CONTENTS

Journal of the American Medical Women's Association

Spring 1997
Volume 52, Number 2

Editor-in-Chief
Wendy Chavkin, MD, MPH

Managing Editor
Jane Williamson

Editorial Coordinator
Deborah Elman

Computer Composition
Richard Metter

Statistical Consultant
Ilene Wilets, PhD

JAMWA Editorial Board

Mary Jane England, MD

Loretta Finnegan, MD

Anne Flitcraft, MD

Vanessa Northington Gamble, MD, PhD

Mary Guinan, MD, PhD

Carol Hogue, PhD, MPH

Susan Love, MD

Joanne Lukumnik, MD, MPH

Donnica Moore, MD

Vivian Pinn, MD

Helen Rodriguez-Trias, MD

Vicki Seltzer, MD

Nadine Taub, Esq.

Editorial
Managed Care and Women's Health
Steffie Woolhandler, MD, MPH 50

Practice Satisfaction and Experiences of Women Physicians in An Era of Managed Care
Karen Scott Collins, MD, MPH; Cathy A. Schoen, MS; Firuzeh Khoransanizadeh 52

Men's and Women's Information Needs When Selecting a Health Plan: Results of a National Survey
Stephen L. Isaacs, JD 57

Women and Managed Care: Satisfaction with Provider Choice, Access to Care, Plan Costs and Coverage
Roberta Wyn, PhD, MPH; Karen Scott Collins, MD, MPH; E. Richard Brown, PhD 60

Religious Freedom, Reproductive Health Care, and Hospital Mergers
Janet Gallagher, JD 65

The Impact of Managed Mental Health Care on Women
Audrey R. Newell, MD; Gregory M. Saltzman, PhD 69

The Impact of Managed Care on Female Caregivers in the Hospital and Home
Suzanne Gordon 75

Medicaid and Managed Care: Implications for Low-Income Women
Alina Salganicoff, PhD 78

Women and Managed Care
Mary Jane England, MD; Sonia Muchnick-Baku, ScM 81

The Impact of Managed Care on Women's Health Research: Innovation versus Renovation
Donnica L. Moore, MD; Stan Bernard, MD, MBA 83

Managed Care—Issues and Opportunities: A View from the CDC
Priscilla B. Holman, MSEd; Jeffrey R. Harris, MD, MPH; Wanda K. Jones, DrPH 85

ALSO IN THIS ISSUE

Correlates of Voluntary Human Immunodeficiency Virus AntibodyTesting Reported by Postpartum Women
Mayris P. Webber, DrPH; Ellie E. Schoenbaum, MD; Karen A. Bonuck, PhD 89

Classifieds 93

The Impact of Managed Mental Health Care on Women

AUDREY R. NEWELL, MD
GREGORY M. SALTZMAN, PhD

By 1995, 108 million Americans were enrolled in managed care mental health programs. Managed care is likely to have a differential impact on women, as indicated by epidemiologic patterns, psychodynamic theory, and data from outcome and cost studies. The challenge of providing compassionate, confidential, and effective care within a budget can be solved by a combination of new treatment methods, better focused managed care interventions, and legislation.

Managed care has had a large and growing influence on the provision of mental health services. In 1976, 6 million Americans in health maintenance organizations (HMOs) were virtually the only people with managed mental health care outside of public sector programs. At that time, the HMO provided both mental and other health care services. In the early 1980s, conventional fee-for-service (FFS) insurance plans also began to manage mental health care. Between 1984 and 1987, the proportion of those with FFS health insurance whose mental health benefits were managed rose from 5% to 44%.[1] By 1992, 78 million Americans were enrolled in managed mental health programs; and by 1995, that number had risen to 108 million.[2]

In addition to covering more patients, managed mental health care programs have adopted a wider array of cost-cutting approaches, particularly in FFS plans. Early FFS managed care plans (circa 1984) entailed only utilization review; but by 1990, they entailed both utilization review and selection of providers.[3] Under this more recent arrangement, the managed care companies have established networks of providers who agree to work for lower hourly fees and adopt a short-term approach to treatment.[4] Referrals are then limited to network providers.

Another important managed care development in the 1990s has been the mental health "carve out," which separates management of mental health benefits from that of other health plan benefits. In carve-out contracts, which both HMOs and FFS plans now use, managed behavioral health care companies accept capitated payments to cover all mental health services provided to enrollees, thereby assuming the risk of cost overruns.[3] When HMOs use mental health carve-outs, they essentially replace one overall capitation system for all services with two more specific systems—one for mental health, the other for remaining health services.

