Revisioning Psychotherapy and Counseling Services: An Alternative Model for the Provision of Behavioral Health Services

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Statistics Anyone?

- In 1993, the direct costs of treatment of mental illness and substance abuse to Americans amounted to approximately $80 billion (Patricelli and Lee, 1996).
- "American businesses spend $46 billion on depression alone, when the cost of treatment, wage replacement, work site injuries, and productivity diminution are factored in" (Patricelli and Lee, 1996, p. 325).
- The direct and indirect societal costs of mental illness and substance abuse for 1992 have been estimated at $370.4 billion compared to cancer ($104 billion), respiratory disease ($99 billion), AIDS ($66 billion) and coronary heart disease ($43 billion) (Dixon, 1997b).

The Erosion of Mental Health

- The number of categories of the American Psychiatric Association's jumped from sixty-six in the first edition (1952) to well over three hundred in its current rendition.

- Witness recent reports (for example, the presidents New Freedom Commission of Mental Health) suggesting that 30 percent of adults and 20 percent of children suffer from a diagnosable mental disorder (Holloway, 2003).

Choosing Mental Illness …

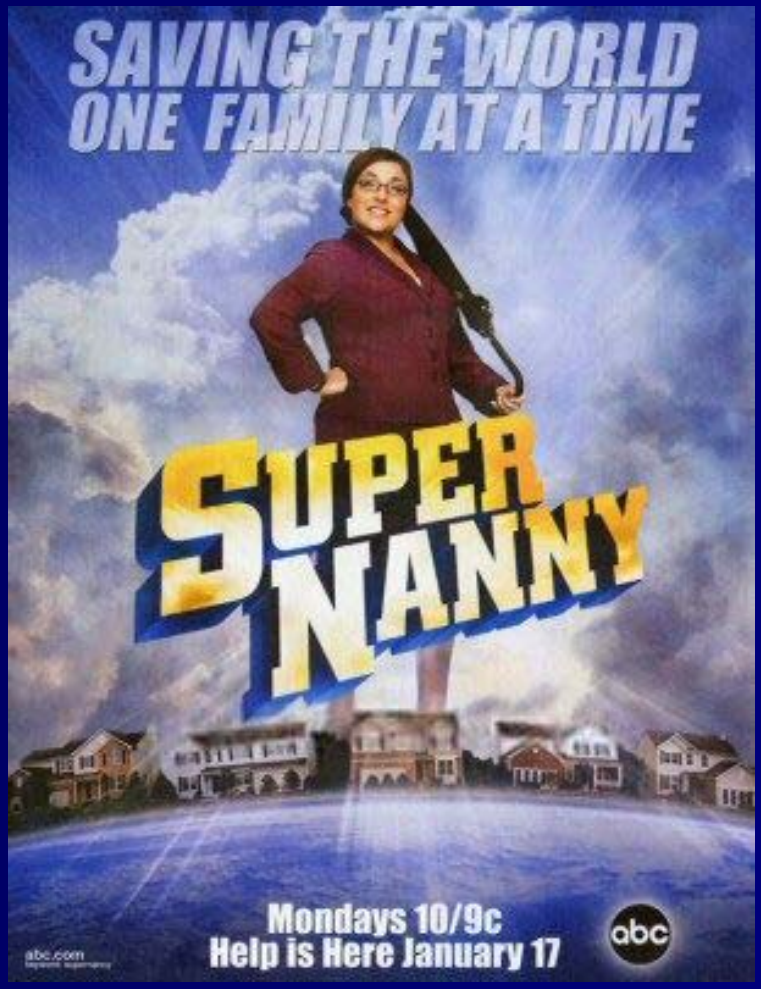
- Buetler (in Duncan, Miller, & Sparks, 2004) offers this explanation:

  > Conventional wisdom portrays a struggling mental health system that is overrun by an ever expanding epidemic, straining under the press of emerging disorders--a system whose scientists are uncovering, daily, new sicknesses and problems, and whose weak efforts to amass an army to fight these diseases is inadequate to stem the tide. But there is another view, one that suggests that new diseases have been manufactured in order to feed a social system that prefers to think of "diseases" needing treatment than of choices that imply personal responsibility and vulnerability (p. xiii).

… or Problems in Living

- Multiple changes in American society over the past three decades have contributed to increased mental health utilization. The increasing mobility, relocation, and separation of families have created geographical and emotional distance from formerly proximal family and neighborhood support networks. The stress and alienation that family uprooting caused for many individuals encouraged them to seek the paid assistance of professional caregivers who were available in increasing numbers to step in the shoes formerly occupied by parents, kin, church, or neighbor. Many of these requests for help were for what can be described as "problems in living" and not for mental disorders as described in the DSM-III-R (Savitz, Grace, & Brown, 1993, p. 8-9).

