Two major issues must be considered throughout the development of the Methods Section of a Treatment Plan to ensure a successful treatment outcome:

1. The intervention methods must be selected based on an individualized , comprehensive assessment of the child’s and family’s needs and strengths. That is, only methods that are appropriate for the child, the family, and the targeted objectives have any chance of being effective.
2. The intervention methods must be described in a clear and detailed way so they can be implemented as designed. That is, no method, no matter how appropriate, will be effective if it is too vaguely stated to be accurately and consistently implemented.

Common Problems Encountered

- ◆ Methods unrelated to information in assessment.
- ◆ Methods unrelated to the goal or objective.
- ◆ Methods not individualized.
- ◆ Methods do not reflect child and family input.
- ◆ Methods written in professional jargon.
- ◆ Methods not age appropriate.
- ◆ Methods not culturally appropriate.
- ◆ Methods rely too heavily on coercive or punishment procedures.
- ◆ Methods rely too heavily on consequences for behavior as opposed to prevention or skill teaching.
- ◆ Methods over-rely on external control as opposed to self control.
- ◆ Methods written as if they were part of a Service Plan rather than a Treatment Plan (i.e., the methods name a place or service, not what will be done there).
- ◆ Methods lack specificity regarding exactly what will be done.
- ◆ Methods lack specificity regarding who will be responsible.

- ◆ Methods lack specificity regarding when or how often they will be implemented.
- ◆ Methods fail to capitalize on strengths of child and family.
- ◆ Methods rely exclusively on professional implementation.
- ◆ Only one method listed per objective (most objectives, especially important ones, should be addressed in a number of ways).
- ◆ Too many objectives and/or methods; both objectives and methods should be prioritized.
- ◆ Methods inconsistent with the settings and circumstances in which they are to be implemented.

APPENDIX 7

PITFALLS IN WRITING TREATMENT PLANS

- Goal or Objective stated in negative terms rather than in strengths-based terms.
- Objective involves decrease in frequency, or elimination, of negative behavior rather than attainment of positive outcome.
- Objective involves full attainment of desired goal in a single step.
- Participation per se identified as goal or objective (e.g., attending therapy or going to school, unless school refusal is presenting concern).
- Provision of services identified as a goal or objective per se.
- Objective does not identify child and/or family as active change agent(s) (e.g., child and/or family actively striving to obtain specific outcomes).
- Objective too general - not observable or measurable.
- Identified goals do not reflect major concerns identified in Psychiatric or Psychological Evaluation.
- Identified goals are not prioritized (e.g., harm to self and psychosis identified first, when present).
- Too many or too few goals.
- Services initiated do not address actual needs of child in relevant or least restrictive way.
- Identified objectives do not accurately reflect meaningful, partial attainment of stated goal.
- Absence of family goals to help child, when appropriate.
- Strengths of child and family not identified within document.
- Roles of family, mental health professional, and other resource persons in helping child not identified.
- Issue of cultural competence not addressed.
- New treatment plan does not document degree of progress attained with earlier treatment plan (e.g., previously identified goals and objectives not discussed).
- New treatment plan identical in both goals and specific objectives to previous treatment plan.

- Language used that a family might find offensive or disrespectful.
- Specific target dates that vary with the interventions are not included.
- Method uses jargons or generics.
- All human services are not addressed.
- Problems were phrased in general terms that lacked behavioral dimensions that one could measure. Examples of general problems statements included: difficulty with relationships, family conflict, and unresolved ACOA issues.
- Problem statements were written as a diagnosis. Although a diagnosis can be written on the treatment plan, it is not to be used as a problem statement.
- Problems were written from the perspective of the family. Even if there is significant family involvement in treatment and family problems are addressed, family related problems should be written from the perspective of the child.
- Multiple problems and symptoms were combined under one problem even when they were not necessarily related. It is acceptable to cluster symptoms and problems as long as there is some interrelationship among these (e.g., you can cluster somatic, behavioral, and psychological symptoms of depression).
- Important problems addressed in progress notes were not delineated on the treatment plan or treatment plan review. There should be a relationship between progress notes and treatment plans so that the child’s progression through treatment can be followed. Significant problems should be listed on the treatment plan and/or treatment plan review.

APPENDIX 8

DEFINITIONS

Need/Problem:

Specific description that identifies why the child was referred to the service and includes reason(s) for intervention(s)

Goal:

Global statement that reflects a positive resolution to the identified need or problem, indicates the specific area of functioning to be addressed and includes an outcome measure or expectation

Objective (Short-Term Goal):

Similar to and directly related to a specified goal but highly specific and reflecting small attainable increments, developmentally appropriate, and reflective of cultural strengths, and clearly incorporating the desires of the child or youth and family

Method/Intervention:

Descriptive statement of treatment that specified who, what and how often in observable and replicable terms. Staff, child and family responsibilities are clearly stated and use the identified strengths to obtain objectives.

APPENDIX 9

SAMPLE TREATMENT PLAN FORM

Name _____ Date _____

BSU# _____ Primary Diagnosis _____

GOAL # _____ Date Started _____ Target Date _____

Strength of Family & Person _____

Family Concern _____

GOAL _____

People/Agencies Responsible _____
(specify in actions section)

Short Term Objectives:

Actions:

**Target
Date:**

**Completion
Date:**

APPENDIX 10

SAMPLE TREATMENT PLAN FORMAT

Child's Name: _____ D.O.B. _____ BSU# _____

Case Manager: _____ Date of Admission _____

Description of child: _____

Reason for referral: _____

Child strengths: _____

Family strengths: _____

Child's name: _____

Date of treatment plan: _____ Review date: _____

Child and family concerns and needs # ____: _____

Goals # ____: _____

Objective: _____

Methods/Intervention: _____

Frequency	Who	Target date	Attain date
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Objective # ____: _____

Methods/Intervention: _____

Frequency	Who	Target date	Attain date
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About the Institute

The PA CASSP Training and Technical Assistance Institute addresses the human resource development needs in clinical best practice for serving children and adolescents with mental health needs and their families. As the training arm for children's mental health services of the state Office of Mental Health and Substance Abuse Services, the Institute's programs include the following:

- Competency-based training that integrates OMHSAS policies with clinical best practice
- Technical assistance to meet the individuals needs of agencies and clinicians
- The Children's Interagency Conference
- Publications and resources
- Research and academic outreach

The Institute adheres to the six core principles of Pennsylvania's Child and Adolescent Service System Program (CASSP) and applies them to all programs and activities. Services delivered according CASSP principles are:

- Child-centered
- Family-focused
- Community-based
- Multi-system
- Culturally competent
- Least restrictive/least intrusive

For additional information about the Institute, contact (717) 232-3125, hsb5@psu.edu, or <http://pacassp.psych.psu.edu>