

# Managed Health Care and Child Mental Health Services: Where Is Horton to Hear the Who's?

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**Abstract:** The impact of managed care has been dramatic in child psychiatric services. This paper describes the clinical evolution of child mental health services in the US in the context of managed care. The paper notes the lack of information guiding the safety and effectiveness of treatment, and the authors argue that there are both clinical and ethical reasons for managed care organizations to share data about their beneficiaries' treatment outcomes in an effort to improve the safety and quality of psychiatric care to children and adolescents. The authors make recommendations for changes in public accountability and call for collaboration between all parties to occur without further delay.

**Keywords:** Child psychiatry, child and adolescent mental health, managed care, quality of care, ethics.

## INTRODUCTION

Managing care as a for-profit business has raised concerns about quality, access and economics. The impact of managed care has been dramatic in the provision of psychiatric care, and most acutely felt in child psychiatric services. Specifically, for-profit managed behavioral health care practices have defined company oriented criteria for credentialing of providers, control of utilization, and case management that may have the goal of improving quality and lowering cost, yet have resulted in decreased availability and intensity of mental health and substance abuse services [1] for the 6 to 9 million American children and adolescents who have serious emotional disturbance [2-6]. In his classic *Horton Hears a Who* [7], Dr. Seuss described a civilization of tiny "Whos" living on a speck of dust. The helpless Whos faced being carried off to oblivion by the black-bottomed eagle or boiled in oil by kangaroos that could not hear them and did not believe they existed. They survived only because Horton, the patient and persistent elephant, heard, listened and decided to protect them. It appears that like the Whos, few are responding to the cries of American's children with mental health needs. What are the forces that allowed this state of affairs to come about? What are the ethical conflicts inherent in the current system, and what are the possible steps to resolving them? What voices will be raised to affirm the comprehensive needs of this vulnerable population?

In theory and practice managed care has positive attributes. The pursuit of quality and efficiency, driven by the market forces of consumer satisfaction and free choice, was a promising approach to allocating increasingly limited resources. Managed care also encouraged evidence-based medicine as part of the effort to deliver the highest quality care possible with limited resources continues. For-profit managed care brought standardized processes and massive information system technology to organize what had been an

impossible to track set of services. In practice, however, profitability shapes the implementation of these principles. Length of stay and intensity of outpatient treatment are primarily influenced by a budget, not outcomes data. Data gathered by health care organizations or plans are usually proprietary and is rather structured for business than for scientific or quality assurance purposes. Much of the data is not accessible by clinicians and researchers. In brief, many children's mental health needs are underserved, poorly served or completely unmet. Like the "Whos," America's mentally ill children are a vulnerable population whose needs have not been adequately heard.

## THE DEVELOPMENT OF MANAGED CARE

The history of managed care is now familiar to most. Less than ten years after Medicare and Medicaid programs were created, Richard Nixon signed the HMO Act of 1973 to promote the development of HMO's. Paul Ellwood and Alain Enthoven pioneered this market-driven strategy for health care delivery and cost containment, predicting a synchrony between market forces and the public's need for healthcare while restraining cost inflation and ensuring universal access [8]. In the next three decades, a growing (and longer-living) population, technological advances and increasing amounts of litigation caused health care costs to grow enormously. The percentage of the gross national product (GNP) going to healthcare grew from 6% in the 1970's to 13.3% in 2000 (more than double the rate for the rest of the American economy) [9]. Of these expenditures, it was estimated in the early 1990's that nearly 13% was for the treatment of mental illness and substance abuse disorders [10].

## MANAGED CARE AND PSYCHIATRY

How psychiatric care fits into this picture has been complicated from the start. Many of the first HMOs in the 1960's and 1970's included basic mental health benefits, but excluded specific illnesses (usually the most severe and

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chronic which were transferred to state funded care). As HMOs became more popular and aggressive in controlling their costs, mental health was difficult to manage. Diagnoses were considered subjective and treatments were time- and labor-intensive, and costs could rise with little obvious consequence. HMOs constrained services in a variety of ways: limiting the number of covered outpatient visits; decreasing the number of mental health clinicians; restricting reimbursement to specific "biological" illnesses; removing coverage for substance abuse; limiting coverage for time-intensive models of care, emphasizing brief outpatient visits; and restricting the criteria for admission to inpatient units to immediate and significant dangerousness, then limiting the length of inpatient stays. Sometimes the flexibility of reimbursement allowed for innovative approaches to community based services. For example, "exchanging" inpatient days for day hospital or after-school programs; however, these options are also constrained and have decreased in recent years.

