Managed Mental Health Care: Reflections in a Time of Turmoil

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This article reviews the history, growth, and evolution of managed care in mental health and substance abuse treatment. Specific issues described are stigma, the important social dimensions and chronicity of some types of mental illness and chemical dependency, and reliance on the public sector for care. Opportunities and challenges for occupational therapists in the rapidly changing mental health system are discussed, including the use of interdisciplinary teams, the importance of measuring functional outcomes of interventions, the need to develop clinical guidelines, the importance of the community setting and a continuum of services, ethical dilemmas, and the importance of assertive occupational therapy advocacy and involvement in health care reform.

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The Development of Managed Mental Health Care

Over the past few decades, deinstitutionalization and consumers' growing acceptance of the value of mental health and substance abuse treatment have accelerated demands for services (Jonas, 1986; Mechanic, Schlesinger, & McAlpine, 1995). Unfortunately, the costs of mental health and substance abuse services have been outpacing costs in other areas of medicine in both the public and private sector (Bevilacqua, 1995; Mechanic, 1987). For
Schreter, Sharfstein, and Schreter (1994) suggested that Medicaid expenditures (an important source of funding for public mental health services) have been growing exponentially in recent years. Total state government budgets used for Medicaid rose from 8.1% in 1987 to 18.4% in 1993 and have now surpassed higher education as the largest category of state spending.

From the private insurer’s perspective, unmanaged fee-for-service for mental health and substance abuse was a disaster. Bartlett (1994) identified concerns about rapidly increasing costs, wide variability of treatment for the same psychiatric diagnoses, lack of accountability on the part of providers who blamed patients for lack of progress, and treatment planning decisions that seemed to be determined according to benefit design. For example, length of inpatient stay and number of outpatient visits consistently corresponded to available reimbursement. In response, the majority of mental health and substance abuse benefits are now managed via utilization review and case management, and the use of behavioral care vendors that specialize in managing mental health care benefits is increasingly common (Bartlett, 1994; Mechanic et al., 1995). In the public sector, the use of managed care has also been growing rapidly (Steinwachs, Kasper, & Skinner, 1992).

Ironically, in spite of increased usage of services, there is strong evidence that considerable unmet need for mental health and substance abuse treatment remains. The Epidemiological Catchment Area Survey of the National Institute of Mental Health (Myers et al., 1984) reported a 6-month prevalence rate of 15% for major psychiatric disorders and a lifetime prevalence of 25%. The frequency of unrecognized or inappropriate treatment for these illnesses in the primary care setting is disturbingly high (Eisenberg, 1992). In addition, in spite of escalating costs, mental health and substance abuse services continue to lag other medical services in terms of available reimbursement (Mechanic, 1987).

**Similarities of Mental Health to Other Types of Managed Care**

Currently, managed care means many things to many persons. Different authors have emphasized varying definitions, depending on their point of view about the appropriateness of managed care and their role as provider, insurer, administrator, or recipient of services.

Some authors emphasized the attempt of managed care to balance resources, cost, and quality of services (Bevilacqua, 1995; Wood, Bailey, & Tilkemeir, 1992). Schreter, Sharfstein, and Schreter (1994) suggested that managed care is not a solution, but a framework for a process... [that involves answering some very basic questions such as 1) how much money is needed, 2) where the money should go, 3) who should pay, 4) who should use mental health services, and 5) who should decide these questions. (p. 214)

Clinicians often highlight the loss of provider control over clinical decision making (Goodman, Brown, & Deitz, 1992). Finally, quality of care under managed care is seen as a sham by some; that is, they believe that the sole intent of managed care in psychiatric services is cost control (Wells, Astrachan, Tischler, & Unutzer, 1995).

