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Managed Care: Ethical Considerations for Counselors

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Key factors and trends in health care will have an impact on the ethical practice of counselors. Ethical challenges to clinical practice presented by trends in managed care are discussed in relation to the American Counseling Association (1995) Code of Ethics and Standards of Practice. Recommendations for practice are also included.

In the past two decades, counselors have made significant strides toward establishing counseling as a separate and legitimate profession, different from other related disciplines, such as clinical social work, clinical and counseling psychology, psychiatric nursing, and psychiatry. Professionalization activities have included gaining licensure in 45 states and the District of Columbia, achieving privileged communication for interactions between counselors and clients (Glosoff, Herlihy, & Spence, in press), and achieving societal recognition of counseling as an important component of mental health services (Sweeney, 1995). At the same time, significant changes have been occurring in the health care delivery system in the United States. In particular, the advent of managed care has affected, and will continue to affect, the work of professional counselors. With the increasing professionalization of counseling, counselors will be held to higher standards of practice, and they will be expected to uphold these standards in a changing practice environment. We believe that these forces will also necessitate changes in how counselors define ethical practice.

A look into the future almost certainly includes a continued departure from fee-for-service models of physical and mental health care and a move toward managed care systems (Hoyt, 1995; Stern, 1993). These systems,

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including health maintenance organizations (HMOs), preferred provider organizations, and government-funded programs such as Medicaid and Medicare, usually control access to services through the use of "gatekeepers" and the monitoring of treatment received by clients.

Typical complaints expressed by mental health clinicians related to managed care arrangements include time limits or caps placed on the number of sessions approved, increased paperwork, decreased flexibility in treatment planning, dealing with the gatekeeper system, and the lack of qualified personnel acting as gatekeepers (Newman & Bricklin, 1991). Many of the ethical concerns raised by managed care systems are related to these complaints and most commonly include matters of informed consent; confidentiality; termination, referral, and abandonment; financial incentives or fees; diagnosis/assessment; competence; limited client choice of diverse providers; and teaching, training, and supervision of practitioners and students.

Clinicians will continue to find themselves faced with ethical dilemmas in their attempts to balance their obligations to both managed mental health care systems and their clients (Haas & Cummings, 1991). In this article, we explore key factors in managed mental health care that may have an impact on the ethical practice of counselors, along with related American Counseling Association (ACA) standards. Although the ACA (1995) *Code of Ethics and Standards of Practice* contain no standards that speak directly about managed care, they offer guidance in meeting these ethical challenges (Glosoff, 1998). Relevant standards are included in parentheses (e.g., Standard A.3.a.) so that readers may refer to the *Code of Ethics* for further information. We discuss ethical challenges to practice, primarily in the areas of (a) client welfare, (b) counselor competence, and (c) confidentiality and informed consent. We then offer recommendations that we hope will assist counselors in exploring possible solutions to dealing effectively with these challenges. We also hope that our suggestions help the counseling profession assess whether new ethical standards, guidelines, or position statements may need to be formulated around these issues.

ETHICAL CHALLENGES RELATED TO MANAGED MENTAL HEALTH CARE

Client Welfare

The primary responsibility of professional counselors is to respect the dignity and promote the welfare of clients (ACA *Code of Ethics*, Preamble). Counselors honor the dignity of individuals by helping clients make free and informed choices about their lives. This is especially relevant in the context of managed care, particularly regarding diagnosis and treatment planning.

Treatment plans as well as diagnoses are often driven by the cost-containment policies that serve as a foundation for most managed care

organizations. These cost-containment limitations influence several areas of practice, such as clinicians' freedom and ethical responsibility to base treatment plans on meeting clients' needs rather than on financial constraints or incentives (Geraty, Hendren, & Flaa, 1992; Hoyt, 1995; Newman & Bricklin, 1991; Stern, 1993).

Problems typically arise when more therapy sessions are needed than the plan allows or because of referrals made by providers to other professionals. This may tempt providers to inappropriately limit services by not appropriately referring clients or prematurely terminating counseling (Glosoff, 1998; Stern, 1993). The potential for ethical conflicts in this area may be reduced by competently assessing clients' ability to benefit from brief therapy (Haas & Cummings, 1991).