Managed mental health care came about for several reasons. Efforts in the 1970s and 1980s by patients, caregivers, the National Alliance for the Mentally Ill,[5] and the National Institute of Mental Health[6] to destigmatize treatment for mental illness and chemical dependency led more people to request mental health care.[7] Effective but costly new medications such as clozapine and fluoxetine were developed. Entrepreneurs built many private, for-profit psychiatric hospitals in the 1980s; and these hospitals used what two managed behavioral health executives called "aggressive marketing practices."[8] For all these reasons, psychiatric costs rose faster than other medical costs,[1] and government and industry payers reacted strongly. Although the rise in costs was entirely accounted for by the increase in adolescent and substance abuse hospitalizations,[1] payers instituted across-the-board policies to limit all types of psychiatric care. Managed behavioral health care companies have secured contracts with employers and some state Medicaid programs by demonstrating their effectiveness in reducing expenditures on mental health services,[9] and not by demonstrating improved clinical outcomes or even improved cost/benefit ratios.

Impact of Managed Care on Mental Health Services

There is compelling evidence that the HMO form of managed care has had a substantial effect on mental health services. The Rand Health Insurance Experiment, which randomly assigned families into HMOs or traditional FFS health insurance plans, found that HMO families incurred much lower outpatient mental health costs due to fewer outpatient visits per user, substitution of psychiatric social workers for psychiatrists and psychologists, and use of group rather than individual therapy.[10] A randomized trial of Medicaid patients in Minnesota found that short-term outcomes were similar for most psychiatric patients in FFS and capitated plans, but that the 370 schizophrenics studied (who were more seriously ill than most other psychiatric patients) did better in the FFS plans.[11] Likewise, an observational study of depressed patients found that outcomes were similar for patients in FFS and capitated plans for those treated by psychologists, other therapists, and general medical clinicians, but that depressed patients treated by psychiatrists (who tended to be sicker than patients treated by other clinicians) did better in the FFS plans.[12] Among the depressed patients treated by psychiatrists, the difference between the FFS and capitated groups was equivalent to half the capitated patients acquiring an additional functional limitation—being prevented from working around the house or at a paying job, for example—that the FFS patients did not acquire.

Dr. Newell is assistant director for psychiatric education at Oakwood Healthcare System and clinical instructor in the Department of Psychiatry at the University of Michigan in Ann Arbor. Dr. Saltzman is associate professor of economics and management at Albion College and adjunct associate research scientist at the Institute of Labor and Industrial Relations, University of Michigan.

No randomized controlled trials have assessed the impact of more recent forms of managed mental health care in non-HMO plans, such as utilization review and high-cost case management,[13] or limiting referrals to providers with low fees and low-cost practice styles. Nevertheless, studies in non-HMO settings suggest that managed care reduces mental health treatment costs for the insurance plan. For example, a mental health carve-out contract for the Medicaid population in Massachusetts (the first state with a statewide managed mental health plan) reduced expenditures from the level projected without managed care by an estimated 22% in one year.[14] Similarly, corporations such as IBM, Federal Express, and Dupont reported expenditure reductions of 30% to 50% when they signed managed care contracts for mental health services.[9]

One reason for these cost savings is that utilization management has substantially shortened lengths of stay for inpatient psychiatric care.[15] Another is that managed care companies select network providers who will accept lower hourly fees and tolerate limitations on both treatment goals and the number of sessions.[16] Clinicians have reported that managed care plans typically limit outpatient psychotherapy treatment to 6 or fewer sessions, even when both the patient and the provider believe more are needed and the benefit plan claims to provide up to 20 sessions per year.[17] Anecdotal reports indicate that, in some managed care plans, physicians prescribing psychotropic medications have been told to see patients less frequently and for shorter intervals—sometimes as little as 15 minutes. Such restrictions on medical practice can make it difficult for physicians to assess the medications' effectiveness, detect and manage side effects, and determine which symptoms should be treated with more or different medications and which should be treated with therapy.

Many HMOs and other managed care plans have recently imposed gag orders prohibiting providers from discussing with patients more comprehensive and higher quality treatments not approved by the managed care company. In response, 16 states adopted laws in the brief span from January to September 1996 nullifying such gag orders. The state senator who sponsored the Colorado law "said she learned about gag clauses from psychologists and psychiatrists who worked for HMOs that allowed only three or four visits with each patient. The therapists, she said, were not allowed to tell patients of these limits, so the patients did not realize that they might need more care" (*New York Times*. September 17, 1996: A9).