Managed care systems as described in the literature may include preferred provider organizations, health maintenance organizations (HMOs), or independent managed care firms. Managed care processes used in mental health and substance abuse services, as well as in other types of medicine, may include precertification (reimbursement preauthorization to treat), concurrent review (ongoing reimbursement evaluation of the appropriateness of treatment), gatekeepers and case management, provider selection, clinical guidelines and protocols, benefit definition and redefinition, general budget constraints, and financial incentives for providers, such as capitation (Mechanic et al., 1995; Wells et al., 1995). However, because mental health and substance abuse benefits and services are different from other types of medical services in many ways, they are often managed separately by companies specializing in these types of services (Wells et al., 1995).

**Managed Care Issues Specific to Mental Health**

Mental illness and substance abuse differ from other types of medical needs in ways that affect the application of managed care practices (Mechanic et al., 1995). Although many persons requiring mental health or substance abuse treatment have acute episodes that resolve quickly, others experience chronic mental illness and may require ongoing support services to cope effectively in the community. Persons with serious mental illness may have major social and functional deficits that persist or recur. A restrictive managed care system that refuses to address issues such as housing, employment, and supportive rehabilitation efforts for persons with long-term mental illness may force families and the community to bear the burden of providing necessary services that the system will not allow. A 1991 survey of National Alliance for the Mentally Ill (NAMI) members reported that more than 60% of them indicated that the primary residence for their relatives with mental illness is the family home and that families serve as the safety net and constant case manager for the adult with mental illness (Flynn, 1994).

Another concern is stigma, which is still prevalent...
and peculiar to mental health and substance abuse. For instance, the executive director of NAMI asks, “Would managed care companies try to discharge cancer patients from the hospital before they have completed their chemotherapy? Do they deny lifesaving medications to people with heart disease? I wonder why mental illness is so often targeted for cost containment?” (Flynn, 1994, p. 203). Because of stigma and the attitudes that it engenders, there continues to be discrimination against persons with mental illness and fewer available benefits for treatment than for nonpsychiatric medical conditions. In addition, prevailing stigma can easily discourage persons with mental illness or substance abuse problems from seeking care or can lead to concerns about confidentiality. Further, stigma may negatively affect the ability of clients and families to advocate for the services they need (Mechanic et al., 1995).

Another issue pertinent to mental health and substance abuse treatment because of chronic effects of long-term mental illness is the importance of the public sector. Downward mobility may occur as persons with serious, persistent mental illness become unable to obtain or maintain employment and eventually depend on the state for health care and basic living expenses. Gerson (1994) suggested that termination of private behavioral health care coverage typically occurs for persons with baseline chronic psychosis; chronic mental illness who are noncompliant with treatment; major depressive illness who are chronically suicidal; severe personality disorder; organic brain syndrome; conduct disorder; and serious, long-term chemical dependency. In fact, persons with chronic mental illness have always had to rely on the public sector for care (Mechanic et al., 1995) in the form of state-run psychiatric institutions or community-based services financed by Medicaid.

Health care reform is not new to mental health providers. Historically, deinstitutionalization and the community mental health movement in the 1960s and 1970s offered the great promise for less expensive care that simultaneously provided better quality of services. The promises of managed care sound similar to the promises of the deinstitutionalization movement; however, mental health care providers also know that the consequences of deinstitutionalization were unlike the promises. Many of our clients who needed care and services ended up in the street with no follow-through or other assistance. The resultant mental health system was fragmented and unmanaged and was characterized by an absence of accountability and follow-up for individual clients; difficulty in clients finding and accessing services; poor coordination among providers and discontinuity in treatment planning; reimbursement disincentives for community-based rehabilitation treatment; and inadequate systems for monitoring necessity, appropriateness, or effectiveness of care (Hoge et al., 1994). Some of the current anger and depression of mental health service providers may be in response to hearing the same promises again. Is it a surprise that a promise of better care for less money is met with cynicism? Cynicism will not assist clients with mental illness or shepherd a positive evolution in mental health practices. Mental health service providers must identify and fight for changes that lead toward a system of care that is not only effective but also mindful of cost.