### THE ROLE OF CARVE-OUTS

A marketing vice president at Magellan, writing in *Administration and Policy in Mental Health* in 2000, reports that "employers for the past two decades have looked for innovative ways of using their purchasing power to bring down costs and improve medical quality...the development of managed behavioral healthcare has been part of this general evolution" [11]. "Carve-outs" emerged as an alternative way of containing costs, where HMO's or managed care companies sub-contacted their mental health coverage to separate for-profit company who would limit the number of credentialed providers using business-oriented definitions. They tend to overemphasize incentives for limiting care and restrict access to specialists. The paper asserts that the introduction of carve-outs has been "a market success", citing that although costs of behavioral healthcare in the 1990s were reduced by traditional managed care to 3-5%, carve-outs managed to reduce the costs further to 1-2% [11]. Even if approximate, these numbers are dramatic. The article goes on to note that some employers have expressed concern that costs have been cut so low that they may not allow for adequate service provision. In fact, they write that one of the largest sources of complaints are related to behavioral health plans [11]. On the other hand, insurance plans that offer better mental health coverage are vulnerable to adverse selection, attracting members with mental health care needs. In contrast to general medical care, where systems such as carve-outs are losing favor, they have been increasingly popular for the delivery of psychiatric care, further widening the gap between mental health and general medical benefits" (9, p. 14) Carve-outs have thus exacerbated problems of access for patients in psychiatric care. For providers, carve-outs have disrupted the usual collegial relationships among clinicians. In traditional medical systems, child psychiatrists had direct and regular contact with the physicians that wanted to consult with informal questions or formal patient referrals (and vice versa). Such relationships are harder when the usual consultants are not credentialed or refuse to join the carved out plan.

### THE IMPACT OF MANAGED CARE ON THE PRACTICE OF CHILD PSYCHIATRY

At a given point in time, approximately 4 million children and adolescents in the United States meet criteria for a psychiatric disorder [12]. A recent study of students aged 11-15 showed that the prevalence of symptoms of depression was approximately 25% in females and 10% in males [13], and another found that approximately 37% of children 9 to 12 had at least one psychiatric disorder by the age of 16 [14], with many of these classified as a serious emotional disturbance (SED). The original promise of managed care was to harness market-driven means (consumer choice, profit incentives) toward a public good: improved access to healthcare, efficiency of services and accountability of providers. The reality of managed care, especially in for-profit child behavioral health, has proven to be quite different from this rosy prediction. The impact of managed care on this particularly vulnerable population is dramatic given that approximately 20 million children being covered by managed care programs.

Carve-outs and managed care have encouraged pharmacologic management of childhood mental illness, yet the overall levels of comprehensive care remain inadequate. While judicious use of medication is clearly a valuable aspect of comprehensive treatment, reasonable observers have to question whether the current emphasis on pharmacologic treatment is being driven more by the carve-outs' bottom lines than by evidence-based medicine [15]. Recent studies report that the rate of psychotropic medication utilization in youth under 20 years old has increased to 6%, nearly the same rate as adult utilization. With this two- to three-fold increase over 10 years, millions of children and adolescents now receive treatment with anti-depressants and stimulant medications [16]. There is emerging evidence of the efficacy of a range of psychosocial and pharmacologic treatments for children, with a call to disseminate and evaluate them in routine practice conditions [6, 17]. However, outcomes studies on these young patients are virtually non-existent, leaving many unanswered questions about the quality of care that they receive and how best to allocate treatment resources. In sharp contrast to the growing need, practicing clinicians and patients seeking care agree that current access to general child mental health services is too limited, with untenable waiting lists for services and uneven geographic availability of services and providers. Those children with the most severe, chronic mental illnesses have the fewest options for care.

