Psychotherapy by Psychiatrists in a Managed Care Environment: Must It Be an Oxymoron?

A Forum From the APA Commission on Psychotherapy by Psychiatrists

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THE ALIENATION OF PSYCHIATRISTS FROM MANAGED CARE AND HOW TO REVERSE IT

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The Commission on Psychotherapy by Psychiatrists welcomes you to its fourth American Psychiatric Association (APA) Annual Meeting Forum. I chair the Commission and am Clinical Professor of Psychiatry at Case Western Reserve University in Cleveland. I'm a solo practitioner in a university hospital's multispecialty, full-service medical building. I have several patients in psychoanalysis and many others in varying combinations of psychodynamic psychotherapy and medication management.

I do not participate in any managed care plan. This is a slight problem because the primary care doctors in the building all have to, even though they don't like it. But whether I was in managed care or not, to make a psychiatric referral these doctors would have to give the patient an 800 number, and I'd probably only see those who might need medication after a social worker had evaluated them and started psychotherapy. When my psychiatry department set up its mental health managed care plan, most medical psychoanalysts like me were excluded. Later the department's plan began contracting only with multidisciplinary groups, with no new solo practitioners. Fortunately, my colleagues send me self-paying, indemnity-insured, and traditional Medicare patients, and I do quite well with these new patients and those who recycle intermittently from 37 years of practice.

Personally and professionally, the last thing I want is any contact with managed care. Though my style may differ from Harold Eist's, I am just as angry about what managed care has done to psychiatry. Managed care is perversely influencing the nature of our profession. I believe psychotherapy by psychiatrists in a managed care environment is an oxymoron. I dwell on my situation and feelings because they are like those of many APA members across the country. Disincentives to take part in managed care are severe for psychiatrists who do much psychotherapy.

So why am I here talking about "does it have to be

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an oxymoron?" Because managed care is big, and it's here for now, and what happens now will influence whatever follows it. According to the industry figures, managed mental health care covers up to 176.8 million Americans, about 78% of those who are insured.[1] Managed care fallout lands on public psychiatric facilities: when managed care reviewers deny necessary treatment, state and county services are the safety net. Furthermore, it is profoundly affecting our training programs and our early career psychiatrists, who don't have an accumulated, loyal practice. Psychotherapy is still taught in most residencies, but there is such concern about its survival that the Psychiatry Residency Review Committee is instituting psychotherapy competency requirements to pressure residencies into beefing up their programs.

American medical graduates are selecting psychiatry 40% less often than in the early 1990s. Managed care may contribute to this in two ways. Big fee reductions imposed on a specialty already at the bottom of the income ladder may deter new graduates, who often carry more than $100,000 in educational debts. In addition, applicants see little appeal in a modern psychiatrist's professional life of doing medication checks and no psychotherapy.

The quality of psychiatric care in organized systems must be our concern. This is APA's business. It had better be managed care's business as well.

Mental health managed care has dug itself into a hole. Extreme consolidation has taken place with leveraged money, jeopardizing the financial stability of the industry (and of anyone to whom some firms owe money). Over the past decade vicious price competition has cut outlays for treatment of mental illness by 54%, compared with 7% for medical and surgical illness.[2] Capitation rates are ridiculously low. Hospitalized patients are discharged "quicker and sicker," foisting serious risks on patients and "24/7" urgent care on their psychiatrists. Expensive inpatient services have been cut, but instead of the cuts producing a compensatory rise in outpatient follow-up services, these services too have been slashed. Outpatient fee scales have fallen to absurd levels, often 70% of Medicare. For that, the psychiatrist must listen to elevator music for hours while seeking authorizations from people with much less training and minimal clinical data to go on—or else divulge masses of confidential information. Managed care fee scales and referral policies almost mandate that psychiatrists do brief medication checks instead of integrated psychotherapy and medication management if they are to make a living. Malpractice insurance claims are soaring disproportionately for high-volume psychiatric practices. (Source: Reports to APA Board and Assembly by Alan Levenson, M.D., President, Psychiatrists Purchasing Group, Inc., which manages APA insurance programs.) I don't want to belabor this series of atrocities, because everyone knows what is happening. But let's look at the inevitable results.