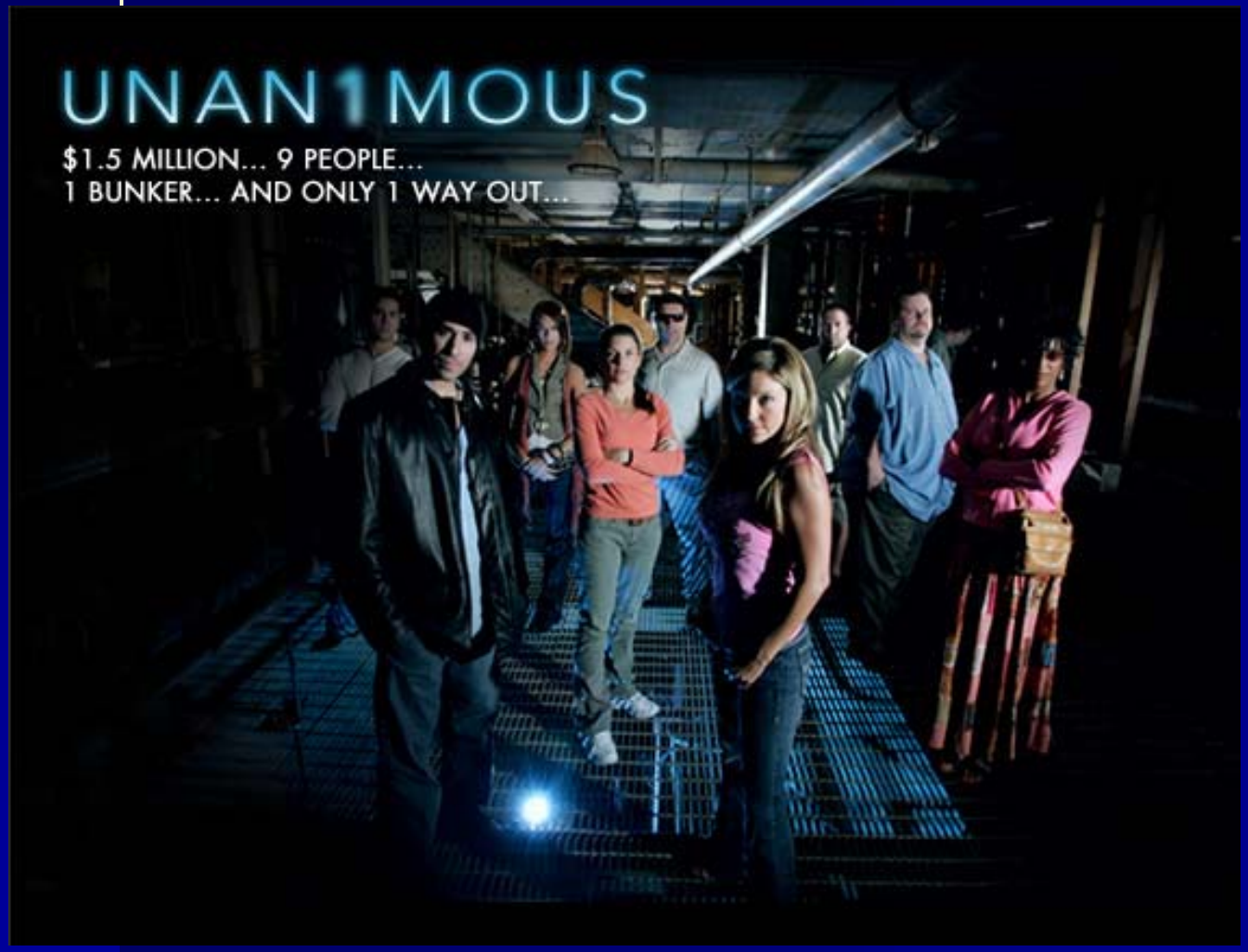
You Make the Choice



ADD, ODD, Conduct D/O Bipolar D/O ...

- As many as 75 percent of the 300,000 adolescents hospitalized per year for psychiatric disorders are estimated to have been inappropriately treated for "routine" problems in living (Anders, 1996, p. 153).

Reality TV … I Couldn't Resist



OUTCAST

The Stigma Rears It's Ugly Head on Fox

- From Philadelphia Weekly reader Meghan K. Caffrey:

"Last night I watched the series premiere of the Fox television show "*Unanimous*." Basically, nine strangers are locked in a bunker until they unanimously decide which of them wins $1.5 million. Of course, there's the dreaded elimination of contestants, but those who are eliminated stay in the bunker and continue voting.

"The process of elimination goes like this: Everyone has anonymously confessed to a deep, dark secret that they don't want anyone to know about. During each elimination round, the contestants hear three randomly selected anonymous secrets and decide which one is the worst; the person whose secret is voted "worst" gets eliminated.

"Last night, the three secrets were:
-filed for bankruptcy when he/she had a combined income of $100,000
-has been detained on more than one occasion for carrying live ammunition
-has been in a mental hospital

"As someone who has spent time in psych wards and mental hospitals, I find it very irresponsible of the show's creators to perpetuate the stereotype that mental illness is a deep, dark secret that should be kept hidden. Also, the fact that the other two secrets involve what sounds like criminal behavior (the circumstances and details aren't given) doesn't help the situation. This just really makes me mad because mental illness alone is tough enough to deal with, without the stereotype that it is something to be ashamed of."

Source: http://trouble.philadelphiaweekly.com/archives/2006/03/more_debate_abo.html

Who is Using These Services?

- A very small percentage of enrollees actually take advantage of these benefits.
- Fewer than two percent of enrollees in CHAMPUS plan utilized mental health benefits (Hudson & DeVito, 1994).
- Another study (Lowman, 1991) found similarly that between 1.8 and 2.6 percent of the covered populations utilized behavioral health benefits over a three year period.

What About Those Who Slip Through the Cracks?

- An important consideration is the premise that patients with untreated behavioral health problems utilize traditional medical and surgical services at significantly higher rates (Fuller, 1995).
- An example of this premise is represented by the depressed patient who is released because further inpatient treatment is deemed not medically necessary only to return to the emergency room and subsequently the intensive care unit for several days as a result of a botched suicide attempt (Anders, 1996).
- In this example, these emergency medical costs would not be reflected in a review of the behavioral health savings analysis as these extra expenses would be "transferred" to the general medical account.

The Quantity of Services Consumed

- A look at utilization data appears to indicate that for most people these limits probably are sufficient. Regardless of theoretical approach and treatment setting, the average length of stay for outpatient psychotherapy appears to be between 4 to 6 visits with a mode of 1 visit (Richardson & Austad, 1991).

- The following numbers reported by Frank & McGuire (1995) are based on data from the Center for Mental Health Services and MEDSTAT:
  - (a) 0.2 percent of an insured population stays for more than 30 days inpatient,
  - (b) 0.16 percent stay between 20-30 days,
  - (c) 0.45 percent use more than 25 OP visits, and (d) 84 percent of those who use

    more than 25 OP visits use no inpatient care.

Why Manage Outpatient?

- Contrary to logic, managed behavioral healthcare organizations often focus an inordinate amount of resources on outpatient services.
- Understanding that outpatient therapy already had built-in cost control mechanisms (e.g., copayments, benefit ceilings, limits upon day/sessions covered, competition between professionals, and a steady trend toward briefer therapeutic approaches), further restrictions upon available services by managed care increase the odds rather significantly that psychologically necessary services will be jeopardized (Miller, 1996a; Pipal, 1995).
- One possible explanation for these seemingly illogical cuts to an already well tightly-controlled outpatient system is provided by the following quote: "A popular perception maintained, however mistakenly, that most outpatient psychiatric services were a hobby of the self-indulgent that enriched only the worried well and their all too willing therapists" (Boyle, 1996, p. 438).

Revisioning Treatment

- Clearly the trend in managed care is toward one of an episodic approach rather than a continuous approach to patient care where "psychotherapy is [seen] as a process that occurs in pieces over time" (Schreter, 1993, p. 326).
- In this model, the patient returns to treatment periodically to conquer new obstacles or when " having difficulty negotiating emotional crises and developmental transitions" (Stern, 1993, p. 172).
- In such a system, short-term goals are identified, and, when completed, treatment ceases.
- Long-term characterlogical changes are beyond the realm of this system.

Moving Out (patient)

- Hospitals are no longer the preferred location for treatment beyond that necessary for stabilization of the patient to a level where they can tolerate a less structured environment without being dangerous to themselves or others.
- What is so wrong with this premise?
- When did a highly structured artificial environment become the best place to provide treatment? Traditional medical hospitalizations have led the way toward shorter stays.
- With the iatrogenic harm possible within such a system as inpatient care short stays seem to have some degree of inherent appeal. Schreter (1993) warns that chronic patients may not do well in this sort of system, but are we really serving their needs adequately by repeated inpatient treatments?
- All too often patients who appear to have the strengths and skills necessary to live a life outside of institutions seem to become victims of the system that is meant to protect their welfare.
- The preference for outpatient forms of treatment seems to be supported by Lowman's (1991) summary of the literature which concluded that inpatient psychiatric and substance abuse treatment is generally no more efficacious than outpatient treatment.