### CLINICAL ISSUES

#### Primary Care Pediatricians as Gatekeepers

The starting point for many children needing mental health care is the pediatrician's office. Primary care pediatricians, who are already burdened with efficiency requirements for shorter visits in managed care settings, are also increasingly relied upon to provide screening, gate-keeping and referral for mental health services [18]. A study of over 10,000 pediatric visits found that clinicians recognized psychosocial problems in only 54% of children who were identified as having difficulties by parent report. Interestingly, recognition by the provider was not correlated

with insurance type, but with increasing provider familiarity with the family [19]. What implications do these findings have in this era of managed care and larger group practices, in which continuity of care may be compromised? What are the clinical thresholds for referral by primary care providers who may or may not be familiar with the family?

Depending on the system of care and the incentives to clinicians, referral patterns may be dictated less by clinical need than by managed care protocols. For example, when pediatricians are not reimbursed for time spent on behavioral issues, they face significant barriers to getting their patients' behavioral needs met. A referral to scarce mental health resources using complex administrative procedures is the only option [20]. Even when the mental health clinicians are reimbursed for their time, there is an incentive for short visits. The costs of medications are often borne by the general medical, not the behavioral, insurance budget.

The current reality is that pediatricians, after brief evaluation, may try to meet their patient's mental health needs. For example, pediatricians and family practitioners treat large numbers of children with stimulants for ADHD without any other behavioral treatment or mental health follow-up [21]. Over the last 5 years, pediatricians have also increasingly prescribed SSRIs for depression [16]. The data supporting this treatment is marginal and follow-up studies do not exist. Furthermore, we do not know how the trend toward using medication rather than more labor-intensive psychosocial treatment affects children's long term functioning and health. Most recently, the Food and Drug Administration has put a warning regarding increased suicidality on SSRI's which will likely dampen primary care utilization. The impact on families coping with adolescent depression is likely to be problematic and frustrating.

### **Mental Health Networks Are Inadequate**

Child mental health care networks formed by managed care companies are not designed to meet the complex needs of children and families. Diagnosis and treatment may be provided by less costly, non-doctoral level clinicians, or clinicians who are susceptible to the influence of HMO or company policies. The time permitted for evaluation, often only one or two hours, is often inadequate. The decision-making regarding treatment of these children may be more influenced by an algorithm than unfettered clinical judgment (as one generally expects than in general medical practice). Psychiatrists, significantly more than specialists and primary care physicians [22], are subject to more aggressive external review and must spend more time advocating for their patients with managed care [23]. Those who attempt clinically-informed comprehensive care of seriously mentally ill children face systemic roadblocks as verbal therapies, frequent visits, and coordination of care are poorly reimbursed. Unless families can and will pay for services entirely out of pocket, they must accept the limited terms of treatment under managed care.

### **Care for the Most Ill Children Is Most Compromised**

Managed care most impacts children who need inpatient psychiatric care because HMO criteria for medical necessity dictate lengths of stay and rates of re-hospitalization. Unlike

with general medical care where physicians admit to a hospital they choose and are part of a collegial medical staff, in mental health managed care, the company contracts and selects the psychiatric hospital. In addition, low reimbursement rates affect hospital staffing and budgets, limiting the number of beds available to children who need inpatient levels of containment [24]. Medical hospitals around the country have become familiar with the phenomenon of "stuck kids," children in need of inpatient psychiatric hospitalization who wait for days on inpatient pediatric medicine wards or emergency rooms for an available child psychiatric bed. These medical and emergency wards are ill equipped to manage these behaviorally impaired children and adolescents, and usually cost more for sub-optimal and occasionally dangerous care. Even when admitted, children with severe mental illness have been found to have higher rates of re-hospitalization under managed care [25], raising questions about quality of care for these most vulnerable children. These issues are further complicated by controversy about methodology for outcomes assessments in child mental health, since data shows that readmission rates in fact have poor validity in measuring outcomes in mental health [26, 27].

For the practicing clinician, the goals of inpatient treatment are generally limited to safety and stabilization, rather than a return to baseline function, and yet there are limited step-down treatment options. In fact, there is evidence that managed care has not shifted care from inpatient to outpatient care as it sets out to do, but that there is simply an overall reduction of care [28].

