Professionals' Treatment Plan and Contract Beliefs and Practices

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Abstract

Treatment plans with so-called "contracts" are either theoretically irrelevant or antithetical to the Client-Centered approach. However, in the mental health field, they are fairly ubiquitous, especially for Medicaid work. Because of this, I surveyed mental health professionals in one state to see how they used treatment plans with contracts and what they thought of them. I intended to: (a) discover whether these were, indeed, a professionally accepted standard of care (b) compare and contrast Client-Centered respondents with professionals of other orientations. Overall, belief that two of the contract requirements (specifying what goals would be accomplished and how this would be done) were helpful fell between "neutral" and "agree somewhat" on a five-point Likert scale. A third (specifying the time when a goal would be accomplished) fell between "neutral" and "disagree somewhat." Thus the contract did not appear to be an accepted standard of care. Nor did the plan as a whole: Fifty-one percent of the Medicaid providers said it was related to what they did only "marginally" or "not at all" and 75% said they used it because of legal or clinic regulations. There weren't enough Client-Centered professionals to allow them to be examined separately, so respondents were combined in two groups, those whose approaches were supposed

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friendly to the plans and those that were skeptical of them. Statistically, the skeptical and friendly groups differed on how helpful they thought the contract requirements were, although the Friendly group's means for each of the three requirements still only fell between "Neutral" and Agree Somewhat." The groups did not differ, however, on how much the plan affected their behavior or why they used it. The results suggest that to make clinical requirements more conducive to Client-Centered practice it would be more helpful to focus on what professionals actually do and what they believe about what they do rather than on theoretical issues.

This research looks at what Alaska mental health professionals believe about a "treatment contract," one requirement of their Medicaid treatment planning procedure. (First Health Services Corporation, 2001, pp. 1-9) It also looked at the impact of the plan as a whole on Medicaid providers' behavior and on their reason for using the plan. The research had two purposes. One was to investigate whether the contract was a standard of care. The second was to compare Client-Centered professionals with others as to the treatment plan as a whole--what they believed, did, and why they did it. It would have been preferable to examine each element of the treatment plan as a standard of care (e.g., the required diagnosis, assessment of client strengths, etc.) but this would have been unmanageable. The treatment contract was chosen because of its requirements, From a Client-Centered standpoint it requires the most potentially coercive interaction with the client. Also, in the writer's experience, for Alaska Medicaid providers it is the most demanding part of the treatment plan process. Indeed, for colleagues, it was synonymous with the treatment plan as a whole. That is, "treatment plan" and "treatment contract" were used interchangeably.

Third parties paying for psychotherapy often require "individualized" treatment plans (Berghuis & Jongsma, 2000). While they vary somewhat, the plans typically incorporate a treatment contract similar to the one Alaska Medicaid requires. This asks client and therapist in the therapy hour to agree upon what behaviors the therapist will engage in, what third-party observable behavioral changes

the client will experience, and when s/he will experience them. In Alaska's case, client and therapist then sign a contract in which this is put in writing

The plan in general, and especially the treatment contract in particular, of course present many special problems for Client-Centered therapists. To detail only two: (a) It hijacks the therapy hour, changing it from Client-Centered to third-party-payer-centered. Instead of the client thinking and talking about what's important to him or her, the client must think about issues important to the payer, concerns not necessarily in the client's frame of reference. (b) The only treatment plan a Client-Centered therapist has is to experience unconditional positive regard, empathy, and congruence, and have the client experience these, regardless of client characteristics (Rogers, 1957). These attitudes are concepts so abstract, though, as to be almost meaningless (if not counter-intuitive) when put into words. For truly informed consent, the attitudes must be experienced, not described.

It also violates common sense. To take just a few examples that stem from having to specify observable changes: A third party can't observe changes that take place within the envelope of the client. Moreover, it's the client who sought therapy, and not some third party. If the change is for something the client sought (feeling, problem, etc.), why should the change have to be observable by someone else? Or, is there something about the therapy that makes the client dumber? That is, while s/he was smart enough to seek therapy is the client not smart enough now to know if it's helpful? Focusing on when the change will happen rather than who will judge the change, how can one know this, third-party observable or not, unless s/he's God?

Beyond Client-Centered theory and common sense there is yet another problem, a personal one. When I practiced in Alaska it was my experience that after doing the treatment contract in the first interview, one of two things happened all too frequently: (a) The next hour, the client would appear to be bewildered by my Client-Centered approach. S/he would expect me to continue asking questions or to make some kind of portentous pronouncement based on what was said the previous hour. This of course, is much in keeping with what Rogers

(1942) said, "When the counselor assumes the information-getting attitude . . . the client cannot help feeling that the responsibility for the solution of his problem is being taken over by the counselor. (p. 81)" or (b) The client didn't return.

My experience, then, agrees with Client-Centered literature: Contracting was at best irrelevant since my client never referred to it again. At worst it was countertherapeutic, either bewildering the client, or discouraging him or her so much s/he didn't return. There is research on medical informed consent, similar enough to the Alaska Medicaid contracting process that echoed my experience. It suggests patients either quickly forget, or never fully understand to begin with, significant treatment information (Epstein & Lasagna, 1969; Schultz, Parder, & Ensinck, 1974; Robinson & Merav, 1976; Muss, White, & Michielutte, 1979; Cassileth, Zupkis, Sutton-Smith, & March, 1980). For example, Cassileth, et al. looked at how much of their signed, so-called "informed consent" form cancer patients would remember after reading and signing it.