Has the increasing role of managed care in mental health services had a differential impact on women? Restricting access to *any* subsidized good or service (such as health care covered in whole or in part by insurance) and forcing consumers to pay more if they really want it obviously has a disproportionate impact on low-income people; and despite recent progress, women still have lower average earnings than men.[18] This article, however, focuses on issues distinctive to mental health services. Epidemiology, psychodynamic theory, and data from outcome and cost studies all provide tools for analyzing these issues.

The Epidemiology of Mental Illness

Although controlled studies have demonstrated that women are not more likely than men to acknowledge that they have psychiatric symptoms such as depression,[19] women seek mental health services more frequently than men.[20-22] Thus, a policy limiting psychiatric services more stringently than cardiac services, for example, would have a disproportionate effect on women; and some reports indicate that psychiatry has, in fact, faced more extensive intervention by managed care than have many other medical specialties.[16]

Furthermore, women have different kinds of psychiatric conditions than men. Women are three times as likely as men to have depression[23] and borderline personality disorder; nine times as likely to have anorexia or bulimia; and two to three times as likely to have phobias, panic, and generalized anxiety disorders.[24] Boys and men, by contrast, predominate in antisocial personality disorder, substance abuse,[20] attention deficit hyperactivity disorder (ADHD),[25] early-onset schizophrenia, autism, and learning disabilities (LD).[23]

Because of the differing psychiatric conditions of women and men, managed care restrictions on mental health services may have a disparate impact on women. Some of the psychiatric illnesses in which men and boys predominate require medical treatment, but the great majority of treatments for autism, ADHD, and LD need to be carried out by the schools. Treatment for the conditions in which women and girls predominate is almost exclusively the responsibility of the health care system, and this partially explains why, although men and women have the same rates of psychiatric disorders in any given year,[20] women seek assistance from the health care system more frequently than men and are therefore more affected by policies limiting such care.

Policies limiting outpatient care to "acute" conditions amenable to short-term therapy and crisis resolution, now a part of many managed mental health services contracts, will have a differential impact on certain patients, most of them women. For example, until a change in Massachusetts law made the practice illegal, Harvard Community Health Plan, as many other HMOs, limited mental health benefits to patients with "psychiatric conditions of recent onset which are judged subject to significant improvement through relatively short term therapy."[26] As a Harvard Community Health Plan psychiatrist noted, "Defining benefits this way limited expenses by excluding a group of disorders likely to require especially costly care."[26] Or to give a current example, M-Care HMO in Michigan specifies that the 20 outpatient mental health visits per year are for "Crisis intervention & short-term therapy" (M-Care HMO benefit summary, 1995). Some managed care plans interpret such policies to exclude patients with anorexia and bulimia, most of whom are women or girls, on the grounds that "A patient who requires more than 20 sessions by definition requires *long-term* therapy and is therefore ineligible for benefits under the plan."[27 (p 396)] There is no similar policy for chronic illness due to atherosclerosis.

Managed Care and Abuse Victims

Experiences of abuse are an important contributor to the development of psy-

chiatric illnesses, particularly in girls and women. Estimates of the prevalence of abuse vary, with studies based on face-to-face interviews reporting higher prevalence rates than those based on self-administered questionnaires,[28] but abuse is far from rare and much more common in women. Interviews of 3,132 Los Angeles adults for the Epidemiologic Catchment Area project found that about twice as many women as men had been sexually assaulted before[29] and after age 16.[30] Another study found that 0.33% of girls and 0.10% of boys were reported to have been sexually abused during 1986, while 0.55% of girls and 0.43% of boys were reported to have been physically abused that year.[31] A survey of more than 8,000 intact couples found that nearly one out of eight husbands engaged in physical aggression against their wives in 1985, and that women were much more likely to be injured by domestic violence than men were.[32]

Incest and physical and sexual assault often cause serious emotional distress by themselves[33,34] as well as worsening any co-existing disorders. Suicide attempts occur in 17% to19% of rape victims.[35] Surveys of clinical populations show high rates of abuse histories among psychiatric patients, especially women.[36] For example, a recent study of 802 alcoholic inpatients found that 49% of the women and 12% of the men reported that they had been sexually abused as children, and 33% of the women and 24% of the men reported that they had been physically abused.[37] A study of a random community sample found that 20.7% of women who were sexually abused as children had psychiatric disorders, compared to 6.3% of nonabused women.[38]

The importance of physical and sexual abuse as a frequent cause of psychiatric problems in girls and women raises the issue of whether the cost control procedures often used by managed care have a disproportionate impact on victims of abuse. Such patients often feel powerless, ashamed, and afraid. Many whose abuse began in childhood never developed a normal sense of autonomy, self-confidence, boundaries, and rights to consent to sex and not be hit.[39,40] Treatment includes discussing what happened;[39] learning to identify, trust, and accept past and current feelings; developing realistic decision-making and active problem-solving skills;[40] developing inner strength and self-confidence; and setting limits when threatened by others.