Even if insurers refuse to pay for additional therapy sessions, testing, or hospitalization requested by clinicians, it is essential for counselors to remember that the ethical responsibility for their clients' treatment rests primarily, if not solely, on them (Newman & Bricklin, 1991; Stout, 1996). This premise is supported by the *Code of Ethics* and by a number of court cases that have dealt with the issue of responsibility for treatment of clients within managed care systems. Although some court decisions have found HMOs liable, noting that the denial of services caused harm, most decisions have found that clinicians are primarily responsible for their clients' care, regardless of the results of use reviews (Geraty et al., 1992; Stout, 1996; *Wickline v. State of California*, 1987). In the future, it is anticipated that more consumers of mental health services will file both legal and ethical complaints against therapists because of clinicians' willingness to end treatment because of decisions made by insurers.

Although counselors must deal with the realities of managed care, the *Code of Ethics* contends that clients' treatment plans should be deemed clinically viable, offer a reasonable likelihood of effectiveness, be consistent with clients' abilities and situations, and be respectful of clients' freedom of choice (Standard A.1.c.). Standard A.11.a. also makes it clear that counselors are not to abandon their clients (regardless of decisions made by third-party payers) and are responsible for making appropriate arrangements for continuation of care that is considered clinically necessary. Because of this, counselors may find themselves providing services for little or no fee in order to implement clinically sound and ethical treatment plans (as directed by Standard A.10.d.). This is not to say, however, that mental health service providers should serve clients for unlimited time periods with no compensation (Applebaum, 1993). Counselors must be able to effectively terminate therapeutic relationships and be adept at making appropriate referrals (e.g., to agencies that use sliding scales for fees). Counselors and facilities will be well served by planning to offer part of their professional services pro bono (Standard A.10.d.), by relying on a portion of their income from sources other than insurance reimbursement, and by including their clients in decisions regarding what to do after insurance benefits expire (Glosoff, 1998).

Counselor Competence

Several facets of counselors' competence must be examined when discussing working within a managed care system. Counselors will be best able to effectively appeal managed care decisions when they are prepared to present empirical support for their clinical judgments and to do so in language that is understood and accepted by insurers (Glossoff, 1998). The *Code of Ethics* calls for counselors to maintain their knowledge of current scientific and professional information (Standard C.2.f.). Counselors are also responsible for monitoring their effectiveness (Standard C.2.d.); however, only about 20% of practitioners collect data on the effectiveness of their treatments or use any standard outcome instrument (Ridgeland Financial Institute, 1995). Managed care organizations clearly are looking for accountability from their providers, and counselors must be adept at collecting and presenting data to demonstrate their efficacy.

Because brief therapy is the most frequently supported mode of treatment in managed care programs, counselors need to be trained to provide such services if they choose to be managed care providers. They also need to be able to competently assess which clients are and are not appropriately served in a time-limited context or would be worse off with no treatment if other options were not available (Haas & Cummings, 1991). If clients will not be well served by a limited number of sessions, counselors must be skilled at making referrals or other arrangements for appropriate care (Standard A.11.a.).

There is a paucity of published research regarding the extent to which counselor preparation programs include training in brief modes of therapy in their curricula. On the basis of our observations, it seems that many counselors, especially those who received their degrees several years ago, may have been inadequately trained in the appropriate use of brief therapy. Our observations seem to be supported by the results of a recent survey conducted by Howard Smith, chair of the ACA Professionalization Committee. Two thirds of the 1,200 counselors who responded to the survey indicated an interest in receiving training in time-limited approaches to treatment (English & Marino, 1998). The participants in Smith's study may not be fully representative of ACA members or of those mental health professionals who are managed care providers. Regardless, we believe it is important to note that untrained counselors may attempt to simply use traditionally taught therapeutic approaches in a shorter period of time. This raises serious ethical concerns in that counselors are obligated to practice within the boundaries of their competence (Standard C.2.a.). As with all new areas of treatment, counselors are expected to gain "appropriate education, training, and supervised experience" and, while doing so, they should "take steps to ensure the competence of their work and to protect others from possible harm" (Standard C.2.b.).

Managed care also raises some interesting issues in that gatekeepers in managed care systems are charged with making cost-containment decisions

that influence treatment. Frequently, they are not mental health professionals qualified to make these decisions (Geraty et al., 1992). Who assumes responsibility for the competence of these gatekeepers? It is anticipated that counselors and professional associations will continue to spend a great deal of energy in the near future to determine therapists' roles in this situation.