> Within one day of signing consent forms for chemotherapy, radiation therapy, or surgery, 200 cancer patients completed a test of their recall of the material in the consent explanation . . . Only 60 percent understood the purpose and nature of the procedure; and only 55 percent correctly listed even one major risk or complication. (p. 896)

The researchers write that what an impressive number may have remembered, instead, was the awkwardness and alienation of the process:

> After completion of the questionnaires, 31 patients spontaneously expressed the feeling that official documents seemed out of place and counterproductive in the clinical setting . . . The consent form's legalistic, perhaps even adversarial, overtones may appear inconsistent to the patient who has a fundamental orientation to and preference for a doctor-patient relation based on trust (p. 899).

In the psychology literature, however, a number of other studies have found two of the Alaska contract requirements, client and therapist agreement upon goals and methods, positively related to outcome, with a large number of these looking at aspects of what

Bordin (1980) calls the "therapeutic alliance." One line of research, building on work by Horvath and Greenberg (1989), conceptualized this as the "Working Alliance." This is composed of three factors measured by a self-report instrument, the Working Alliance Inventory: therapist-client agreement on therapy goals and on procedures as well as client bonding with the therapist. The largest number of alliance studies use this instrument (Hatcher & Barends, 2006). One meta-analysis of 24 found an overall effect size of .26, ". . . not very large [but] within the range of values reported for other important psychotherapy variables . . . " (Horvath & Symonds, 1991, p. 146). A second meta-analysis of 22 studies found an overall correlation between Working Alliance and outcome of .24 (Martin, Garske, & Davis, 2002). These results, and others that use related measures of client-therapist alliance (also reviewed by Martin et al.) argue some kind of overt agreement on goals and strategy may be important for treatment results.

Others have looked at how clearly the client conceptualizes his or her therapy goals and have found this also positively related either to outcome or to other variables related to outcome. Miller, Duncan, and Hubble cite a number of these (1997, p. 106). One reports specific goals ("at least one behavioral sign of future improvement") led to greater expectations of therapeutic success, which in turn was related to actual success (Beybach, Morejon, Palenzuela, & Rodriguez-Arias, 1996, p. 320). Others they cite, of an experimental nature, concur. They quote Locke, Saari, Shaw and Latham (1981) who surveyed this literature: "Twenty-four field experiments all found that individuals given specific, challenging goals either outperformed those trying to do their best or surpassed their own previous performance when they were not trying for specific goals" (p. 129)

The previously discussed studies then appear to show the importance of client-therapist agreement on methods and goals as well as of goal clarity. There are some difficulties, however. Although many investigators studied agreement on goals and methods, with few exceptions (e.g., Long, 2001), almost all measured client perceptions of, not actual, agreement (Horvath & Greenberg, 1989, p. 226). Also, in the main, evidence that specific goals aid performance comes either from experimental studies where outcome variables were measures

such as speed of card sorting (London & Oldham, 1976) and color discrimination (Masters, Furman, & Barden, 1977), or from research within a particular therapeutic framework such as Solution Focused therapy (Beybach et al., 1966). The positive relationship experimental studies find is, of course, only suggestive. Most of the participants are not clients and the outcomes measured are much more molecular and less involving than those found in therapy. It is hard, for example, to see a meaningful relationship between a nonclient performing a card sorting task and a troubled husband agonizing over divorcing his wife. At best, then, the experimental studies point to the need for more definitive research.

The results from research done within a particular therapeutic framework, as exemplified by Beybach, et al. (1966), present another difficulty. They looked at clients in Solution Focused therapy and found, essentially, "well-formed goals were positively related to outcome." Had they not found this, however, it would have been a surprise. Treatment plans with concrete, specific goals are an integral part of this approach in the same way that free association is integral to classical Psychoanalysis (Duncan, Hubble, & Miller, 1997). The problem with this research, then, is that it studies the outcome of a kind of therapy that employs the same kind of treatment contract that Alaska Medicaid requires. As with Solution Focused therapy, one would also expect positive research findings of other approaches such as Cognitive-Behavioral, Desensitization, or Strengths-Based Case-Management therapies which use closely detailed collaborative treatment plans.

A better test would be to look at the impact of Medicaid style treatment contracts on established therapies whose treatment strategies do not rely on these. For Client-Centered therapy they appear at best irrelevant because the therapist alone, or together with the client, does not formally prescribe content areas to be dealt with. (Of course, not only is there no explicit contract, there is no treatment plan at all, except to establish a therapeutic relationship that facilitates the client's self-directed exploration of inner experience [Rice, 1980]). At worst, as discussed previously, they reify a process which is more meaningfully experienced than discussed. They are even more antithetical, though, to other treatments that rely on exactly the client naiveté that these

plans are meant to inform. Psychoanalytically oriented treatments are examples. These use therapist inscrutability as an instrument to induce therapeutic regression (Menninger, 1958). To detail specific interventions vitiates their impact (Ross, 1991). A different kind of therapist inscrutability is also utilized for strategic or paradoxical interventions in varieties of family therapy approaches (Foley, 1989).