For one thing, most managed systems cannot offer quality in psychiatric care. With their low premium rates, 3% to 4% of the health care dollar, they just can't afford to provide comprehensive psychiatric care. Quality psychiatric care includes psychotherapy. For another, they are having a devil of a time getting psychiatrists to work in their systems. Reports now come from psychiatrists all over the country about managed care organizations (MCOs) being unable to recruit or refer to participating psychiatrists and having to refer patients out of network. This is no surprise: psychiatrists have had enough.

But these systems are responsible for funding treatment for most of the populace. And responsible psychiatrists within managed care genuinely want to provide quality care at reasonable cost. How can we ally ourselves—bring the profession together—to meet the needs of patients?

Let us focus on psychotherapy by psychiatrists. There is no doubt that psychotherapy is a vital part of psychiatric care. There is abundant evidence for its efficacy in most psychiatric illnesses—often on a par with medications, sometimes more efficacious, and frequently clinically combined with medication for enhanced effectiveness. The data are there; this is not the time to review them. Studies on cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are rigorous enough that MCOs are forced to acknowledge them and authorize some treatment—but often in courses of treatment shorter than the 12 to 20 sessions used in most of the research, and usually administered by social workers and psychologists, not psychiatrists. Psychiatrists just do the medication checks, as a rule.

In fairness, most psychiatrists aren't trained in CBT and IPT, which exacerbates the problem. But most of us are trained in psychodynamic psychotherapy and experienced in tailoring it to the needs of the individual patient, often providing therapy that is short-term and focused on specific problems. Luborsky and colleagues'[3] meta-analysis of a limited number of studies

comparing short-term psychodynamic treatment with other treatments found equal efficacy. Long-term, usually psychodynamic, treatment is the recognized approach for most personality disorders and other persistent conditions.[4] What managed care finds hard to tolerate is a nondirective, listening environment, where the patient's flow of thoughts sets the agenda and opens surprising new vistas of understanding the roots of the problem. Managed care organizations can't systematize and manage that, even though the basic method overall is well established. So they discourage psychiatrists from doing psychodynamic psychotherapy. One managed care executive reportedly asked, "Can't you listen faster?"

We believe, though we can't now prove it, that psychotherapy and medication management integrated in the hands of one person, the psychiatrist, are more effective than split treatment where other clinicians do the psychotherapy and the psychiatrist (or internist) does medication checks. Integrated treatment increases efficiency of data collection, avoids communication breakdowns, and, most important, deals with the transference issues and distorted thought patterns that often disrupt medication compliance. Studies by Dewan[5] and Goldman et al.[6] suggest that integrated treatment doesn't cost more. The Goldman study was conducted by a major MCO, but it did not look at clinical outcome. Nonetheless, MCOs generally haven't gotten the message yet. Even if they have gotten it, they have driven away psychiatrists who have strong training and experience in conducting psychotherapy and can't find many psychiatrists to do this work. They have "phantom networks" in many areas. The result is a tremendous loss of value in what managed care can offer its clients.

How can we work together to achieve value in managed psychiatry? How can we bring about a working alliance? Inevitably, this will involve change and enhanced understanding on both sides. Here is my prescription to increase the involvement in managed care of psychiatrists expert in psychotherapy:

1. Managed care must restore respect for psychiatrists' expertise in conducting psychotherapy.
    a. Actively recruit psychiatrists trained and experienced in psychotherapy.
    b. Avoid economic profiling that discriminates against psychiatrists with high psychotherapy case mixes, particularly long-term treatment of serious problems.
    c. Contract with solo practitioners, not just multidisciplinary groups.
    d. Establish a decent fee schedule for psychotherapy by psychiatrists.
2. We must insist on systemic changes, the scope of which would require that APA and MCOs work together to achieve them.
    a. Advocate for significantly increased health plan outlays for mental health care to restore their previous levels proportionate to general health care.
    b. End discrimination against the mentally ill. Here's a real challenge: Eliminate mental health carve-out companies and integrate psychiatric evaluation and treatment with the rest of primary and specialty medical care. Failing that, make mental health management no more stringent than for other services.
    c. Allow all patients direct access to psychiatrists for evaluation and treatment . . . .
    d. Or at least maintain point-of-service plans—with reasonable copayments—that allow patients the choice of clinician.
    e. Advocate truth in advertising that divulges actual limitations on available psychiatric care.
    f. Fire the management consulting companies that sell widely used patient review criteria based on economic rather than clinical considerations, and instead use APA Practice Guidelines that meet the needs of both acutely and chronically ill patients.
3. There must be sweeping changes in review and oversight procedures, based on recognizing that effective psychotherapy requires continuity, confidentiality, and trust in the doctor–patient relationship.
    a. Eliminate case management of outpatient evaluation and therapies of fewer than 20 sessions, and authorize treatment in clinically realistic blocks thereafter.
        i. Recognize that some people need long-term psychotherapy.
        ii. Permit denial of care only by comparably trained professionals, who identify themselves and accept responsibility for consequences.
    b. Eliminate MCO access to confidential psychotherapy records. The process and personal content of psychotherapy should be a black box to

