

*TECScript 2*  
*Written Treatment Plans and*  
*Mental Health Outcomes*  
*Messages from March 2000 – April 2000*



*An Unedited Compilation of Email Messages from the*  
*Outcomes Evaluation Topical Evaluation Network*  
*(OUTCMTEN) at [outcmten@world.std.com](mailto:outcmten@world.std.com)*



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Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)

This **TECScript** was compiled by *the Evaluation Center@HSRI*. The Center is funded through a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

**TECScripts** are one component of the **Topical Evaluations Networks (TENs) Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below.

The **TECScripts** are designed to provide interested persons with unedited compilations of Internet messages from the various mental health listserves that the Evaluation Center operates. The Center operates four listserves that deal with different aspects of mental health evaluation. Following are descriptions and subscribing instructions for the four listserves:

- **Legal and Forensic Issues in Mental Health Topical Evaluation Network (LEGALTEN)** The purpose of the LEGALTEN listserv is to facilitate the implementation and use of rigorous evaluations at the interface of the mental health system, the criminal justice system, and the courts.
- **Managed Behavioral Health Care Evaluation (MBHEVAL)** The purpose of the MBHEVAL listserv is to discuss the evaluation of managed care as it affects the delivery, outcomes and costs of mental health care and substance abuse treatment services at the state, local, program, or consumer level.
- **Outcomes Evaluation Topical Evaluation Network (OUTCMTEN)** The purpose of the OUTCMTEN listserv is to develop a broad collective expertise with respect to problems of assessing and analyzing outcomes of interventions aimed at improving mental health systems. The list also serves to provide assistance, information, and contacts regarding (1) issues in evaluation, (2) experimental and quasi-experimental design, (3) instrument and survey development, and (4) statistical analysis for mental health.
- **Multicultural Mental Health Evaluation (MCMHEVAL)** The purpose of the MCMHEVAL listserv is to foster discussion of issues related to the evaluation of mental health services for diverse cultural, racial and ethnic populations. Potential issues for discussion include measuring ethnocultural identity, cultural competence, and access to mental health services for diverse groups.

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H. Stephen Leff, Ph.D.  
Director & Principal Investigator

Clifton Chow  
Program Manager

Written Treatment Plans and Mental Health Outcomes *TECScript*  
April 6, 2000

Date: Tue, 21 Mar 2000 09:38:52 -0800  
From: "Kenneth M. Weiss" <kmweiss@yahoo.com>

Does anyone know of any studies which examine the effects of a written treatment plan on outcome in mental health clinics?

Kenneth M. Weiss, Ph.D.

Date: Tue, 21 Mar 2000 11:51:59 -0600  
From: "Ivan S. Williams" <isw@PVI.ORG>

Am also interested in this & more. I've never heard of someone becoming a clinician because they enjoy documenting but with all of the current documentation requirements it's becoming the best reason. Does anyone know of any studies that look at the relationship between the quality of clinical documentation (or documentation compliance) and the quality of outcomes? I would guess that there is plenty of literature on poor documentation and its relation to adverse events (suicide, readmission within 30 days, etc.) but not on its relation to decreasing symptoms or improving functioning.

Ivan Williams

Date: Tue, 21 Mar 2000 13:07:56 -0500  
From: "Colton, Dave" <DCOLTON@DEJARNETTE.STATE.VA.US>

Have you given any thought to the use of goal attainment scaling in the development of your treatment plans? This would incorporate outcome measures in the treatment plan itself and would involve the client in the development of meaningful goals and plans. Kiresuk's book (Goal Attainment Scaling: Application, Theory, and Measurement, 1994, Erlbaum Assoc., Inc.) provides examples of how goal attainment scaling has been used in a number of settings, including outpatient treatment.

David Colton, Ph.D.

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Date: Tue, 21 Mar 2000 14:56:53 -0500  
From: "Scott T. Meier" <stmeier@ACSU.BUFFALO.EDU >

I have not seen any such studies. I wouldn't be surprised if there are "file drawer" studies somewhere on this. Given the number of factors that typically influence outcome, I would be surprised if the presence of a written treatment plan would have a direct effect on client outcome--but it might influence therapist behavior and indirectly affect outcome...

Date: Tue, 21 Mar 2000 17:28:40 -0500  
From: Max Molinaro <maxm2@IX.NETCOM.COM >

"Scott T. Meier" wrote: [edited]

> > ...Given the number of factors that typically influence outcome, I would be surprised if the presence of a written treatment plan would have a direct effect on client outcome--but it might influence therapist behavior and indirectly affect outcome... > >

Back in the late '70's I was on a couple of committees which attempted to help our narrative-writing (if anything at all was written) therapists to write behaviorally-based, comprehensive treatment plans. Huge resistance and griping followed, until most of the therapists learned that after you learned the desired form ("reports decreased depression" as opposed to "is less depressed" etc.), you could continue to do whatever you wanted as long as the right words were in place. In most agencies and institutions I am aware of, the "form committees" quickly found that you could only fit in so many rows and columns before you ended up with five and six page forms (at the last state hospital I worked at, they used a fold-out monstrosity with a total of eight pages...you can imagine how carefully \*that\* baby was filled out--it was a standing joke among the staff. But it sure gave the form committee a lot to do). As a result, my current part-time outpatient job gives you roughly one half of a letter-sized page to fit in problems, goals, methods, specific caregivers, length of treatment, estimated time of treatment and behavioral outcomes expected. There is room for two (2) problem areas. If there are more problems, one is supposed to fill out another entire form. I have never seen anyone with more than two problem areas, oddly enough.

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The idealists thought that if therapists were "encouraged" (which ended up as "required") to think in behavioral terms and do a careful treatment plan with active client participation, agencies would end up with wonderful treatment plans which reflected all the best practices of therapy. Of course, what happened--what always happens when you try to do something on the cheap (through form design and a single service--maybe)--is that everyone learned how to do the minimum required with no regard to what was actually happening. The good therapists still make good plans. The less good therapists make sloppy plans but either word them adequately to get by, or reword them when the supervisor says: "This ain't gonna pass review."

I would just as soon do a study of office decorations effect on therapy outcome. Although, come to think of it, that one has been done.....

In the most recent edition of "Handbook of Psychotherapy and Behavior Change" (Bergin & Garfield), the lengthy chapter on "Therapist Factors" makes no mention of documentation practices. Nor does the entire 850+ page book...for good reason, I expect.

--Max Molinaro, Ph.D.

Date: Wed, 22 Mar 2000 10:34:21 +1200  
From: Eric Medcalf <MedcalfE@ACC.ORG.NZ>

I'm interested in this too, but from the angle that well written treatment plans may get more funding from Managed Care Organizations but might not equate with good quality care. The obverse may also be true, poor documenters may sometimes be good clinicians but get less funding because of their writing skills. Any work on this?

Eric Medcalf

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April 6, 2000

Date: Tue, 21 Mar 2000 16:26:43 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU>

>> Does anyone know of any studies which examine the effects of a written treatment plan on outcome in mental health clinics? >>

I am very doubtful that there are any such studies. On the other hand, I am a bit surprised that the question is raised. Proper documentation is simply a professional obligation. There is, I am sure, no evidence that pilots who file a flight plan have better outcomes than those who do not. There is no evidence, I am equally sure, that auto mechanics that write down for you what they plan to do to your car have better outcomes than those who do not. Surgeons write down what they plan to do, and I do not care whether it makes any difference or not; I want it in writing. On the other hand, I have seen quite a few clinical psychology case records that had no treatment plan and also nothing in the way of outcomes after meandering along for 50-100 sessions. Think of all the things professionals do for which there is no evidence of effectiveness--office decor, diplomas all over the walls, introducing themselves as "Hello, I am DOCTOR so and so...", and it seems to me that good documentation fits right in.

Lee

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April 6, 2000

Date: Tue, 21 Mar 2000 18:08:19 -0600  
From: "Ivan S. Williams" <isw@PVI.ORG >

Actually I agree with both Max and Lee. On one hand it is a professional duty and ethical obligation to document. On the other hand I question the usefulness of most clinical documentation when it does exist. Making treatment plans behaviorally based may bias them against subjective experience and seems to me to be so reductionistic that you will lose sight of the forest for the trees. This could/would actually be a detriment to treatment/achieving a meaningful outcome. I would like to think that clinicians that find/found documentation meaningful would be more compliant than those who find it to be a pain in the back. Unfortunately it seems like it is becoming a bigger pain due to more requirements from the Health Care Finance Administration, JCAHO, MCOs (Hedis driven), states and others. Unfortunately many of these requirements seem arbitrary and capricious at best and meant to limit treatment at worst. Just trying to make sense of all of them alone is a tremendous drain on resources that could be put to much better use elsewhere. I also have to admit being astounded at clinicians who dare call themselves professionals and neglect any documentation of an entire session let alone course of treatment.