The psychology literature, then, as stated previously, is uncertain. This is unfortunate because my experience of unilateral or premature client termination isn't unique, There is much evidence that clients of therapists of all persuasions remain in treatment a very short time, and not by provider design, a problem dating back at least as far as the 1930 Berlin Psychoanalytic Institute (Garfield, 1994): Surveys of therapy termination literature from Meltzoff and Kornreich (1970) to Garfield all find premature termination endemic. Garfield, for example, cites 21 studies of outpatient clinics between 1948 and 1989. These studies report the median number of therapy sessions from a wide variety of settings. The median of these medians cluster "around 6 interviews" (p. 193).

Because of the evanescence of the psychotherapeutic relationship and the nearly universal requirement of treatment plans incorporating at least some of the contracting elements of the Alaska plans, and because such plans interfere with Client-Centered practice as well as with those of other approaches, whether such plans help or hinder treatment is a critical question. Therefore, one would expect their use to be evidence-based (APA Presidential Task Force on Evidence-Based Practice, 2006). However, it isn't. In principal, this appears fairly straightforward to remedy. One could simply examine outcome variables for clients randomly assigned to two groups, one for which a contract is used and one for which it is not (Of course, a method would have to be devised to keep the therapist ignorant of the client's status.). Not so parenthetically, were the results for the two groups at least equivalent, it would argue to third party providers for the acceptability of the Client-Centered therapist's not using a contract.

However, there was a significant barrier. Third party payers or credentialing agencies would not agree to reimburse for clients without contracts. Attempts to elicit their interest in this proved fruitless, with one saying this would be unethical because such plans were a

professionally accepted standard of care. The refusal suggested a strategy. A first step would be to examine whether indeed a third party imposed treatment plan with its contract requirement was a professionally accepted standard of care. As discussed previously, it clearly can't be for Client-Centered therapists, but they are only a microscopic minority of practitioners. For example, Norcross, Hedges, and Castle (2002) found only 1.7% of members of the American Psychological Association Division of Psychotherapy said they were Client-Centered. Were this the case for a significant number of professionals, though—that is, were it not an accepted standard of care regardless of orientation—it would be easier to find financial support for directly looking at its impact on treatment.

Professional opinion, however, is an interesting question itself. Sampling it has been a long-standing strategy as a first approximation for looking at clinical utility. Miller, Bergstron, Cross, and Grube (1981) and Smith and Kraft (1983) examined psychologists' reactions to two iterations of the American Psychiatric Association Diagnostic and Statistical manuals. Also, Norcross, Koocher, and Garofalo (2006) examined psychologists' opinions of the possible ineffectiveness of different psychological tests and treatments. Lastly, Neimeyer, Taylor, and Wear (2009) reported psychologists' perceptions of the value of continuing education. For the present study, sampling all mental health professionals, or even all psychologists, proved an impossible task. It was possible, though, to survey all Alaska mental health professionals.

This research, then, had two intentions, to: (a) Examine how what Alaska mental health Medicaid practitioners as a whole and Client-Centered therapists in particular said the impact of the treatment plan was on their behavior and why they used it. (b) See what all professionals, whether practicing psychotherapists or not, thought of arguably the most significant part of the treatment plan, the contracting requirements, and to compare their views with those whose orientation was Client-Centered. Thus it was intended to establish by self-reported actions and beliefs to what extent the treatment plan and contract were standards of care for mental health professionals in general as well as for Client-Centered professionals.

Method

Since the impact of Medicaid treatment plans and their contracts couldn't be investigated directly, I constructed the Biography, Attitude, and Practice Scale to look at both the opinions and practices of Alaska professionals of different orientations. The BAPS provides data about mental health professionals in three areas their: (a) *Personal and professional information*: age, orientation, number of Medicaid clients seen per week, the clients' ethnicities, etc. (b) *Opinions on Medicaid treatment contract requirements*: There are four Likert-scaled items which ask how helpful is each of the four requirements detailed previously (behavior and time specific goals, etc.); also, three open ended questions. Two of the items ask about advantages and disadvantages of treatment planning; a third, provides an opportunity for any additional comments the respondent might have. (c) *Practices with Medicaid clients*: Four items are Likert-scaled (e.g., the importance of the treatment plan to what's actually done in treatment). Two are multiple choice (e.g., the most important reason one uses a treatment plan). These items, of course, were only answered by providers who actually saw Medicaid clients. Early drafts of the instrument were inspired by instruments by Miller et al. (1981) and Smith and Kraft (1983) whose research was discussed previously

I mailed the BAPS to all Alaska non-medical licensed mental health professionals, 998 in all. These were social workers, marriage and family therapists, professional counselors, and psychologists.

Results

Of the 998 questionnaires, respondents returned 369. Excluding forty-two that were undeliverable, there was a 38% rate of return. Table 1 lists some of the personal and professional demographics of the entire sample as well as of those who identified themselves as "Client-Centered (Rogerian)."

