
Real World Resource Allocation: The Concept of "Good-Enough" Psychotherapy

by James E. Sabin and Carlos Neu

Principles can be established within a managed care plan to assist clinicians in managing resources. The concept of "good enough psychotherapy" is illustrated as a principle by which resources in a managed mental health program can be allocated in an ethically justifiable manner.

Discussions of health care reform often invoke the concept of a basic level of health care which society should provide to all, as by specifying a minimum set of health services that all insurance plans would be required to include. Presumably individuals would be entitled to purchase a richer array of health services on their own, but society would guarantee universal access to the basic package.

We believe that society — through a form of public dialogue and legislative process that has thus far occurred only in Oregon (Pollack et al. 1994) — should decide how much social resource to expend on health care and the broad outlines of what the priorities should be within health care. Although health professionals acting alone should not arrogate this public responsibility to themselves, testimony from front line clinical practice is clearly a crucial ingredient for an informed social debate.

This paper addresses the complex and controversial issue of defining the level of health care society should guarantee to all from the perspective of practicing clinicians. The authors — psychiatrists with a combined thirty-seven years of practice in managed care and who are actively involved with medical ethics and managed care policy — have attempted to formulate practical guidelines for the allocation of resources within the domain of psychotherapy on the basis of our own clinical experience in a health

maintenance organization.

In the context of this issue of *Bioethics Forum*, our reflections on one domain of health care (mental disorders) and a particular form of treatment (psychotherapy) should be regarded as an example of the kind of reflection about resource allocation that needs to occur across the spectrum of managed care practice. Psychotherapy is an especially useful testing ground for the study of resource allocation. While a surgical procedure or MRI either is or is not allocated, psychotherapy can be offered on a continuum ranging from single sessions to five times a week psychoanalysis over the course of many years. As a result, resource allocation decisions about psychotherapy are often not a matter of "yes" versus "no" as much as a question of "how much and for what reason?"

For us as clinicians, the question of defining the boundaries of "basic psychotherapeutic health care" is highly personal. We have to be able to face patients, their families, and ourselves and answer the question of whether the limits we

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propose in practice are consistent with our moral commitment to patients and our sense of professional integrity.

With regard to psychotherapy services, D. W. Winnicott's concept of "good-enough mothering" provides a useful starting point for considering what basic health care should include (Winnicott 1965). In his effort to understand the infant's progress towards what he calls ego integration or the formation of a true self, Winnicott argues that mothering need not be perfect to foster a healthy developmental process — it must be "good-enough." In Winnicott's view the mother cannot *create* the desirable state of ego integration; that depends on the infant's innate capacities and the many vicissitudes of environment and opportunity. Good-enough mothering, however, allows the infant to set off on this journey.

Drawing on Winnicott's framework and our own experience in managed care practice, we believe that basic health care should offer "good-enough psychotherapy," which we define as psychotherapeutic intervention that allows patients to return to their own developmental paths. Here are five clinical principles that begin to define our view of the essence of "good-enough psychotherapy." To make these principles practical we state them as assertions about what we believe basic health insurance in a first world economy should cover.

1. Clinicians are "caretakers," not "gate-keepers."

Psychotherapy can be helpful in many circumstances. Basic health insurance, however, is responsible for covering only those psychotherapy services that are directed to treatment of suffering and dysfunction arising from mental disorders (Sabin and Daniels 1994). A basic health care package, however, should allow mental health clinicians to help patients *clarify* the nature of the problem for which they are seeking services and *identify* what kinds of interventions might be helpful to them, whether or not the desired interventions would receive coverage under the basic insurance package.

Although this activity is often called "gate keeping," we must teach clinicians to conduct it as a form of "caretaking," and structure insurance programs to allow them to do so. If a patient's suffering or dysfunction will not receive insurance coverage because it does not arise from a mental disorder, an ethical or just managed care program would ask the clinician to advise the

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patient on alternative directions to take (that is, identifying other gates through which the patient can pass) not simply to send the patient away (i.e., closing the gate).

In practical terms we believe that in order to provide good-enough psychotherapy, a basic insurance package should allow — without utilization review — at least five sessions for evaluation of the patient's problem and collaborative planning for what can be done about it. In research contexts a single structured interview can often ascertain whether a mental disorder is present. Real clinical situations, however, are often ambiguous and need to be revisited for proper assessment and planning.