My complaining aside I would like to see some evidence of what types and quality of documentation enhance/improve the treatment process. Is there a form of treatment planning/documentation of treatment planning that enhances outcomes (i.e. a format that helps guide and focus the treatment process)? I would hope that if an aspect of documentation can be found to impact outcomes it could/would become meaningful to clinicians. Where there is no significant/valid/reliable connection between documentation and outcomes (including minimization of undesired outcomes) what remains for a professional document? Documenting anything beyond that which impacts outcomes or is ethically required seems to me to be excess and unnecessary. Maybe my view of why to document is too narrow but we need to draw some reasonable and effective lines somewhere!

Ivan

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Date: Tue, 21 Mar 2000 18:30:42 -0500  
From: Max Molinaro <maxm2@IX.NETCOM.COM>

"Ivan S. Williams" wrote: [edited]

>> Actually I agree with both Max and Lee. On one hand it is a professional duty and ethical obligation to document. On the other hand I question the usefulness of most clinical documentation when it does exist....My complaining aside I would like to see some evidence of what types and quality of documentation enhance/improve the treatment process >>

Looking at documentation as we look at doing outcome evaluation of treatment modalities, I can see the following questions which would need to be part of any documentation efficacy study:

1. Is the person who uses the documentation scheme adequately trained in its use (would have to use training to a competency standard as judged by independent blind raters...and of course, a manual would be necessary to insure uniform training)?
2. Is the way the documentation is actually used affected by therapeutic alliance, severity of disorder, type of setting, age, gender, or ethnicity of clinician, or any other of the usual variables?
3. Does the clinician remain competent in the documentation scheme throughout the study (need for periodic competency sampling and "booster sessions" or elimination from the study)
4. Is there some way to assure that the clinicians being judged on their documentation are equally competent in every other significant area that can affect outcome?
5. How would you word a release for participants that wouldn't leave them helpless with laughter?

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Seriously, outcome research is so difficult and time-consuming, that I'm not sure documentation as a variable is a good subject to spend much energy on, although I agree with most of what both Ivan and Lee have said.

--Max

Date: Wed, 22 Mar 2000 08:26:26 -0500  
From: Pat Nelson <pnelson@LYS.ORG >

You might look at the Utilization Review/CQI/QA/TQM literature. In our agency, peer review of client records is used. Professional staff review client files (not their own files or even files from their program/service) paying particular attention to assessment, treatment plan, and discharge planning to examine whether services are comprehensive and well coordinated. They then give feedback to the responsible clinician, which, hopefully, improves future service planning and implementation. The only data we have, of course, is evidence of decreased "deficiencies" on service plans.

Patrick R. Nelson, Ph.D.

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Date: Wed, 22 Mar 2000 09:25:53 -0500  
From: Max Molinaro <maxm2@ix.netcom.com >

Pat Nelson wrote:

> > You might look at the Utilization Review/CQI/QA/TQM literature. In our agency, peer review of client records is used. Professional staff review client files (not their own files or even files from their program/service) paying particular attention to assessment, treatment plan, and discharge planning to examine whether services are comprehensive and well coordinated. They then give feedback to the responsible clinician, which, hopefully, improves future service planning and implementation. The only data we have, of course, is evidence of decreased "deficiencies" on service plans. > >

I think this is a good approach that can work well if the staff giving feedback knows how to do it in a constructive way.

The key is in getting the documenting clinician to think about how the whole case is fitting together, whether all necessary ancillary services are being utilized, and whether, in some cases, perhaps the clinician is stuck or has given up on making significant progress and needs a consult. A good supervisor should help a clinician do all this, but the quality and availability of clinical supervision at agencies, of course, varies drastically, and frequently a supervisee will talk about cases that are "interesting" or those which require immediate attention, not the no-progress ones that fall through the cracks. I think in many agencies, especially in the public sector, they would plead "no time" to a peer-review approach. Too bad.

One other issue I thought of which works against good documentation: no one other than the Chart Police ever reading them. In my last job, I was coming up with forms in a fast and furious manner for several years until I caught on that no one ever even looked at them. Before I quit, I was advising against almost every single new "improved" form idea that anyone came up with, armed with formal and informal surveys which showed that no one used the progress notes and such for any treatment purposes whatsoever--I argued that we could better spend our time on efforts which someone felt were valuable. Some psychiatrists wouldn't look at progress notes before prescribing, some staff wouldn't look at the psychiatrists' reviews, other counselors essentially never looked at their peers' notes.

One powerful way to make any records mean something is to make the record part of the staff clinical review (if any) and say: "Let's look at what's going on with client XYZ." All of a sudden, documentation means something. It can also be a powerful teaching tool.

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Many times I think that new forms are a substitute for effective supervision: the staff aren't consulting with the psychiatrist enough? Okay, instead of talking it over and requiring changes in behavior for the (usually few) non-compliant staff, we'll institute a new "Psychiatrist-Staff Contact Form" which will be more work for everyone, and will "force" the staff offenders to make the contacts. Of course, the staff simply learns how to delay, fake, or ignore the new form, and the supervisors, who didn't want to make the personal contact efforts to correct the situation to begin with get tired of following up, and the brilliant new form languishes.

--Max

Date: Wed, 22 Mar 2000 10:59:12 -0500  
From: Polly Ginsberg <pginsberg@utica.ucsu.edu>

This is old, but germane to the discussion of record keeping: Garfinkle, H. (1967). "Good" organizational reasons for "bad" clinic records. In H. Garfinkle (ed.) Studies in Ethnomethodology. Englewood Cliffs, NY: Prentice Hall. pp. 186-207.

-- Pauline E. Ginsberg

Date: Wed, 22 Mar 2000 09:33:58 -0800  
From: "Ross Andelman, M.D." <rossa@ITSA.UCSF.EDU>

Only one comment to add to this interesting discussion. Written treatment plans, for better or worse, can provide a common orientation for multi-disciplinary teams. As the medicine man on the team, I am very attentive (too so?) to the case manager's and the therapist's treatment plans. However, I can't imagine attempting to look at written plans in relation to outcomes.

Ross

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Date: Wed, 22 Mar 2000 17:37:03 -0800  
From: "Kenneth M. Weiss" <kmweiss@YAHOO.COM>

I was heartened to see that my two and a half line inquiry about treatment plans and outcome evoked so much thought. Since I get the "Digest" version of the list, I saw several responses at a time, so let me try to respond in general.

While I agree that it is good professional conduct to document what you plan to do, the accreditation agencies now mandate and therefore influence the form and character of these documents. As such, I think there needs to be some justification that they either affect outcome or have some other justification (such as identifying who may have legal responsibility). Where I work, treatment plans must be both multidisciplinary and have the signature of a physician.

I am also struggling with the outbreak of "documania" which has swept mental health treatment. Many of the treatment plans are appendages to treatment they often bear little impact on treatment and serve only to fulfill an administrative requirement. One should remember the purpose is not function. My question was posed to asked if anyone has actually measured the function of treatment plans not to question the purpose.

Kenneth M. Weiss, Ph.D.

Date: Wed, 22 Mar 2000 20:50:57 EST  
From: "<Patrick Courtney>" <P8861@aol.com>

Dr. Weiss, your comment makes me wonder about how many trees have died needlessly for the sake of health care paperwork. :-)

Patrick Courtney  
Houston, TX

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Date: Thu, 23 Mar 2000 08:45:21 -0600

From: James D Kloss <jkloss@GUNDLUTH.ORG >

We figure that about one tree dies to provide the paper for each patient admission.

Date: Thu, 23 Mar 2000 09:55:11 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

I agree that we are generally too much inclined to blame individuals rather than the system in which they function. But it is difficult not to do that. Consider the case of Lt. William Calley, who was an immediate cause of the slaughter of hundreds of villagers at My Lai and who was prosecuted for HIS crime, although that crime was certainly also a system failure. Calley was released after a very brief imprisonment, which infuriated liberal, anti-Vietnam types. Apparently they wanted him held responsible as an individual. Well, at some point....We can suppose that virtually any criminal (error-prone person) is the product of a system, but we still want to hold them responsible for their own acts. But, we liberals think that Al Gore was merely playing out the system in raising campaign funds, and we don't think he should be individually blamed for his telephone pécadillos. But George Bush, well that's different. Hey, I'm getting confused.

But, agreed, we should do everything we can to structure systems so that mistakes are averted. I have read that in the U.S. Navy nuclear sub service, ALL errors are investigated, whether they result in any damage or not. Not "no harm, no foul," but "if a foul, then harm." As a consequence, there has never been a harmful accident aboard a nuclear sub. That is probably what we have to do.

That sort of inquiry will be painful, one problem is that we do not have any very ready way of detecting errors if they do not lead to harm. Presumably, in a nuclear sub, if someone presses the wrong button, someone else knows about it. But if in a therapy session a therapist almost, but not quite, drives someone over the brink, that will never be known to anyone. When that therapist finally does drive someone over the brink two years later, everyone will be, or profess to be, amazed, on the grounds that the therapist has a fine, unblemished record.