Choices?

- In an effort to protect their professional existence and financial survival, many mental health professionals have reluctantly been swept-up in a scurry to sign on to managed care contracts ... Other disenchanted mental health professionals are attempting to remain financially solvent by treating only private pay clients or by leaving the field altogether (Arena, 1998).

The Call for Outcomes Data

- As managed care companies compile data regarding utilization trends, demographic information, and patient satisfaction, the use of economic credentialing of providers based upon cost effectiveness will become more and more widespread (Petrila, 1996).

- In order to remain active in a preferred provider group, to retain hospital privileges, or to continue to receive referrals from the payor, clinicians will be required to show that their services are cost effective (Arena, 1998).

Policy Issues

- What is the goal of making mental health services available to the public?
- If we were thinking in terms of physical illness, the medical model usually provides for symptom relief and ultimately the provision of a "cure" if available.
- How well do these concepts translate to mental illness?
- Most mental health services concentrate on symptom relief because a "cure " is not available for many mental illnesses.
- Important factors influencing who receives treatment, for what conditions, by what methods, and with what goals include technological developments, changes in professional practice styles, legislative mandates, and the underlying public perception of these conditions (Levine & Fleming, 1987).

Necessary vs. Discretionary Services

- An important nuance to this discussion involves a step back to look at the broader issue. Payment of mental health services through a third-party payor, whether employer or government funded, is part of a healthcare benefit package. There is a theoretically distinct but often practically blurred difference between behavioral health services provided to alleviate pain and suffering of mental illness and those available to help facilitate personal growth (Arena, 1998).

- Berman (1992) clarifies that managed mental health care deals exclusively with the domain of "functionally necessary mental health care" and does not tread upon the "discretionary treatment of adults for personal growth, self improvement, advanced training, or symptoms that do not interfere with functioning" (p. 40).

- These "discretionary" goals of psychotherapy do not fit well within the rubric of health care as it is typically defined. An analogy might be made to plastic surgery to fix a minor blemish or augment a particular body part for purely cosmetic purposes. The question can be raised, "at what point is therapy a frill, like cosmetic surgery, for which the patient alone should bear the financial burden?" (Olsen, 1995, p. 177).

The Medical Model Formula

According to Duncan, Miller, & Sparks (2004), the medical model works with the following equation:

- PROPER DIAGNOSIS + PRESCRIPTIVE INTERVENTION = EFFECTIVE TREATMENT

OR

- TARGETED DIAGNOSTIC GROUPS + EVIDENCE-BASED TREATMENTS = SYMPTOM REDUCTION

The bottom line: the medical model of mental health prevails and is so much a part of professional discourse that we do not notice its insidious influence (p. 6).

Limitations of the Medical Model

- The medical model of mental illness proposes that psychological problems result primarily from organic, biochemical, and physiological concomitants (Wyatt & Livson, 1994).
- Maladaptive behavioral patterns are traced to errant biochemical pathways, organic dysfunction, or other physically-linked causation.
- This focus may result in an overly reductionistic search for the microcausative factor involved in each mental disease (Engel,1977; Wyatt & Livson, 1994).
- The problem that this search poses is that (Arena, 1998):
  - (a) neurophysiology is an infant science with few clear answers,
  - (b) even if a biochemical pathway or chemical imbalance is found, we are faced with the "chicken or the egg" problem in terms of determining which came first, the behavior or the chemical imbalance,
  - (c) two very different biochemical pathways may result in the same behavior or two very different behaviors may result from the same biochemical pathway; and,
  - (d) the medical model ignores or minimizes the importance of environmental and intrapersonal factors.

Fitting a Square Peg Into a Round Hole

- "The predominant healing practice in our culture is modern medicine. We may question a particular diagnosis or procedure, but most Westerners unquestioningly accept the basic premise that disease is caused by some physiochemical abnormality that can be corrected through the administration of medicine or physical procedure" (Wampold in Duncan, Miller, & Sparks, 2004, p. ix).
- The medical model fosters an underlying belief that the only "real" cures or treatments must involve chemical or other medically-focused methods (Wyatt & Livson, 1994).
- The influx of managed care upon mental health and substance abuse services, magnifies the already tenuous fit of psychological services within the rubric of the traditional medical model (Arena, 1998).
- Third-party payors adhering to this biological bias may provide reimbursement that unfairly favors or provides higher reimbursement for these medical treatment approaches (Boyle, 1996).
- This model is much too simplistic when human behavior is our target. Since the exact chemical or genetic causation of few mental disorders is even hypothesized, psychopharmacological treatment often can do little more than relieve symptoms. This treatment fits well with the "quick-fix" mentality of American culture as well as with the cost containment philosophy of managed care (Arena, 1998).
- Furthermore, a purely organic causation model to mental illness discounts the importance of interpersonal and social factors in determining behavior. Albee (1995) points out that the classification of mental disorders as purely organic or biochemical in cause leads to a tunnel-vision-like approach to treatment and research centering upon finding a better drug or organic approach at the costs of ignoring larger "social pathology" that influences the manifestation of these maladies (p. 206).

Badness of Fit

Data from over forty years of increasingly sophisticated research shows little support for:

- utility of psychiatric diagnosis in either selecting the course or predicting the outcome of therapy (the myth of diagnosis)
- The superiority of any therapeutic approach over any other (the myth of the silver-bullet cure)
- The superiority of pharmacological treatment for emotional complaints (the myth of the magic pill)

(Duncan, Miller, & Sparks, 2004, p. 8).

The Biopsychosocial Model

- One of the strengths of psychology has been a more holistic perspective of human behavior. Only within this more comprehensive model can we look beyond simple symptom relief to conflict resolution.

- A model more similar to the biopsychosocial model proposed by Engel (1977) is necessary to truly understand and successfully treat behavioral problems. Engel's model incorporates and recognizes the importance of biological, psychological, and social spheres into a hierarchy of system levels. Of particular importance in the biopsychosocial model is the patient's own framework and context for his or her mental illness. A model such as this will help alleviate incompatibility between a patient's understanding of his problem and subsequent treatment recommendation.