A managed care system that simply tells would-be patients that they are not eligible for services is being managed too tightly to be "good-enough." The following case example shows how a clinician can act as a caretaker — not simply a gate keeper — even when the insurance will not cover potentially beneficial treatment.

Case Example

Mr. Adams was referred to Dr. Jones for

depression. Evaluation (two sessions) showed that he did not have a depressive illness but was intensely unhappy in his marriage. His wife attended the third appointment, which deepened their understanding of the nature of the marital conflict and confirmed that, while Mr. and Mrs. Adams were both chronically angry and unhappy, neither was suffering from a psychiatric illness. Dr. Jones explained that marital discord did not constitute a psychiatric disorder, and while couples counseling might well be helpful, it would not be paid for by their insurance. He told them about marital communication and enrichment programs sponsored by local religious organizations and gave a list of self-help books that could be consulted. He set a fourth appointment one month later to review what they had done with the different options but the couple canceled it, explaining that they were planning to participate in a program sponsored by their church and thanking Dr. Jones for his help.

2. The "short-term" fallacy

In ethical managed care programs, clinicians attempt to achieve the agreed upon outcomes in the least costly manner that can reasonably be expected to attain the result. In psychotherapy this often involves coaching the patient about constructive steps that can be taken outside the office and then reviewing the results and planning next steps — a clinical version of the quality improvement cycle — rather than locating the therapeutic process ("working through" the problems) within the patient-therapist interaction (Sabin 1995). Although this way of conducting psychotherapy often does not require large numbers of appointments, it may require months and years for taking trial actions and reviewing results.

In other words, many psychotherapeutic outcomes can be achieved with relatively little resource use ("time efficient") but not rapidly ("short term"). While there is ample outcome data demonstrating that intensive psychotherapy

(once or twice weekly for months or years) is an effective mode of treatment for many conditions, there is essentially no evidence showing it to be superior to responsibly conducted "time-efficient" psychotherapy. Given this circumstance, we are comfortable proposing intermittent appointments to our patients even if the patient would prefer more frequent psychotherapy visits and the community standard in the fee-for-service sector would favor higher intensity treatment.

It is entirely reasonable for a state (for example, Oregon), a nation (for example, Canada), or a managed care program to place limits on the amount of resource available for achieving clinical outcomes, but there is no clinical or ethical rationale for limiting psychotherapy to "short-term" forms. When a managed care system is clear and honest about its commitment to using resources efficiently on behalf of the population it serves, it will not place arbitrary limits on the calendar time during which the psychotherapy must be completed. The following case example shows how this clinical approach can be presented to the patient in an honest and open manner.

Case Example

(adapted from Sabin 1992)

Mr. Bradley, a fifty-five-year-old married father of three, was forced to join an HMO when his employer changed insurers. He arrived at Dr. Jones's office in a highly argumentative mood, saying "I need long-term therapy! I need to see a doctor — not a social worker! You guys are just trying to save money!"

Dr. Jones asked Mr. Bradley what he felt he needed, what "long-term therapy" meant to him, and why he wanted to see a doctor. Mr. Bradley correctly believed that his problems were chronic and would require ongoing management, and he wondered if his irritable and depressive moods might represent a "chemical imbalance." He was partly mollified by being told that the treatment would indeed be open ended, but on hearing the

proposal for sessions only every four-to-six weeks he objected because "I can't believe I will get better as well that way than if we met every week."

Dr. Jones explained that while the public generally thinks of psychotherapy as weekly or even more frequent, and while much of the professional community locally agreed with that view, outcome research does not answer the question and that his own experience suggested that they could achieve their objectives in the plan he was proposing. He acknowledged that the HMO did indeed try to save money where possible, which was then available for other aspects of care.

Ten years later Mr. Bradley was still meeting with Dr. Jones every two-to-four months to review and revise coping strategies. At times the treatment included antidepressant and anxiolytic medication. While Mr. Bradley joked about the infrequent appointments he agreed that the "time-efficient" approach was achieving the objectives he and Dr. Jones had established.

3. Measurable function is important but should not be overemphasized.

As long as treatment is 1) directed to alleviating the negative impact of a mental disorder, 2) has a reasonable chance of attaining the desired outcome (cure or adaptation), and 3) is planned in the most cost effective manner, there is no principled justification for covering psychotherapy only when objectively measurable dysfunction (poor work performance, social isolation, and so on) is present. Assessing psychotherapy by monitoring changes in function is important, but the patient's suffering matters too. This is clearest in depression where some patients are able to function well by most criteria but suffer significant inner misery, sometimes to the point of suicidality.