Table 1
Selected Respondent Personal and Professional Demographics

Characteristic	N	%	N	%
	Entire Sample [a]		Client-Centered	
Sex:				
Male	119	33 [b]	0	0
Female	241	67	13	100
Usable Responses:	360		13	
Highest Degree:				
M.S.W.	121	34	8	62
M.S./M.A.	120	34	4	31
Ph.D.	68	19	0	0
Psy.D.	13	4	0	0
B.A. / B.S.	2	1	0	0
Other	20	8	1	8
Usable Responses	352		13	
Primary Work Setting:				
Substance/Alcohol Treatment	9	2	0	0
Private Office/Clinic	140	39	2	15
University Psychology Department	9	3	0	0
Public Mental Health Center	57	16	1	8
Government Administration	25	7	3	23
Inpatient Mental Health	8	2	0	0
Other	102	28	7	5
Usable Responses	352		13	
License				
Social Worker	139	40	8	62
Professional Counselor	96	28	4	31
Marriage and Family Therapist	31	08	0	0
Psychologist	86	24	1	8
Usable Responses	352		13	
Orientation				
Behavioral	9	3		
Cognitive-Behavioral	87	26		
Eclectic	110	33		
Family Systems	40	12		
Gestalt	0	0		
Motivational Enhancement	3	1		
Neoanalytic	0	0		
Client-Centered	13	4		
Psychoanalytic	18	5		
Reality Therapy	5	2		
Rational Emotive Therapy	2	1		
Strengths-Based Case Management	17	5		
Other	28	8		

Usable Responses	332

Note. [a] Median age for both groups is 45-55 years.
[b] Percentages don't always sum to 100% because of rounding.

The present article reports results from four items or item clusters that examined aspects of the plan and of its use: (a) How important was it to what providers actually did in treatment? (b) Why they used it. (c) How much professionals agreed that the treatment plan components were helpful. (d) What advantages and disadvantages professionals saw to using the plan.

For the results to be clear, some terms should be defined: (a) *Providers* are respondents who report they "typically" in a week do some face-to-face therapy. (b) a *Medicaid provider* was a provider who indicated s/he treated some Medicaid clients. A *Professional* was a licensed mental health practitioner, whether or not s/he actually provided direct service (i.e., all the respondents in this survey).

Importance of Treatment planning to Treatment

As discussed, a Likert-scaled item asked Medicaid providers "How important is a (Medicaid style) treatment plan to what you actually do in treatment?" One hundred and eighty-eight responded. Forty or 21.3% said it was either "critically" or "very" important. A majority, 96 or 51%, said it was only "marginally" or "not at all" related to what they did.

It wasn't possible to compare and contrast Client-Centered therapists on this variable because, in total, there were only five. It was possible, however, to look at therapists whose orientation, like Client-Centered therapy, in general should be unfriendly to Medicaid-style treatment plans (Certainly, however, each of these orientations would differ in their amount of hostility.) and contrast them with therapists whose approach was amenable to the plans (again, with different amount of acceptance). To do this, therapists whose orientation suggested their stance was "friendly" to Alaska-mandated treatment plans were combined into one Treatment-Plan-Friendly group. Their orientations were Behavioral, Cognitive-Behavioral, Reality therapy, Rational-Emotive therapy, and Strengths-Base case management. Those whose orientation seemed less so were combined into a second

Treatment-Plan-Skeptical group. These were respondents whose approaches were Family Systems, Motivational Enhancement, Client-Centered, and Psychoanalytic. A *t*-test was computed for the groups and wasn't significant, $t(97)=1.096$, $p < .138$. That is, there was no statistically significant difference between groups in the degree to which their treatment plan influences their therapy.

Why Medicaid Providers Use Treatment Planning

A multiple choice item asked: "What is the one most important reason you use a Medicaid style treatment plan with a particular client?" Of the 195 who answered, 147, or 75%, said they did so because of "either clinic and/or third party payer regulations." Thirty-two or 16% reported it was because they judged "it's therapeutically helpful for this particular client." Three, or a little less than two percent, said his/her treatment plan use stemmed from the kind of treatment practiced. Nine, or about six percent, cited other reasons. Again, it wasn't possible to compare and contrast the responses of the Client-Centered group because there were only five. Instead, a Chi-Square statistic was computed for the Treatment-Plan-Friendly and Skeptical groups. It examined these groups to see whether, on the one hand, their choice was treatment driven (Was it because of the kind of therapy employed or because of client needs?) or was it motivated by extraneous considerations (because of state or clinic regulations). The Chi-Square didn't reach significance, $\chi^2 (2, 103) = .189$, $p < .331$. That is, there is no difference between groups so far as why they use the plans.

Professionals' Acceptance of the Four Medicaid Treatment Contract Components

There were four items, each asking about a different requirement. These are: (a) The therapist's and client's signature (b) measurable and behavior-specific goals (c) a time by which each goal would be accomplished, and (d) the specific intervention that would accomplish a particular goal. Respondents indicated to what extent they agreed each was helpful for treatment on a five-point Likert scale.