The treatment limitations and procedural requirements imposed by managed care not only cut this process short, but also compound and exacerbate the original traumas by invalidating the severity of the experience and the resulting need for long-term therapy. The woman's feelings of powerlessness may be reinforced by requirements that patients obtain pre-authorization to begin therapy and obtain continued authorization every four to six sessions. Furthermore, the contents of the therapy session may be on the insurance company's computer network and available to thousands of curious readers (*New York Times Magazine*. June 16, 1996: 38-41). This violation of privacy may reinforce the patient's sense of shame.

Managed care's restrictions on length of hospital stay can also have a particularly adverse effect on some abuse victims. In one case, an incest survivor:

> thought that suicide was the only way to eradicate the horrific memories of her father's incestuous relationship with her, a daily occurrence from age 7 to age 14. She had been in and out of hospitals for brief stays with no improvement. Only when she was allowed to stay for 3 months was she able to develop a network of supportive relationships that enabled her to reexperience and work through her past trauma. She finally overcame her wish to kill herself and was able to be treated in an outpatient setting.[41 (p 27)]

Managed care plans often assume that psychotherapy beyond a few sessions is an "elective consumer purchase" that is unnecessary and, therefore, not reimbursable.[42] Yet the experience of trauma researchers at Cambridge Hospital near Boston[39] and the University of Washington[40] is that victims of rape, incest, or physical abuse require considerably more than a few sessions in order to recover, particularly if they endured prolonged, repeated, or childhood abuse.

Outcome and Cost Studies

Regardless of the origin of a patient's illness, a critical issue for managed care is how much treatment is enough? The answer depends on the outcome criteria used. If treatment goals are restricted to overcoming major functional limitations, then less treatment is necessary than if goals also include improving the patient's symptoms, such as anxiety, flashbacks, and depression. In our view, though, both functional limitations and subjective well-being ought to be considered.

Outcome studies suggest that providing more sessions of psychotherapy increases the percentage of patients who get better, though the rate of improvement slows as the number of sessions rises. One study of female outpatients found that, based on patient self-ratings after each session, 22% of 974 depressed patients reported some improvement in subjective well-being after one session, 44% after four, 60% after 13, and 77% after 52. Smaller percentages of anxious and borderline psychotic patients reported improvements after only 1, 4, or 13 sessions; but at 52 sessions, the percentages reporting improvement were similar to those for depressed patients. The study also measured improvement using researchers' clinical chart ratings after termination of treatment. This measure indicated less improvement for all three diagnoses than the patient self-ratings did early in treatment, but the two measures gave similar results by 13 sessions for depressed or anxious patients and by 52 sessions for borderline-psychotic patients.[43] A more recent study by two of the same authors assessed recovery using the Symptom Checklist—90—Revised with 854 psychotherapy outpatients (both male and female) before their first therapy session and later during treatment. This study found that it took an average of 11 sessions of weekly psychotherapy to achieve clinically significant improvement in 50% of patients with 18 common symptoms that were responsive to psychotherapy. It took an average of 58 sessions to achieve such improvement in 75% of patients.[44]

Limiting reimbursement to a very small number of outpatient sessions on the grounds that the plan only covers acute conditions makes no sense clinically. There is no accepted definition in psychiatry for "acute" conditions, and the

term has no scientific validity. More than 400 disorders are listed in *DSM-IV*,[24] and only two—"Acute Stress Disorder" and "Brief Psychotic Disorder"—connote a rapid onset and a brief course. Even "Adjustment Disorder" can persist for years, due to chronic stressors.[24] A woman can have one major depressive episode that resolves quickly with medication and never recurs, or several episodes over a lifetime. Anorexia may have an acute onset of weight loss, but it occurs within a family and societal context of several years' duration.[45]

Furthermore, some chronic conditions may also respond to treatment. For example, one study of opiate addicts in a methadone-maintenance program used a variety of standardized measures (the Beck Depression Inventory, the Maudsley Personality Inventory, the Symptom Checklist-90, the Shipley Institute of Living Scale, the Schedule for Affective Disorders and Schizophrenia, and the Addiction Severity Index) to assess the impact of psychotherapy. At 7 months, addicts who received psychotherapy evidenced greater improvement on these psychiatric measures and on such measures as money earned through legal employment and days committing crimes than did those who did not receive therapy. Furthermore, those who received 6 months of psychotherapy maintained their gains at 12 months, whereas the control group showed deterioration on some measures.[46]

Limiting care to acute conditions amenable to short-term treatment allows the insurer to deny coverage for conditions that may prove expensive. In no way does this limit ensure that funds are allocated rationally to maximize benefits from the available funds. A rational allocation of our limited resources would balance the costs of treatment with the severity of the patient's illness and the expected benefits of treatment.