### **Schools and Juvenile Justice Systems Try to Fill in the Gaps**

The constraints applied to mental health services for children result in parents' search for care elsewhere. Many children receive mental health services outside of the medical setting. Educational settings are actually the most common point of entry, followed by specialty mental health clinics for children and the juvenile justice system for adolescents [29, 30]. For nearly half the children with serious emotional disturbances who received services, the public school system was the sole provider [6]. The public schools, already facing very tight budgets, often lack the resources to manage these children and assist their families.

The inevitable result is that children with mental illnesses receive too little care until they are in a crisis. When numerous systems are involved, co-ordination of care becomes even more difficult. If an older child or adolescent has behavioral problems, his or her care may default to the juvenile justice system, as children with untreated mental illnesses often commit crimes or status offenses. In their report on Mental Health Assessments in the Juvenile Justice System, members of the American Academy of Child and Adolescent Psychiatry's Consensus Conference (a group of expert researchers and practitioners convened to generate practice guidelines) concluded that there is a very high incidence of diagnosable mental illnesses among children detained within the juvenile justice system [31]. Many of these youths never received psychiatric attention prior to their incarceration. Recent scientific studies using well-

standardized procedures concur that as many as 65% of youths in the juvenile justice system have diagnosable disorders [32-34]. However, many youths with mental health problems enter the justice system without having been either identified or treated in their communities. In one study of juvenile detainees, only 40% of those with a diagnosed substance use disorder and only 34% of those with anxiety, mood, or disruptive behavior disorders had received earlier services [35].

Increasing numbers of families are taking the desperate, heartbreaking step of relinquishing custody of their emotionally disturbed children. As wards of the state, they may receive needed care, but will also suffer the consequences of growing up in residential treatment programs and without the advocacy of their parents. There is a financial incentive for for-profit behavioral managed care companies to shift the cost of care to school systems, the state or the general medical insurance system.

### **Clinicians Call for Change**

National organizations charged with caring for children and adolescents continue to advocate for parity between behavioral health and medical services, increased training and adequate reimbursement of child mental health providers, and comprehensive access to and coordination of care. A consensus statement from pediatric and psychiatric professionals recommends an investment in quality of care through research to establish criteria for levels of care, best practices, and incremental expectations of progress [36]. Like the Who's voices that were raised to express their existence and need for protection, our children's voices are not yet loud enough to be heard. Even adding the voices of mental health clinicians, children's mental health needs continue to be ignored. As Horton says, "A person's a person no matter how small".

### **Politics and Economics Drive Disparities in Care**

"The business of constraining health care resource use has become today's profitable health care industry" (9, p. 14). What are the economic and political forces that have fostered a for-profit approach to children's mental health? Of note, the first foray into for-profit mental health was the expansion of adolescent inpatient care that took advantage of generous insurance benefits. This first level of profit sets the stage for the pendulum to swing back, but with no counterbalance to the current level of constraint.

Conventional wisdom holds that providing comprehensive psychiatric care to children will be costly. We do not know the medical, educational, social and legal costs of not providing care. We do not know the short term or long term costs. However, these costs are not borne by the behavioral health care companies and their shareholders, but rather by families and taxpayers that remove any financial incentive for the HMOs to invest in the preventive or longer term approaches to care.

Given the epidemiology of mental illness, these consumers are hardly a powerful advocacy group, over-represented by poor families and children. The actual "consumers", children, have a small voice. The shame and

stigma of mental illness and the guilt that is often inappropriately felt by parents diminishes their impetus to speak up. While the powerful business interests involved in for-profit healthcare have no problem being heard, these children and their families are truly as audible as the tiny Whos on a speck of dust. To worsen matters for them, the most recent cuts in Medicaid and cycles of contract bidding among competing for-profit companies have made our social safety net quite thread bare.