Generations of Managed Care in Mental Health

Perhaps some of the confusion about the meaning of managed care results from the fact that it is evolving. In mental health, its tools and tactics are changing, and one can identify three generations of managed care (Bartlett, 1994). First generation approaches (still evident in many plans and organizations) focus on extensive utilization review by reimbursers who may lack mental health experience or expertise. To make matters worse, reviewers often have used clinical criteria that were kept secret from clinicians. As can be imagined, first generation managed care was and is coercive, adversarial, and the source of tremendous distrust, paranoia, and hostility between managed care companies and providers, and clients have often been caught in the middle of their battles.

First generation managed care has sometimes cut costs, but it has not improved quality of care. It has alienated providers and clients and has the potential to project an uncaring or greedy image that could discredit managed care organizations. In response, some companies have evolved to second generation approaches that are more collaborative and flexible. Second generation managed mental health care may use networks of providers, often shifts financial risks (e.g., through capitation) from reimbursers to providers, focuses on measurement of outcomes, and encourages sharing of clinical criteria and standards of care. Managed care agents using second generation approaches may actually serve as part of the treatment team to deemphasize the belief that “outsiders” are the decision makers (Olsen, Rickles, & Travlik, 1995). The intent is to include providers in the quest for cost-effective mental health care to overcome the barriers created by first generation approaches to managing care. Second generation managed care not only maintains the focus on cost-containment but also attempts to reinsert the concept of quality and effectiveness of care.

According to Bartlett (1994), third generation managed care approaches are just beginning to develop. These
approaches go beyond mechanisms of control to development of optimal mental health care that truly provides flexible, comprehensive, cost-effective care in a continuum of settings. It remains to be seen whether third generation managed care becomes a reality or remains as wishful thinking. In the meantime, a number of challenges and opportunities arise for occupational therapists to address as health care systems continue to develop and change.

**Challenges and Opportunities in an Evolving System of Care**

*Measuring Outcomes and Effectiveness of Care*

Managed mental health care is emphasizing the importance of measuring the outcomes of service delivery. Although occupational therapists have known for years that outcome measures are the only way to evaluate the impact of treatment and improve the quality of the services provided (American Occupational Therapy Association [AOTA], 1995; Stoffel & Cunningham, 1991; Thien, 1987), the economic incentive to become more cost-effective is what is driving the widespread measurement of outcomes.

It is critical to systematically gather a broad range of data to understand the results of treatment and the meaning of outcome studies. For example, the client's baseline status, sociodemographic factors, clinical factors, and treatment are all pertinent to understanding outcomes (Kane, Bartlett, & Potthoff, 1995). The International Association for Psychosocial Rehabilitation Services (IAPSRS) has identified a number of domains of outcome measurement for psychosocial rehabilitation programs, including frequency of rehospitalization, employment status, independent living status, educational status, income, program of attendance, and accomplishment of rehabilitation goals (Lacayo, 1995). Additionally, IAPSRS has identified that more research is needed on complex outcome domains, including social activities and skills, level of functioning, quality of life, and client satisfaction with services. Occupational therapists can contribute important information to the measurement of many of the outcomes associated with these domains. In particular, occupational therapists can contribute their expertise in the use of observation of performance versus self-report and the effect of measurement of occupational performance in the natural environment versus the clinical setting.

Measuring effectiveness of care will allow occupational therapists to determine clinical guidelines or protocols that outline appropriate clinical decision making. Mental health professions have avoided taking the lead in identifying appropriate parameters of practice or clinical guidelines partly because of fear of losing control of treatment decisions and concern that reimbursement will become even more restricted (Ellek, 1995). It is true that clinical decision making must remain flexible, reflecting the complexities of mental health and substance abuse issues, but refusal to identify treatment guidelines has put occupational therapy professionals at great risk. By continuing to demonstrate wide variability in clinical decision making, occupational therapy practitioners appear subjective and lacking in professional expertise. In response to lack of identified protocols, managed care companies have taken the lead, announcing that if professionals cannot identify dimensions of cost-effective care, then the insurers will. It is paramount that practitioners regain control of the clinical process by clearly articulating the processes and outcomes of mental health services.