The All Too Often Ignored Medical Cost Offset

- Hudson & DeVito (1994) summarize the result of several studies that indicate the existence of a savings in general medical expenses resultant from the provision of psychotherapeutic services (See also Pace et al. (1995) for a list of studies on this topic). This savings is often referred to as the **medical offset** (Fiedler, 1989; Karon, 1995; Fraser, 1996).
- Of the millions of patients who present to primary care physicians for symptoms attributable to a psychiatric disorder or substance abuse problem, some will see as many as ten different doctors before they receive a correct diagnosis (Slay & Glazer, 1995). With this in mind, the existence of a medical cost offset resultant from easily accessible behavioral health services appears logical.
- How much of a savings results from this offset is a point of great contention with estimates varying from five to eighty percent (Frank & McGuire, 1995).
- Over the last four decades, studies have repeatedly shown that as many as 60 to 70 percent of physician visits stem from psychological distress or are at least exacerbated by psychological or behavioral factors. In addition, those diagnosed with mental "disorders" have traditionally overutilized general medical care and have incurred the highest medical costs (Tomiak, Berthelot, & Mustard, 1998).
- "50 to 70% of usual visits to primary care physicians are for medical complaints that stem from psychological factors" (APA Practice Directorate, 1996a). Similarly, 60 to 90 percent of patients seen by primary care doctors suffer from symptoms attributable to "stress and lifestyle habits" (Slay & Glazer, 1995, p. 1119).

Examples of the Medical Offset

- The medical literature is replete with examples of the medical offset resultant from providing mental health services to those in need of these services. A few examples will illustrate the point (APA Practice Directorate, n.d., a).
  - One study of 300 veterans who were psychiatric patients as well as high utilizers of the health systems showed a reduction from 5.5 to 3.5 annual outpatient visits following brief mental health treatment while a control group receiving no mental health benefit actually increased utilization of the health system.
  - Another study of 10,000 Aetna enrollees showed a health care savings of 33 percent per person per year two years after the introduction of mental health treatment.
  - A comparison of 20,000 participants in one health plan in Maryland showed that untreated mentally ill patients increased medical utilization by 61 percent while a group who received mental health treatment increased their utilization by only 11 percent during the same one year period.
  - Within the quickly growing elderly population, the availability of mental health treatment provided a reduction of an average of 12 inpatient days per year.

Quality of Life Too

- Traditional analyses of the cost offset associated with the provision of psychotherapy services may overlook important considerations such as quality of life that can not be measured by a purely dollars-and-cents analysis.
- When measuring the actual cost effectiveness of psychotherapeutic interventions, the costs of implementing these procedures must be weighed not only against projected savings in inpatient and medical costs but also against measures of loss of wages, productivity, and quality of life (Gabbard, Lazar, Hornberger, and Spiegel, 1997).
- When these components are all considered, psychotherapy proves to be a cost effective and valuable product.

Quantity is Not Always Quality

- The following quote from Boyle (1996) illustrates the confusion that some clinicians and the public at large may have regarding issues of quality and quantity:
  - Sometimes those who critique the quality of managed care's collapse confuse the issue of *quantity* of the care with *quality* of care. Contrary to popular opinion, more service does not necessarily mean better outcomes. More service may actually increase the potential for iatrogenic effects; unneeded inpatient care might have untoward medical, psychological and social consequences (p. 447).

I'm a 296.54, What's Your Code?

- Diagnosis-based reimbursement encourages the provider to fit or stretch their patient into a diagnostic category that the reviewer will approve and reimburse (Pipal, 1995; Brown, 1997).

- Increasingly reimbursement hinges upon, and subsequently, behavioral health professionals are becoming more proficient at attaching " the right label and five-digit code to fit the subjective distress " (Pipal, 1995, p. 325). The divergence of mental illnesses from traditional medical diagnoses is readily apparent, particular with respect to the relative subjectivity of symptomology. The following point illustrates this point rather well:

  > Symptoms can be vague, they shift frequently and they involve an element of volition. A syndrome may exist more as the professional's agreement on a label, than as an objective, circumscribed entity that exists irrespective of observation. The best example of this is the personality disorder. Although not considered a major mental illness, its co-occurrence with the major mental illnesses is so high as to make it nearly ubiquitous in the treatment populations (Olsen, 1995, p. 174).

- Murphy, DeBernardo, and Shoemaker (1998) found that 63 percent of those surveyed indicated that psychologists alter diagnoses to protect client confidentiality, future employment, or medical insurance. Sixty-one percent believed that psychologists submit the lowest level of diagnosis that is reimbursable and leave off Axis II diagnoses.

To Diagnose or Not To Diagnose ...

- Diagnoses come and go, each with its time in the spotlight until the MBHO's utilization reviewer decides that payment is no longer forthcoming for that particular mental ailment. How quickly those patients' diagnoses change in an effort to keep that funding stream rolling in.

- The ethical concern and possible liability connected to this fudging or over-diagnosis can not be overlooked particularly in light of a recent national study's estimate that nearly 50 percent of adults seeking outpatient mental health treatment had no diagnosable condition (Narrow et.al., 1993).

- For these reasons, managed care, through utilization review whether prospective or retrospective, is seen by many as an intruder upon the therapeutic relationship (Corcoran & Winslade, 1994; Pipal, 1995).

- Clinicians risk violations of ethical guidelines by "fudging" a patient's diagnosis merely to obtain reimbursement. This practice of diagnosis-based reimbursement perpetuates the stigma associated with mental illness. General medical procedures, although requiring a diagnosis to prove that treatment is in response to a health condition, base reimbursement on services received. Rarely is a diagnosis excluded from reimbursement in general medicine (Corcoran & Winslade, 1994).

… That is the Question

- The current concern regarding labeling a patient with a mental health diagnosis is no longer connected to the stigma of this label but misuse of diagnostic categories for reimbursement purposes.

- Brown (1994) provides a concise summary of this concern:
  - Experience suggests that if a system which *can* violate privacy and personhood is established, it will ultimately be put to that purpose even if its originally avowed intent was to "promote research." One quantification seems to lead to another. Now that a multi-axial numerical system is established as encoding a descriptive truth about the patient, it would be no surprise for some "quotient" figure to be proposed, based upon the "functioning" number. Such a figure would give the appearance of a "rational" way to distinguish between cases of "medical necessity" and cases of being "worried but well" (p. 69).

- Overutilization of rigid diagnostic categories as the determinant of reimbursement removes the treatment decision-making power completely from the clinician. Diagnosis as a determinate of length of treatment or amenability to treatment is often irrelevant (Luborsky, Diguer, Luborsky, & McLellan, 1993).

Diagnoses Lack Reliability and Validity

- Twenty-some years after the reliability problem has been declared solved (by lowering standards and only comparing general classes), not one major study has replicated the field trials or shown that regular mental health professionals can routinely use the DSM with high reliability (Kutchins & Kirk, 1997).

- Kendell and Zablansky (2003, p. 7), writing in the American Journal of Psychiatry, conclude that at present there is little evidence that most contemporary psychiatric diagnoses are valid, because they are still defined by syndromes that have not been demonstrated to have natural boundaries." They make the significant point that psychiatric symptoms are continuous with normal human experience and do not coalesce into well-defined clusters.

- Another way to evaluate the validity of diagnosis is to examine its utility. In this light, validity asks the question: How useful is diagnosis to treatment? Consider borderline personality disorder (BPD), the mental health equivalent of "the thing" in horror movies. The prevailing diagnostic guide provides 126 possible ways to arrive at a prevailing 126 possible ways to arrive at a diagnosis. All it takes is to meet five out of nine criteria. If one can be diagnosed as BPD in 126 possible ways, how distinctive or valuable can such a diagnosis be? (Duncan, Miller, & Sparks, p. 25-6).