Beyond age, social class and stigma, the popular misconceptions about psychiatric illness ("kids don't get depressed") and about treatments for children (such as "dangerous" medications) diminish popular pressure for adequate coverage. The media also informs the popular view of children's untreated (or inadequately treated) mental health problems by dramatizing cases in the juvenile justice system. Stories that sell papers and appeal to television news shows usually concern the (rare) profoundly disturbed children who commit violent and tragic acts. Rather than increase the call for adequate early care, such stories often provoke fear and misunderstanding. Beyond worsening the stigma of mental illness, they compel the political response away from screening and treatment, and toward a harsher punitive approach, such as transfer of juvenile criminals to adult courts and prisons.

## **ETHICAL IMPLICATIONS**

### **Managed Care Is a Business**

Although critical to health care, managed care ethics are not medical ethics. Managed care is a for-profit business [37] that follows a set of ethics quite different than clinicians. The primary focus of business has to be shareholder profits. Decisions are made based on profit and loss, rather than on effectiveness and need [37, 38]. Businesses are not legally bound to meet professional standards of care. They may be liable for negligence, or misrepresentation, but there is neither legal duty to protect the customer's best interest [39] nor a highly personal moral duty to "do no harm".

### **Information Is Proprietary**

Business competition may make companies hesitant to share their procedures, treatment algorithms, policies, and information [40]. Businesses have proprietary protocols and procedures that are not subject to external review or clinical quality assurance. The public may be denied access to proprietary databases and decision-making algorithms because of licensing agreements. What business goal is met by knowing how many children discontinue treatment?

### **Clinicians Are in a Bind**

Mental health clinicians by their mission and professional ethics are advocates of both child and family. Since the advent of managed care, they are expected to work in some capacity as advocates of society as well by keeping the overall allocation of mental health care resources in mind. Although the movement in medicine for clinicians to become more aware of scarce resources is worthwhile, at its core are competing concerns that place clinicians at risk for inevitable dilemmas and conflicts of interest. Even if clinicians come to

peace with their role as dual agents for society and patient, they are still faced with conflicting loyalties between patients and their employers, who mandate practice guidelines to monitor resources and quality. In general medical care, these guidelines are developed by professional societies, attempt to be evidence based, and are often evaluated by outcomes. Guidelines used for child mental health care do not meet these important standards because outcomes data are both hard to define and, if tracked, unavailable.

### The Need for Information

Over a decade ago, researchers in mental health had been called for the need to understand the effects of managed care and to document differences in outcome [41]; yet, over a decade later, we still do not have access to link together mental health care and outcomes, especially for children. The literature on managed care and mental health care for children is sparse and provides virtually no information on health outcomes or quality of care received under these plans or under less organized fee-for-service reimbursement.

Managed care may differentially impact different children. While some studies suggest that managed care increases or broadens access to care, this not necessarily applicable to patients with the most severe illnesses [25]. What does this mean for children who require intensive services as they face the challenges of socio-economic disadvantage, family histories of mental illness and substance abuse, and multiple psychiatric co-morbidities? The varied clinical presentations of childhood mental illness, the complex nature of development and family systems, and difficulties with psychiatric nosology further cloud the picture, raising questions about consistency in documentation and coding diagnoses and treatment. However, managed care systems could begin the tracking process by providing access to data such as diagnostic criteria, specialty of prescribing physician, medication doses, duration, compliance, number of visits, associated therapies, etc. These data are available for cancer and diabetes treatment. Why not for child mental health? Furthermore, we need to understand the non-medical community resources that are part of treatment.

Lastly, we need access to managed care data on the increasing use of psychotropic medications that are being used in children. Some studies of Medicaid populations are available because of mandates for sharing information from publicly funded programs [42]. What about the millions of children with private insurance, free care, or no insurance? Attempts to document quality and outcomes should not become "window dressing" [43]. Research is needed that actually links purported quality measures such as improved access and reduced hospital admission rates to improvements in mental health and favorable outcomes [44], and that evaluates both over- and under-treatment of children with mental illness [45].

The burden of proof is now on the providers and their employers to demonstrate quality [24]. Aside from a small number of public managed care organizations, where the service to the state is contracted by taxpayer-supported Medicaid services, there is a lack of publicly documented performance measurements that demonstrate accountability

and quality [38]. For quality assurance and to further the evidence base, access to proprietary information is required to measure the nature and outcome of care.