Because outcome measurement is complex, there is the danger that cost-effectiveness may be evaluated from a perspective that focuses exclusively on cost as opposed to one that addresses effectiveness (Wells et al., 1995). The business goal of cost-containment in managed mental health care has been demonstrated in a number of studies, although the results have sometimes been inconsistent (see Mechanic et al., 1995). However, questions about the quality and effectiveness of services have not yet been answered with any precision. It is clear that cutting costs by reducing use, but doing so in a manner that maintains quality, is a greater challenge (Mechanic et al., 1995). In evaluating the effects of managed care, it is necessary to describe specifically which managed care mechanisms were used and what outcomes were measured. For example, a study examining the practices of managed care programs for mental health, alcohol abuse, and drug abuse during the late 1980s found that large variations in utilization review programs were common (Garnick, Hendricks, Dulski, Thorpe, & Horgan, 1994). Review personnel, clinical criteria to authorize care, the use of mental health “carve outs” (in which psychiatric services are managed separately from other medical benefits), integration of employee assistance programs, penalties for not following plan procedures, and the type and amount of outpatient review varied considerably among managed care companies. The authors concluded that the diversity seemed to be growing into the 1990s and that this will make it difficult to ascertain which aspects of managed care actually work to control costs while protecting quality of care. Similarly, another research team reviewed what is known about the effects of managed care on mental health and substance abuse services (Mechanic et al., 1995). These authors found the task difficult given the wide heterogeneity of managed care plans.
Generally, they found that there was cost savings through decreased use of inpatient days, but that decreased inpatient time was not always accompanied by increased outpatient or partial hospitalization use, suggesting that cost-containment merely reflected more unmet need or a shifting of the burden of care to the family and community. By assertively becoming involved in outcome research, providers, including occupational therapists, may be able to focus more directly on cost-effectiveness as opposed to cost-control of services.

Best Care Practices

As outcome measurement occurs, we will be able to identify which types of mental health and substance abuse practices are best. Currently, in the private sector, managed care emphasizes brief, focused therapies for persons with mild to moderate psychological difficulties. Budman (1992) characterized the dominant values of brief and long-term therapists. Brief therapists prefer pragmatic solutions, emphasize client strengths and resources, and see being in the world as more important than being in therapy. Long-term therapists focus on seeking changes in the client's basic character, assume that presenting problems are always indicative of underlying pathology, and view being in therapy as the most important part of the client's life. It is my impression that most occupational therapists would actually agree with many of the values espoused by the brief therapist and already apply them in practice. More research is needed to determine when brief therapies are appropriate.

In the public sector, some long-term empirical studies have been completed concerning the outcomes of programs for clients with complex and chronic psychosocial problems. The most effective tested approaches to date include assertive community treatment for adults with severe mental illness and multisystemic therapy for adolescents with serious emotional disturbances (Santos, Henggele, Burns, Arana, & Meisler, 1995). In both approaches, several operant principles were at work, including the use of:

- a socioecological model of behavior that emphasizes the importance of context to support functional capacity
- pragmatic treatment that focuses on action-oriented, well-specified interventions and careful monitoring of treatment outcomes
- field-based services that occur in the client's natural environment
- individualized treatment that addresses flexible, collaboratively developed goals
- accountability in which staff members are discouraged from blaming clients for lack of progress and encouraged to focus on the use of creative solutions to problems.

Both assertive community therapy and multisystemic therapy are congruent with basic occupational therapy beliefs and principles. The roles and tasks in these descriptions of best mental health practice for clients with chronic psychosocial problems include therapy that is collaboratively determined, is functionally oriented, and takes place in the client's natural home and community settings (e.g., Nielsen, 1993; Quinn, 1993). If increasing numbers of empirical studies demonstrate the cost-effectiveness of comprehensive, intensive, community-based practice, then occupational therapy practitioners will have strong ammunition to argue for reimbursement of these services. It may be hard for professionals struggling with first generation approaches to managed care to envision more extensive coverage for services, but it is important to advocate for these types of programs and assist in the process of demonstrating efficacy and cost-effectiveness. The current emphasis on an inpatient medical model for mental health practice needs to be examined and preparations made for the transition into flexible, integrated, community-based practice (AOTA, 1995).