Advocates of managed care have advanced two other arguments for limiting treatment. First, they argue that a substantial portion of mental health care goes to the worried well, rather than to the seriously ill. Second, they believe that limits on outpatient mental health care are essential to keep health care costs from exploding. Studies based on the Rand Health Insurance Experiment, however, undermine both these arguments. The Rand experiment measured mental health status at the time each participant enrolled and also gathered data on participants' use of reimbursed and unreimbursed health services.[47] Results showed that the sickest patients were most likely to receive outpatient treatment and were likely to be treated more intensively by a mental health specialist. Furthermore, patients scoring in the unhealthiest third on the mental health questionnaire spent more than three times more per year, on average, than patients scoring in the healthiest third. Nevertheless, even for patients randomly assigned to an insurance plan providing free care, less than 20% of patients scoring in the unhealthiest third on the mental health questionnaire received *any* outpatient mental health care in a given year. These results suggest that the problem is not so much overuse of services by the worried well, but rather, underuse by the seriously ill. As one editorial comment on the Rand experiment noted, stigma and other unknown disincentives inhibit mentally ill patients from seeking treatment, even if care is free.[48]

Another study based on the Rand data analyzed the effect of cost sharing on the use of outpatient psychotherapy services.[49] It found that spending on outpatient psychotherapy more than doubled when patients had no out-of-pocket payments compared to when they paid 95% of the fee, subject to an annual catastrophic limit. Nevertheless, the total amount spent was small. Even when health insurance was generous, expenditures on outpatient psychotherapy amounted to only 4% of total health care expenditures and 9% of outpatient health care expenditures. Even in the plan with no out-of-pocket payments, the average patient who used outpatient psychotherapy had only 11 visits per year; and since less than 5% of the population received any psychotherapy, the average cost for psychotherapy per enrollee in the free care plan was only $32 (in 1984 dollars).[49] Given that the Rand study insurance plans paid for up to 52 psychotherapy sessions per year for each patient[47] (much more generous than many current health plans) and that the FFS plans in the Rand experiment had neither utilization review nor selection of providers on the basis of low fees or a low-cost practice style, it seems that the cost concerns expressed by managed care advocates are exaggerated, at least with respect to outpatient mental health care.

In summary, based on the Rand Health Insurance Experiment results, providing up to 50 outpatient sessions per year without selecting the patient's provider or insisting on personal information and micromanaging care would not entail large absolute costs, would not concentrate expenditures on the worried well, and would not even result in all seriously ill patients getting needed treatment. Furthermore, as other studies have shown,[43,44] providing up to 50 outpatient sessions per year will result in a higher percentage of mental health patients recovering than if outpatient treatment is limited to 4 or even 20 sessions. Thus, a first recommendation for managed mental health care is: relax the controls on outpatient mental health care and focus instead on the relatively small number of inpatient cases that account for a disproportionate share of costs. After all, the rapid increase in adolescent and substance abuse inpatient costs in the 1980s was the main problem that inspired the growth of managed mental health care.

Reshaping Mental Health Services

What is to be done? Resources are limited. Now that more people are requesting treatment and more types of treatment are available, neither patients nor providers can do whatever they want. Both providers and patients have a responsibility to use resources carefully, so that others are not denied care. Currently, patients and providers are demanding more of the same, while payers insist on less of the same, and neither is a solution.

One alternative would be to make fundamental changes in our health care reimbursement system to control costs in ways different from those of managed care. For example, one study identified large potential savings in administrative costs by adopting a Canadian-style single-payer system in the United States.[50] Another study found that child psychiatrists working under the Canadian sys-

tem were more satisfied with the quality and affordability of services for inpatients and outpatients and with the behaviors of third-party payers than their US counterparts were.[51]

It is probably politically more realistic, however, to focus on incremental reforms within the framework of the existing US reimbursement system. If inpatient treatment were reserved for patients who were truly a danger to themselves or others, resources would be freed to provide much more outpatient care with less intrusive monitoring. Managed care companies can balance their need for information and cost control with the patient's need for privacy and self-determination by separating large expenses such as inpatient care from smaller ones such as outpatient sessions for therapy or medication management.