Tort law drives a lot of this stuff, and that is a powerful, if unmanageable, engine. I do not know how to rein in the avaricious lawyers and the greedy (yes, that is what they are) plaintiffs. Here is one suggestion, though. In our legal systems crimes are offenses

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against the state. That is why the state prosecutes them and punishes the offender. Victims have no inherent "rights" to either function. I believe that offenses that lead to punitive damages are also crimes against the state, not against persons. A person who is damaged by a corporation has a right to "be made whole" by that corporation, maybe even for pain and suffering.

But if the corporation is to be further \*punished\*, e.g., for carelessness, venality, that is a function of the state, and the state should carry out the punishment and experience any consequences. Therefore, punitive damages should be paid to the state (government) rather than to the victims; they will have been indemnified for their losses. Thus, "triple damages" as punishments should be paid to the state (and benefit us all) rather than be awarded to victims, making them sometimes incredibly rich for no reason related to their social contributions. The current system is like a lottery and (probably) greatly reduces the threshold for trying to find someone to blame, sue, and get wealthy from.

Lee Sechrest

Date: Fri, 24 Mar 2000 12:25:59 -0600  
From: "Ivan S. Williams" <isw@PVI.ORG>

Clearly the degree of "fault"/responsibility of an individual belongs on some kind of continuum with much of the remaining fault belonging to the system or process. From the systems/process perspective even when the acts are as egregious and intentful as those of a Lt Calley or Dr. Swango the system needs evaluation/critique. Of course the Army would much rather "hang" Lt Calley then take a look at their screening, hiring, training and leadership that at a minimum allowed this to happen and likely even encouraged it. Hospitals that allowed Dr. Swango on their staff had some credentialing/privileging issues as does the broader cred/priv system. Though we can't catch many or most errors and evaluation of the data that is captured can be difficult in terms of its representativeness this is what risk management is all about. The difficult thing may be setting up a system to gather this kind of info in outpatient behavioral health or social service settings. Of course satisfaction and clinical outcomes data and comments can provide some info on this (i.e. a complaint from a patient about a clinician's concern, competence, etc.). The trick may be how you identify and then sort out the "minor" errors that may or may not impact the potential for "major" errors.

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I really like the idea of redirecting liability settlements/awards to avoid the current lottery system!!! How does such a great idea get implemented? Lee's suggested a great fix to the liability system that encourages and handsomely rewards behavior that harms society and often inappropriately provides too much reward to lawyers and their plaintiffs.

- Ivan

Date: Thu, 23 Mar 2000 14:03:03 EST  
From: Pythigyst@aol.com

In our monitoring and practice development work in mental health, child welfare and education we find major problems with care when the written plans are not functional tools. We focus attention on increasing the functionality both in terms of focusing attention on the target conditions/behavior/symptoms that need to change and in being clear on overall goals and which team members are responsible for implementing different aspects of the plan. The more complex the client the more important having functioning plans becomes. In our case review work we find that when plans are actually working documents the documentation is better, the treatment process has better fidelity and near term results seem to be better. I cannot speak to longer-term outcomes in most cases.

Ivor Groves PhD

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Date: Thu, 23 Mar 2000 14:44:59 -0800  
From: Neal Adams <nadamsmd@trail.com >

I agree wholeheartedly with Ivor. I do treatment-planning training and in my experience the problem is not with the process but with the lack of attention and skill. Because people have come to resent the expectation of planned and documented treatment as an irrelevant externally imposed administrative requirement, I think for the most part they do a poor job. So the initial question reframe is: Do well written treatment plans developed with truly active and meaningful participation of the person served yield better outcomes--and I would say yes.

In the end the written plan is really just the documentation of the process of engaging the person served in a conversation about their needs hopes and expectations in seeking services. Assuring that this conversation occurs in every case is essential. Treatment is a complex process--how many other endeavors in this world proceed without clear and conscious plans? I contend very few and mental health treatment should be included in those processes that benefit from some forethought and planning.

Neal Adams MD MPH

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Date: Sat, 25 Mar 2000 13:00:40 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

We need to ask ourselves why treatment plans are imposed on us. It is not, I think, because HMOs and insurance companies are unthinking or just like to bother clinicians. There really is a good reason, and it has to do with the fact that at least a few clinicians are unthinking and, perhaps, not completely competent. And why do they insist on a fairly rigid template for submitting treatment plans? Because, I suspect, they have found that without a template they get many responses that are uninterpretable. These problems are not those of the payers; they are problems--shortcomings--of the profession. Professionals generally find them onerous. Their response is to complain. To whine loudly and at length. The response of the profession should be to contribute to the solution of the problems on each side: the need on one side for accountability and predictability and the need on the other side for efficiency and clinical integrity.

I have heard and read any number of complaints (whining) from APA and from various other psychologist practitioner groups. I have not heard nor read any useful counterproposals that would deal with the problems of the payers. I have had enough experience to know that the problems of the payers are serious. We have a lot of professionals out there who are careless, who are unthinking, who are not, let us say, fully competent. We even have a certain number who are venal. If we want to rid ourselves of the current system, then it is our responsibility to propose a good alternative. It will not be sufficient to suggest that we simply go back to fee for service, that we abandon reporting requirements, that we let clinicians decide for themselves what they want to do, how much of it they want to do, and how they want to be paid for it.

In my judgment, professional psychology has assisted greatly in excavating the hole in which it now finds itself. If it is going to get out, it is going to have to help find its own ladder. Psychology does not have the power to impose its own solutions. We need to learn to work collaboratively with the health care industry.

Lee

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Date: Mon, 27 Mar 2000 09:09:19 -0500

From: Renee Kopache <ReneeK@HAMILTON.MH.STATE.OH.US>

I would like to take Lee's arguments one step further. Even if a clinician is fully competent, how can one direct treatment and recognize progress if some sort of treatment plan is not developed. The treatment plan not only allows the client and clinician to measure progress/success, but it drives the process. For example, just about everyone I know makes a New Year resolution every January 1st but very few of them are successful with their resolution. Why? Because if we humans don't establish concrete goals with mechanisms for achieving those goals, we tend to be less than successful. Hence, the value of the treatment plan.

Renee Kopache

Date: Mon, 27 Mar 2000 08:18:28 -0800

From: Neal Adams <nadamsmd@trail.com>

Lee--

Well said--and for the most part I agree. My simplistic point--in my tx plan training (which by the way I do annually in Tucson for CARF) I emphasize that planning is a powerful tool for yielding outcomes. People outside the field who look at our tx plans/issues kind of yawn and ask 'what's the big deal/' After all, this is how business is done with at least some problem analysis and the origination of resources towards realization of the goal.

We shouldn't expect less of ourselves--nor expect the folks we serve to accept less. If there are better tools out there than tx plans to help assure this kind of success, I'm all for it. But we (and society) cannot afford/allow us to proceed willy-nilly down the road of providing services without a clear expectation of the intended impact/outcome.

We should not resist but rather welcome that kind of accountability in our field. Either we can demonstrate results or find out why in fact we can't make good on our promises of effectiveness and value.

Neal

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Date: Mon, 27 Mar 2000 11:16:38 -0600

From: James D Kloss <jkloss@GUNDLUTH.ORG >

So we have logical, ethical and bureaucratic reasons for treatment plans, but no empirical evidence that they make any difference?

Date: Mon, 27 Mar 2000 09:25:08 -0800

From: "Spicer, Gary" <SPICER@BHCS.MAIL.CO.ALAMEDA.CA.US >

Congratulations, everyone. With the following words we have arrived at the completed circle of reasoning: "Why? Because if we humans don't establish concrete goals with mechanisms for achieving those goals, we tend to be less than successful. Hence, the value of the treatment plan. "

Was not the original inquiry whether anyone knew of any research regarding the efficaciousness of completed treatment plans in achieving mental health outcomes? It's still a reasonably good question. We can take it on faith that completing treatment plans provides better outcomes. We can say that it depends on the quality of the plans themselves or the skill of the clinician, which might or might not be manifest in the construction of a written treatment plan. Or we can disagree, basing our own opinions on cultural, political, social, and economic factors that we might each feel are most salient to the discussion. However, nobody has convinced anybody. Thus, the question about whether anyone knows of any good research on the issue appears more and more to be the right question to ask. Does anyone?

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Date: Mon, 27 Mar 2000 21:32:26 -0500  
From: Max Molinaro <maxm2@ix.netcom.com >

"Spicer, Gary" wrote: [edited]

> > Was not the original inquiry whether anyone knew of any research regarding the efficaciousness of completed treatment plans in achieving mental health outcomes? It's still a reasonably good question. We can take it on faith that completing treatment plans provides better outcomes....Thus, the question about whether anyone knows of any good research on the issue appears more and more to be the right question to ask. Does anyone? > >

Good point! Although, of course, a subject can be interesting to discuss even without hard data. My contribution was checking out Bergin & Garfield (my standard text for checking on therapy outcome research, although it's getting a bit dated) and finding nothing. Nor did I find anything in a couple of internet searches. No doubt someone has done something, but in another post I pointed out the difficulties in researching the "efficacy" of tx. plans given the myriad factors one would have to control to do a good study.

