Strangers In The Night: Research And Managed Mental Health Care

Is good research good if it does not inform policy and practice?

by Saul Feldman

Like strangers in the night, dimly aware of each other’s presence, health services researchers and managed mental health organizations have been exchanging glances but not much more. As a result, research findings have had only a negligible effect on managed mental health care. This is not to suggest that clinical practice—what clinicians actually do when they work with patients—has been unaffected by new knowledge, some of which does stem from research. The development of psychoactive drugs, the National Institute of Mental Health (NIMH)—funded studies on the treatment of depression, and, more recently, the research-based practice guidelines, are three such examples.

However, the dominant changes in the way mental health services are provided and paid for that developed in the latter half of the twentieth century (community mental health care and managed care) were not the products of or particularly influenced by research findings. Rather, they came about much more as the result of economic and social factors in the larger society of which mental health services are a part.

When, for example, the idea of community mental health centers was gaining momentum in the early 1960s, fostered by the plight of the state mental hospitals, serious consideration was given to first developing a pilot that would evaluate whether and to what extent such a program would work. Although rational and attractive, this idea was abandoned for what appeared to be compelling reasons: It would take too long and thus risk a change in the legislative and executive climate that at the time appeared highly favorable to the passage of major federal mental health legislation.

There was also considerable doubt about the value of such research, about whether enough would be learned to make the delay worthwhile. Of course, health services research was much less well developed then than it is today. A great deal of evaluation research on community mental health centers was done, but much later and far removed from the initial policy-making process. By and large, the research results were used to help justify policy decisions already made, to sustain the program, and to meet the needs of the powerful advocacy groups that had coalesced around it.

Similarly, but in the private sector, managed mental health care came into being with little, if any, research base (with the exception, perhaps, of what had been done in managed medical care). It was an attempt to fix what appeared to be a major and rapidly growing problem: the escalating costs and questionable quality of mental health services.

Saul Feldman is chairman and chief executive officer of United Behavioral Health, a national managed behavioral health organization headquartered in San Francisco. Earlier in his career he served as an executive at the National Institute of Mental Health, where he headed the Staff College as well as the national community mental health and applied services research programs. Feldman is the founding editor of Administration and Policy in Mental Health and holds a doctoral degree in public administration from New York University.
in the 1980s. The costs were in good measure the result of another change that had no empirical base: the rapid growth of private for-profit psychiatric hospitals. Because of what appeared to be the economic success that managed care was having in general medicine, the belief (or, perhaps more accurately, the hope) was that similar results could be attained in mental health.

Still Strangers

So, like other major changes in mental health policy and services, managed mental health care began and grew up with little or no empirical base. It of course takes time for research to be sufficient in magnitude to inform practice, but some twelve years later managed mental health organizations and health services researchers are still strangers in a relationship that has never really been consummated—this, despite the fact that these organizations now influence the way more than 100 million Americans get their mental health care. This is not to suggest that no progress has been made. Research findings on such factors as access, utilization patterns, and costs have helped policymakers, consultants, and purchasers to better understand the effects of managed mental health care. Also, the pace of such research has quickened. But there has been little effort to look at the extent to which the changes that have taken place were influenced by how managed mental health organizations actually operate, how they manage the benefits and care for which they are responsible, what they do well, and what they could be doing better.

Some Collaborative Research

The major managed mental health organizations do have an internal research capability, but its magnitude and quality vary considerably. More accurately described as analysis rather than formal research, it is used to develop organizational policy and modify operations. Work is being done in conjunction with outside researchers, some of which has been published—for example, research on Massachusetts's managed mental health program.

At United Behavioral Health we encourage outside researchers, who, using our vast database, work with the staff researchers in our behavioral health sciences department. Such research, some already completed and published and some under way, is the result of our work with RAND/University of California, Los Angeles (UCLA), the Harvard Medical School, the University of Oregon Health Sciences Center, the American Psychiatric Association, and the researchers on our Board of Scientific Advisors. This collaboration has resulted in the publication of six articles, with several others in press. We have no veto power either on the results or on whether and where the research will be published. The subjects include utilization patterns, the effects of parity behavioral health benefits on costs in a managed care environment, and the relative value of integrated versus split treatment for depression.

Our internal research covers two broad areas: studies that are specific to the needs and interests of our customers (for example, medical cost offset and psychiatric disability), and those that deal with organizational policy, quality, and the like (for example, patient outcomes, the clinical effects of best practices, medication management, rehospitalization, and quality of care in child/adolescent residential treatment).

Relevance Gap

Why has health services research had so little effect on the work that managed mental health care organizations do and the policies under which they do it? Why do the people in these organizations continue to learn essentially from their own experience? Why have patients whose care is managed benefited only slightly, if at all, from research findings on the quality and effectiveness of that care? It is these and other questions that the Cosmos Colloquium (so named because it was held at the Cosmos Club in Washington, D.C., in January 1999) began to address and hopes to clarify if not resolve. The meeting, the first of a
series, brought together a group of top clinician-administrators in managed mental health organizations, health services researchers who have published in the field, and representatives of organizations that make research policy and fund such research. An annotated bibliography of the empirically based research published in the past four years was prepared for the meeting. The bibliography has ninety entries—not a huge amount, but substantial.