Confidentiality and Informed Consent

Confidentiality is one of the cornerstones in the establishment of a therapeutic relationship (Herlihy & Corey, 1996), and clients have the right to expect that their privacy will be respected (Standard A.3.a.). Managed care systems present new dilemmas for clinicians regarding who is privy to clients' information and how much information must be disclosed for reimbursement to occur. Use reviews typically call for therapists to justify their treatment plans and intrude on the confidentiality and exclusive nature of therapeutic relationships (Stern, 1993). ACA's *Code of Ethics* mandates that counselors avoid unwarranted disclosures of client information (Standard B.1.a.), except in those situations in which clients waive their right to privacy (Standard B.1.b.) or when there is "clear and imminent danger to the client or others or when legal requirements demand that confidential information be revealed" (Standard B.1.c.). ACA's *Code of Ethics* does not, however, mention that counselors may disclose information simply because financial arrangements or policies require such disclosure to receive payment for services. If clients' consent to release confidential information is obtained, the ethics code directs counselors to reveal only that information considered "essential" (Standard B.1.f.).

Managed care systems will often dictate that clinicians maintain their records in a specific manner and that they occasionally submit their records for review (Edward, 1997; Haas & Cummings, 1991; Welfel, 1998). The ethics code instructs counselors to keep records (Standard B.4.a.) but also notes that counselors are responsible for maintaining the confidentiality of these records (Standard B.4.b.) and for obtaining written permission from their clients before disclosing or transferring their records, unless the exceptions to confidentiality noted in Standard B.1.c. exist.

In addition to having an impact on client confidentiality, managed care policies affect the course of treatment in a variety of ways. Clients often do not understand how their health plans may limit the length of their treatment and the approaches used by their counselors. Standard A.3.b. of the ACA *Code of Ethics* clearly charges counselors with helping their clients make informed choices about entering into or continuing in a counseling relationship. Counselors working as managed care providers are ethically bound to ensure that clients understand all financial arrangements (and their implications) and any other policies or arrangements with managed care systems that are related to treatment before entering into a therapeutic relationship (Standard A.10.a., D.1.b., and D.4.; Applebaum, 1993; Glossoff,

1998). According to the ethics code, clients have the right to be provided with a description of the goals, techniques, limitations, and potential risks and benefits associated with counseling; the implications of diagnostic labels; and any limitations to the confidential nature of their therapy (Standard A.3.a.).

RECOMMENDATIONS

Counselors share a fundamental commitment to promote the rights and welfare of recipients of services (Standard D.1.g.). Counselors working within managed care environments are likely to be faced with ethical conflicts and are advised to be aware of and plan for such challenges. We strongly recommend that counselors gain a full understanding of mechanisms such as preauthorization, cost containment, clinical criteria requirements, and use review procedures used by their clients' managed care systems because they will very likely be required to abide by these (Birne-Stone, Cypres, & Winderbaum, 1997; Geraty et al., 1992; Newman & Bricklin, 1991). Before counselors become preferred providers and accept client referrals from managed care networks or become HMO employees, they are responsible for reading the fine print associated with how these networks conduct business (Haas & Cummings, 1991; Hoyt, 1995; Richardson & Shaw Austad, 1991; Welfel, 1998). Standard D.1.l. notes that an agreement to become a service provider implies that a clinician is in accord with the policies and principles of the managed care system. Of course, it is still ethical for a counselor to accept employment or a contract with an agency even if he or she does not agree with every policy in place.

Counselors faced with work situations that do not allow them to fully meet their ethical responsibilities have several options. One such option is to build a client base from other sources and not work within, or rely on, managed care systems that restrict their ability to treat clients as they see fit (Glossoff, 1998). Another option is to enter into an informed agreement with an organization, abide by their policies, and clearly inform clients of the limitations of those policies (Standards D.1.b., D.4., and B.1.c.). If counselors choose to do this, Standard D.1.c. directs them to be prepared to inform managed care organizations about conditions that interfere with clinicians' ethical responsibilities to their clients or restrictions that limit their treatment effectiveness. In addition, counselors should be prepared to make formal appeals of use or other review decisions that limit treatment choices and to request the treatment they believe is clinically sound (Applebaum, 1993). We further recommend that counselors become more involved in managed care systems by becoming members of their boards of directors and by getting themselves into decision-making positions to affect needed changes (Standard D.1.l.; Glossoff, 1998).