Let me go more provocatively further: a study concerning treatment plans would be an extravagant waste of time for the following reasons (among others):

1. There is no standard "treatment plan." Every single agency (going on ten at this point) I have worked at has had a different idea of what a tx. Plan should be, some of them radically different. How would you choose "the" treatment plan to use?
2. Let's assume you did a large study and discovered that whatever you defined as "a tx. plan" was associated with some desirable outcome as opposed to cases in which no treatment plan was made, or in which the tx. plan was rated as "poorer" than the tx. plans in the better outcome cases. Let me suggest the real world outcome:

-The majority of people who decide about tx plan policy wouldn't even read the research  
-The minority who read the research would say: "Good thing we do treatment plans."  
-The minority of the minority who read the research and made an attempt to understand why the particular tx plan used was associated with some kind of good

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outcome, might, possibly, perhaps, say: "Gee, that's a good idea, as soon as I can take care of my (staff shortage, reimbursement problems, lack of services for Spanish speaking clients, lack of qualified clinical supervisors for staff, inadequate quality assurance program) we'll have to talk about that at a staff meeting...although I know the groans I'll get about changing the form of the paperwork, and the fact that most of my staff will simply say: 'Just tell me how to fill it out and I'll do it when I have time.'"

-If by some amazing chance some agency somewhere adopted the type of tx plan used in the research study, the sum total of the evaluation of how the new tx. plan was working would be the director asking: "So how's that new tx. plan form working out?" What agency has the time or inclination to take even one tenth of the absolutely vital policy changes (such as the one I got a memo about concerning documentation of suicide attempts, child abuse etc. the other day) and actually, carefully evaluate whether there had been a significant difference made by the new tx plans, controlling, somehow, for other factors.

Have I simply had the bad fortune to be stuck in nine or ten agencies in a row (some of them excellent, clinically, in my opinion) where no one has the time or inclination to utilize the "latest research"--or if they do, no one has the time to assess its effectiveness in a careful, organized way?

I certainly don't want to suggest that we stifle scientific inquiry by dictating what gets researched (although, of course that happens through the funding process). But I do want to suggest that most providers of mental health services in my country (USA) do not have any comprehensive plan of assessing the outcomes of their therapists' cases \*and comparing those outcomes to any kind of standard whatsoever\* (this latter point is important, because I know that just about everyone keeps global assessment scores or tx. plan attainment scores....but these are meaningless because they almost totally subjective and never used in any meaningful comparison to standards of care). Why that is not happening and how it could be made to happen would be near the top of my priority list in terms of research.....the effect of tx. plans would be down around number 5,000. I am aware of a few agencies which do careful selected outcome studies and compare them to some kind of meaningful standard....a tiny, tiny minority. If someone has evidence that I am wrong and the standard at most behavioral health agencies is careful outcome measurement, which is weighed against meaningful standards, I will be happy to stand, corrected, incidentally.

--Max Molinaro, Ph.D.

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Date: Tue, 28 Mar 2000 05:31:24 -0800

From: "Kenneth M. Weiss" <kmweiss@yahoo.com>

I note a tone of indignation that I should have had the naiveté or temerity to question (by implication) the practice of creating treatment plans. All I did was to pose the question if there was any research relating treatment plans to outcome. Clearly, to some, this appears near heresy.

The outpouring of tangential claims that Tx Plans should be done regardless both misses the point and raises interesting questions about our own beliefs and behavior.

I agree with Gary Spicer and James Kloss, that after all the superfluous verbiage, there is little attention to the original question.

I believe that the sensitivity to this issue may be the heritage of attempting to blend science and practice. Many of us trained in an empirical background struggle with the disparity between how we practice and what we believe has been shown to be effective treatment. Have I dared to ask about the Emperor's wardrobe?

Kenneth M. Weiss, Ph.D.

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Date: Tue, 28 Mar 2000 09:13:00 -0700  
From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

I, for one, was not indignant at your question, but I did want to point out that the issue addressed was not one that could or should necessarily be resolved by the empirical data. In that case, the question whether there are empirical data might sink into irrelevancy. There are no data on a whole range of peccadilloes into which clinicians get themselves with their clients, e.g., whether all those things really harm anyone. But we have resolved many of those matters by declaring them to be in the realm of ethics and, hence, insulated from the force of data. Similarly, many aspects of clinical practice are "professional" in nature, and, therefore, similarly at least somewhat insulated from data. Should therapists maintain confidentiality of information? Of course, but I will make an informed guess that no one has ever demonstrated empirically that to do so improves outcomes. Should therapists treat patients with "respect?" Certainly, but there is not likely to be a single study that demonstrates that disrespect has a baleful effect on outcome. Should therapists prepare written treatment plans? Of course.

Lee

Date: Mon, 27 Mar 2000 11:07:34 -0800  
From: Neal Adams <nadamsm@trail.com >

While it is no doubt a worthy research project for someone to undertake, I think the face validity of the proposition that they are effective and useful should prevail until clearly demonstrated otherwise. And it will be difficult research to conduct because I don't doubt at all that a poorly written treatment plan done just to satisfy the bureaucratic expectation is in fact pretty worthless--but that a well developed thoughtful plan in which both person served and provider are mutually invested does make a difference. Sure there are a lot of business deals that can proceed without a written contract--but how many of them would you want to enter into?

Neal

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Date: Mon, 27 Mar 2000 22:43:20 +0200  
From: Knud Ramian <ceps@inet.uni2.dk >

Neal Adams wrote:

> > but that a well developed thoughtful plan in which both person served and provider are mutually invested does make difference. > >

We are trying to take written treatment plans seriously, because if we don't.....It is difficult research to conduct - so was gravity in the beginning.

The best research at the moment might be series of carefully conducted analytic case studies. We need some kind of 'Concept mapping' of the plan process.

We think the outcome is dependent on many variables of which the 'written variable' obviously is not the most important.

We are running a cluster evaluation on nine Danish rehabilitation projects. They are trying to use thoughtful written treatment plans.

We try to answer the following questions:

1. How can we describe differences in the context for the plan? System driven, user driven or what?
2. Is the plan based on expert diagnoses or shared views?
3. What type of priority processing is used?
4. What principles of goal setting?
5. How is responsibility shared in the plan?
6. What types of feedback mechanisms are scheduled in the plan?
7. What is the timing of 1-6 processes?

After the case studies we need good advises for further research.

-Knud

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Date: Tue, 28 Mar 2000 15:24:23 GMT  
From: Paul Fagen <pfagen@ADAPTUSA.COM >

The "face validity" of written service plans does not carry much currency with direct service practitioners who do not have the benefit of academic training in psychology, social work, etc. Actual research on the value of effective service planning may be the missing link to a persuasive argument for our front line staff.

Date: Tue, 28 Mar 2000 10:47:06 -0500  
From: "Stephen E. Beller, Ph.D." <nhdspres@BESTWEB.NET >

This discussion about treatment plans is very interesting...and frustrating. It seems to boil down to this: No one knows what constitutes a good plan and if such a plan impacts outcomes.

Why such ignorance? I contend it is because our field can't do two absolutely critical things:

- (1) Match a particular patient with a particular treatment regimen proven to get the best results most cost-effectively
- (2) Determine the optimal amount of treatment, that is, the duration of care that results in the most substantial and prolonged improvement in a particular patient's condition.

How can anyone write a meaningful treatment plan or judge its usefulness if there's no consensus on what's best for any patient?

Can this situation improve? Sure, if we were willing to put the necessary time and money into comprehensive, coordinated, widespread, field-based outcomes research. But due to all the reasons discussed on this list (e.g., scapegoating, fear of discipline, lethargy, distrust, animosity, ignorance, incompetence, selfish self-interest, etc.), I'm not holding my breath.

Steve Beller

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Date: Tue, 28 Mar 2000 09:19:05 -0700

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU >

On Tue, 28 Mar 2000, Stephen E. Beller, Ph.D. wrote:

> > This discussion about treatment plans is very interesting...and frustrating. It seems to boil down to this:

No one knows what constitutes a good plan and if such a plan impacts outcomes. Why such ignorance?

I contend it is because our field can't do two absolutely critical things:

- (1) Match a particular patient with a particular treatment regimen proven to get the best results most cost-effectively
- (2) Determine the optimal amount of treatment, that is, the duration of care that results in the most substantial and prolonged improvement in a particular patient's condition. How can anyone write a meaningful treatment plan or judge its usefulness if there's no consensus on what's best for any patient? > >

You are probably right, Steve. So, the next question has to be: how can any clinician with a conscience undertake to "treat" a patient at all if he or she has no basis for deciding what is best for any patient? If it is all up to individual clinical judgment, where is the basis for any definition of a profession?

Lee

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Date: Tue, 28 Mar 2000 10:04:06 -0700

From: Paul Cook <pcook@PROBH.COM >

I've been following this discussion with more of an interest in the empirical than the ethical aspects of treatment plans (although the ethical points are of course relevant). I wanted to second Steve Beller's opinion on why it would be so difficult to do empirical work on this topic: We don't know what a "good" treatment plan looks like.