Table 2

Respondents Opinions of Treatment Plan Requirements [a]

	M		SD		N	
	All	Client-Centered	All	Client-Centered	All	Client-Centered
Behavioral Goals Help?	2.45	2.30	1.31	1.189	359	13
Signatures Help?	2.32	2.45	1.27	1.308	358	13
Detailing Specific Intervention Help?	2.69	2.62	1.34	1.272	350	13
Fixed time period helps?	3.09	3.16	1.32	1.291	357	13

Note. [a] 1 = "Strongly Agree," 5 = "Disagree Strongly"

For the entire sample, as well as for those of the Client-Centered professionals, the mean for three of the four items fell between *Agree Somewhat* and *Neutral.* The fourth—whether it was helpful to specify a time by which a goal would be accomplished—was between *Neutral* and *Disagree Somewhat.* As was the case previously, there weren't enough Client-Centered practitioners to contrast them with others so the two pooled groups were used again.

Table 3
Friendly and Skeptical Treatment Plan Groups' Opinions of Treatment Plan Requirements [a]

	Skeptical			Friendly		
Do these help:	M	SD	*n*	M	SD	*n*
Behavioral Goals ?	2.63	1.36	67	2.18	1.19	116
Signature?	2.45	1.41	67	2.31	1.25	116
Detailing specific	2.91	1.28	67	2.55	1.28	116

interventions?						
Specifying time period?	3.34	1.41	67	2.99	1.30	116

Note: [a] 1 = "Strongly Agree," 5 = "Disagree Strongly"

Item means were in the expected directions for all items, with Friendly groups agreeing with the item more than the Skeptical group. For three of the items, means for both groups again fell between *Neutral* and *Agree Somewhat*. For the fourth, though, the agreement with the helpfulness of specifying a time limit, there is a difference. While the Skeptical group's mean was between *Neutral* and *Disagree Somewhat*, the Friendly group again had a mean between *Neutral* and *Agree Somewhat*. *T*-tests for the difference between them on three of the four requirements were significant. These were on the helpfulness of specifying: time periods, specific interventions, and specific goals. The *t*'s were, respectively, $t(189) = 2.063$, $p < .041$: $t(185) = 1.88$, $p < .031$; and, $t(185) = 2.351$, $p < .01$. There was no statistically significant difference between groups for requiring signatures, $t(.189) = .867$, $p < .194$.

Through Mental Health Professionals' Eyes: The Advantages and Disadvantages of Medicaid-Style Treatment Plans.

There were three free-response questions. Two invited the respondent to note any advantages or disadvantages of Medicaid treatment plans. A third asked about any miscellaneous thoughts s/he might have.

Respondents discussing miscellany shared a very wide range of ideas. These are difficult to categorize. Comments ranged from thanking me for doing the research to suggestions about how I could have phrased the questions better. Many were simply elaborations of what the respondents answered to the *Advantages* or *Disadvantages* items. Indeed, the meat of the results were in those two items where, as expected, almost all discussed advantages and disadvantages of treatment contracting.

Two hundred and twenty-nine people cited advantages. The mean number of words per response was 16.1 ($SD = 14.6$) some of the more common ideas mentioned by people were "focus" (49

people), "measurable" objectives or outcomes (29) "accountability " (22) "structure" or "framework" (19), "agreement" between client and therapist (15). The following are somewhat representative.

> "It helps maintain focus for client and practitioner."
> "Helps client and therapist agree on focus and how to get there. Step-by-step approach (a plan)"
> "Client and therapist talk about what is helpful, beneficial, and what isn't."

Two hundred and twenty-eight cited disadvantages. Their mean response length was 29.1 words (*SD* = 23.4). A major disadvantage cited 170 times was "time." However, predominantly it was used in two different ways. One hundred and two used it in the context of wasting therapist or client time, sixty of these with the same exact phrase, "time consuming." Another 35 cited time as a disadvantage in the sense of requiring a time statement about goal attainment. They said this wasn't possible, that clients didn't think in terms like this, or they perceived this requirement as a demand goals be achieved quickly, something that was unrealistic.

Thirty responses were critical of "rigidity" or lack of "flexibility." Others objected to having to formulate measurable (15 responses) or behavioral (14) goals. Among other things, some felt such requirements favored Cognitive-Behavioral approaches to the exclusion of other established therapies. Some found this simplistic, unrealistic, counter to the client's frame of reference, or trivializing. Following are examples of *disadvantage* responses:

> "'Medicalized' approach to TX does not adequately capture process of therapy. This approach assumes that therapist will know ahead of time how Tx will 'unfold'—can paradoxically place therapist in role of 'expert' in regard to client's problems. Many clients consider these Tx plans to be condescending in that they don't trust the client's report of their subjective experience but require 'objective' facts or markers of improvement."
> "Having to sacrifice so many hours writing the treatment plan. Having to pathologize the client's symptoms to justify coverage and then having them read in the treatment plan the various

interventions to be 'used on them.' I have had the experience impair the progress of several clients."

Respondents agreed on many of the same characteristics but viewed them differently. One example: "Measurable objectives or outcomes" were cited as advantages in 29 responses and, as stated previously, were mentioned by 15 respondents as disadvantages.