If, however, we are to have a system where a patient can select any provider and receive up to 50 truly confidential outpatient sessions per year without insurance company management, then patients and clinicians will need to change the way that they view these services. Physicians have been described as perfectionists who believe "that with enough work, dedication, knowledge, and skill, suffering *can* be alleviated, disease *can* be overcome, and even death defeated."[52 (p 2)] When the patient does not respond quickly and fully, doctors respond by "trying harder, working longer," which may put doctors in conflict with managed care organizations whose mandate is to control costs. A "need to control others is also an important component of the doctor's personality."[53 (p. 25)] These traits are exceedingly helpful in some circumstances, but they can also lead doctors to assume more responsibility and do more work for the patient than they should.

Not all therapeutic power comes from the therapist. Educational videotapes, computer-assisted interactive learning modules, skills workbooks,[54] and self-help groups already exist. They are, however, underused by many professionals for a number of reasons: unfamiliarity, fear of being replaced, and a blow to their self-esteem ("How could watching a videotape be as good as having a session with me?"). Patients with major depression appreciate a physician who explains the side effect profiles and dosage schedules of several different antidepressants and lets them choose the one they are least uncomfortable with. Some of this education could be done by videotape or written materials.

A second recommendation for mental health services in an age of managed care is that patients and clinicians must share the responsibility of using services effectively and getting the most from each session. This can be accomplished by requiring patients and providers to sign treatment contracts at the onset of treatment and at three-month intervals. Both agree that, while the clinician can do some helpful and essential things, the patient needs to do a lot of work on his or her own, too.[54-57] The patient agrees to do two hours of self-help work (eg, reading, anger management workbooks, attendance at AA, or vigorous exercise) for every hour of clinical services provided. A managed care organization could pay a clinic to develop innovative methods and give referrals to clinics that use them.

Some women working in large HMOs are beginning to use the work of Carol Gilligan and Nancy Chodorow to explain why some women find brief therapies disempowering. They assert that women need both time and continuity of connections to develop. Susan Edbril and colleagues[58] have developed a model of therapy where women are treated over an extended period of time with weekly sessions at first and monthly sessions later; a patient might use 30 sessions over a three-year period. The patient uses the time between appointments to work on an issue she and her therapist have identified, choosing among strategies and readings suggested by the therapist. Learning to identify her needs and renegotiate her relationships with others are frequently identified goals in this program.

In the past, women have won important rights in the legislatures and the courts. Just as patients and their families have lobbied state legislatures and Congress to secure mandatory reimbursement for 48-hour postnatal stays (*Wall Street Journal*. September 20, 1996: B1, 5), so they can lobby for laws requiring managed care companies to provide 50 outpatient sessions per year for therapy or medication adjustment at the patient's request. Such laws would benefit both men and women, but they are likely to be especially helpful to women.

Since trust and privacy are essential ingredients of effective treatment, laws should also be passed guaranteeing that treatment data will be accessible only to clinicians caring for the patient, especially when these data are stored in computer files. If insurance companies wish to collect data and conduct research, they ought to observe the same precautions that university researchers must: obtain the approval of a human subjects committee and secure written informed consent from the patient for the specific project they wish to pursue.

Conclusion

The challenge of meeting women's mental health needs within a budget can be solved by a combination of focusing managed care interventions more appropriately, using new treatment methods, and enacting legislation. Managed care plans compete to win contracts with employers and government payers; some also compete to provide the highest return to stockholders. Successful competition in these markets stems primarily from providing the plan with the lowest premium. We need legislation to set minimum standards for health plans, preventing such a race to the bottom, and to protect privacy rights. Legislation alone, however, cannot solve the problem. We must innovate to make the best use of each health care dollar.

References

1. Sharfstein SS. Managed mental health care. In: Tasman A, Riba MB, eds. *Review of Psychiatry*, vol 11. Washington, DC: American Psychiatric Press; 1992:570-584.
2. Hiebert-White J. Managed care and the new economics of mental health. *Health Aff.* 1995; 14:5-6.
3. England MJ. From fee-for-service to accountable health plans. In: Schreter RK, Sharfstein SS, Schreter CA, eds. *Allies and Adversaries: The Impact of Managed Care on Mental Health Services*. Washington, DC: American Psychiatric Press; 1994:3-8.
4. Abrahamson DJ, Lucco AA. The role of the psychologist: The clinician's view. In: Schreter RK, Sharfstein SS, Schreter CA, eds. *Allies and Adversaries: The Impact of Managed Care on Mental Health Services*. Washington, DC: American Psychiatric Press; 1994: 124-133.