- There is no correlation between diagnosis and outcome nor between diagnosis and length of treatment (Brown et al., 1999; Beutler & Clarkin, 1990).

Cookbook Treatment

- "Concurrently, evidence-based practice has become the buzz word du jour. They represent those treatments that have been shown, through randomized clinical trials, to be efficacious over placebo or no treatment (or in psychiatry's case, via research review and clinical consensus)" (Duncan, Miller, & Sparks, 2004, p.7).

- Some provider systems resort to "plugging in" patients into "canned" treatment regimes with little or no understanding of the patient as an individual (Mohl, 1996, p. 86).

- Mental illness and substance abuse are too intertwined with the individual's personality and life situation to be handled by this cookbook mentality. All too often patients are misdiagnosed at the initial intake by poorly trained, inexperienced, bachelor or master level clinicians with inadequate supervision. The appropriateness of subsequent treatment recommendations may be jeopardized by these faulty diagnoses (Arena, 1998).

A Comprehensive Model for Behavioral Healthcare

- This comprehensive model for behavioral healthcare is an integration of ideas from several different authors and sources (Arena, 1998).

- This model includes the following components:
  - (a) an overarching systems perspective,
  - (b) an environment of cooperation and collaboration,
  - (c) a strong emphasis on prevention and early intervention,
  - (d) services easily accessible through a 24 hour precertification system,
  - (e) a continuum of services which emphasizes outpatient alternatives,
  - (f) an emphasis on quality of services and credentialed providers, and
  - (g) strict case management and planning for "heavy utilizers" of services.

An Overarching Systems Perspective

- Only by viewing behavioral healthcare from a systemic perspective can one hope to institute a meaningful change. This author believes that one reason that the behavioral healthcare system has so easily been conquered by managed care is the failure of individual clinicians to see this "bigger picture." For these reasons, this comprehensive model begins with a discussion of perspective (Arena, 1998).

- The importance of perspective in the negotiation of the managed behavioral healthcare field can not be stressed enough. Managed care has largely resulted from skyrocketing costs for which we as a professional group are partially responsible. The excesses of the 1980's marked by the privatization of mental health and substance abuse residential treatment as well as the general trend toward high medical costs have led us to the situation we are in today (Arena, 1998).

- If psychology is to remain as a viable profession, we must stop viewing managed care as an " 'evil' monolith that exists only to destroy our profession " (Hersch, 1995, p. 17). In order for mental health policy to adequately reflect the needs of consumers while maximizing cost containment, mental health professionals need to avoid becoming polarized into an " us and them " battle with managed care organizations. Instead, mental health professionals must join with managed care companies in a collaborative effort to assure quality of care while controlling costs and preventing abuses (Eckert, 1994).

More Systems Perspective

- Belar (1995) warns " perhaps the most significant threat to integrated health care is the mind-body dualism embedded in American health care policy " (p. 144).
- Failure to understand or accept a biopsychosocial perspective can result in significant overlap in treatment between the medical and psychological systems.
- One patient may be receiving significant medication and repeated visits to the primary care physician for gastrointestinal distress, for example, as well as be receiving psychotherapy around the issue of anxiety (Arena, 1998).
- Without communication and integration of the primary care doctor and the behavioral health professional, the somatic symptoms may never be adequately framed in terms of the psychological and social framework in which they have manifested.
- Active collaboration between behavioral healthcare professionals and physicians treating traditional medical conditions and illness would provide a great step toward the implementation of a biopsychosocial approach to medicine (McDonnell, 1995).

Make Mine Holistic

- Phrases as seemingly simple as medical necessity connote much different meanings depending upon the orientation of the person making this determination.
- From the viewpoint of the more holistic biopsychosocial model, the more appropriate phrase for this type of determination should be clinical necessity (Hoyt & Budman, 1996). This phrase provides room for the clinician to gather appropriate information from observation, assessment, and interview to make a more complete determination based upon his or her clinical judgment.
- This orientation would prevent complete reliance on strict treatment protocols and session limits based solely upon psychiatric diagnosis.
- Reimbursement for alternative therapies and holistic techniques must be incorporated into third-party payors vocabularies so that those consumers who wish to have a non-chemical alternative that better fits their understanding of their mental health problem can receive reimbursement equal to that allowed for traditional chemical treatments (Support Coalition International, n.d.).

An Environment of Cooperation and Collaboration.

- As managed care entities continue to refine their patient networks, those providers who are unable to justify admissions based upon clinical criteria will be eliminated, either by the managed care entity or by themselves. Those providers who build positive relationships with managed care will be given more leeway with some cases as they prove the clinical judgment over the course of the relationship. This cooperation between providers and payors will inevitably result in higher quality services.

- Barnes (1991) lists five ways to diffuse this adversarial situation between managed care and direct service providers:
  - (a) collaboration between managed care and facilities,
  - (b) collaboration between managers of care and practitioners,
  - (c) determine standards of care for which there is a consensus,
  - (d) legislative or regulatory involvement [to insure] minimum benefits and certification of UR companies,
  - (e) patterns of managed care and practice will [ultimately] become more similar.

Talking to the Primary Doc's

- Whether due to the gatekeeper function of many primary care physicians, a greater familiarity or comfort level with these doctors, ease of access, or stigma associated with the use of psychiatric services, primary care physicians are the major provider of mental health and substance abuse services in the United States (Pace, Chaney, Mullins, & Olson, 1995).

- Knowing that the primary contact for those seeking or otherwise in need of behavioral healthcare services takes place at the locus of the primary care physician, it is only logical that collaboration with mental health professionals at this level would be of great service to the best interests of the patient as well as the professionals involved.

- If collaboration makes so much intuitive sense, then why is it not more widespread?

What's Stopping the Collaboration

- Pace et al. (1995) discuss three major obstacles to collaboration between primary care doctors and psychologists (these are equally as applicable to all nonmedical mental health providers):
  1. locus of focus within training in the scientific method,
  2. degree of focus and training on particular areas of behavior and illness (biological, psychological, and social), and
  3. differences in views of control and authority.

- The first of these seem to focus upon primary care doctor's predisposition to view the patient through a problem-focused approach which emphasizes specific observable facts and "well-defined assessment and treatment protocols" (p. 8). On the other hand, psychologists are more likely to take a process-oriented approach giving much more value to the patient's subjective experience of their own distress. In terms of the second obstacle, physicians often are much more committed to a biomedical perspective and congruent medical and pharmacological interventions. Psychologists are more likely (although this is very debatable with the medicalization of psychology) to view the patient through the multifaceted lens of biological, socio-cultural, and psychological influences. Finally, the structure of many institution and provider networks are hierarchically based with physicians making the ultimate treatment decisions. Combined, these factors can severely impede the formation and maintenance of effective collaboration between these disciplines.