Discussion

While the results appear fairly straightforward, there are a number of questions: (a) Can we believe the respondents? (b) To what extent are these results generalizable to other providers? (c) The treatment-plan-friendly respondents agree more than the skeptical ones that three of the four treatment plan components are helpful for therapy. Yet they don't differ from the skeptical group in reporting the impact of the plan on their behavior or the reason they use it. Why?

Can We Believe the Respondents?

One needn't do research to know mental health professionals would like to eliminate as much paperwork as they can. One could argue they saw this survey as their chance to do this. First, they were told it was underwritten by the Alaska Mental Health Trust Authority. This is a major nongovernmental force in Alaska public mental health policy and funding that has the potential to act as a check on government policy. Second, the study's stated purpose was to investigate provider Medicaid treatment plans and contracts. This may have led them to believe the investigator's intent was to discredit required treatment planning; otherwise, why research something universally required? Given the supposed purpose and the audience, it could be tempting to answer the items strategically rather than honestly.

The best strategy would be to look as if one conscientiously complied with the requirements while, none the less, disagreeing with them; otherwise, one runs the risk of appearing merely lazy and disagreeing by virtue of sloth. Looking at the group as a whole, if this happened, there should be little or no relationship between reported beliefs about the helpfulness of treatment contracts and therapy

behavior since all would report highly compliant behavior. The results, however, belie a "faking good" strategy.

Table 4
Intercorrelation (Pearson r's) of Self-Reported Treatment Plan Beliefs and Behavior with Clients

Item	How detailed an explanation	Importance of plan to behavior	Time taken w/ client on plan
Behavior Goals	-.31**	.64**	-.25**
Help?	(*n*=182)	(*n*=182)	(*n*=179)
Fixed time period	-27**	.57**	-19**
helps?	(*n*=185)	(*n*=185)	(*n*=183)
Client Signature	-.32**	.61**	-.16*
Help?	(*n*=187)	(*n*=188)	(*n*=185)
Detailing Specific			
Intervention	.200**	.61**	.11
Helps	(*n*=183)	(*n*=188)	(*n*=181)
Time Taken w/	-.239**	-.305	
Client on Plan	(*n*=181)	(*n*=180)	

Note. ** $p < .01$ * $p < .05$

With two exceptions, respondents' beliefs do significantly correlate with their self-reported behavior. The more one disagrees that each of the four contract requirements is helpful, the less time s/he reports spending with the clients on the plan, the less detailed the explanation reportedly given, and the less the plan is said to govern therapist behavior. Respondents don't appear to be trying to look good. They appear to be answering honestly.

On an individual level, the free response data suggests honesty rather than strategy as well. In discussing advantages and disadvantages of treatment plans, the respondents often agreed on the same characteristics but viewed them differently. One example: "measurable, behavioral objectives or outcomes" were cited both as advantages in 29 responses and as disadvantages by an equal number. Beyond this, the mere volume of responses on both sides of the issue suggests thoughtfulness. There were 282 advantages cited and 287

disadvantages cited by 368 people. This means many cited both. What emerges here, as well as from the other data discussed, isn't the shrill, polemical response one would expect were respondents simply trying to rid themselves of a tedious requirement. Instead, the data suggest thoughtful, nuanced responses. Respondents appear to be speaking to what they believe is best for treatment and not what's easiest for them.

Are the Results Generalizable?

Rather than look at all survey respondents, it made the task more manageable to examine only one group, psychologists. It can be said, in advance, the available data is sketchy, inconclusive, and merely suggestive.

Without a guiding theory, there are an infinite number of characteristics one could examine to see if nonrespondents were similar to respondents. A typical strategy survey researchers use is to compare sample sex and age with that of the population from which it was drawn (Moore & Tarnai, 2002). Moreover, besides being common procedures, looking at age in particular appears useful because, all things being equal, psychologists of different ages will have been educated at different times when different treatment approaches and assumptions were popular.

It wasn't possible to compare the Alaska sample with all Alaska licensed psychologists because the state licensing board has no record of age and sex. On the other hand, it was possible to compare the age and sex of the present sample with that of the members of some relevant American Psychological Association divisions.

Table 5

Demographic Characteristics for Alaska Psychologist Respondents and Some Relevant APA Divisions in 2007—Percentages of Each Group and Gender

Characteristic	Alaska Psychologists	Div. 12 (Clinical)	Div. 18 (Public Service)	Div. 29 (Psychotherapy)	Div. 42 (Independent Practice)
	n=86	*n*=4497	*n*=4491	*n*=2862	*n*=4063
Age 25-	22	13	14	4	5

44					
Age 45-54	42	28	28	21	24
Age 55-64	27	32	37	44	46
Age 65+	9	27	21	32	25
Male	48	65	67	63	60
Female	52	35	34	37	40

*Note. r*etrieved from http://www.apa.org/about/division/officers/services/profiles.aspx

It's clear that the age and sex of the sample differ consistently from those found in the four divisions in which practitioners would be expected to belong. There are a higher proportion of Alaskan psychologists in each of the three youngest age groups than for any of the four APA divisions. Likewise, for the three oldest age groups, the proportion of Alaska psychologists is less. Lastly, there are more women than men in the Alaska sample while the proportions are reversed in all four divisions.