5. Flynn LM. The stigma of mental illness. *New Directions for Mental Health Services.* 1987;34: 53-60.
6. Long E, Runck B. Combating stigma through work for the mentally restored. *Hosp Community Psychiatry.* 1983;34:19-20.
7. Pardes H. Future of psychiatry. In: Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry.* 5th ed. vol. 2. Baltimore, Md: Williams & Wilkins; 1989:2154-2157.
8. Feldman S, Goldman W. Editors' notes: Managed mental health care. *New Directions for Mental Health Services.* 1993;59:1-3.
9. Iglehart JK. Managed care and mental health. *N Engl J Med.* 1996;334:131-135.
10. Wells KB, Manning WG, Benjamin B. Use of outpatient mental health services in HMO and fee-for-service plans: Results from a randomized controlled trial. *Health Serv Res.* 1986;21:453-474.
11. Lurie N, Moscovice IS, Finch M, Christianson JB, Popkin MK. Does capitation affect the health of the chronically mentally ill? Results from a randomized trial. *JAMA.* 1992;267: 3300-3304.
12. Rogers WH, Wells KB, Meredith LS, Sturm R, Burnam MA. Outcomes for adult outpatients with depression under prepaid or fee-for-service financing. *Arch Gen Psychiatry.* 1993;50:517-525.
13. Mechanic D, Schlesinger M, McAlpine DD. Management of mental health and substance abuse services: State of the art and early results. *Milbank Q.* 1995;73:19-55.
14. Callahan JJ, Shepard DS, Beinecke RH, Larson MJ, Cavanaugh D. Mental health/substance abuse treatment in managed care: The Massachusetts Medicaid experience. *Health Aff.* 1995; 14:173-184.
15. Wickizer TM, Lessler D, Travis KM. Controlling inpatient psychiatric utilization through managed care. *Am J Psychiatry.* 1996;153:339-345.
16. Jellinek MS, Nurcombe B. Two wrongs don't make a right: Managed care, mental health, and the marketplace. *JAMA.* 1993;270:1737-1739.
17. Karon BP. Provision of psychotherapy under managed health care: A growing crisis and national nightmare. *Professional Psychology.* 1995;26:5-9.
18. Blau FD, Kahn LM. Rising wage inequality and the U.S. gender gap. *American Economic Review.* 1994;84:23-28.
19. Wolk SI, Weissman MM. Women and depression: An update. In: Oldham JM, Riba MB, eds. *Review of Psychiatry,* vol 14. Washington, DC: American Psychiatric Press; 1995:227-259.
20. Robins LN, Locke BZ, Regier DA. An overview of psychiatric disorders in America. In: Robins LN, Regier DA, eds. *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study.* New York, NY: The Free Press; 1991: 328-366.
21. Wells KB, Manning WG, Benjamin B. A comparison of the effects of sociodemographic factors and health status on use of outpatient mental health services in HMO and fee-for-service plans. *Med Care.* 1986;24:949-960.
22. Simon GE, VonKorff M, Durham ML. Predictors of outpatient mental health utilization by primary care patients in a health maintenance organization. *Am J Psychiatry.* 1994;151:908-913.
23. Blumenthal SJ. Improving women's mental and physical health: Federal initiative and programs. In: Oldham JM, Riba MB, eds. *Review of Psychiatry,* vol 14. Washington, American Psychiatric Press, 1995:181-204.
24. *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed *(DSM-IV).* Washington, DC: American Psychiatric Association; 1994.
25. Weiss G. Attention deficit hyperactivity disorder. In: Lewis M, ed. *Child and Adolescent Psychiatry: A Comprehensive Textbook.* 2nd ed. Baltimore, Md: Williams & Wilkins; 1996: 544-563.
26. Sabin JE. Research findings on chronic mental illness: A model for continuing care in the health maintenance organization. *Compr Psychiatry.* 1978;19:83-95.
27. Wooley SC. Managed care and mental health: The silencing of a profession. *International Journal of Eating Disorders.* 1993;14:387-401.
28. Wyatt GE, Peters SD. Methodological considerations in research on the prevalence of child sexual abuse. *Child Abuse Negl.* 1986;10:241-251.
29. Siegel JM, Sorenson SB, Golding JM, Burnam MA, Stein JA. The prevalence of childhood sexual assault: The Los Angeles Epidemiologic Catchment Area project. *Am J Epidemiol.* 1987; 126:1141-1153.