I was reminded of an experiment I took part in during my internship at a CMHC. At one of our weekly outpatient staff meetings, one of our psychologists presented us with three case vignettes and asked us to write short treatment plans for each of the patients described. The outpatient staff included psychologists and social workers at all stages of their professional careers, from a variety of theoretical orientations (psychodynamic, behavioral, and systems). We each wrote our own plan, and then compared notes. Treatment goals for a woman with Borderline PD ranged from "patient will demonstrate less use of splitting as a defense mechanism to "patient will show less reliance on her children to meet her emotional needs" to "patient will report that she experiences uncontrollable crying only once per week or less." (Our clinical director suggested that the patient's goal should be "more appropriate interactions with others, as shown by decreased staff annoyance with this patient"). Clearly, even when we start with a common diagnosis and the same pool of clinical information, highly-trained and skilled clinicians can come to very different conclusions about what type of treatment is needed.

In my opinion, this situation is less due to the fact that we have different theoretical views, and more due to the fact that our diagnostic system is virtually useless. If the DSM was really the best standard for understanding people's problems, you wouldn't need treatment goals at all. The only relevant goal would be to reduce symptoms so that the person no longer qualified for that particular DSM diagnosis. Of course, this isn't what people are looking for when they come to treatment, and arguably it isn't what therapists are best able to provide. And of course, the DSM is lousy at prescriptive treatment matching--overall, the outcome literature suggests the dodo bird conclusion "regardless of your problem, seek any form of psychotherapy."

If diagnoses aren't useful for selecting the best available treatment, we're left with a lot of other clinical data, and no good scheme for making sense of it. That's where theoretical orientations seem to come in--what information do you focus on, to the exclusion of what else, and what do you decide to make of it? A recent article in *JCCP* demonstrates that the more irrelevant clinical information you give people, the worse they are at making useful decisions--sometimes even when obviously relevant information is included in the mix. Even worse, people tend to feel more confident in their predictions the more extreme those predictions are. This is a very good

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argument for using actuarial data (rather than the clinician's judgment) to make clinical decisions.

However, to have good actuarial data, you have to know what variables are strong predictors of the individual's response to a given treatment. I happen to think there are other predictors that would do a better job than the DSM--the "readiness" (stage of change) variable from the transtheoretical model, for instance. But not much research is being done on these variables, because academic outcome researchers focus mainly on particular DSM diagnoses. If we want to know how to provide people with the best possible treatment, we have to start by asking ourselves better questions.

Paul F. Cook, Ph.D.

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Date: Tue, 28 Mar 2000 12:43:18 -0500

From: "Stephen E. Beller, Ph.D." <nhdspres@BESTWEB.NET >

That's an excellent question, Lee. I had been a practicing psychologist for 20 years and had struggled continually with that very issue.

Being a cognitive-behaviorist/RET'er by training, I found myself automatically framing all treatment-related issues in those terms and, lo & behold, virtually all the treatment methods I used were from that same school of thought. While my outcomes data indicated generally good results, not all patients benefited from my interventions. I often wondered if a different approach or combination of methods would have gotten better results. After all, my psychodynamically-oriented colleagues raved about their treatment approach, medication is often very useful, what about eye movement therapy, and what about spirituality, etc., etc. I was also frustrated by the fact that there was no practical way to tell if a physiological problem was causing or exacerbating patients' psychological symptoms. I even got involved with the psychotherapy integration movement in hopes of finding the answers, but to no avail. And when I urged my colleagues to get involved in comprehensive, coordinated outcomes research, I was often chastised.

The effect of all this was my disenchantment with the direction of our profession. Maybe it's me, but I have a difficult time when ignorance is so easily accepted or ignored and when we spend more time fighting amongst ourselves than in working together to find the answers we need.

While I believe psychological treatment has great potential in very many ways -- after all, what's more important than the mind -- the profession continues down a self-destructive path toward ever more ridicule and economic adversities. We belong at the center of the healthcare continuum, where mind and body come into focus, but we continually diminish our worth because we do very little to develop a valid way for deciding what is best for any patient.

Just my opinion,

Steve Beller

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Date: Tue, 28 Mar 2000 10:20:59 -0800

From: "Kenneth M. Weiss" <kmweiss@yahoo.com>

Professor Berman's comments remind me that one should remember that absence of evidence is not evidence of absence. I agree that this is an area that is ripe for inquiry.

Professor Sechrest raises an interesting point that perhaps this is an activity which is "professional' and ... at least somewhat insulated from data. "I would suggest that a better approach is to examine the data and empirically determine what kind of treatment planning is most likely to improve outcome.

Treatment planning is a professional behavior that may serve a variety of functions. I contend that one function is to improve treatment and its outcome. We should examine how best to do this. Some years ago, I made a rudimentary attempt along these lines (Weiss, K.M. & Chapman, H.A., *Hospital and Community Psychiatry*, 1993, 44:1097-1100) to encourage systematic treatment planning for the seriously mentally ill.

Ken

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Date: Tue, 28 Mar 2000 14:47:19 -0500

From: Renee Kopache <ReneeK@HAMILTON.MH.STATE.OH.US>

I have read, and for the most part agree with, most of the comments over the past few days about treatment plans. I have noticed, however, one key component that is missing in the discussion. No one has talked about evaluating the value of treatment plans from the perspective of the client. After all, aren't treatment plans supposed to be developed to benefit the client. So why not ask them? This type of research could be done much more easily.

Paul Cook gave the example "We each wrote our own plan, and then compared notes. Treatment goals for a woman with Borderline PD ranged from "patient will demonstrate less use of splitting as a defense mechanism" to "patient will show less reliance on her children to meet her emotional needs" to "patient will report that she experiences uncontrollable crying only once per week or less." (Our clinical director suggested that the patient's goal should be "more appropriate interactions with others, as shown by decreased staff annoyance with this patient"). Clearly, even when we start with a common diagnosis and the same pool of clinical information, highly-trained and skilled clinicians can come to very different conclusions about what type of treatment is needed."

I see a significant problem with this exercise: none of the participants had ongoing interactions with the client. How can one develop an effective treatment plan without knowing the client? More importantly, why does the clinician, by himself, have to come up with the most effective treatment approach. No one knows the client and their needs better than the client themselves. Who better to ask how they want their treatment to proceed?

Just my two cents worth--of course I'm biased. Either way, I think this is a great discussion.

Renee Kopache

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Date: Tue, 28 Mar 2000 15:49:11 EST  
From: Pythigyst@AOL.COM

This discussion has highlighted several critical issues that are currently major challenges to the Behavioral health field and do critically need to be addressed. I guess I will see if I can make everybody mad and please forgive me for the length.

While I have not done a complete survey it is my impression that all professional standards of practice set the expectation that the "clinician" will assess the patient properly, based on the understanding gained through the assessment, develop a plan of intervention, in collaboration with the patient, and implement the agreed on plan and assess the progress on one or more dimensions and make adjustments as necessary. It is clearly expected that the process will be documented for a multitude of reasons.

The plan resulting from this process can be very simple i.e. reduce symptoms, take pill, symptoms improve, goals met. On the other hand it can be very complex with functional life domain goals, symptom reduction goals, maintenance goals. etc., and require the intervention and coordination of multiple service providers across settings. The professional's job is to translate the formal knowledge, theories and empirically based interventions to the individual clients context and make adjustments in treatment modality, intensity and scope to achieve results.

It would be very difficult to research the efficacy of a written treatment plan without examining the whole process. When that is done the issue is not whether the process met the form/rule requirements but whether it was a "functional" process that achieved results. It seems to me that this is where the "accountability" of the professional to the payer and client intersects with the professional obligation to learn how to improve practice by making increasingly fine discernment as to how to apply empirically based interventions to each individual's context.

Admittedly this is a complex task requiring professional judgment and careful discernment. The current state of behavioral health is that there is wide inconsistency and gross discrepancies in how effectively professionals meet these expectations and maintain the "fidelity" of the treatment/intervention process.

It appears to me that payers tend to take an overly simplistic, rule governed, mechanistic approach to achieving the expectations described above under the stated intent of achieving "cost effective" quality professional practice and results. On the other hand professionals tend to excuse themselves from these expectations for a variety of reasons including reimbursement schedules, confidentiality, someone else's problem, because it is imposed by rule, lack of time, professional arrogance/ignorance/incompetence etc.

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Currently it is not clear to me how to bridge this gap and create a situation where payers and professionals mutual interest are met by applying empirically based interventions to individual context in a wise and discerning manner that produces documented results.