Counselors need to expand the types of information they provide to clients being served within managed care systems as compared with other clients (Glossoff, 1998; Wolf, 1994). Clients must be made aware of the im-

pact their insurance policy will have on the length of their treatment, the types of treatments available, confidentiality of treatment and records, clinicians' freedom to independently work with clients in developing and implementing treatment plans, and how diagnoses will be made and used (Corey, Corey, & Callanan, 1998; Haas & Cummings, 1991; Hoyt, 1995). Furthermore, clients should be informed that counselors have no control over what is done with therapy-related information submitted to a third party (Haas & Cummings, 1991; Hoyt, 1995; Welfel, 1998).

Clients should be integrally involved in the development of their treatment plans (Standard A.1.c.), and counselors must make them aware of how cost-containment policies may affect the implementation of these plans. Standard A.3.a. also notes that it is incumbent on counselors to confirm that clients understand "the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements." For example, it is important for counselors and clients to discuss the possibility that certain diagnoses of mental disorders may be considered to be "pre-existing conditions," just like diagnoses of physical conditions. This can be used to deny coverage of mental or physical health treatment if clients change insurance policies within certain time periods (Cottone & Tarvydas, 1998; Glossoff, 1998).

All of the issues previously discussed should be addressed at the beginning of the counseling relationship in the counselor's professional disclosure statement. Counselors should include in their disclosure statements information that explains the limits to confidentiality required by managed care plans, what types of information will be shared (Haas & Cummings, 1991; Wheeler & Bertram, 1994; Wittmer & Remley, 1994), and how this information will be communicated (e.g., by phone, regular mail, or electronic mail; Cottone & Tarvydas, 1998). Furthermore, these procedures must be shared with clients when counseling is initiated and throughout the course of treatment (Standards B.1.g. and B.1.i.). According to ACA's ethics code, counselors' responsibilities do not end there. They are also obligated to understand what happens to the disclosed information once it is in the hands of managed care personnel in order to confirm that agencies have policies in place to protect client confidentiality (Standard B.6.b.) and to ensure that agency personnel are sensitive to the confidential nature of the information that has been disclosed (Standard B.4.e.).

Adequate training in brief therapy is essential for future clinicians if they are to make informed treatment decisions. We strongly suggest that practitioners who did not receive such professional preparation seek it out through continuing education courses. Counselor educators must also recognize and meet their responsibilities for being skilled as teachers and practitioners (Standard F.1.a.), for presenting varied theoretical positions (Standard F.2.f.), and for teaching students about the realities of how managed care systems may influence students' work with clients in order to prepare future practitioners to make ethical decisions (Standards F.2.d.). Educators must stay in touch with how managed care systems are directly and indirectly influ-

encing the delivery of services in community agencies, private practices, hospitals, rehabilitation facilities, nursing homes, schools, and other settings in which their students may seek employment.

Counselors should make appropriate arrangements for those who cannot be served effectively through brief therapy. Examples of such arrangements include trying to negotiate authorization of longer term treatment; agreeing to see clients and have them pay "out of pocket" for treatment (rather than seeking reimbursement from the managed care organization); including clients in decisions regarding what they want to do if treatment is limited by managed care policies; and referring clients to alternative treatment sources, such as community facilities and other mental health providers (Applebaum, 1993; Glosoff, 1998).

To conclude, we offer two further suggestions. The first is directed to individual counselors grappling with managed care issues. The second is directed to our professional associations. For counseling practitioners, participating in a peer supervision or consultation group on a regular basis can offer a vehicle to explore ethical and clinical obligations and dilemmas and to identify possible solutions. Members of a peer supervision group can also provide support during crisis situations by serving as consultants (Glosoff, 1998). Finally, we echo the charge put forth by Newman and Bricklin (1991) for professional organizations to develop clear guidelines for the delivery of mental health services in managed care settings. We recommend that ACA adopt a policy on managed care that offers such guidelines. Until that time, ACA members are referred to the American Psychological Association (1989) Policy Statement created by the Council of Representatives.

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