

Implementation of a Consumer-Directed Approach in Behavioral Health Care: Problems and Prospects

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Consumer-directed care, a payment system designed to make patients aware of the costs of care, requires treatment seekers to be active participants in their health care. Core components of consumer-directed care, such as higher deductibles and increased decision-making responsibilities, might preclude its easy translation from medical to behavioral health care. Aspects of behavioral disorders will force providers, insurers, and patients to compensate for unique barriers to increasing self-care, such as stigma, neuropsychological complications, and poor self-efficacy. This column describes important components of consumer-directed care and the unique barriers that behavioral health care creates for those components. Possible best practices are suggested for surmounting those barriers. (*Psychiatric Services* 58:300–302, 2007)

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Health care in the United States seems to be heading toward change, as scholars, policy makers, and members of the health care industry propose to implement consumer-directed care, a payment system designed to make patients aware of the costs of care. Because this transformation likely will include behavioral health care, it is important for proponents of consumer-directed care to consider the unique characteristics of behavioral health care that may act as barriers to the implementation of consumer-directed care. These barriers also need to be taken into account in developing, within consumer-directed care, best practices related to behavioral health care.

Consumer-directed care is designed to contain health care costs through high deductibles to constrain the use of services; consumer choice of providers, along with treatments based on effectiveness and cost; and the increased use of self-care (1). [A bibliography is available in an online supplement to this column at ps.psychiatryonline.org] In this column we describe how these three principal components of consumer-directed care—high deductibles, consumer choice, and self-care—could generate unintended negative consequences for consumers' health and the cost of

care. We suggest strategies to adapt consumer-directed care to the complicating factors of behavioral health care.

High deductibles

In managed care, consumers make small copayments that do not vary with the actual cost of different treatments. Proponents of consumer-directed care argue that this payment system causes unrestrained use of health care services because it insulates consumers from the true cost of treatment and provides no disincentive for seeking unnecessary, potentially expensive care. To minimize "overuse" of health care, proponents of consumer-directed care recommend implementing a high deductible (the amount of out-of-pocket money that plan members must spend for care) (2). The rationale is that paying out of pocket should raise consumers' awareness of health care costs, which will prompt them to purchase cost-effective treatment and avoid seeking unnecessary care.

However, high deductibles may lead to reduced treatment seeking and increased health problems. Unrestrained use of health care is not characteristic of behavioral health care. There is a gap between the number of people who need treatment for behavioral health and the number of people who receive such treatment (3). The origins of this gap include the pervasive stigma toward people with behavioral illness (such

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as believing that they should be able to deal with their problems without professional treatment), denial that one is mentally ill or that one's symptoms satisfy such a diagnosis, avoiding seeking treatment because of the symptoms or characteristics of the disorders themselves (such as motivational and cognitive effects), and forgetting or not understanding physicians' instructions regarding behavioral health treatment because of disorder-related impaired cognition.

The primary concern about implementing high deductibles for behavioral health care is that the gap between treatment need and treatment seeking might consequently expand even further. Indeed, evidence suggests that when costs for behavioral health care are raised, people tend to avoid seeking treatment. Simon and colleagues (4) found that after a health maintenance organization introduced a copayment for behavioral health care services, significantly fewer enrollees utilized behavioral health care. The cost increase affected individuals across the spectrum of disorder severity.

If the behavioral health care treatment gap were to expand because of higher deductibles, both behavioral health and physical health would potentially decline because of the common co-occurrence of behavioral and somatic diseases (5). Evidence suggests that when patients do not receive adequate care for behavioral disorders, their use of general health care increases. Conversely, appropriate treatment for behavioral disorders leads to a reduced need for general health care. Therefore, raising consumers' out-of-pocket costs for behavioral health care might not decrease health care costs overall because behavioral health care savings would be offset by increased utilization and costs of general health care.

Choosing providers and treatments by effectiveness and cost

Central to consumer-directed care is consumer choice. Proponents of consumer-directed care state that if consumers choose their own physicians and treatments on the basis of cost, quality, and effectiveness, then providers will compete with each other

for consumers' business (6). In theory, health care quality would consequently improve, and costs would decline. Proponents of consumer-directed care recognize that behavioral health care consumers need to participate in their own health care decisions because many of them have unique preferences and values regarding treatment effects, side effects, and risks. Physicians who argue that involved patients are more likely to adhere to a treatment plan bolster this sentiment.

However, lack of high-quality information and consumers' decision-making abilities may create barriers. Consumers need to have sufficient relevant and accurate information to make behavioral health care decisions. However, information on the effectiveness of behavioral health care providers and treatments remains rare, and evidence-based practices, though expanding, are not widely available. Although these and other issues concerning information are beyond the scope of this column, they need to be addressed in order to implement consumer-directed care.