I'll use one example to highlight these issues. In the Surgeon General's report on Mental Health the findings of the NIMH Multimodal Treatment Study of ADHD. The study examined three experimental conditions: medication management alone, behavioral treatment alone, or a combination of medication and behavioral treatments. The study compared the effectiveness of these three treatment modes with each other and with standard care provided in the community (control Group). The behavioral component consisted of parent training, school intervention and a summer treatment program. Notably the combined treatment resulted in significant improvement over the control condition in six outcome areas-social skills, parent child relations, internalizing symptoms, reading achievement, oppositional and/or aggressive symptoms, and parent/consumer satisfaction. Whereas the single forms of treatment (medication or behavior therapy) were each superior to the control condition in only one to two of these domains. The conclusions from this study are that carefully managed and monitored stimulant medication, alone or combined with behavioral treatment, is effective for ADHD over a period of 14 months and followed up for an additional 22 months. The data also break out co-morbidity and show differences in results based on different co-morbid conditions. Question: Will payers change their reimbursement schedules and combinations of units of service approved to support this empirically demonstrated more effective approach to treatment of ADHD and will professionals adjust their practices to assimilate the knowledge, skills in applied behavioral applications and coordination with other professionals necessary to implement combined therapy based on individual need at home and school and extended school year??? How long will these change take to achieve consistent application across all public sector systems. How can we create an environment where both parties value and support both accountability and clinical judgment and practice?

Questions: How can payers be assured if they change their reimbursement schedules that that clinician will actually implement the ADHD multimodal treatment with high fidelity and actually achieve the promised results?

Ivor Groves

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Date: Tue, 28 Mar 2000 18:34:25 -0500

From: "Prof. William Berman" <berman@fordham.edu >

For those of us who are "believers" in the concept of quality improvement, there is an article in the February 2000 issue of *Medical Care* that reports that TQM interventions to improve the care of patients receiving CABG surgery had little impact on site-by-site variations in the outcomes of care. It will be interesting when we can get far enough to find out if this helps in mental health.

Bill Berman

ref: Shortell, SM, Jones, RH, Rademaker, AW et al (2000) Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients." *Medical Care*, 38(2), 207-217.

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Date: Thu, 30 Mar 2000 15:34:45 -0500

From: "Colton, Dave" <DCOLTON@DEJARNETTE.STATE.VA.US>

In regard to the current discussion on treatment planning, Bill Berman notes that, "TQM interventions to improve the care of patients receiving CABG surgery had little impact on site-by-site variations in the outcomes of care." (as based on a report by Shortell and his associates) In other words we followed the plan, but the patient didn't improve. I think this highlights the difficulty of using treatment plans to assess outcomes. CABG (by-pass surgery) is dependent on a multitude of factors, such as the age of the patient, other pre-existing conditions, the skills of the surgeon, and more importantly, whether or not the particular surgical intervention is appropriate and effective for that condition.

Some studies conducted by state peer review organizations have demonstrated that commonly practiced medical treatments are not effective. Often these studies are based on risk-adjusted epidemiological data. When possible, alternative, more effective interventions are identified. So, it is possible to have a good plan, an effectively implemented treatment process, but ineffective, undesirable, or unplanned outcomes.

Dave Colton

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Date: Wed, 29 Mar 2000 00:16:31 -0500  
From: Alan Eppel <eppela@FHS.CSU.MCMASTER.CA >

I think there are a number of different issues here. Firstly the fact of being compelled to write treatment plans for managed care companies is irrelevant to the question as to whether or not writing treatment plans correlates with better outcomes. I think this original question is a good one because it is useful to question long held assumptions - this is a fundamental tenet in CQI i.e. "Why do we do this?"

Secondly DSM diagnosis does predict treatment response with medications in specific psychiatric illnesses such as major depression, schizophrenia, and panic disorder. There may be less of a specific effect with psychotherapies although cognitive and interpersonal therapy have been demonstrated to be effective for depression; dialectical behavior therapy for certain measures in borderline personality disorder etc.

The therapist should have a plan to apply the proven interventions. Will the outcome be better if he writes this plan down versus carrying it out without writing it down?

The same question could be asked about other things we traditionally document but which may be of no benefit to the recipient of care.

Alan

Date: Wed, 29 Mar 2000 11:33:34 -0500  
From: "Scott T. Meier" <stmeier@acsu.buffalo.edu >

Such providers are also aware that such paperwork can be another tactic used by managed care companies to delay and deny care and payment...

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Date: Wed, 29 Mar 2000 11:34:36 EST  
From: Ruth Ross <DOCTORUTH@aol.com>

As I understood the problem, the research would be Treatment Plan or no Treatment Plan and not necessarily what or which kind of Plan. In order to have a comparison group, it seems to me, one would have to define the non-Treatment Plan Group of clinicians by determining how they process sessions and how they use their clinical knowledge to move forward. Once the clinician w/o a TxPlan sets down what they do and how and when, etc. you lose the distinction. Unless, of course, you have a really un-determined situation with clinicians at the start and they do not set anything down beforehand but only give some sort of a retrospective analysis of what they did and then try to link the retrospective description with the outcome and compare that with the outcome for clinicians following a Plan. As in any good evaluation, one needs a means of evaluating whether the clinicians (with the Plan) actually did what the plan said and then whether there is any evidence that the linkage between the process and the outcome for non-TxPlan clinicians have any validity.

At the risk of incurring the wrath of the anti-Freudian camp I will say the following. Before there was DSM IV there was a very comprehensive system of understanding a person's character, dynamics, development, symptoms, family situation etc. This came out of the Freudian/Analytic Community with additions and amendments by the Ego Psychologists (the Blancs, the Object Relations People (Melanie Klein, etc.) and the Developmental People (Margaret Mahler, Daniel Stern, etc.). It was dependent upon a very good education and a comprehensive supervision and, finally, the dreaded analysis. The latter has been modified by most programs to simply require that the clinician in question have had some time in therapy/treatment themselves. Based on this, after a few sessions in which, the clinician obtains enough history to put together an understanding of the client and to proceed with treatment based on a plan of understanding 'where the client was at' in a manner of speaking.

Ruth Ross

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Date: Wed, 29 Mar 2000 11:40:17 -0600  
From: "Ivan S. Williams" <isw@PVI.ORG >

This is exactly the kind of basic applied research/descriptive study I'm interested in seeing given the previously mentioned complexities of doing "good" research from which to draw causal connections. From a practical real world perspective it is helpful to know if clinicians who do some sort of written treatment plan (Grp A) have better or the same outcomes as those who don't (grp B). Of course some minimal criteria for what constitutes a trt plan would likely be necessary along with a very large sample size. If such exploratory research revealed that Grp A tends to have better outcomes and is similar in terms of other potentially important variables (i.e. treatment alliance, training, experience, patient severity, etc. etc.) there seems to be a practical case for encouraging treatment planning. If on the other hand Grp B does the same or even better there may be a case for not doing them (or not doing them unless done right). Of course the main result of such a study, or better yet a meta-analysis of several studies, might be to provide some direction for future research and/or determining what, if any, aspects of treatment planning documentation facilitate achieving the desired outcomes. Does this type of research exist? If not, would it be worthwhile?

Ivan Williams

Date: Wed, 29 Mar 2000 12:27:33 -0500  
From: Max Molinaro <maxm2@IX.NETCOM.COM >

Ruth Ross wrote: [greatly edited]

> > As I understood the problem, the research would be Treatment Plan or no Treatment Plan and not necessarily what or which kind of Plan. > >

Dr. Ross, I thought you made all excellent points in terms of research design, and I enjoy the unusual clarity of your writing. I have to say once again, however, that the practical impact of such a research study would be nil, in my opinion. The minority of clinicians who read and utilize research are probably the ones who also try to do good treatment plans (I include myself as such a striver). And I could simply not imagine a director of outpatient saying at a meeting: "People, a study has come out that confirms that, on the average with a variety of exceptions, clinicians in a (fill in the setting here) setting actually had better outcomes with their clients than clinicians who did not set a single thought on paper. See, you should do your treatment plans."

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I wouldn't even hazard a guess at what might be chosen as a reasonable type of outcome measure: client satisfaction? Symptomatology? Working alliance? (that's the one I'd go for, but I would bet the barn that tx. plan vs. no tx. plan has nothing to do with alliance). Also, what about the ethics of the no-plan group refraining from doing something that no doubt at least some clinicians would find interferes with good treatment...not to mention what the site administrator would say about not keeping tx. plan records! (I suppose a non-research participant could independently write up a treatment plan??? But how to do that without talking to the treating clinician, which would introduce another variable).

I'm enjoying the discussion as an exercise in research design and treatment philosophies, but, again, I hope no one spends any time or energy whatsoever on this sort of study, given our other priorities and the likely gains from such a study even it were shown that average scores in some setting with some mix of clinicians was better at the .05 level than clinicians who did something that almost no clinicians working in an agency can get away with.

And, Dr. Ross, you won't get any wrath from me by questioning the DSM-IV, even though I think it is far better than the "old way." It is simply not relevant. Classical analysis was never practical for more than a tiny proportion of mostly elite members of the population, which makes its efficacy, unsupported by modern studies (I suspect no one even does them), a moot point. In addition, there is no solid evidence that I am aware of that training, personal therapy, or analysis produces better client outcomes, variously measured, by clinicians. There are a few studies that suggest that it might, but they are outnumbered by "no difference" studies. Sad to say for those of us who put so many years, tears, and money into our doctorates.