Paradoxically, a basic insurance package will have adequate resources to allow clinicians to say

"yes" to this broad range of treatment goals only if they are prepared to say "no" to insurance-covered treatment for suffering and dysfunction that arise from causes other than mental disorder. Poverty, discrimination, poor education, bad choices, and simply expecting too much from life produce suffering and dysfunction, but alleviation of these evils is not the province of health insurance, *even if psychotherapy might help.*

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The following example illustrates appropriate prescription of psychotherapy despite the patient's excellent level of function.

Case Example

Ms. Carlyle performed well at work and in her active social life. However, she was persistently unhappy and contemplated suicide. Diagnostically her condition met criteria for depression. Trials of several antidepressant medications were not helpful. In the course of long-term, time-effective psychotherapy (eight-to-fourteen appointments per year for four years), her condition gradually improved.

4. Efficiency, empathy and utilization review

In our practices we have found that patients are generally prepared to work on limited goals via efficient techniques if the clinician is able to create a strong caretaking bond between them (Sabin 1992). This can only be accomplished if the clinician is able to make reliable commitments. Thus while ethical managed care systems are appropriately concerned with limiting expenditures, they will express this concern by establishing a culture that understands, accepts, and uses

cost-effective modes of treatment, not through micromanagement techniques like only approving treatment in small dollops (three sessions at a time).

It is one thing for the therapist to use a clinical technique involving recurrent short-term contracts to achieve specific goals, and another for the therapist not to be empowered to negotiate a treatment plan with the patient. The following case example illustrates that time-efficient forms of treatment can be "good enough" treatment, even for patients with serious illnesses when conditions of trust can be established.

Case Example

Ms. Dunlap, a thirty-five-year-old married woman, suffered from a severe bipolar disorder moderately well controlled by medication. Psychotherapy clearly supported constructive self-management and morale. She intermittently checked whether there was any limit on how long she could see Dr. Jones, explaining that she felt he understood her, the illness, and the circumstances of her life. Each time Dr. Jones answered that there was no arbitrary time limit, Ms. Dunlap commented "as long as I can count on that I really don't need to see you too often."

5. When is "personality" an appropriate target for treatment?

In our practices, the most difficult and controversial clinical decisions about allocating psychotherapy involve what the most widely used diagnostic system (American Psychiatric Association 1994) calls "Personality Disorders," which include people who are suspicious ("Paranoid Personality Disorder"), shy ("Avoidant Personality Disorder"), selfish and self-centered ("Narcissistic Personality Disorder"), and volatile ("Histrionic Personality Disorder"). There are at least three major sources of controversy. First, it is often difficult to make reliable distinctions between "disordered" personalities and "difficult" or "problematic" personalities. Second, even when a patient's situation clearly fits the criteria for diagnosing a

personality disorder, the public (including insurers, employers and benefit managers) is unsettled about whether these conditions should be ministered to by collective funds. Individuals with personality disorders do not appear ill in the same way that someone with schizophrenia or major depression does, and the public often recommends aphorism-driven approaches (for example, "pull up your socks" and "don't make a mountain out of a molehill") and applies terms of stigma (for example, "worried well" and "Woody Allen syndrome"). Finally, the treatment most commonly recommended by contemporary community standards is intensive psychotherapy, so relatively costly treatment is at stake.

Practicing as we do in an HMO system in which the group practice manages resource allocation (with oversight from a board of directors that includes members of the HMO), we have had to allocate psychotherapy for personality disorders without being able to wait for the empirical, philosophical, or social stigma questions to be resolved, or for randomized controlled trials of different treatment approaches that would provide definitive data on effectiveness. Reflecting on our own practice and that of our colleagues, we discern several practical guides by which psychotherapy resources have actually been allocated.

First, there is no principled basis for categorically excluding personality disorders from insurance coverage. Personality disorders often cause substantial dysfunction and suffering. Treatment of these disorders cannot simply be dismissed as "trivial," "elective," or not "medically necessary." Further, personality disorders often exacerbate other psychiatric and medical conditions, so it may be economically unwise as well as ethically misguided to preclude psychotherapeutic treatment. A system that excludes treatment of personality disorders is not "good enough."

