



Ethical Guidelines in Managed Mental Health

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Center for Practical Bioethics' Mental Health Consortium

Beginning in 1995, facilitated by staff of Midwest Bioethics Center, representatives of forty mental health care providing organizations began meeting to look at ethical issues in mental health practice. The group consisted of community providers and those from managed care organizations (both managers and clinicians). There was no specific consumer representation. Meetings were held monthly for two hours. Our mission was to sensitize providers of mental health services to the ethical implications of their organizational policies and treatment decisions and to enable them to integrate ethics more effectively into their organizations and practices.

We initially brainstormed about issues in mental health that had ethical implications. There was strong agreement that the most pressing current issues occur in providing mental health services in a managed care environment. The first few meetings were a combination of educational discussions about general ethical principles, presenting cases, and sharing experiences in practice.

Three staff members from MBC took notes of the conversations and constructed them into the written document for the group to review and revise. While this process seemed laborious, it did allow for the principles or assumptions to be revisited several times which ended in general content consensus from the members.

Our initial goal was to develop an ethically informed managed mental health care model. We started by identifying assumptions that we believed ought to be true when providing mental health care in an ethically informed managed care environment. After identifying the assumptions, we also wrote a clarifying paragraph expanding the implications of each assumption.

We then moved to consideration of rights and responsibilities as a way to give substance to the

assumptions in practice. We looked at the rights and responsibilities for the plan, for the provider, and for the consumers. One of the most difficult issues was limiting access to information. Providers may occasionally (but rarely) believe limiting access to information may cause harm to the health or well-being of a client whose mental health status may interfere with one's ability to understand or appropriately deal with information about his or her own condition. A corollary concern was trying to determine what, if any, limitations or responsibilities fall to the providers to assure that they are as forthcoming with information as is possible. There was discussion about encouraging the development of "behavioral" advance directives that would be provided to clients whose diagnosis or history indicates that they might experience future episodes of decisional incapacity. These clients can specify in an advance directive what their preferences would be for treatment during such episodes.

Our intention is to share this document with mental health providers and managed care leaders throughout the community. We anticipate that it may have an impact on policies that will not only enhance the quality of mental health care, but also enhance the appropriate access to and allocation of mental health services.

Assumptions about Ethically Informed Managed Mental Health Care

1. A managed care plan is responsible for providing equitable access to mental health care benefits to all members.

While there is disagreement about what constitutes a "basic" or minimally adequate mental health care benefit, there is agreement that all those covered by a plan should have equal access to mental health care. In our society mental illness has often been undertreated, and those with mental illness have often been discriminated against. Access to mental

health care is as important as access to medical care, and there should not be additional limitations placed on mental health treatment.

2. Each member covered by the same contract should have equal access to the same benefits.

At times, plan members covered by the same contract may be treated differently due to perceived differences in power, influence, or status. Such inequitable treatment is inconsistent with the basic principles of ethics and the underlying concepts of managed care. Managed care organizations should use internally consistent standards in authorizing and providing benefits.

3. Mental health care resources are limited.

The amount of resources that our society is willing to expend for mental health care has been less than it is willing to spend on other health care. There are also claims that unproved, or long-term, costly interventions should be further limited. Achievement of a balance of quality mental health care within cost limits is the goal of an ethically informed managed care plan.

4. Societal demand and need for mental health care is increasing.

The needs of aging and underserved populations; pharmacological advances; increasing consumer awareness and expectations; changing manifestations of mental disorders; social acceptability, societal and cultural changes (e.g., substance abuse); and increasingly vulnerable children and adolescents contribute to the increasing demand for and cost of mental health care. Meeting these increased demands is both ethically and medically appropriate as well as cost effective.

5. Mental health care should promote health with an emphasis on prevention.

Although managed care already offers preventive care and promotes wellness, such programs have not been fully implemented and used in the mental health field. Primary prevention — e.g., providing education to the membership about promoting mentally healthy development — is cost-effective and should be provided as much as other health

care and wellness education. Likewise, providing secondary prevention — e.g., early diagnosis and support groups — should also be emphasized.