the MCO (in keeping with the principles stated in the 1996 Supreme Court decision *Jaffee v. Redmond*).
    i. Conduct prospective review of intensive or long-term psychotherapy with a consulting psychiatrist, who reports only "yes" or "no."
  c. Stop wasting our time! Improve the mechanics of review procedures.
  d. Facilitate clearly accessible appeals to an independent panel.
4. There must be appropriate fee scales.
  a. Make psychiatric fees commensurate with those of other specialist physicians.
  b. Make mental health care fees directly proportional to time and administrative work involved.
  c. End the fee structure that drastically favors medication checks over psychotherapy.
5. Managed care organizations must support psychotherapy training in residencies and Continuing Medical Education for practicing psychiatrists to assure the future supply of well-trained, well-rounded psychiatrists with psychotherapy skills. Experience in intensive, long-term psychotherapy is fundamental to build the skills and the knowledge base for diagnosis, effective management of the psychiatrist-patient relationship, and facility with short-term psychotherapy.
6. We as psychiatrists have to make this work. We need to show flexibility and creativity while still preserving the essentials of our craft.
  a. Respect managed care systems that understand the value of psychotherapy by psychiatrists and genuinely want to provide quality psychiatric care.
  b. Understand the management system, including the potential (currently unrealized) benefits of increasing broad access to quality care and gathering valuable data about psychiatric care.
  c. Improve skills in conducting short-term psychotherapy where clinically appropriate—knowing that this modality is not for everyone.
  d. Improve skills in prescribing specific psychotherapy modalities, including the option of intensive or long-term treatment, based on diagnosis, individual circumstances, motivation, and personality structure.
  e. Improve skills in communicating appropriate administrative and clinical data without divulging personal details or the content of psychotherapy. We need to clearly express our reasoning about clinical decisions.
  f. Develop APA Quality Indicators for psychotherapy in organized systems.
  g. Participate in residency training in psychotherapy skills so that future psychiatrists will preserve the uniqueness and effectiveness of psychotherapy and the doctor– patient relationship while dealing with administrative systems.
  h. Promote research to validate longer-term psychotherapies, especially psychodynamic, since research studies have already given time-limited psychotherapy some credibility with MCOs.

Can we do it? I don't know. We are talking about enormous changes to deal with an enormous problem. But we have to start somewhere with a message and a plan, and the Commission on Psychotherapy by Psychiatrists is committed to accomplishing this.

ORGANIZATION OF AN EFFECTIVE MULTIDIMENSIONAL PSYCHOTHERAPY TREATMENT PROGRAM

K. Roy MacKenzie, M.D.

Managed care can be viewed as a reincarnation of the Community Mental Health programming efforts of the 1960s and 1970s. The principal difference lies in the development of a "for profit" system. In the long term, this will likely be viewed as a major political error. It is clear that the shift from cottage industry to corporate systems is now established and is unlikely to reverse itself. Most psychiatrists now entering the field will have a system component to their practice. A substantial proportion of current early career psychiatrists are either salaried or heavily involved in systems.

It is unclear whether the large integrated systems currently evolving in America can function successfully. Is it realistic that the great majority of medical care in the entire country is dominated by a handful of corporations who must respond to shareholder demands for profit? Can the nation tolerate this perspective, or will there be a backlash to demand systems under tighter

governmental control? Can such systems produce effective treatment at affordable cost without objectionable denial of service?

Service system models in Western countries demonstrate that moderate-sized systems can operate reasonably effectively. In such models, clinically informed administrative leadership is essential. This is an important role for the psychiatrist. Without a firm clinical presence, pressures for cost containment will almost certainly triumph.

Assessment by an experienced psychiatrist is the critical initial component at the operational level. The goal is to direct the patient at an early point to the optimal treatment resource, which is often combined medication and psychotherapy. Early and accurate diagnosis and institution of treatment are the most effective ways to provide adequate service with cost responsibility.