Even when information is available, the impairments that are characteristic of many behavioral disorders can undermine sound decision making. For example, research has consistently found that people with schizophrenia (even when the illness is not in an active, symptomatic state) show deficits in various cognitive abilities, including the understanding, insight, and reasoning abilities required for decision making (7). These cognitive deficits and others have also been found among patients with bipolar disorder even when the patient is between affective episodes (7), major depression, and substance use disorders. Moreover, even when behavioral health care patients with intact decision-making capacities can access and understand information about treatment alternatives, they might lack the motivation to finalize difficult decisions that have potentially far-reaching consequences.

Increased self-care

Consumer-directed care also emphasizes self-care, or patients' promotion of their own health through everyday

behavior. Self-care includes implementing healthy lifestyle choices—such as adopting a healthy diet, exercising, and avoiding smoking—and managing specific chronic illnesses, such as diabetes or bipolar disorder. Proponents of consumer-directed care anticipate that self-care will expand because increased out-of-pocket costs will motivate consumers to take more responsibility for their own health care. They also anticipate that this shift in the burden of care will reduce reliance on professional health services.

However, some behavioral health characteristics may impede self-care. The same barriers that adversely affect treatment seeking and the utilization of behavioral health care services, including cultural variables and functional impairments, also undermine self-care. People with behavioral disorders often blame themselves for their problems and feel ashamed because of the public's negative attitudes toward mental illness. Many then internalize these attitudes. Shame and self-blame can reduce self-efficacy—or the confidence to carry out actions to achieve desired results—which in turn can undermine patients' ability to self-manage their disorders (8).

Patients' lack of understanding about the nature of behavioral disorders and their treatment also has the potential to sabotage patients' capacity to self-manage their illness. A dramatic example is the disturbingly low rate at which patients with depression adhere to prescribed medication regimens (9). Finally, many of the neuropsychological manifestations of behavioral disorders that impair treatment seeking and treatment-related decision making can also act as barriers to self-management. For example, persons with behavioral disorders often experience low motivation and a sense of hopelessness. These factors, in addition to memory and decision-making impairments, compound the stigma-related obstacles to effective self-care.

Discussion

Our examination revealed that we cannot assume that consumer-directed care reforms that target somatic

care will translate easily to behavioral health care. Patients who utilize behavioral health care treatment face unique barriers that complicate the implementation of the core features of consumer-directed care. Nevertheless, some aspects of consumer-directed care are compelling, such as promoting self-care and providing information about treatment options for people who are willing and able to use it, as well as providing quality improvement information related to treatments and providers. Practitioners, health researchers, insurers, and consumer advocacy groups should work together to determine the best way to minimize the impact of barriers and thereby achieve the benefits of patient-centered care. Failure to consider these barriers could exacerbate existing problems and perhaps create new ones for the entire health care delivery system. These barriers also need to be taken into account in formulating best practices for consumer-directed care.

Although an extensive discussion of how to address these barriers is beyond the scope of this column, we mention a few possibilities. One would be to lower financial barriers to initiating or continuing behavioral health care. Another would be to increase the utilization of evidence-based practices. Research is desperately needed on the effectiveness of less costly behavioral health treatment solutions, such as Internet-based self-help tools and teletherapy.

If the effort to promote self-care is comprehensive enough to take into account the needs of patients with motivational and cognitive impairments, the self-care component of consumer-directed care could be used to benefit behavioral health care consumers. For example, health insurance companies or provider organizations

might generate both more and more easily accessible self-care training programs that encompass all aspects of self-management, including teaching patients how to monitor their symptoms, reduce stress, use community resources, cope with their symptoms, and communicate with their doctors (8).

In this context, the chronic care model (see www.improvingchroniccare.org) provides useful insights for developing within behavioral health care a more collaborative, information-driven relationship between patients and physicians. In much the same spirit, Deegan and Drake (10) have argued in the pages of this journal that pharmacotherapy is a “dynamic journey” that demands the partnership of the client and the practitioner in shared decision making.

It is also worth considering whether the care coordinator role in the primary care model could be adapted for use in behavioral health care. Finally, new ways of facilitating behavioral health care, such as public outreach, consumer education campaigns, proactive screening for early identification, and the utilization of paraprofessionals such as “health coaches” for lifestyle modification (11), hold promise for changing the negative attitudes regarding behavioral health.

The lessons learned from the managed care “backlash” of the 1990s—concerning service access, quality, and member satisfaction—are equally relevant to consumer-directed care. Collectively, the long-term success or failure of consumer-directed care will depend on its impact on health care costs and on the outcomes for all consumers of health care services.

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