The emphasis at the first meeting was on the managed mental health clinician-administrator (from five major managed behavioral health organizations), particularly on what they feel is the “goodness of fit” between the published research and their own performance and/or that of their organizations. Their comments were not encouraging. They believe that there is a substantial “relevance gap” between the published research and the “real world” in which they work. The published studies in the bibliography tend to validate this belief. Painfully few of those studies have much to do with how managed mental health organizations actually operate, what they do and how they could do it better, the differential effects of the ways in which they actually manage care, their use of information and clinical protocols, the determinants of access, how managed mental health services affect particular diagnostic groups, how and to what extent financial and other factors influence the work of their network providers, quality management, best practices—and the list goes on. These are among the major factors that really determine the value and effects of managed mental health care for patients.

This is not to question the quality of the research, simply its relevance. Considering the influence that managed mental health organizations have on care in this country, this is not a small problem, particularly if one believes that health services research, properly targeted, can make a major contribution to the quality and efficacy of mental health care.

**Barriers To Change**

The relevance problem persists because the three major parties to the research/services conundrum permit it to. Without intent, they are locked into a circular, self-reinforcing process that resists change. Managed mental health organizations, for example, are not yet convinced that health services research has much to offer them. They have not aggressively reached out to health services researchers to make their extensive patient databases more available. Nor are they convinced that research results would enhance the quality of what they do, their growth, or their competitiveness. They also may be concerned that published research about such factors as access, quality, and utilization could be useful to their competitors. This is not unreasonable given the fact that researchers require (as they should) that there be no restrictions imposed on them that would affect their findings or limit publication of their research.

As for the researchers (still relatively few in number but more numerous than in the past), what they decide to study is influenced by their own interests, the availability of data, what they feel capable of doing, and the policies and priorities of their potential funders. Primarily based in academe, they have had little direct interaction with managed mental health organizations and thus do not understand the world in which these organizations operate. As the number of entries in the bibliography suggests, researchers have not neglected managed mental health services research, but the topics they have studied do not appear to be those that are important to managed mental health organizations.

Those that fund health services research,
thereby establishing research policy and influencing what and how much is done, include the federal government (the major source of such funds) and foundations. Like the researchers, they, too, have been detached from the work of managed mental health organizations. The research that they fund depends upon priorities that may be set for them “from above”—on the interests of their staffs, on the views of advocacy groups, on unsolicited proposals, and on their research review committees. The grant process, from submission through review to final action, is too slow and cumbersome. The strong bias of the review committees toward methodological purity, even to the detriment of utility, contributes to the relevance problem. And so the funded studies, meticulously done by well-respected researchers and methodologically correct, qualify for publication in journals that, by and large, are read by other researchers, not by those with power over who gets what kind of mental health services.

The Iron Triangle

How methodologically correct must health services research be to be useful? Which is the greater hazard—methodologically excellent research not read or used by those who influence services, or the implementation of research findings more relevant but less methodologically sound that could turn out to be misleading? Where should the line between relevance and research design be drawn, if it has to be drawn at all? Is good research really good if it does not inform policy and practice? Do we need a new definition of good, and, if so, how should it be determined? Can we find a way to do excellent research that is also accessible and useful?

A research version of the “iron triangle” may be at work here. Traditionally used to describe the legislative process, the triangle is made up of forces with a strong commonality of interest that, when working together, exert enormous power over what gets done and how quickly. The enactment, for example, of the major federal mental health legislation in this country—the National Mental Health and Community Mental Health Centers Acts, as well as the appropriations required for them—would not have been possible without a well-constructed and powerful version of the iron triangle. Involved at each point in the process were the Public Health Service/NIMH, the responsible congressional sub-committees, and outside advocacy groups. And so it may be with research. Without the intent to do so, researchers, funders and their review groups, and the journals that publish mental health research findings resemble the legislative iron triangle. It strongly influences what research is done, who does it, what gets published, and where.

If change is to take place, managed mental health organizations, researchers, and funders will need to develop a greater interest in each other and a better way to communicate. Otherwise, the process through which research is conceived and implemented will continue to inhibit progress. The disconnect between health services researchers and managed mental health care is not caused by anyone’s lack of expertise or desire to do good and useful work. There are no villains here, no intent to dissemble. Nonetheless, the behavior of all of the parties to the process has resulted in a process more insular and less effective than any of them wishes it to be.

NOTES

3. Copies can be obtained by writing to the author at United Behavioral Health, Twenty-seventh Floor, 425 Market Street, San Francisco, California 94105.