While there is a difference in sex and age between Alaska psychologists and those in the four APA divisions, its impact on the present results is problematic:

In terms of contract requirements, two-way ANOVA's were computed for the Alaska psychologists and there was no statistically significant effect for sex, age, or for their interaction on each of the four requirements. The result were for: *Specific goals*, $F(1,336)= 1.539$; $p = .112$ (Sex); $F (4,336) = .849$, $p = .495$ (Age); $F(4, 336) = 1.539$, $p = .191$ (Age X Sex); *Specific Time period*, $F(1,341) = .020$, $p = .888$ (Sex); $F(4,341) = .949$, $p = .436$ (Age); $F(4,341) = .329$, $p = .858$ (Age X Sex); *Signature*, F, $(1,342) = .001$, $p = .980$ (Age); $F(4,342) = .742$, $p = .564$ (Sex), $F(4,342) = .824$, $p = .511$ (Age X Sex); *Specific interventions*, $F(1,334) = 1.055$, $p = .305$ (Sex), $F(4,334) = .661$, $p = .620$ (Age); $F(4,334) = .787$, $p = .534$ (Age X Sex).

For therapists' actual use of treatment plans, and the reason for it, Chi-Squares were computed for the Alaska sample, looking at age or sex and their impact on either the importance of the plan to behavior

or the most important reason for using the plan. As was the case for beliefs, neither age nor sex appeared to have a statistically significant effect. To the relation of sex to treatment plan importance, χ^2 (4, N =186) = 2.017, $p < .733$; to the reason one uses the plan, χ^2 (1, N = 192) = 2.119, $p < .146$. To examine the relation of age to the plan's importance, $\chi^2(8, N = 173) = 6.152$, $p < .630$), to the reason for using the plan, $\chi^2(2, 178) = 1.631$, $p < .442$;

In short: While the difference in sex and age between the Alaska and American Psychological Association samples is indisputable, these differences don't cast doubt on the generalizability of the results.

Why Do Respondents Differ About Contract Requirements But Not On Plan Impact or Reason For Use?

So far as what therapists do or why they do it, there's no statistically significant difference between the Treatment-Plan-Friendly and Treatment-Plan-Skeptical groups. The items that measure contract requirements, however, present a different and mixed picture. For all but the requirement of a signature, there are statistically significant differences. There are several possibilities for this. One is that perhaps respondents didn't equate the contract with the treatment plan since the latter actually encompasses many more things like diagnosis, assessment of client strengths, etc. This doesn't seem likely. In the writer's experience, colleagues used the terms "treatment planning" and "treatment contract" interchangeably. Also, when the respondents were asked to write about strengths and weakness of treatment planning, almost every answer had to do with the contracting process.

A more likely explanation is that the results are for two different samples: Only those who did therapy regularly answered the two questions about the importance of, and the reason for using, treatment plans while all licensed mental health professional, both practitioners and others (administrators, teachers, government workers, etc) answered the questions about the helpfulness of the four contract requirements. Thus it's tempting to hypothesize that, no matter what one's orientation, what s/he actually does in the therapy

hour, and why s/he does it, is the same while what one believes *about* therapy, especially for those who don't actually practice, cleaves closer to orientation. That is, it seems plausible that when one moves from the rarified world of theory to the more concrete sphere of practice, one's beliefs are as likely to come from experience as they are from theory.

Some evidence for this comes from looking at how providers and nonproviders view the four combined requirements. The items have a high intercorrelation and are conceptually related.

Table 6
Intercorrelation (Spearman's Rho) Between Items Indexing Four Plan Requirements

Requirement:	Time Period	Signature Helps	Specific Intervention
Behavioral Goal	.69** (n = 350)	.61** (n = 350)	.67** (n = 343)
Fixed Time Period		.53** (n = 357)	.68** (n = 349)
Signature			.62** (n = 350)

Note. **p < .01, 2-tailed.

Therefore, they were combined into a *Belief* scale whose reliability was .875 (n = 343, Chronbach's Alpha) A t-test was then computed for *Belief*, comparing practitioners with nonpractitioners. Those people who actually practiced significantly disagreed that the requirements were helpful more than those who didn't, $t(206) = 8.02$, $p = .000$.

Conclusion

One can only conclude that the Alaska Medicaid treatment plans are far from a standard of care for licensed Alaska therapists because they only honor the plans in their breach. More than half report they're either *marginally* or *not at all* important to what they do in therapy. Only about 11% report they're *critically* or *very important* to

their treatment behavior. Moreover, professionals as a whole generally agree, at best, in a lukewarm fashion that the four contract requirements are helpful for therapy. The mean response for three are between *Neutral* and *Somewhat Agree* and for the fourth, between *Neutral* and *Somewhat Disagree*. Compare these responses to how physicians would answer a parallel questionnaire that asks about their treatment behavior, the reason for it, and their belief about using an x-ray to diagnose a broken bone. Except for a few outliers, one would expect one hundred percent to say their treatment plan is *Critically Important* to what their therapy is and the plan is formulated because it's helpful for the patient. Of course, all would *Strongly Agree* an x-ray is helpful for therapy. In short, the Medicaid treatment plan, and its contract compares very badly with a true standard of care.