There is a parallel need to understand how the service system utilizes time. In the face of likely utilization pressures, there are substantial data to provide guidelines. These have generally been termed the dose- response curve.[7] For frontline mental health services such as mental health centers and hospital outpatient clinics open to unscreened walk-in services, it can be confidently predicted that the utilization pattern for psychotherapy interventions will be a steeply rising response curve. Forty to 50 percent of patients will respond within 6 to 12 sessions. These are primarily stress-precipitated reactions. By the 6-month point the response rate is about 75% improved and 50% recovered. After this point the response rate flattens and continues upward with a slower slope. Although these data are robust, they are homogenized patterns, useful for programming decisions but not patterns that every patient will fit. Accurate diagnosis and psychosocial treatment prescription can direct patients into the most appropriate service quickly.

A crisis service with a few sessions focusing on the precipitating stress and general coping strategies will adequately treat most patients. Since most patients will have discontinued by the twelfth session, there is little advantage to spending time and perhaps goodwill by instituting utilization limits.

From a service standpoint, a more critical decision is prescribing longer-term treatment. Such treatment can be thought of within three categories: 1) formal time-limited psychotherapy from 12 to 24 sessions; 2) longer-term, open-ended treatment beyond 6 months, primarily for patients with characterologic dysfunction and/or difficult social circumstances; and 3) specific maintenance programming for patients with a history of rapid relapse or chaotic social and interpersonal dysfunction.[8] One goal of these longer treatments is to reduce hospital days and maintain work capacity.[8] All three approaches have well-developed treatment models.

One advantage of larger systems is that areas of expertise can be easily developed. For example, the most common diagnostic category is major depression. Major depression responds well to both psychotherapy and medications within a few months. It would be useful to selectively refer for psychotherapy those patients with clear psychosocial triggers or psychosocial maintaining factors, with or without medications. A strong history of recurrence would suggest use of a systematic maintenance program, perhaps scheduled around a monthly visit. CBT, IPT, and brief dynamic psychotherapy are all structured around 12 to 24 sessions, and all have substantial evidence for efficacy.

The major anxiety syndromes respond well to behavioral and cognitive strategies.[9,10] Bulimia nervosa and binge eating respond to the same range of models as depression.[11–13] For all of these conditions, a history of recurrent episodes would suggest a maintenance approach, scheduled at longer intersession intervals and designed to reinforce the treatment strategies of the original model. The goal of maintenance is to expand the time between recurrences, and above all to prevent hospitalization. Slow growth in adaptive capacity may be found.

Personality disorders do respond to intensive treatment, but the timeline is likely to be significantly longer.[14,15] The other major mental illnesses, schizophrenia, bipolar disorder, and anorexia, need to be conceptualized as requiring "eternal" treatment. This may be structured as intensive treatment blocks when required and a formal maintenance program in between.

The group modality offers greater cost-effectiveness.[16] Good empirical evidence indicates equivalent outcome to individual psychotherapy for conditions treated with the same model.[17] "Group therapy" is not a unitary treatment: it has the same range of specific models as individual therapy and the same need for trained therapists. Larger service systems provide the opportunity to develop groups for common psychiatric syndromes and to train clinicians in specific models. Such an organizational structure is an attractive format

through which larger service systems can deliver a variety of treatment models to meet the needs of the patient population.

A successful group program requires writing a clear description for each group that includes the goals, format, and referral criteria. Larger systems find that a regular information sheet of available groups circulated to all clinicians doing initial assessments facilitates rapid placement. All patients need a thorough screening and preparation process to ensure the early development of a working group environment. Patient information sheets and psychoeducational handouts are helpful. Time-limited homogeneous closed groups based on diagnoses can effectively treat the majority of more severely ill psychotherapy candidates. Medication management can be incorporated into the group schedule.

Group psychotherapy provides a 2–4 cost-effectiveness ratio over individual psychotherapy, as well as enhanced financial return for the clinician. Treatment-resistant conditions call for greater clinician skill and experience, but they are often assigned to less trained clinicians. Group programs offer a challenging role of administrator/supervisor/psychotherapist for the psychiatrist.

In summary, larger service delivery systems offer opportunities to develop complex programming based on the needs of the patients being assessed. This can be an exciting forum for the eclectic psychiatrist with psychotherapy interests. The role of the Community Mental Health Center is re-emerging from these programs.

