PART II

THE SOURCEBOOK

FOR

THE SECOND NATIONAL CONFERENCE ON MASTER'S TRAINING IN PSYCHOLOGY:

"MASTERS IN PSYCHOLOGY ACTION FOR THE PUBLIC INTEREST"

Sponsored by:

The Council of Applied Master's Programs in Psychology (CAMPP)

Co-sponsored by:

The Northamerican Association for Master's in Psychology (NAMP)

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PREAMBLE

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Four years ago, members of CAMPP institutions and others met in Norman, Oklahoma, for the First National Conference on Applied Master's Training in Psychology. This was the first conference on master's issues in psychology to be organized and attended by those who provide that training. The Conference was a direct response to the need for consensus about standards of quality for training master's-level practitioners in clinical, community, counseling, industrial, and other fields of psychology. Such standards did not exist because of the failure of organized psychology to acknowledge and address the role of the master's practitioner in a way which dealt with the realities of the needs of society, educational systems, and potential students.

The First National Conference took major strides in advocacy for master's training. The Conference produced standards for curricula in applied master's programs and statements of the competencies expected of graduates of these programs ("Resolutions and Standards," 1990). In addition, conferees agreed to examine the issues of accreditation for master's programs and licensure for master's graduates, and to work toward the adoption of an appropriate title to identify master's graduates in psychology. The need for a "professional home" in psychological organizations was identified, as well as the need for more reliable data on programs, graduates, and their work.

Some progress has been made on these issues since the First National Conference. The Conference curriculum standards have been adopted by the Council of Applied Master's Programs in Psychology (CAMPP) as its criterion for full membership. These standards have been used by institutions seeking to initiate applied master's programs or to improve existing ones. The standards have also been incorporated into credentialing legislation in at least one state (Vermont, "An Act," 1994). The Society for Industrial and Organizational Psychology (SIOP) has developed standards for education and training which are complementary to its doctoral training standards, and which are the first master's training standards in a specialty area of psychology (SIOP. 1994).

The description of graduates' competencies has been used by programs to evaluate the success of their training. Accreditation is being addressed by a newly formed organization, the Northamerican Association for Master's in Psychology (NAMP), which has emerged as one professional home for master's practitioners and with CAMPP is co-sponsoring this Second National Conference. Information

on licensure in various states has been collected but because it is diverse, constantly subject to change as a result of political forces within the states, and directly relevant to employment, this continues to be an area of serious concern for master's training programs. Additional data are now available as a result of the survey of master's graduates in various specialty areas by the Office of Demographic, Employment, and Educational Research (ODEER) at APA (ODEER, 1994). In the four years since the First National Conference, the employment environment for psychologists has changed and much remains to be done to identify and develop viable roles for master's practitioners in the health care delivery system and work organizations of the future. The Second National Conference is being convened to address this need for "action for the public interest".

The agenda for this Conference reflects this action orientation toward the future. We stress understanding the future educational and employment contexts for master's psychologists. We advocate for the CAMPP model of training which provides a clear psychological foundation for practice. We address program accreditation, practitioner licensing, and the need for a recognizable title to designate the master's-level psychological practitioner. We seek to chart a course for psychological practice for master's graduates which responds to our dynamic societal and professional environonment. Three relevant forces in this environment are the research needs identified by the APS/APA Human Capital Initiative, the posture of other psychological organizations toward master's practitioners, and the changing environment for the delivery of mental health services. We will also identify roles for master's graduates that suit the changing demographic make-up of our society, the concern for health and wellness, and the likely nature of the workplaces of the future.

This is an ambitious agenda for action. To be successful, we must be well informed, united in our advocacy, and creative in our approaches to the problems and opportunities of the future. These concerns have guided your Planning Committee in designing a conference to forge a clear future for Master's in Psychology: Action for the Public Interest.

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THE CAMPP MODEL: REAFFIRMING THE PSYCHOLOGICAL BASIS OF TRAINING

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The Council of Applied Master's Programs in Psychology (CAMPP) was established in 1986. The organization emerged from discussions among the members of the Association of Heads of Departments of Psychology (AHDP) in the Southeastern Psychological Association (SEPA) region and at the annual meetings of the Council of Graduate Departments of Psychology (COGDOP). From these discussions, it became clear that there was no organized voice to speak on behalf of graduate education and training in applied master's programs in psychology and to serve as a focal point for discussions on issues involved in such training. As a result of these discussions, CAMPP was formed in the SEPA region in 1986 and expanded from this region to include programs across the nation in 1987.