6. Managed health care plans should provide care that meets the needs of members who are part of underserved and/or at risk populations.

A full range of services that address varying levels of severity of mental illness and special needs of members should be provided. A continuum of care including early diagnosis, inpatient and outpatient services, rehabilitation and maintenance support for the chronically mentally ill are important aspects of appropriate treatment.

The provider panel should include a variety of providers who are able to meet the diverse needs of members. This includes providers who are able to address the cultural needs of members, providers competent to provide particular needed services, and providers who are accessible to members. Services should be adapted with provider and member input to meet the changing needs of members.

7. Value conflicts that require resolution are pervasive in health care.

Value differences are compounded in a pluralistic society. Disagreements are common about what is normal or abnormal, acceptable or unacceptable behavior. Concerns about the costs of health care, problems with delivery and access, and a lack of agreement about the goals of health care all magnify the potential for ethical conflict. An effective plan will have processes and procedures in place to resolve conflict while respecting the values and choices of individual members.

8. Individual autonomy is limited in health care because contracting for benefits is dominated by employer-payors and government.

Both government policy and employer negotiating power displace, to some degree, the preferences and choices of individual plan members. Consumers have little power to choose health plans or to negotiate their health plan contract. For these reasons, all parties, including plans and providers, must protect and advocate for the

individual autonomy of members (even in the contracting process) by honoring member rights and developing mechanisms to include members in decision making. Maximizing consumer input will optimize the effectiveness of managing care.

9. The plan is responsible for educating members about benefits and costs of care.

Members need to be informed in understandable language and, when possible, prior to enrollment about covered services and costs, access and utilization/referral patterns, and other relevant terms of the contract. Such education needs to be provided at least on an annual basis to the membership.

10. As health care continues to move to a managed care model, the managed care organization assumes increased responsibility to demonstrate appropriate stewardship of health care resources.

Managed care organizations should be accountable to the public for the percentage of health care resources under their management that are directly used to provide health care to members. Just as it is incumbent on consumers to become prudent in their use of health care and to recognize the need to balance their requests with those of the entire membership, so also is it incumbent on managed care organizations to demonstrate their responsible stewardship of health care resources.

11. Although the primary focus of mental health care is the individual, providers have obligations to the collective membership as well. There may be instances in which these obligations are in conflict.

In managed care, the traditional relationship of the provider to the individual patient has been expanded to include considerations for the benefit of the plan membership as a whole. The primary obligation to the entire membership is to ensure a balance between quality and cost. Maintaining this balance may result in tension between advocating for the needs of an individual and responsibility to the membership as a whole. When a provider believes that a plan's obligations to an individual

and the membership are in conflict, the provider must exercise clinical judgment supported by professional virtues of integrity, respect, and compassion. Managed care plans should promote an organizational culture that nurtures these virtues. If conflict persists, an appeal process must be available.

12. All participants in managed care have an ethical responsibility to balance their interests in a way that maximizes health care outcomes and ensures that appropriate, cost-effective, high-quality care is available to all.

All participants in managed care — members, providers, managed care plans, and purchasers — need to be aware of the shifting dynamics that influence the provision of health care and the balancing required to provide high-quality, cost-effective care in a managed care setting. Providers and plan managers must be aware that incentives and other contractual arrangements may create conflicts of interest and have the potential to disturb the balance. Purchasers need to be aware that continual cost containment must be balanced by continual attention to quality. Members assume responsibility for being informed and active consumers of appropriate health care.

13. The distinctions among beneficial, marginal, futile, alternative, and experimental care are ethically relevant when making resource allocation policy and individual treatment decisions.

While it may be important to distinguish these several categories, they are hard to define. Diverse theories of mental health care compete for credibility and acceptance. Outcome studies have not resolved many competing claims for effectiveness. A deliberative process is required at the policy development, benefit contracting, and treatment levels to determine whether any particular treatment is cost-effective and is to be provided.