THE GEORGE WASHINGTON UNIVERSITY HEALTH PLAN: HOW PSYCHOTHERAPY TRAINING SUCCEEDED IN AN HMO

James L. Griffith, M.D.

In 1993, Sabin[18] noted the following phenomenon:

> In the early 1960s a half dozen medical schools founded HMOs that were designed to be operated within the academic medical center. Only one—The George Washington University Health Plan—continues in anything like its original relationship to the parent academic medical center. (p. 176)

In the 1960s, the George Washington University Medical Center designed an innovative plan to place primary care medicine at the center of its academic enterprise. The academic divisions of General Internal Medicine, Family Medicine, and Pediatrics were integrated within a Department of Health Care Sciences. To provide a training population for primary care, the George Washington University Health Plan (GWU Health Plan), a closed-panel health maintenance organization, was created. Over three decades, this institutional commitment to primary care education has endured. Although the Department of Psychiatry was not central to the institutional mission at the start, the GWU Health Plan eventually became the primary setting for psychotherapy training in the George Washington University (GW) psychiatry residency program. The success of this training exemplifies what might have occurred in psychiatric education during the 1990s had education been part of the mission of managed care.

The Early Years: Initially, primary care medicine at GW considered mental health services one of its primary roles. Consequently, the GWU Health Plan was first organized with psychologists and social workers to provide mental health services in collaboration with primary care physicians, who would be the point of first contact for psychiatric patients. A half-time psychiatrist served as medical director for mental health services. This medical director, the sole psychiatrist in the GWU Health Plan, held a joint academic appointment in the Department of Psychiatry. The Department of Psychiatry, however, was referred only cases considered too severe for the psychologists, social workers, and primary care physicians employed by GWU Health Plan. Such referrals were discouraged and were too few to play a significant role in Psychiatry's clinical or educational programs.

The Middle Years: By 1991 the university's Vice-President for Medical Affairs recognized major problems in the GWU Health Plan's provision of mental health services. There were high rates of subscriber complaints about effectiveness of the care provided. There was repeated turnover in the position of medical director for mental health services, who was isolated in his role in a nonpsychiatric model of care. Medical student training in psychiatry, for which the GWU Health Plan played a major role, was deemed inadequate by medical school faculty and administrators.

Drs. Jerry Wiener, Chairman of Psychiatry, and Stuart Sotsky, Director of Outpatient Psychiatry, proposed that the Department take charge of mental health services for the GWU Health Plan. Despite vigorous objections by the Department of Health Care Sciences,

the Vice-President concurred. In the new system, Psychiatry assumed control of the half of the capitated GWU Health Plan patient population whose medical care was based in downtown Washington (approximately 35,000 covered lives), with care for other patients contracted to a community psychiatric practice group. These negotiations resulted in an integrated clinical and educational system of managed care with the following features:

- There was no psychiatric gatekeeper. It was felt that patients seeking psychiatric treatment would not wish to discuss problems first with primary care physicians. Patients could call freely to make appointments.
- Consistent with the original training mission of GWU Health Plan, psychiatry residents treated patients at all levels of care alongside faculty and staff—inpatient, day treatment, consultation-liaison, outpatient.
- Outpatient psychotherapy benefits were generally 20 visits or 40 visits per year, depending on selection of "low-option" or "high-option" contract benefits. Psychiatry residents could use the benefits for psychotherapy to their limits, but could not extend them. This led to emphasis in the residency curriculum upon didactic teaching and clinical supervision in CBT, IPT, family systems brief therapies, and group therapy.
- Although GWU Health Plan patients could not complete long-term psychodynamic psychotherapy within their benefit plan, they could use the benefits to begin such therapy with a resident. When GWU Health Plan benefits were exhausted, they could then convert to a sliding-scale payment for continuing psychotherapy with the resident.
- Inpatient and outpatient utilization review procedures, collaboration with nonpsychiatrists on an interdisciplinary treatment team, and time-sensitive, problem-focused brief psychotherapies were taught as components of residency education.

Between 1991 and 1997, the GW residency gained broad recognition for training that balanced psychosocial with biological therapies. Residents in outpatient training typically were assigned two supervisions for long-term psychodynamic psychotherapy and a caseload of 2 to 6 hours weekly. However, they also were assigned five weekly supervisions and weekly case loads of 2 to 4 hours for brief individual psychotherapies, 1 to 2 hours weekly for couple or family therapies, 3 hours weekly for psychopharmacology, and 2 hours weekly for group therapy. A primary role for the Chief Resident was to ensure that all therapies were represented in residents' caseloads with appropriate numbers of patients at all times. This plan meant that PGY-III residents typically conducted a total of 20 to 24 hours of outpatient care each week, including 4 hours of community psychiatry and 4 hours of consultation-liaison psychiatry.