Second, the real-world alternative to rigorously managed treatment for personality disorders is not more intensive (unmanaged) treatment, but no insurance coverage at all. Given this situation, it seems justifiable to recommend time-efficient

forms of individual and group treatment, rather than accept (on the basis of belief but not adequate outcome data), the need for costly forms of intensive psychotherapy.

Finally, among the personality disorders we have given higher priority to conditions with extensive subjective suffering and dysfunction and those with significant implications for other health expenditures. Beyond these unsurprising criteria for allocation, we discern a final "rule of thumb" we have used to determine the boundaries of "good-enough" psychotherapeutic treatment. We present it here to foster reflection and debate and not as a validated clinical or ethical guide.

The effectiveness of psychotherapy depends to a significant degree on what is called the "therapeutic alliance" between clinician and patient. Clinical training appropriately emphasizes the clinician's role in cultivating this collaborative bond. In making resource allocation decisions for psychotherapy, however, we have found ourselves emphasizing the patient's role as well. When patients make active efforts to produce the desired outcomes in the treatment of a personality disorder — as by participating in pertinent twelve-step or other self-help programs and carrying out "homework" assignments that we have recommended — we are more inclined to allocate psychotherapy (our own time) than when the patient appears to be giving us full responsibility for achieving the results. In a context of limited resources, when the patient's demonstrated motivation for change appears low, we believe that withholding psychotherapy for the present and reevaluating at some time in the future is consistent with provision of "good-enough" care, as illustrated in the following case example.

Case Example

Ms. Evans had tested the patience of many clinicians. She had been diagnosed as having Borderline Personality Disorder with possible Post Traumatic Stress Disorder, and had been admitted to the hospital many times. Individual and group psychotherapy, a wide range of

medications, and electroconvulsive therapy had been provided. Notwithstanding the extensive interventions, Ms. Evans continued on a persistently unhappy and self-destructive path. Her caretakers convened a meeting — at which the patient was present — of all the clinicians involved in her care.

The team concluded that while Ms. Evans clearly suffered from a serious disorder, she was not actively participating in the multiplicity of treatments that were being offered, and to continue to offer active treatment would falsely imply that she could improve without active effort on her part.

The team offered intermittent contact to assess how Ms. Evans was coping with the chronic disorder and whether any new motivational energy and possibility for treatment had appeared. The team believed that attentive waiting was good enough treatment in the particular circumstances. After a year Ms. Evans and her team developed a new plan, which over time led to substantial improvement.

Patients who join the clinician in collaborative responsibility for achieving therapeutic results receive higher priority than those who do so less.

Conclusion

Our reflection on clinical practice in a system that relies on clinicians in a large group practice to determine "medical necessity" within the context of a defined budget suggests that a clinically coherent and ethically defensible set of practical principles can be discerned in the ways in which psychotherapy services are actually allocated.

We have had the good fortune to practice in a managed care environment dedicated to high quality cost-effective care. Our HMO expects clinicians to embrace the traditional fiduciary commitment to their individual patients and a stewardship commitment towards the interests of the entire HMO membership (Sabin 1994). In this setting, clinicians appear to practice in accord with D. W. Winnicott's conception of "good-enough mothering." Resources for psychotherapy appear to have been allocated to achieve "good-enough" results for the population served by the HMO, not the fullest results imaginable for each individual member of that population. In the HMO system, patients whose dysfunction and subjective suffering are the most extensive and those whose mental disorder intensifies other medical and psychiatric conditions receive higher priority. Patients who join the clinician in collaborative responsibility for achieving therapeutic results receive higher priority than those who do so less.

We agree with Boyle that the concept of managing the care of individual patients within the context of a budgeted system responsible for the care of a population is at least as ethical as the former fee-for-service system (Boyle and Callahan 1995). The current American health care system consists of competing health care organizations. Each manages care within the context of its own resources in accord with its own values and interpretation of clinical evidence.

We recommend that each entity create ways for clinicians and members to shape a philosophy of resource allocation and study how it works when put into practice. We envision clinicians bringing to the table questions arising from the kind of observations on which this paper is based. How

much should patients' efforts on their own behalf be considered in allocating scarce resources? How much should we emphasize objectively measurable dysfunction as opposed to subjective suffering? If a system dominated by competing managed care organizations is to be ethically viable and politically acceptable, we will need to devote much energy to discussions of this sort in the years to come.

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Dr. Sabin wishes to thank the Harvard Pilgrim Health Care Foundation for its generous support.