### The Ethical Obligation for Public Accountability

Business ethics actually support a managed behavioral health care company's obligation to disclose procedures and information, since fair competition relies on having informed consumers [46]. With disclosure, companies might be able to compete with each other on the basis of quality such as patient satisfaction and effectiveness of treatment plans. Are for-profit HMOs also ethically obliged to share information about the quality and outcomes of care they provide? We argue that they are. Efforts to restrict access to data for any reason must be weighed against the need for important and legitimate medical research [47]. Managed care organizations have an obligation to be accountable to "reasonableness" in order to evaluate appropriateness of patient care. This requires that the public have access to managed care policies and decisions, and that they aim at delivering quality care within limited resources [48]. This information should then be tied to outcomes, which requires that data held by managed care organizations be accessible, in a HIPAA-compliant manner, to researchers in academia and in turn, the public.

### Conclusion and Recommendations: How Horton Could Begin to Rescue the Whos

Attempting to manage medical care was and is a worthy experiment. The goals of increasing efficiency, decreasing unnecessary utilization, tracking quality and improving outcomes have in some cases been realized, yet in other areas they are still only a hope. Increasing use of information systems such as the electronic medical record and the structuring of large databases are further cause of optimism. However, these hopeful outcomes have not been achieved in child psychiatry. Here the profit motive in managed care is particularly aggressive. The target population, emotionally disturbed children, is weak and stigmatized; the potential profit by cutting utilization substantial and tempting; and the audience of employers and insurers willing. Some would say that the lack of "evidence base" and efficacy is a rational motive, yet the past decade has been a golden age of psychiatric research. In other areas of medicine - the value of bypass surgery, the growth in radiology procedures, the decision to do a cesarean section, the use of hormone replacement therapy - have all been richly supported for adults without a hint of economic credentialing or substantive prior approval. In a perversion of language, the word most often used by for-profit behavioral health care companies is "quality". One can look at shortened length of stays and more flexible, community based treatment as a real early gain. However, the reductions in needed treatment are now well beyond quality considerations, and the total dollars removed from child mental health is staggering. Most concerning is that the commitment to profit and proprietary data is greater than the commitment to improving the mental health of children.

We would like to end this review with two recommendations that might rescue the "Whos" and improve the fate of millions of children with emotional disorders:

1. As mandated by ethics and good will, any data within the systems of for-profit behavioral health care companies should be used to assess current practices regarding diagnosis, treatment, and outcome. Regardless of the system of care in place, the field of child psychiatry can only learn if academia is involved and if data is available. Managed care companies must first come to terms with having outside scrutiny [49]. An understanding of what is truly available and what is limited because of cost concerns can only be based on having "real-time" data from the decision-makers who track the progress of individuals. A multidisciplinary approach is warranted. Managed care organizations, health care consumers, private industry, and health services researchers must work together without conflict of interest, and report systematically to insurers, employers and the public. It may be that federal or other state regulation is required to encourage these alliances. A collaborative, open spirit must be developed before children's mental health care deteriorates even further. There are methods of assessing risk and tracking a child's needs and functioning. We should use these methods and allocate our resources effectively.
2. Beyond managed care, we need to coordinate and track our efforts to help children with mental disorders. Currently the health care system, schools, courts, social services and the juvenile justice system all intervene with this group of children separately or in combination. This patchwork of uncoordinated care results in: denial of care; recognition of needs by a school system who cannot provide services; detection with no way to refer for treatment; abuse or neglect without follow-up; foster care without consistent health care; etc. Rather than using local and state agencies as cost-saving alternatives, for-profit behavioral managed care could do its part by setting standards and incentives for collaboration to encourage seamless care.

Ultimately for-profit managed care is an extension of our values which over the last two decades have turned a deaf ear to the mental health needs of children. We have researched these needs, but done little to meet them. Our children, "the who's" that Horton so courageously defended, need a renewed commitment to comprehensive, high quality, and integrated care. As stated by Daniels and Sabin, "If health plans fail to meet our needs fairly under necessary resource constraints, an injustice is done" (48, p. 54).

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