The GWU Health Plan provided a reservoir of referrals for residents drawn from its primary care patient population of lower to upper middle class patients, for whom affective, anxiety, alcohol/substance abuse, and eating disorders were common diagnoses. While this patient population was optimal for psychotherapy training, other training sites in community mental health centers and at other psychiatric hospitals were needed for adequate multicultural training and for training with severely mentally ill patients—those with psychoses and severe personality disorders.

Recent Years, 1997–Present: In the Washington metropolitan area, the GWU Health Plan gained a reputation as a "boutique HMO" that was somewhat more expensive than other health maintenance organizations but exemplary in quality and range of benefits. In 1994, the GWU Health Plan was rated by *The Washingtonian* magazine as third best in an analysis of the many health plans operating in the metropolitan region. Its subscribership peaked at about 100,000 covered lives. Until 1996, the GWU Health Plan remained profitable. Its leadership was regularly consulted by other academic centers seeking to develop academic HMOs.

Around 1995, however, the economic health care climate shifted. Competition among managed health plans progressively drove down premium costs to businesses. In 1996, the GWU Health Plan suddenly faced an operating deficit for the first time and began cutting costs, including curtailing benefits. Although these measures stabilized the Health Plan economically, the mental health portion of the premium was cut each subsequent year, dropping first to half its original size, then to one-third. In the early 1990s, the GWU Health Plan contract had been profitable to the Department of Psychiatry. But as its capitated payments fell, the same mental health benefits remained mandated. Moreover, departmental income from other managed care contracts was also falling. As a result, the outpatient clinical

department eventually shifted back toward fee-for-service arrangements that would avoid the risk of capitated contracts. In July 2000, the department's relationship with GWU Health Plan changed to that of preferred provider, with capitated risk and utilization review assigned to a new corporation, Acute Psychiatric Services (APS), which was independent from the department.

As the department dismantled its HMO model of care, formal utilization review for residents' cases was eliminated in a cost-cutting measure. Although training of residents in managed care practices was lost, this change increased involvement of GWU Health Plan patients in long-term psychodynamic psychotherapy with psychiatry residents. Because faculty psychotherapy with GWU Health Plan patients had been largely eliminated through utilization review, GWU Health Plan patients were motivated to seek psychodynamic psychotherapy with residents as their best financial alternative. As APS entered the picture this year, its contract continued to protect the training provision that psychiatry residents are to treat GWU Health Plan patients. The GWU Health Plan continues to provide the largest portion of residents' outpatient cases, including all of the psychotherapies.

How the GWU Health Plan Has Worked to Support Psychotherapy Training: The most important role of the GWU Health Plan has been its provision of a sufficient primary care patient population to more than supply the cases needed by the residents. This has made it relatively easy for the Chief Resident to monitor residents' caseloads, ensuring that each therapeutic modality is represented in appropriate numbers. For this system to work, however, it has been requisite that the Department of Psychiatry supply the needed resident supervisions without cost to the GWU Health Plan. The 300-member clinical faculty has yielded sufficient highly qualified psychotherapy supervisors without financial cost to the Department for teaching time.

Ironically, the best option for GWU Health Plan patients to have psychotherapy lasting longer than 10 sessions has been with a resident, since psychiatric faculty have been largely restricted from conducting psychotherapy. It has thus become common for residents to provide psychotherapy to individuals with professional backgrounds, who in most health care systems would not seek a resident clinic.

At the least, the GWU Health Plan has shown that an academic HMO organized around resident care of cases can succeed as well as nonacademic HMOs in the medical marketplace. Although its clinical services may be more expensive than other HMOs', its academic identity establishes a reputation for higher quality of care, especially for mental health services. Resident provision of care, including psychotherapy, is consistent with an identity as a "high-end" HMO. From an educational perspective, the GWU Health Plan has been for a decade among our strongest assets for psychotherapy training in our psychiatry residency at GW, and one that we advertise to residency applicants.

DISCUSSION

John C. Markowitz, M.D.