From its inception, CAMPP developed guidelines for applied master's training which were used as the criteria for membership in CAMPP. These initial guidelines evolved from the discussions among those providing applied master's training in the SEPA region. These guidelines recognized that a distinctive feature of the discipline of psychology is a long history of research which has produced a substantial body of literature and major theories on fundamental processes of behavior. Other disciplines (e.g. management, social work, nursing) who train individuals for applied work may borrow extensively from psychology and other fields which have produced this theory and empirical data base and may attempt to fit these theories and data to their specific problems. Individuals with training in psychology can apply these principles directly. A fundamental characteristic of the initial guidelines was the recognition that individuals who attempt to solve applied problems without reference to these foundational methods, data and theories risk accumulating a "bag of tricks" which may or may not be reliable in producing the desired outcomes and which do not form a coherent framework for future action regarding new problems.

In 1990, CAMPP organized and sponsored the First National Conference on Applied Master's Training in Psychology at Norman, Oklahoma. Among the purposes of this conference was to consider the guidelines originally developed by the committee which organized CAMPP in the SEPA region from a national perspective. The 1990 conference included individuals who were involved in master's education and training from across the nation. After considerable discussion, these guidelines were modified to reflect the collective wisdom of these representatives. These revised guidelines established that a master's degree in applied psychology should normally require 40-45 semester hours of study in psychology. This program of

study was to include an assessment of competence in general/theoretical psychology including the biological, acquired, social and individual bases of behavior. In addition, students were required to develop competence in statistics or the research methods used in acquiring knowledge in the discipline. Competence in research methods and the foundational areas is to be combined with applied training, including courses and supervised experience in the application of psychological principles and theories, competence in ethical and professional standards, and sensitivity to social and cultural diversity.

Thus, education and training in applied psychology are combined with work in the products of basic research and the methods of that research. This approach is reminiscent of the Boulder Model in doctoral education and training. The Boulder Model espoused the goal of developing graduates who were trained as competent scientists who applied their science to the practice of psychology. The CAMPP guidelines also promote a view that graduates should have basic competence in the science of the discipline as well as in the applications. While the CAMPP guidelines do not require that graduates become competent scientists, the guidelines do stress the importance of the linkage between the science and the systematic application of psychology. This linkage helps prevent an applied field which consists of a simple "bag of tricks", but instead is enriched by important conceptual linkages to others who do not do applied work as well as to those who attempt to apply psychology to other kinds of problems in a wide array of settings. The CAMPP standards adopted by the 1990 conference are provided below.

GENERAL STANDARDS OF EDUCATION AND TRAINING

I. The program should be identifiable as a psychology program. This is to be defined primarily in terms of the disciplinary affiliations of those who teach in and administer the program.

II. The program and its curriculum should have a coherent organization and structure that reflects its mission statement.

III. The program should be the equivalent of two academic years of full-time study. This would normally include 40-45 semester hours, or the equivalent, of program requirements.

IV. The program must include evidence of competence in the following areas:

A. A base of general/theoretical psychology to include the following:

1. **Biological bases of behavior (to the degree that it is appropriate for the subdiscipline)**
2. **Acquired or learned bases of behavior**
3. **Social/cultural bases of behavior**
4. **Individual or unique bases of behavior**

B. **Understanding of the methods of acquiring knowledge in the discipline. This could include study in research design, statistical procedures, hypothesis generation and testing, and critical thinking. At a minimum, there should be one course in statistics and/or research design.**

C. **Applied Psychology**

1. **Coursework in the theory and applications of psychological principles and theories appropriate to the discipline**
2. **Significant supervised experience appropriate to the subdiscipline and the mission of the program**
3. **Ethical and professional standards**
4. **Sensitivity to social and cultural diversity, resulting in appropriate assessment and intervention strategies and other professional behaviors**

D. **Entrance requirements for the applied master's program in psychology should reflect the responsibility that the program has to the public. Efforts should be made to ensure that admitted students have the intellectual and personal capabilities of becoming competent professionals in the subdiscipline.**

E. **Students will demonstrate competence and professional behavior consistent with each program's mission statement and goals prior to the completion of the program.**

F. **The program will have a sufficient number of appropriately trained faculty to accommodate the labor-intensive nature of teaching the skills of applied psychology.**

PROGRAM ACCREDITATION AND INDIVIDUAL CERTIFICATION OR LICENSURE FOR MASTERS LEVEL PRACTITIONERS IN PSYCHOLOGY: A WHITE PAPER FOR THOUGHT AND DISCUSSION

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At the First National Conference on Applied Masters Programs, participants outlined an ambitious agenda in support of the training and practice of masters-level psychologists. The Second National Conference will devote itself to how this agenda can be realized. Perhaps the most critical aspect of this work will be discussions about accreditation, certification and licensure. It is hoped that this paper will serve to stimulate discussion and thinking on these topics by considering some broad introductory issues as well as more specific concerns that need to be addressed.