- Although a pilot project has been reported with the goal of facilitating collaboration efforts between rural family practitioners and psychologists by introducing joint training (Bray & Rogers, 1995), little empirical data is available concerning the potential advantages or savings associated with collaborative practices. Much of the potential for savings inherent to collaboration has yet to be supported by empirical research, but the medical cost offset at least theoretically appears to hold promise.

A Strong Emphasis on Prevention and Early Intervention

- Karon (1995) exposes the opinion that prevention efforts are few and far between within a managed care framework because the savings attributable to preventative efforts is only realized in the long run.

- In a commercial managed care world ruled by current profits, waiting for long-term investments is thought to be unlikely. Prevention is likely to be much more common within the managed care of the public sector (Medicare and Medicaid), for as MBH providers begin to get multi-year contracts, the probability of prevention mindedness greatly increases as the risk for failure to do so increases equally as drastically with this heavy utilizer populations (Arena, 1998).

Prevention Explored

- An argument can be made that preventative efforts will actually increase future utilization simply by prolonging the lifetime of the individual for whom the efforts benefit (A. Elwork, personal communication, January 29,1998).

- The real benefit of prevention and early intervention is that quality of life can be improved. Actual dollar savings may also be realized, even in the long run, as costly acute hospitalization and heroic efforts may be avoided by a much lower cost prevention and early intervention efforts. The real benefit may be to future generations at the individual and societal levels.

- This benefit to future generations is twofold:
  - (a) early detection and treatment of individuals with mental illness and substance abuse problems can lead to their raising "mentally healthier children", and
  - (b) treatment of adults provides a source of identification of children at risk from dysfunctional parents, which results in earlier treatment and intervention for the children" (Olsen, 1995, p. 177).

Consulting in Primary Care

- Prevention is often overlooked within the behavioral science community as most clinicians are trained not at preventing mental illness but at treating those who are struck by it.
- Consultation by mental health professionals in a primary care setting should involve screening and diagnosis of mental health-related conditions as well as short-term psychoeducational intervention around specific questions or concerns.
- In this way mental health and substance abuse issues that would otherwise likely be undetected can be assessed early on with the highest level of coordination and cooperation among providers.
- Psychologists may also be called upon to provide therapeutic interventions around major life events such as births, deaths, and major illnesses. Many of these adjustments involve grief and loss reactions that would benefit greatly from short-term intervention by a mental health professional.

An Example of Collaboration

- One example of "carving in" the behavioral health services into the primary care setting is Bay Shore Medical Group (Slay & Glazer, 1995). This multidisciplinary practice incorporates integration and collaboration between mental health providers and primary care doctors. The providers act as a team with open communication between all involved. This communication allows for attention to important issues such as noncompliance with treatment. Behavioral health providers are readily accessible to primary care physicians for consultation and to patients who may be in need of emergency care or reluctant to see a mental health professional outside of the primary care office for a much needed assessment.

Embracing Collaboration

- Psychologists must become more active in the planning and implementation of collaborative programs in the areas of public policy, education, and prevention.
- Psychologists who are successful at marketing themselves should be able to take on the role, alongside of the primary care physician, of a primary health care professional. In this role, we may utilize our knowledge of the human psyche to more efficiently treat and prevent stress-related conditions and psychological concomitants of physical illness (Arena, 1998).
- The role of the psychology in the evolving healthcare system should move from that of an independent, often second class or forgotten element, to a position of an "equal partner representing 'the other half' of medicine" (Hersch, 1995, p. 17).

Services Easily Accessible Through a 24-hour Precertification System.

- If services are not easy accessible to the consumer, the ultimate costs of treatment will undoubtedly increase while quality of care suffers. The insurance precertification hotlines, although seen by many clinicians as interfering with the provision of services, serve a needed referral function. All too often direct services providers are simply not available when their client is in crisis. The managed care agency with 24-hour toll-free hotline service can provide the necessary information and referral function. Patients can be routed to the most appropriate level of care by this service.

- A pilot project in Colorado has found that the use of their Mental Health Assessment and Services Agencies (MHASA's) to direct Medicaid recipients to the correct level of care has reduced inpatient hospitalization from 50 percent of the public mental health expenditures prior to managed care to 17 percent of the budget following the implementation of the program (Colorado Dept. of Human Services, 1997). Other benefits of the initiation of this program included the development of alternatives to inpatient care such as 24-hour crisis residential services, respite care, family preservation services, and drop-in centers as well as a reduction in waiting times to access mental health services. Prior to the program Medicaid patients often had to endure a wait of several weeks to several months for a routine appointment which they now receive within one week of their initial contact to the MHASA.

A Continuum of Services Which Emphasizes Outpatient Alternatives

- The opportunity exists for tomorrow's managed care networks to overcome the traditional over willingness to hospitalize the difficult patient inherent to the fee-for-service system by providing relapse prevention through the provision of a continuum of nontraditional mobile care, partial hospital programs, and crisis intervention alternatives (Patterson, 1993). Not only will these alternatives save money, but they will also provide care in the least restrictive environment with a minimum of disruption to the patient's life.

- The availability and accessibility of comprehensive and appropriate community-based services is an ideal that is rarely achieved by the chronically mentally ill, their families, and mental health workers. In general, the existing "nonsystem" of care, treatment, and rehabilitation is filled with gaps, cracks, and obstacles, and is characterized by inflexibility and a lack of responsiveness to individual needs; this creates problems and unnecessary suffering on a day-today basis for those who must depend on the "system" (Levine & Fleming, 1987, p. i).

Increasing Accessibility

- Copayments of $20, $30, $40, and $50 per visit are not uncommon with mental health services. These copayments appear to significantly reduce the likelihood of initial service utilization and may result in severe consequences or increased expenses down the road for those who can not afford to pay the copayment, and as a result of this forgo needed treatment. Limiting or eliminating copayments for initial sessions would provide an opportunity for consumers to access the mental health system at least initially.
- The problem with strict limits on outpatient sessions is that those consumers with the most serious problems may be denied needed services.
- Stern (1993) notes that most outpatient therapy is "naturally occurring brief therapy" where patients terminate within a relatively short time (10 to 20 sessions) feeling satisfied with their progress and ready to discontinue treatment (p. 169).
- In the German health insurance system, even though outpatient psychotherapy is readily accessible to the 90 percent of the population who are insured by the system with benefits of 60, 160, or even up to 300 sessions available, only three percent of outpatient medical costs result from psychotherapy (Karon, 1995).

Walmart of Psychotherapy

- As capitation becomes the preferred management strategy, provider networks will be forced to develop more alternatives to inpatient care. Intensive outpatient, partial hospitalization, and other step-down services will proliferate in number due to the potential for savings (Schreter, 1993).
- Large provider systems centered around traditional inpatient hospitals provide an ideal environment for these step-down units as fewer and fewer beds will be used for traditional acute care treatment.
- What could be more ideal than to have all services under one roof. A traditional psychiatric hospital could include acute, sub-acute, crisis residential, partial hospital, and outpatient services in the same facility. An analogy could be drawn to the one-stop-shopping available at the superstores of today.