30. Sorenson SB, Stein JA, Siegel JM, Golding JM, Burnam MA. The prevalence of adult sexual assault: The Los Angeles Epidemiologic Catchment Area project. *Am J Epidemiol.* 1987; 126:1154-1164.
31. Cappelleri JC, Eckenrode J, Powers JL. The epidemiology of child abuse: Findings from the Second National Incidence and Prevalence Study of Child Abuse and Neglect. *Am J Public Health.* 1993;83:1622-1624.
32. Stets JE, Straus MA. Gender differences in reporting of marital violence and its medical and psychological consequences. In: Straus MA, Gelles RJ, eds. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families.* New Brunswick, NJ: Transaction Publishers; 1990:151-165.
33. Carmen E, Russo NF, Miller JB. Inequality and women's mental health: An overview. *Am J Psychiatry.* 1981;138:1319-1330.
34. Council on Scientific Affairs, American Medical Association. Violence against women: Relevance for medical practitioners. *JAMA.* 1992;267: 3184-3189.
35. Stewart DE, Robinson GE. Violence against women. In: Oldham JM, Riba MB, eds. *Review of Psychiatry,* vol 14. Washington, DC: American Psychiatric Press; 1995:261-282.
36. Rose SM. Acknowledging abuse backgrounds of intensive case management clients. *Community Ment Health J.* 1991;27:255-263.
37. Windle M, Windle RC, Scheidt DM, Miller GB. Physical and sexual abuse and associated mental disorders among alcoholic inpatients. *Am J Psychiatry.* 1995;152:1322-1328.
38. Mullen PE, Romans-Clarkson SE, Walton VA, Herbison GP. Impact of sexual and physical abuse on women's mental health. *Lancet.* 1988; 8590:841-845.
39. Herman JL. *Trauma and Recovery.* New York, NY: Basic Books; 1992.
40. Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* New York, NY: Guilford Press; 1993.
41. Gabbard GO. Inpatient services: The clinician's view. In: Schreter RK, Sharfstein SS, Schreter CA, eds. *Allies and Adversaries: The Impact of Managed Care on Mental Health Services.* Washington, DC: American Psychiatric Press; 1994: 22-30.
42. Gould B, Hill ED. Managed care, mental health, and the marketplace. *JAMA.* 1994;271: 587-588.
43. Howard KI, Kopta SM, Krause MS, Orlinsky DE. The dose-effect relationship in psychotherapy. *Am Psychol.* 1986;41:159-164.
44. Kopta SM, Howard KI, Lowry JL, Beutler LE. Patterns of symptomatic recovery in psychotherapy. *J Consult Clin Psychol.* 1994;62: 1009-1016.
45. Pipher MB. *Reviving Ophelia: Saving the Selves of Adolescent Girls.* New York, NY: Putnam; 1994.
46. Woody GE, McLellan AT, Luborsky L, *et al.* Twelve month follow-up of psychotherapy for opiate dependence. *Am J Psychiatry.* 1987;144: 590-596.
47. Ware JE, Manning WG, Duan N, Wells WB, Newhouse JP. Health status and the use of outpatient mental health services. *Am Psychol.* 1984;39:1090-1100.
48. Borus JF. Coverage, care, cost, and outcome. *JAMA.* 1986;256:1939.
49. Manning WG, Wells KB, Duan N, Newhouse JP, Ware JE. How cost sharing affects the use of ambulatory mental health services. *JAMA.* 1986;256:1930-1934.
50. Woolhandler S, Himmelstein DU, Lewontin JP. Administrative costs in US hospitals. *N Engl J Med.* 1993;329:400-403.
51. Newell AR, Saltzman GM. Impact of reimbursement systems on child psychiatrists: A comparison of Canada and the United States. *J Am Acad Child Adolesc Psychiatry.* 1995;34: 1326-1335.
52. Menninger RW, Gabbard GO. The impossible dream. In: Gabbard GO, Menninger RW, eds. *Medical Marriages.* Washington, DC: American Psychiatric Press; 1988:1-9.
53. Gabbard GO, Menninger RW. The psychology of the physician. In: Gabbard GO, Menninger RW, eds. *Medical Marriages.* Washington, DC: American Psychiatric Press; 1988:23-38.
54. Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder.* New York, NY: Guilford Publications; 1993.
55. Pomerleau OF, Brady JP, eds. *Behavioral Medicine: Theory and Practice.* Baltimore, Md: Williams & Wilkins; 1979.
56. Pasnau RO, ed. *Diagnosis and Treatment of Anxiety Disorders.* Washington, DC: American Psychiatric Press; 1984.
57. Kazdin AE. *Behavior Modification in Applied Settings.* Homewood, Ill: Dorsey Press; 1975.
58. Edbril SD. Gender bias in short-term therapy: Toward a new model for working with women patients in managed care settings. *Psychotherapy.* 1994;31:601-609.