--Max Molinaro, Ph.D.

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Date: Thu, 30 Mar 2000 12:24:13 -0600  
From: "Harriet W. Meek" <hmeek@MCS.COM >

Thanks, Ruth. Your description of treatment plan development is how some of us still go about it. Further, some people on this list seem confused by the difference between psychoanalysis proper and psychoanalytically oriented therapy. There is a very large difference.

So far as I am concerned, I think the treatment plan must include something of underlying dynamics (how did this person come to be the way they are now?) and not just symptom focused. That doesn't mean my treatment plan will necessarily advocate spending session after session rummaging around in the past.

For instance, if a child has symptoms of ADHD, I generally inquire about other things going on in the home, school and other environment about which the youngster might have some emotions. I also want to know how this child manages emotion in general, particularly anxiety and anger. And how do others in the family manage such emotions? And, if I find some familial patterns, I don't immediately assume we are talking about genetics. Instead I am more likely to be thinking in terms of regulatory difficulties. After all, those of us who know the literature well also know that people learn to manage their emotions through relationship, generally with a caregiver, but sometimes later in life with a therapist.

When I was working more with third party payors and in agencies, I often had to develop one treatment plan that actually guided my work with a client and another that I had to write down for the chart. The agency/insurance company rules didn't allow me to develop the depth of intervention I thought necessary. So I would operationalize my own treatment plan, collapsing it into a sort of code to fit the external requirements. I tried to make the two match as much as possible, but it was hard to fit what I actually thought needed to happen into the structured format required by the administration or third party payor.

Because I am quite experienced and have the sort of education Ruth described, I could keep clear about what I was doing and generally didn't have difficulty with the external parties, but I must say it is easier when nobody but the patient and I are involved in setting our treatment plan. (BTW, I do this collaboratively with the patient in the first few sessions, checking back and adding and subtracting items intermittently as we go along.)

Now that I am mostly teaching, I find that students have extraordinary difficulty with this. If their treatment plan (often written by someone else) says "develop social skills", they feel they must be "teaching" social skills. (While I am a firm believer in psychoeducational methods, this is not psychotherapy.) But, if a child's fingers are

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going into their mouth and they regularly are drifting off into a daze with some form of dissociation, no amount of harping on "social skills" will be of any help whatsoever. Treatment plans need to be dynamic and to have built into them some consideration of where the objectionable behavior comes from.

The other problem encountered is that treatment plans need to be flexible, able to incorporate new information as it emerges, while still keeping the 'big picture' in mind.

I don't hear any of these things being discussed other than by a very few people here. It worries me. I haven't a clue how you would deal with these issues in "research". It seems like meaningless research to me. BTW, maybe Max would like to look at the work done by Peter Fonagy at the Anna Freud Centre in London (and also at Menninger in the USA). He is a renowned psychological researcher and has done studies of the efficacy of long term treatment, with positive results.

And, re: the therapy/analysis (I recommend the latter) requirement for people doing therapy, has anyone criticizing this rule ever thought that perhaps the measures we've managed to devise aren't specific enough to "catch" the difference?

Harriet Meek

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Date: Wed, 29 Mar 2000 13:44:31 -0500

From: "Colton, Dave" <DCOLTON@DEJARNETTE.STATE.VA.US>

I think Max Molinaro makes some salient points about trying to develop a research design for studying the association between treatment plans and outcomes. For example, what outcomes would you look at: whether clients are more satisfied with services because they are involved in the development of their treatment plan or whether they experience a decrease in severity of illness? I'd add that a treatment plan is like a blueprint for a house. Numerous factors go into building the house: the quality of the building materials, the expertise of the builders, the physical site, the weather, as well as the blueprint. Which factor has more influence on the outcome?

The blueprint provides guidance, but does not create the final product. The purpose of the treatment plan is to guide treatment and to provide a system for measuring results (for example, through measurable behavioral objectives) (and when implemented with the client, it is a way to engage patients in treatment), however it is not in and of itself a process meant to produce clinical outcomes.

If this is indeed the case, then the purpose of the treatment plan is to describe what results are desired, what will be done to attain those results, and how the results will be measured. Taken from this perspective, the question might be restated as: "how do we create a better more sensitive blueprint."

David Colton, Ph.D.

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Date: Fri, 31 Mar 2000 12:36:24 EST  
From: Ruth Ross <DOCTORUTH@AOL.COM>

In response to Dave Colton's comment, the research can show excellent results - Treatment plans work, the patient agreed with it, it was carried out as planned but the 'patient' was not cured. Again I venture: I had a fairly traditional 10-year analysis - 4x/week with a progressive by Freudian analyst. I'm cured - no, really and truly. It did what an analysis says it can do, it did what I want - both up front and down a little ways. I am not the person I was. I can point to specific events and exchanges and aha's! that occurred which, pushed me along the path to being cured, as far as I'm concerned. Now did my analyst have a treatment plan - absolutely - although not written except in his head and based on not only his initial evaluation of me but modified and redirected as we went along and some things happened and other things did not. What does this have to do with our exchange: This is a very complex and complicated matter although' it can certainly be simplified. And theoretical position, match, time, money, circumstance, therapeutic alliance all matter.

Ruth Ross

Date: Wed, 29 Mar 2000 19:15:12 -0500  
From: Paula Robin Margolis <pmargolis@VCU.ORG>

Accountability for limited funds does not necessarily equate with a desire to deny effective, necessary care.

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Date: Wed, 29 Mar 2000 21:15:47 EST  
From: Sheila Baer <Smbaer@aol.com >

So far this discussion has focused on diagnosis as the basis for a treatment plan. What about considering presenting problems, as described by the client? Is there a difference in outcome if the tx plan is based on the problem area itself, rather than the symptoms/diagnosis, which may have little bearing on the underlying problem? For example, problems managing one's career may cause depression or anxiety, as might interpersonal problems (of one variety or another).

Sheila M. Baer, MS

Date: Thu, 30 Mar 2000 09:43:31 -0700  
From: Paul Cook <pcook@PROBH.COM >

I agree with several list members that it would be more helpful to compare different types of treatment plans than simply plan vs. no-plan groups. I think that if you're doing any type of psychotherapy, you DO have a treatment plan—some theoretical scheme that guides your interventions—even if it's only "respond to whatever the client brings in today." If that's your method, you use it because you believe it will be helpful.

On the other hand, it makes sense to ask a variety of questions about which types of treatment plans work best:

- (a) is it more helpful to have a formal, written treatment plan, vs. an informal, non-written one? Are there particular questions that we should be asking ourselves in order to develop the best possible plan?
- (b) is it more helpful to involve the client in writing the treatment plan, vs. having the therapist do it alone? In cases of disagreement, which participant should have the final word?
- (c) is it more helpful to base interventions on empirical predictions or on clinical judgment? If empirical predictions are best, what are the best predictors?

It seems that a number of people share my opinion of the DSM, but I do want to respond to Alan Eppel's point that:

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> > DSM diagnosis does predict treatment response with medications in specific psychiatric illnesses such as major depression, schizophrenia, and panic disorder. There may be less of a specific effect with psychotherapies although cognitive and interpersonal therapy have been demonstrated to be effective for depression; dialectical behavior therapy for certain measures in borderline personality disorder etc. > >

I agree that some DSM categories (e.g. schizophrenia, bipolar disorder) are useful for predicting response to medication. This isn't surprising, given that the DSM is a psychiatric classification system. (As I understand it, some diagnostic categories were developed on the basis of which medications they responded to--GAD for instance. On the other hand, a lot of different problems now seem to respond to treatment with SSRIs. Maybe this will lead to a single "anxiety/depression" category in the next DSM).

However, my argument is that DSM categories aren't useful for choosing a mode of psychotherapy. Although research shows that cognitive-behavioral therapy is effective for people with depression, CBT is also effective for dysthymia, social phobia, GAD, panic disorder, PTSD, anger management, etc, with only slight variations in the procedure. Similarly, interpersonal therapy is just as effective as CBT for depression, eating disorders, etc.--and both have only about a 70% success rate with any disorder. The DSM adds no information that's useful for selecting one psychotherapeutic modality over another.

Of course, there are treatments that have been tested (like CBT and IPT), and treatments that haven't been tested (like Thought Field Therapy, for instance). In most cases, professionals should use the treatments with proven efficacy. Dialectical Behavior Therapy is the only proven treatment for borderline personality disorder, so we should probably all be using it. But a lack of research doesn't mean Thought Field Therapy doesn't work—only that it hasn't been properly evaluated yet. EMDR seems strange to me, but we're beginning to see some evidence that it works just as well as behavior therapy for various anxiety problems. In fact, almost any treatment that has been formally evaluated seems to produce about the same 70% success rate. Again, this suggests to me that we aren't able to select the best treatment modality based on a client's DSM diagnosis alone.