An Emphasis On Quality Of Services And Credentialed Providers.

- Efforts such as the recent National Committee for Quality Assurance (NCQA) Managed Behavioral Healthcare Accreditation Program show that employers, consumer groups, behavioral health providers, MCO's, professional societies, and state and national organizations can work together toward the goal of improving quality (NCQA, 1997).

- Areas that are measured by the NCQA Standards include: quality improvement, accessibility of services, utilization management, credentialing, member's rights and responsibilities, preventative services, and treatment records.

- The power of private accreditation is often greatly enhanced by state reliance upon such organizational standards as a replacement for review by state regulatory bodies (Furrow, 1998).

Quality and Outcomes

- Quality control should incorporate outcomes data as this information becomes more available. Outcomes measures should include quality-of-life measures to provide a more accurate representation of the actual effect of services to the consumer.

- Lehman (1995) provides a good summary of this idea in the following quote: "Although definitions vary, the quality-of-life concept encompasses what a person is capable of doing (functional status), access to resources and opportunities to use these abilities to pursue interests, and sense of well-being"(p. 94).

- Assessment of quality-of-life is invaluable in program development and evaluation at both the individual and systemic level. Nowhere is this kind of information more important than with the chronically mentally ill population.

Strict Case Management & Planning For "Heavy Utilizers" Of Services

- The managed care organization operating as a clinical database has a wealth of information on patterns and trends of individual patient utilization. This can be very important to prevent unnecessary hospitalization of patients who go " facility-hopping or doctor-shopping " until they find a clinician who does not know them. The managed care reviewer can provide pertinent clinical information to an unknowing evaluator without which inappropriate or unnecessary hospitalization would be the likely result.
- Heavy utilizers can not only be tracked but can also have predetermined crisis plans in place ready for the next potential disaster.
- Continuity of care should be given strong consideration in these plans.
- Consumers that are frequently hospitalized should be considered for one of several options depending upon the facts and needs of each individual case:
  - (a) frequent short-term hospitalizations continue to be needed as the patient operates at a relatively functional level between these "crises",
  - (b) outpatient commitments should be expanded for those patients who "abuse" the system and fail to comply with outpatient treatment,
  - (c) alternative intensive outpatient programs such as partial hospitalization should be instituted for those consumers who have limited supports in the community,
  - (d) mobile crisis teams and crisis residential placement should be considered as alternatives for inpatient care for those patients that are frequently hospitalized but pose minimal lethality risks to themselves and others, and
  - (e) long-term residential placement should be considered for those consumers who simply can not make it in the community due to the severity of their illness.

Substance Abuse

- Substance abuse services for heavy utilizers with no primary mental health diagnosis pose another interesting dilemma. In this author's opinion, substance abuse as a "disease" is the most tenuously fitting of all behavioral health diagnoses. Many substance abusers go in and out of rehabs and detoxes as if they were motels. Strict limits must be placed on yearly and lifetime benefits for these services particularly for those individuals who show no real commitment to maintaining sobriety in outpatient treatment. In a world of limited resources, difficult decisions must be made as to who can benefit best from a particular treatment. (Arena, 1998).

- At some point when a patient proves to be continuously non-compliant with treatment, his or her "volition" to continue to engage in these self destructive behaviors must factor into whether or not unlimited treatment dollars should be allocated (Olsen, 1995, p. 177).

Shifting the Risk

- Costly utilization review will likely be replaced by selective contracting and networks of providers who will provide internal utilization management and must prove their cost effectiveness in order to remain within the provider network (Schreter, 1993).

- As managed care principles become integrated into practice, the managed care organization may be challenged and eventually replaced by "large, multidisciplinary provider groups that are able to assume financial risk and to practice in cost-conscious fashion" (Shore & Beigel, 1996, p. 118). The following excerpt illustrates this possibility:
  - The strange conclusion is that managed care needs to eventually disappear through the integration of its principles with the mainstream practice … What remains will be the emphasis on intermediate programs such as partial hospitalization, an increased emphasis on case management of care which looks realistically at discharge planning, a decreased variability in lengths of stay between facilities, the elimination of fixed length programs for adolescents and chemically dependent people, and the merging of payor and facility interest (Barnes, 1991, p. 55).

Resocialization

- Cummings (1995, p 10-12.) describes the adjustment to a field dominated by managed care as a "resocialization" process composed of five steps:
  - (a) The Stampede Into Group Practice
  - (b) Acquiring the Growing Arsenal of Time-Effective Treatment Techniques and Strategies
  - (c) A Shift in Values and a Fundamental Redefinition of the Role of a Helper
  - (d) The Ability to Demonstrate Efficiency and Effectiveness Through Outcomes Research in One's Group Practice
  - (e) Regaining Autonomy by qualifying as a Prime (Retained) Provider

Resocialization (a-c)

- The first of these is well under way as the solo practitioner has moved close to extinction replaced by group practices, provider networks, and independent practice associations.
- The second aspect, the move toward brief therapy has been discussed throughout this paper. Graduate programs must meet the challenge of preparing doctoral students with the skills necessary to compete in an environment where brief therapy is the norm.
- The third of these aspects involves the "office-without-walls" which is characterized by mobile services, "house calls", and consultation in many different locations (Cummings, 1995, p. 11).

Outcomes, Outcomes, & More Outcomes

- The fourth of these aspects can not be stressed enough. Repeat these words, "outcomes research, outcomes research, outcomes research."
- Defining appropriate outcomes measures is a difficult matter. Current outcomes measures include:
  - utilization data,
  - patient self reports,
  - clinician reports,
  - objective measures of symptoms and diagnostic entities, and
  - objective measures of functioning (Olsen, 1995).
- The accumulation of outcomes research and data will likely lead to the proliferation of practice guidelines. Practice guidelines, although in the early stages of development within the behavioral healthcare industry (Eckert, 1994), appear to have a bright future. Often developed by managed care organizations, these algorithms or diagnosis specific-treatment protocols attempt to control cost effectiveness through standardization of treatment and diagnosis (Richardson & Austad, 1991).

Prime Providers

- Cummings (1995) defines "prime providers" as:

  Practitioners who have formed multimodal group practices through which a total array of treatment and diagnostic services can be delivered on a capitated or prospective reimbursement basis. Thus the group named as a prime provider is responsible for a defined population in a geographic area …. have demonstrated exceptional skills in time-effective therapies … they demonstrate their continued and growing effectiveness by conducting their own outcomes research (p. 11).

Survival of Those Who Can Adapt

- If psychologists are to survive the whirlwind of changes accompanying managed care, an effort must be made to expand upon traditional professional roles, which have unnecessarily been limited to the diagnosis, assessment, and treatment of mental illness (Arena, 1998).