Interdisciplinary Teams

Interdisciplinary teams have been around for a long time in mental health practice (e.g., Greenberg et al., 1986), but managed care is emphasizing them even more as a cost-effective way to deliver care. An interdisciplinary focus is encouraging to occupational therapists who may envision themselves as part of the core team. Recent descriptions of managed care teams, however, do not identify occupational therapists as possible members. Of even more concern is the importance of master's-level providers in assuring quality team care (Goodman et al., 1992; Olsen et al., 1995; Schuster, Kern, Kane, & Nettleman, 1994). The assumption seems to be that only master's-level training is adequate to successfully perform the skilled tasks required in a managed mental health care setting. My own experience as a clinician providing mental health and substance abuse services in an HMO is congruent with this observation because the advertisement for my job stated that only occupational therapy practitioners with a master's degree were eligible to apply.

Ethical Considerations

Sabin (1994) identified a credo for ethically managed mental health care in which he suggested that clinicians...
must learn how to care for clients while acting as stewards of society’s resources; must recommend the least costly treatments, unless there is strong evidence that a more expensive intervention is clearly superior; and must advocate for justice in the health care system in addition to advocating for clients. Can we apply this credo in occupational therapy? Backlar (1995) highlighted the dilemma of concern for the individual client versus the larger needs of the mental health care system. It is difficult to envision what it means to act as “stewards for society” while meeting obligations to clients. In addition, until more outcome research is completed, the efficacy of various interventions is controversial. Finally, as long as the perception exists that any cost savings go into the pockets of large managed care companies as profit instead of being funneled back into the development of a just and fair health care system, the concept of stewardship is false (Sabin, 1994). In that case, I believe that our responsibility is to fight the inappropriate care rationing and unfair profit making that occur at the client’s expense.

Moving Forward

Occupational therapy may be in particular danger of being lost in the turmoil of mental health care system changes. We are currently a small part of the mental health treatment picture because there are few occupational therapy practitioners in mental health and substance abuse practice settings (AOTA, 1991; Bonder, 1987). Occupational therapists need to be visible, proactive, and accountable in the process of defining and developing a cost-effective continuum of programs and services that emphasizes the community over the inpatient setting as appropriate, identifies effective methods to measure outcomes, and develops clinically reasonable and flexible guidelines and protocols. While the occupational therapy profession struggles over its role in mental health and continues to refer to community-based mental health practice as nontraditional (AOTA, 1995), other providers have already recognized the critical nature of function for clients with mental illness, are addressing community living skills (Farkas & Anthony, 1989; Liberman, 1988), and are actively developing guidelines and measuring outcomes for these services (Andrews, Peters, & Teeson, 1994; Lacayo, 1995).

Lazarus (1994) described a number of reasons why psychiatrists may dislike managed care. Many of those reasons probably also apply to occupational therapists, including underfunding for services, new practice patterns, turf wars, demand for proof of value of services, bureaucratic hassles, and moral dilemmas. But occupational therapy professionals cannot ignore the evolving mental health care system or pretend that the past few decades have been a golden era. Empirical support for alternatives to inpatient hospitalization (e.g., partial hospitalization, community-based programs) has existed for years, but recommended programs were never implemented because they were not reimbursed by traditional indemnity insurance (Bartlett, 1994). Occupational therapists must vigorously advocate for appropriate mental health services and assist in moving beyond the most negative attributes of first generation managed care that emphasize cutting costs and care. At its best, managed care may actually support innovations and diversity of treatment approaches as long as empirical evidence supports the effectiveness and efficiency of those approaches. It is even possible that mental health and substance abuse practices and outcomes may be improved. ▲

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