14. The deliberative process that managed care systems use for determining when mental health care is "necessary and appropriate," and, thus, covered, assumes consensus on standards of care by which to measure outcomes. Consensus about

such standards has not yet been achieved among health care providers.

There are few nationally accepted standards for care, and the development of such standards is a difficult and uncoordinated process. While some managed care systems may be taking the lead in developing and relying on outcomes data, how the data are collected, reported, interpreted, and applied varies significantly among systems.

15. Information about the efficacy of treatment modalities should be shared among plans and providers, rather than treated as proprietary information.

Information about treatment modalities that have been more successful needs to be openly shared among providers and organizations.

16. Both technical competence and the therapeutic relationship are important in the delivery of quality mental health care.

As more attention is given to the competent and efficient management of mental health care, the importance of the relational aspect of patient care may be compromised. A caring relationship between a competent, empathic provider and the member is essential to the provision of quality mental health care, and must be encouraged and protected. When plans change their panels of providers or when employers change plans, there will be disruptions in provider-patient relationships that may have a negative impact on the treatment process. Such decisions about change need to include consideration of treatment implications as well as economics.

17. In selecting a provider panel, the plan must maintain a balance between providing quality care and cost of care.

The competence to provide a necessary service should be the primary criterion for selecting a provider panel. A variety of professional perspectives should be available to match specific, diverse needs of members. A panel competent to meet a full range of clinical needs should be provided rather than a panel based solely on economic considerations.

18. Physical and mental health are linked in important ways.

All managed care plans should provide adequate and appropriate mental health coverage. Separating the treatment of mental and physical health may disrupt effective treatment. Whether in an integrated or carved-out model, managed care plans need processes to integrate and coordinate medical and mental health care.

19. Discrepancies between the need for and use of mental health services occur most frequently in groups that, because of ethnicity, age, income, or location, experience more difficulty in accessing appropriate care.

Managed care plans need to offer services that are geographically and financially accessible. Plans should make efforts to alleviate attitudinal barriers to treatment in some populations.

20. Access to choice of provider is important in mental health care.

Due to the significance of the relationship between provider and consumer in the provision of mental health care, it is critical that individual consumers have the option to choose a provider who relates effectively to them.

21. The societal costs of not providing adequate mental health care need to be considered by plans in their cost containment efforts.

Not only does society bear emotional and financial costs in dealing with the untreated mentally ill who inhabit our streets and communities, there are also documented costs for medical care for needs that are better addressed by providing appropriate mental health care. Access to adequate, appropriate treatment is as important in mental health as in medical care. Managed care plans and their members are better served by providing appropriate mental health care, and alleviating the higher medical and societal costs of the symptoms of untreated mental illness.

Rights and Responsibilities of Members, Providers, and Plans

Statements of rights and responsibilities are an attempt to give substance to the ethical principles of autonomy, beneficence, and justice and can be a helpful screen for determining whether an action is guided by ethics. They serve to provide behavioral guidance that is congruent with the previously mentioned assumptions.

Members' Rights

All health care accrediting organizations require attention to patient/member rights. The task force reviewed a variety of rights statements and incorporated them into the list below. New rights have been added and statements of responsibilities for plans and providers have been developed.

Members have a right to

1. Be treated with respect, which includes the right to have their cultural and spiritual values and beliefs respected.
2. Be treated equitably regardless of race, color, religion, sex, age, national origin, ethnicity, sexual preference, lifestyle choice, disability, or geographic location.
3. Choose a mental health care provider from the panel of available providers.
4. Receive services in response to medically appropriate and reasonable requests that are within the responsibility of the organization.
5. Have access to information in the clinical records and to an explanation of all information contained in the records unless, in the provider's judgment, the information would create harm to the member.
6. Receive relevant information, in language(s) the member can understand, regarding the member's clinical condition, including diagnosis, prognosis, and treatment options.
7. Have any proposed procedure or treatment explained in language(s) the member can

understand, including descriptions of the following:

- the nature and purpose of the treatment;
 - possible benefits;
 - known serious side effects, risks or draw-backs;
 - the recovery process, including potential problems associated with recovery;
 - likelihood of success;
 - optional procedures or treatments, including nontreatment; and
 - costs, including those for which the member may be responsible.
8. Participate in treatment decision making, which includes the rights to
 - accept or refuse any procedure, drug or treatment and to be informed of the possible consequences of any such decision. This right may be limited depending on the member's current decisional capacity;
 - a second opinion within the context of the plan;
 - appeal treatment decisions within the grievance process;
 - request consultation from an ethics committee or other appropriate source regarding ethical issues surrounding care.
 9. Give informed consent to treatment, or if unable to consent, to have consent obtained from the appropriate surrogate decision maker.
 10. Give informed consent to or refuse care that involves research, experimental treatments, or educational projects.
 11. Make advance treatment directives, including the right to name a surrogate decision maker in the event the member cannot participate in decision making.

12. Voice grievances about the managed care organization (or care provided) through an internal grievance procedure.
13. Receive education and relevant information, in language(s) the member can understand, about the managed care plan, its services, and the practitioners providing care, such as,
 - names, qualifications, and titles of providers;
 - benefits and services included and excluded;
 - procedures for choosing and changing practitioners;
 - access, including out-of-plan coverage;
 - charges the members may incur;
 - scheduling information;
 - referral procedures;
 - termination of membership and denial of claims;
 - grievance procedure;
 - names, titles, and qualifications of those whose decisions influence one's care;
 - conflicts of interest, including financial incentive arrangements, that may impact access to care;
 - ethics consultation;
 - corporate nature of plan (i.e., whether for profit or not-for-profit);
 - data regarding outcomes and quality;
 - data regarding the percentage of financial resources used to provide direct care; and
 - health education.
14. Have personal privacy respected (i.e., care discussion, consultation, examination, and treatment shall be conducted discreetly).
15. Have all communications and records related to care kept confidential except for those persons who have a need to know because

they are participating in the delivery of care, or where otherwise required by law.

16. Know that employers and other payors will not be given access to clinical information about individual members without permission of the member, except where otherwise provided by law.
17. Members who are minors, may participate in treatment decisions to the extent of their capacity, including giving informed consent.

Member Responsibilities

Many members of the task force pressed for a model of health care delivery in which the consumer participates to the fullest extent possible, including accepting a share of responsibility. Some felt that consumer participation and involvement is necessary before one can benefit from mental health treatment.

However, the consensus of the task force was that the right to health care cannot be denied on the basis of a member or members failing to live up to member responsibilities.

Members have a responsibility, to the extent of their capacity, to

1. Participate in decision making.
2. Seek and give needed information to providers.
3. Follow mutually developed treatment plans.
4. Notify providers when treatment plans will not be followed, are not followed, or are not effective.
5. Use the plan's preventive and early intervention programs.

Provider Responsibilities

The provider's primary ethical responsibility is to provide care with integrity to the member in a respectful and compassionate way. Providers have

responsibilities to the plan and to the members.

Providers have a responsibility to

1. Respect member rights, including those identified in this document.
2. Disclose to the member treatment options not covered by the plan that may benefit the member.
3. Recommend the least costly treatment unless a more costly intervention can be expected to yield a superior outcome.
4. Adhere to the plan's standards of care or, where the provider judges the standards not to be in an individual member's interest, to advocate another treatment option to the plan.
5. Provide information so that the member can consent to treatment plans; or, when the member is unable to participate in decision making, solicit consent from an appropriate surrogate.
6. Minimize the frequency and impact of situations in which a member's mental health status becomes the rationale for limiting a member's right to fully participate in their care decisions.
7. Educate and encourage members to maintain health and use preventive and early intervention services.
8. Educate and encourage members to use the plan's resources prudently.
9. Be sensitive to the implications of guidelines and standards, and participate as able in the development, implementation, and revision of appropriate clinical guidelines and standards of care.
10. Participate in the collection of outcome and quality assurance data.
11. Speak out and resist when unethical practices are being pursued by peers, purchasers, or the plan. It is not enough to quit the

plan; the provider should also work to see that the unethical practice is ended.