Moreover, when licensed mental health professionals whose orientations favor Medicaid style treatment plan are compared with those, like Client-Centered therapists, who don't, the picture changes only a little. Statistically, the groups aren't differentiated by the impact of the plan on their behavior or why they use it. They do differ, however, in their endorsement of the contract requirements. Although responses by the Friendly group still hover around the midpoint of the Lickert scale, three of the four treatment plan components are endorsed as being helpful significantly more by professionals with Treatment-Plan-Friendly orientation than by those with Treatment-Plan-Skeptical approaches.

Why Friendly and Skeptical groups don't differ in their reported behavior, or the reasons for it, but do differ in their endorsement of the contract's requirements may be explained by the difference between theoretical consideration and actual practice. On a theoretical level, Treatment-Plan-Friendly therapists believe (most of) the Medicaid contract requirements are somewhat helpful. In the actual practice, though, they disregard treatment plans in the same way as do therapists with Treatment-Plan-Skeptical orientations. Some additional evidence comes from examining providers and nonproviders. The former disagree significantly more than do the latter that the treatment contract requirements are helpful, according to an index that is an aggregate of scores for the four items. These

findings suggest, then, just as there may be "no atheists in a foxhole," there are few ideologues in actual practice.

The results are encouraging to Client-Centered therapists. They say that practitioners of all theoretical orientations disregard treatment plans in practice, plans that the Client-Centered approach disregards. Their practice is our practice and, of course, affirms our theory. The results are encouraging in a second way as well. They point to a direction that we, as Client-Centered therapists, can interface with others to make the therapy workplace more congenial to our practice. This certainly can't be done by somehow melding our theory with others. The radical nature of the approach separates us from other practitioners because how we see the treatment world is so very different: Solution Focused and Cognitive-Behavioral therapists, for example, have differences in shades of gray. On the other hand, the difference between Client-Centered therapy and its nearest cousin, Focusing, is held by a significant number of Client-Centered therapists to be the difference between black and white (e.g., Brodley, 1986). While we can never agree on theory, we can agree with others on practice. Thus were the results of the study replicated, it could be the camel's nose under the tent of conventional requirements which hinder what we do. But there are other possibilities for paradigm changing research as well. For example, to what extent does diagnosis (another non-Client-Centered concept) determine therapy behavior? Perhaps even more importantly, replicating the current results would open the way for funding studies on what the impact of plans with these elements have on the therapeutic outcome, the motivation for this research to begin with.

While the results are encouraging for the Client-Centered community they should be disquieting for others. They suggest at least one state requires a professionally unaccepted treatment procedure. If providers acquiesce, it raises an ethical issue for both. To the extent that other payers require the same procedure, and their payees comply, it creates an ethical dilemma for them as well. Besides the ethical problem, compliance perhaps exposes practitioners to an unnecessary legal risk as well: Bennet, Bryan, VandenBos, and Greenwood write: "Some practitioners prefer to write treatment plans with their clients. To the extent that the therapeutic contract is explicit, you might find

yourself sued . . . . for breach of contract." (1990, p. 36). Thus, the results of this study, legal possibilities, ethical considerations, and Client-Centered practice all converge to suggest that requiring Alaska Medicaid treatment plans, and others like them, is at least unneeded, at worst counter-productive, and from a risk management standpoint inviting unnecessary exposure.

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Appendix A: Alaska Medicaid Treatment Plan Requirements

Individualized Treatment Plan:

All clients receiving services at a Community Mental Health Clinic must have a treatment plan. An individualized treatment plan is a written document that is developed in cooperation with the recipient and other members of any interdisciplinary team and is in compliance

with all program rules, regulations, and statutes.

All community Mental health Clinic services must be specified in an individualized treatment plan, which describes the recipient's diagnosis, symptoms, and plans for intervention and treatment, and is included in the recipient's clinical medical record. The individualized treatment plan must include:

- Identifying recipient information
- A list of the members of any interdisciplinary team participating in the planning and implementation of the plan.
- A prioritized summary of the presenting problems and needs as stated by the recipient and identified during the intake and functional assessments.
- A summary statement of the strengths and current resources of the recipient
- A diagnosis established through an intake assessment
- Clearly stated goals and measurable objectives derived from the intake and functional assessments designed to accomplish specific, observable changes in skills, symptoms, behaviors, or circumstances that directly relate to a better quality of life for the recipient.
- Specific interventions, services, or activities that are designed to accomplish the stated goals or objectives, that promote active treatment and are medically necessary.
- The frequency and duration of each intervention, service, or activity included within the plan
- Identification of the individual provider responsible for implementing each goal, intervention, and service included in the treatment plan
- Locations where the intervention, service, or activity will be provided
- Specific time periods for each goal or objective
- Documentation that recipient or the recipient's representative actively participated in the development of the treatment plan, or if active involvement is not possible a statement of the reasons for the lack of participation.

- Signatures of the following individuals, indicating review and approval: a) the recipient or the recipient's representative, unless the recipient or the recipient's representative is not willing or able to participate as described above; b) at least one physician or mental health professional clinician; c) the case manager, if one is assigned; d) those participating members of any interdisciplinary team who have approved the plan.
- A description of any need for additional assessment.