- In a market place filled with less expensive master's level practitioners, those psychologists who find success will be those who prove able to " 'sell' " themselves as cost effective alternatives (Framer, 1996, p. 335).

- A historic perspective on the growth and development of psychology as a field may provide a helpful guide to the future of our field. Humphreys (1996), utilizing this historical perspective, states: " … our early history has shown us that there can be a growing field called clinical psychology that uses psychological knowledge to promote human welfare but does not adopt psychotherapy for mental health problems as a central focus " (p. 191).

Opportunities

- Health psychology is a field burgeoning with opportunities. One area of medicine that is ripe for consultation would be pain control and stress management.
- Psychophysiological techniques, such as hypnosis, biofeedback, and cognitive behavioral therapy have been empirically validated as effective techniques for the treatment of many somatic problems (Wickramasekera, Davies, & Davies, 1997).
- Collaboration with dentists around pain and anxiety management provides yet another opportunity for psychologists (Murray, 1997).
- The general trend toward limiting referrals for tests that is seen in managed medical practice is sure to be reflected within psychological assessment. Continued viability of psychological testing and assessment may require a " medicalizing [of] language to case managers to establish medical necessity " and those interested in doing a significant amount of psychological assessment may be well advised to focus on "noninsurance based reimbursement frameworks" such as forensic evaluation and educational context (Acklin, 1996, p. 189).

Proof is in the Pudding

- Psychology as a "new science" is being asked to prove efficacy of treatment when data is often sparse or unavailable. No longer is the goal of psychotherapy to help facilitate an individual to maximize their potentials and personal happiness, rather it is to reach a premorbid level of functioning or reduce symptomology. Clinicians and researchers alike must provide valid empirical support for their treatment approaches.
- The simple adage that any treatment is better than no treatment at all has no place in an era of managed care. The standard of care must be continually questioned and reevaluated in light of research and empirical validation.
- The status quo of long-term inpatient care across the board at the first sign of crisis simply does not work. Alternative crisis management services and intensive outpatient modalities must be developed and expanded.
- A renewed focus on early detection and prevention is sorely needed (Arena, 2008).

Patient/Client/Consumer Centered

- In the quest for acceptance by the scientific community as well as the public, the behavioral sciences seem to have lost touch with a basic tenant upon which these disciplines are grounded—the best interests of the patient must come first.
- Psychotherapy and related treatments centers not on the psychopathology, but on the individual human being who is seeking services.
- Most psychopathology can not be distilled down to a simple chemical, genetic, or biological causative factor. Psychotherapy is an art as much as a science.
- Depression can not be removed through microsurgery and grown in a Petri dish like some foreign microorganism to be studied by the pathologist.
- The patient must be seen from a holistic perspective that takes into account intrapsychic, social, environmental, as well as biological factors.
- A comprehensive resource system is necessary to adequately provide behavior health services to consumers.

Don’t Forget the Cost Offset

- Managed care needs to understand the value of prevention inherent to psychotherapeutic services. The sheer savings in terms of productivity increases will compensate for the additional output of benefits. Another measure of the preventative benefit intrinsic to a comprehensive system is the potential for savings in general medical expenses that would result from increasing access to behavioral health services.

More Recommendations

- Strict controls can be maintained on inpatient services as they are the most costly of the behavioral health provisions and do not appear to provide better outcomes than less costly forms of care.
- Case management and utilization review should be incorporated into a single administrative body to reduce duplication of expenses. Integrated delivery systems must be explored within the realm of behavioral healthcare.
- Preventative care services should be provided according to a wellness model (American Mental Health Alliance) without the encumbrance and stigma of a formal diagnosis.
- Managed care "has the potential to rationalize the delivery of care" if proper guidance and a "consumer-friendly" attitude is provided by statutory protection, private accreditation, and quality-conscious, ethical providers (Furrow, 1997, p. 426).
- Managed behavioral healthcare companies must be staffed by behavioral health professionals whose bottom-line is not saving money at any cost, but reducing waste and protecting access and quality of services.
- Managed care has the potential to be a much more fair and equitable system than fee-for-service reimbursement has been (Boyle & Callahan, 1995).

Just a Few More Thoughts

- If clinical psychology is to survive as a profession, psychologists must pursue leadership roles within the administration and management of these managed care entities or provide alternative structures aimed at assuring accessibility and quality of behavioral health services.
- Continued blind resistance or "naive opposition" to the forces of managed care "will simply leave psychology the 'odd man out' " (Dorken, 1993, p. 105).
- Hoyt and Budman (1996) eloquently state: "Lest one follow the dinosaurs, a lot of energy spent in fear and loathing would be better expended in training and supervision " (p. 173).
- We as clinicians must take an active role in determining the policies underlying reimbursement for behavioral health services as these policy will ultimately determine the future of clinical practice.

Imagine the Future

Duncan, Miller, and Sparks (2004) offer two alternate futures:

- Imagine a fixture in which the arbitrary distinction between mental and physical health has been obliterated; a future with a health care system so radically revamped that it addresses the needs of the whole person--medical, psychological, and relational. In this system of integrated care, mental health professionals collaborate regularly with M.D.'s, and clients are helped to feel that experiencing depression is no more a reflection on their character than is catching the flu. This new world will be ultraconvenient: people will be able to take care of all their health needs under one roof-—a medical superstore of services. Therapists will have a world of information at their fingertips, merely opening a computer file to learn the patient's complete history of treatment, including familial predispositions, as well as compliance issues or other red flags (p. 3-4).

- Now imagine a future in which every medical, psychological, or relational intervention in a patient's life is a matter of quasi-public record, part of an integrated database. Here, therapy is tightly scripted, and only a limited number of approved treatments are eligible for reimbursement. In this brave new world, integrated care actually means a more thoroughly medicalized health care system into which therapy has been subsumed. Yes, counselors will work alongside medical doctors but as junior partners, following treatment plans taken directly from authorized, standardized manuals. Mental health services will be dispensed like a medication, an intervention that a presiding physician orders at the first sign of "mental illness" detected during a routine visit perusal of an integrated database... (p. 4).

- These are not two different systems; rather, they are polarized descriptions of the same future, one that draws nearer every day (p. 4).

Food For Thought

- Therapists have hoped, perhaps, that accommodating the medical model would ensure survival in these tumultuous times of managed care. Complicity, however, merely ensures second-class status for therapists and clients in a climate dominated by the specialized languages of diagnosis and treatment models …The time has come to just say no: no to diagnosis and no to evidence-based treatments. It's time to establish a separate identity, free our adolescent dependence on the medical model, and offer a different equation based in a relational model:

  CLENT RESOURCES AND RESILIENCE + CLIENT THEORIES OF CHANGE + CLIENT FEEDBACK ABOUT THE FIT AND BENEFIT OF SERVICE = CLIENT PERCEPTIONS OF PREFERRED OUTCOMES

  (Duncan, Miller, & Sparks, p. 48).