Paul Cook

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Date: Thu, 30 Mar 2000 12:22:25 -0500

From: Richard Evenson <mimhre@SHOWME.MISSOURI.EDU>

I think that it would be very difficult to do research on the effectiveness of treatment plans, the reason being that your control group would likely have a plan, even if not written. So you would have to pose the question "does having a written, formal treatment plan result in better outcome."

Date: Thu, 30 Mar 2000 12:39:58 -0500

From: Richard Evenson <mimhre@SHOWME.MISSOURI.EDU>

Most of the treatment plans in public psychiatry only cover the results desired, with usually very little to suggest how. They concentrate on how the results would be measured. This results in a plan such as "Bob will talk less frequently about his delusions," and "Mary will eat 8 meals a week without complaining."

Date: Thu, 30 Mar 2000 13:47:44 -0500

From: Renee Kopache <ReneeK@HAMILTON.MH.STATE.OH.US>

So the problem isn't with the concept of a treatment plan, the problem is with the elements of the treatment plan and how the provider develops them. Based on the examples that you've provided, these treatment plans appear to benefit the clinician more than the client. In other words is the goal of Mary eating 8 meals a week without complaining her goal or the goal of others?

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Date: Thu, 30 Mar 2000 22:50:33 -0500

From: Max Molinaro <maxm2@IX.NETCOM.COM>

"Harriet W. Meek" wrote: [edited]

> > It seems to me that one major variable in relation to treatment plans and their connection with outcomes might be the degree to which both therapist and patient actually agree that what is written down in the treatment plan is what they are working on. > >

Yes, good point. Then you would be measuring two of the three traditional dimensions of working alliance as defined by Bordin: agreement on goals and agreement on tasks (the third is "bond"--trust & good feeling). Given the extensive research supporting the significant correlation between most measures of alliance and outcome, there probably would be a significant relationship between agreement on goals and plans/tasks, and outcome. However, the question is whether it has to be written down in order for that agreement to happen. Given that therapists with all sorts of gradations of bookkeeping skills can get good results with certain clients in certain circumstances, the answer is quite likely to be that the writing makes no difference.

However, what I am really concerned with on this list on this subject is the near total absence of consideration of what kind of impact a study on treatment plans might have. I believe the fact that no one wishes to comment on or discuss this is why research remains so largely irrelevant to the majority of practitioners.

For example, let us suppose that the researcher Harriet Meek mentioned, Peter Fonagy, actually has dramatic proof that "long-term treatment" (I was speaking of classical analysis, with the production and analysis of the transference relationship etc., but never mind) makes a significant difference in the symptomatology of some group of clients when performed by certain therapists in certain settings. (Remember, since no results are universal, the question must be "which therapy with which client under what circumstances") But even with some significant correlation, what can we DO with that information???? (Also, I can't help but add that those people who have the time, resources, and motivation to stick with lengthy psychotherapy are a special, self-chosen, and tiny population)

When making decisions about what we spend our limited time and money on in terms of research questions, don't we owe it to ourselves and the people we help to ask the kinds of questions and do the kinds of research which will could conceivably have a significant impact on the enormous problems and cost of mental and emotional problems? How many people or societies can afford "long-term treatment?" What

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will that do for the traumatized people of Cambodia, the sexually assaulted women of Kosovo or the depressed and dysfunctional residents of our inner cities--who will never, ever get a sniff of this kind of treatment? Who is going to do "long-term treatment" with them? For that matter, how many middle-class people in the wealthiest country in the world have an insurance plan that will pay for "long-term treatment?"

Let me anticipate one response: "We should not let what is possible to currently implement, dictate what we study." And if we were talking quantum mechanics I would agree. And yes, someone has to do "pure" research. But we are talking about disorders that seem like they may have approaches that actually work AND are feasible to implement. And I assume that everyone commenting has been part of a research study and appreciates the incredible time and energy even the "simplest" study of treatment takes? Which is why the vast majority of research projects never have a follow-up study performed.

Let's put it another way: there are a lot of effective medications out there for everything from anxiety disorders to depression to bipolar disorder to schizophrenia. But, as physicians have discovered, COMPLIANCE can turn a highly effective hypertensive medication into a worthless bottle of pills which sits on the shelf while the patient is in denial. So if you have a choice between seeing which hypertensive might have slightly fewer long-term systemic effects as opposed to how can you get more people to take their meds, what choice should we make (if we're after money, it would be the former :)? How about the addictions research that's done on cannabis and cocaine and heroin while 500,000 people a year are dying from tobacco addiction in this country alone--more than every other addiction (except alcohol) combined, many times over.

Not to put too fine a point on it, who the hell cares about whether how you do a treatment plan might contribute .2 % of the variance to outcome, when no one has figured out how to optimize treatment settings such that the therapeutic alliance, a known and potent variable, is engendered to the maximum extent possible? Or how to get more clients to take meds correctly? Or how to do outreach such that more Asian and Hispanic peoples will even come in for an evaluation when they start having serious symptoms of mental disorders? I feel like I'm observing a debate among clerics about where God will consign heathen infants while the church is losing 20% of its members each year!!

--Max Molinaro, Ph.D.

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Date: Thu, 30 Mar 2000 16:29:20 -0500  
From: "Deliberty, Rich N" <RDeliberty@FSSA.STATE.IN.US >

I've had a feeling of déjà vu reading these discussions about treatment plans. Then it struck me. They sound astoundingly like the discussions about consumer satisfaction. Being a good bureaucrat, I'm always willing to take a simplistic view of one situation and apply it to another. So my answer here is that treatment plans probably have no relation to clinical outcome, but are important in their own right in a completely different domain.

Richard N DeLiberty

Date: Thu, 30 Mar 2000 16:39:15 -0500  
From: Renee Kopache <ReneeK@HAMILTON.MH.STATE.OH.US >

I would guess that you are right. There is, however, research which indicates that consumers who participate in their treatment plan have better outcomes than those who don't. This is especially the case if you look at the research on empowerment and recovery. The good news is, that some states are making state wide initiatives to incorporate recovery principles into the treatment plan process.

Renee Kopache

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Date: Thu, 30 Mar 2000 12:39:19 -0800

From: "Darien S. Fenn, Ph.D." <fennd@PIPELINE.COM>

The original question of whether treatment plans affect outcome is a good one, but there are a few intervening variables to consider. Treatment plans may have many purposes, depending on the setting and the audience, and this needs to be taken into account. I can think of several "purposes" of treatment plans:

1. To categorize a case for record keeping, statistical, or other evaluative purpose
2. To CYA for payors or supervisors
3. To communicate among professionals cooperating on a single case
4. To help the clinician think through and formulate a plan of action

There are probably more you could add. If 1 or 2 above, there may be little incentive to create a plan that is actually directed at creating an optimal outcome. If 3 or 4, there may or may not be an effect on outcome, but these functions fit better within a medical model (e.g. a hospital setting) than in many psychotherapy practice settings.

Research findings would have to control for the latent and manifest purposes of the treatment plan, and the degree to which presenting problems can be conceptualized within an empirically-established "Symptoms X -> Diagnosis Y -> Treatment Z" framework. I personally suspect that many treatment plans claim to be #4 but end up being #2 because the cases cannot be easily fit into a diagnosis/treatment model, and that plans that focused improvements in functional impairment irrespective of diagnosis would stand a better chance of influencing outcome.

Darien S. Fenn, Ph.D.

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Date: Fri, 31 Mar 2000 08:57:36 EST  
From: Pythigyst@aol.com

I would place a large bet that agreement between therapists and patient about treatment goals and intervention strategies is a key characteristic of a functional treatment plan which would have a higher probability of leading to a positive outcome. I would also like to emphasize that treatment planning is a functional process not a document.

Ivor Groves

Date: Fri, 31 Mar 2000 09:00:50 EST  
From: Pythigyst@aol.com

Are treatment plans more analogous to a syringe than an intervention?

Ivor

Date: Fri, 31 Mar 2000 09:07:02 -0600  
From: "Tuan D. Nguyen" <tdnguyen@AIRMAIL.NET >

> > Are treatment plans more analogous to a syringe than an intervention? Ivor > >

From some of the discussion, treatment plans seem more like a lab coat than a syringe! Analogically, then, their existence may be more to prevent harm to follow from intervention, than to achieve positive outcome. Somewhat like purpose number 2 in Darien's post. Kind of like worrying about "dissatisfaction" when measuring consumer satisfaction.

Tuan Nguyen

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Date: Fri, 31 Mar 2000 15:38:12 GMT  
From: Paul Fagen <pfagen@ADAPTUSA.COM >

Devising a study on the effects of treatment plans would be tricky. Comprising two groups (A and B as suggested) is a good idea, but I think the variables need to be changed. The criteria for Group A needs to also include some component that measures whether or not the written treatment plan is actually implemented. A treatment plan can be written without it ever being genuinely put into practice. If this was overlooked and the study was conducted, we would end up drawing conclusions based on the existence of a treatment plan and not a change in practice.