12. Treat members without regard to reducing the provider's financial exposure or maximizing the provider's financial gain.
13. Permit the member to have access to the member's medical records and explain all information contained in such records, unless, in the provider's documented judgment, access would cause harm to the member.
14. Keep confidential all communications and records related to care, within legal limitations and requirements.
15. Deny access of employers and other payers to clinical information about an individual member unless permission of the member is obtained, except where otherwise provided by law.
16. Conduct care discussion, consultation, examination, and treatment discreetly in order to respect personal privacy.
17. Appropriately maintain and transfer or dispose of client records.

Plan Responsibilities

An extensive list of plan responsibilities provides guidance for the construction of a system for the ethical management of care. The care with which this extensive list of responsibilities was developed emphasizes the importance task force members place on organizational ethics and the need to create a structure in managed care organizations that supports ethical sensitivity and behavior.

The plan has a responsibility to

1. Respect member rights, including those written in this document.
2. Assess the health care needs of the membership and provide care commensurate with those needs.
3. Make available relevant information about benefits and limitations within the plan and

outcomes data to providers, prospective members, and members.

4. Provide equitable care to all covered members in a fiscally responsible manner.
5. Minimize financial pressures that encourage providers to make treatment decisions on economic grounds rather than clinical criteria.
6. Determine whether providers are basing treatment decisions on inappropriate financial considerations and take corrective action.
7. Provide adequate resources including adequate time with patients, information, and professional development so that providers can fulfill their obligations to members.
8. Recruit providers to participate in the development, implementation, and revision of clinical guidelines, standards of care, and the provider credentialing process.
9. Choose to cover or exclude treatments on the basis of appropriate clinical information and cost effectiveness.
10. Provide quality care and improve care by participating in continuous quality improvement.
11. Engage in standardized data collection and reporting activities.
12. Acknowledge the benefit of continuity of care in the relationship between member and provider and minimize disruption of that relationship.
13. Educate and encourage members to maintain health.
14. Offer and encourage the use of preventive and early intervention services.
15. Select and maintain compassionate, caring, competent, credentialed providers who are prudent users of plan resources, committed to continuous quality improvement, and who adhere to quality guidelines and measures.
16. Provide a copy of policies regarding members' rights and responsibilities to providers and members in the languages of the populations served.
17. Ensure that providers are giving appropriate information to everyone involved in treatment decisions, even members with reduced capacity, to allow for informed consent to treatment.
18. Encourage providers to involve minors and members with reduced capacity in health care decisions to the fullest extent possible.
19. Make information about provider payment methods and incentives available to members and persons considering membership.
20. Educate members, staff, providers, and the community about advance directives and ensure that directives are honored and forwarded to the appropriate setting, such as the hospital.
21. Have a timely and organized system for resolving member complaints, grievances, and concerns.
 - Complaints must be documented and analyzed to be used for quality improvement.
 - Grievances must be reviewed by a panel and must include an opportunity for the member to participate, as well as an opportunity for review by persons not involved in the grievance.
 - There must be an expedited procedure for emergency cases.
22. Provide a timely and organized system for members to obtain ethics consultations.
23. Eliminate barriers to equitable access to covered care and services as a means of resource allocation;

24. Ensure that providers have timely access to utilization decision makers.
25. Involve members and providers in policy development.
26. Ensure members' access to their medical records and to have all information contained in the records explained to them.
27. Keep confidential all communications and records related to care, except in cases in which persons have a need to know because they are participating in the delivery of care, in quality assurance, or in administering or resolving claims or grievances.
28. Build ethics into the organization by providing education to all staff that promotes ethical practice.

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