You've heard excellent presentations that deserve a broader audience. It's interesting that none of the presenters actually works in managed care. To answer the question posed by the symposium's title: Yes, psychotherapy by psychiatrists within managed care does appear to be an oxymoron. Maybe this is a realistic position: psychiatry is interested in helping people, whereas managed care was spawned by and focuses on the profit line alone. Ultimately, there may be little common ground between what's best for patients and the narrow pursuit of acute profits.

Let me comment briefly on each presentation.

Dr. Clemens nicely described all that is wrong with managed care and the difficulties attached to psychotherapy by psychiatrists within that system. I agree with most of his well-considered solutions, but I don't know whether MCOs would, or if they have any incentive to do so. Why should they negotiate? I'm sure they'd like to claim good psychiatrists within their system, but not if they're expensive: price will likely remain an issue. Managed care organizations would also probably require strict criteria for authorizing more than minimal psychotherapy benefits, even if these criteria are broader than the current ones. They would probably want to know under what circumstances Dr. Clemens would deny psychotherapy to a patient.

Dr. Clemens noted in an aside that the managed care system would provide psychotherapy to patients only "after a social worker had evaluated them"! Dr. MacKenzie appropriately stresses the need for intake assessment by an experienced psychiatric clinician. This would at least establish the psychiatrist as psychotherapy-triager—an important improvement in clinical

quality—but it's still some distance from the role of treating psychotherapist. The concept of psychiatrist-administrator would seem to limit the psychiatrist's role as a psychotherapist. The comparison to the Community Mental Health Center model may be apt, but that was an underfunded, understaffed model that we may not want to emulate.

Dr. MacKenzie's recognition of the length of typical treatment is a good point: most psychotherapies are brief, and are terminated by patients in 7 sessions or less.[19] Managed care may be shooting itself in the foot by discriminating against psychotherapy benefits that in fact would rarely be overused.

Imagine taking Dr. MacKenzie's suggestion that we provide patients with good initial psychoeducation. This would entail educating patients about the utility of time-limited psychotherapies (TLPs) as treatments for the disorders from which they commonly suffer. It would strike at the heart of the managed care approach. The psychotherapy groups Dr. MacKenzie advocates are also interventions that managed care should support. They can provide psychotherapy at lower cost, especially if led by qualified, trained professionals.

Dr. Griffith presented a wonderful example of a utopian experiment and its rise and fall in a managed care environment. The GWU Health Plan was utopian in using empirically based TLPs, incorporating resident training into this setting, and providing generous psychotherapy benefits. This model unfortunately couldn't survive the ugly reality of managed care economics.

What can we do to fight the current situation? To add to the suggestions you've already heard, we can do the following:

1. Avoid it. This seems to be a growing trend. Should managed care end up with no psychiatrists, that might hurt their ability to advertise that they provide comprehensive care. It might also become evident that we can provide more, and probably at lower cost,[5] than an internist plus a social worker.
2. Fight it. Call our Congressmen and Congresswomen to push for legislation to close liability loopholes.
3. Provide training in evidence-based TLPs (as at GWU) for therapists to ensure appropriately "time-limited" doses of treatment for patients, based on clinical need rather than profit margin. We can demonstrate that these treatments work. What evidence does managed care have that treatment denial is clinically effective?
4. Advocate that psychiatrists provide integrated combined treatment. This is something of a fallback position, and psychiatrists should be allowed to do psychotherapy under other circumstances. But the provision of combined medication and psychotherapy is an area where managed care may agree with us that psychiatrists have special expertise. Treatment of medically ill patients with comorbid psychiatric disorders may be another such instance.
5. Encourage outcome research in psychodynamic psychotherapy; many psychiatrists practice it, but its efficacy remains largely untested for DSM-IV disorders. Belief alone will not finance the field in the future.
6. Encourage outcome research in managed care. Little research exists from which to rationally determine the cost-effectiveness of treatment provision and treatment denial, particularly with regard to psychotherapy. As Dr. Clemens noted, some of the little research done on managed care has looked at economics alone, ignoring whether patients clinically improved.[6]

AUDIENCE COMMENTS

Several members of the small (Thursday afternoon) but articulate audience testified to the benefits to psychiatrists of holding out and remaining psychotherapy providers outside the system. Much of the audience, by show of hands, was not involved in managed care, and only a small subset practiced psychotherapy within it. Some audience members were residents; one private practitioner was not in managed care at all. Someone commented that psychiatrists practice covert psychotherapy to enhance their everyday pharmacotherapy.

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