BASIC ISSUES

Definitions. Although the terms accreditation, certification and licensure are widely used, it is helpful to begin by considering the differences between these three related concepts. Accreditation is a distinction awarded to programs or agencies involved in the training process. It states that a program meets certain minimum standards in areas which are deemed essential in the training process. Accreditation can be offered by either professional organizations or governmental entities. If the professional organization offering accreditation is widely recognized, states often offer automatic accreditation to programs meeting the standards of the organization.

In contrast to the programmatic focus of accreditation, certification is an individual award. Generally certification states that an individual meets certain minimum standards in terms of their training and competence, so that they can be allowed to do a particular type of work. Certification can be granted by either a governmental or a professional entity. Governmental certification can blur the distinction between certification and licensure by allowing only individuals with certification to refer to themselves as a certain type of professional. For instance, the old Indiana psychology certification law did not allow non-certified individuals to refer to themselves as psychologists. Licensure is also an individual award.

Like certification, licensure is a statement that an individual meets acceptable minimum standards for engaging in a particular type of work. It differs from certification in two ways. First, licensure is a governmental award. Second, licensure is also tied to controls over who can participate in a particular type of

work. For instance, if you are licensed as a psychologist there is an implication that those without a license should not be allowed to do the work of a psychologist. This means that licensure laws must carefully define what constitutes the professional work unique to that person's discipline.

Interrelationships. Program accreditation and individual licensure are separate issues, but they are not unrelated. While you can have accreditation without licensure, it is unlikely that masters' level psychology graduates will succeed in the quest for licensure without program accreditation. Many states have different licensing procedures for graduates of non-accredited programs; individuals from these programs usually face a more difficult path to licensure. The existence of program accreditation can also be persuasive to legislatures considering the utility of requiring certification or licensure for individuals. A full solution to the problem of licensure and accreditation thus demands that an organization address both areas.

ACCREDITATION ISSUES

Some issues that need to be decided initially by developers of program and licensure criteria for psychology graduates are as follows:

1. Should masters' level psychology graduates and programs seek a separate identity from other helping professions, or attempt to work in concert with an already-established professional group? As the conference considers program and accreditation standards and procedures, we must acknowledge that we do not operate in a vacuum. Many organizations, including the National Association of School Psychologists (NASP) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) have well-established standards and procedures which have been accepted by numerous governmental entities. These standards need to be carefully considered as we define the similarities and differences between masters-level psychology training programs and curricula in other disciplines.

2. Should accreditation be driven by academic programs and individuals responsible for training, or by masters level professionals? Some organizations (E.G. NASP) combine these groups, while others (e.g. APA and COGDOP) have some degree of segregation. In general, the more successful organizations have been those where trainers and practitioners have worked together to fashion appropriate standards and procedures. This issue is also relevant to questions about certification.

3. What will the role of the central agency be in the granting of accreditation? CAMPP currently limits itself to review of a brief application which outlines the basic features of the program. Other professional organizations require much lengthier procedures including on-site visits. A more rigorous inspection has the potential for better quality control, and may be more attractive to legislatures.

However, many institutions may not support an accreditation procedure that demands high levels of cost and a large time commitment.

4. Should accreditation be required or available for organizations participating in the field training process, (e.g. hospitals and clinics, businesses and industries)? Some organizations (e.g. APA) have ventured into this area, but others (e.g. NASP) allow institutional control over this process. Other groups specify that placement supervisors must be certified by their organization, but do not address the institutional issue.

5. What specific accreditation standards should apply to psychology programs? This issue was addressed by the First National Conference, but we may wish to review its decisions. Accreditation standards often address the following issues:

A. Number of credits required for a degree, and the extent to which these credits may be acquired through transfer or non-course experiences
B. Residency requirements
C. Practicum and/or internship requirements, including the length and timing of the experiences and the types of supervision; standards related to these experiences typically occupy a large section of the accreditation application
D. Coordination between the training goals of the program and its content
E. Diversity issues, in terms of admission of students and coursework to help students serve diverse populations
F. Specific coursework that should be included in the program, such as bases of behavior, diversity, human development, assessment, procedures for behavior change, consultation, statistics and research skills, and professional/legal/ethical issues

6. Accreditation standards should include an outline for the type of proposal expected from institutions. Proposals generally address the following issues:

A. The objectives of the program, and how the program design helps it meet these objectives
B. Program curriculum, including details of courses
C. Program policies and procedures
D. Program resources, including budget, physical resources, and faculty
E. Program history and statistical information
F. Appendices which contain supporting information including faculty vitae, student transcripts, etc.

CERTIFICATION AND LICENSURE

Two basic issues need to be decided with regard to certification and licensure:

1. Should masters-level psychologists be certified by a professional organization or licensed by individual states? There are advantages and disadvantages to either approach. Licensure would be much more effective in securing a spot in the marketplace for masters-level practitioners, as well as offering better quality control for the public. However, certification would allow greater control by the profession over appropriate standards, as well as avoiding a long-series of expensive and time-consuming political battles with groups opposing the practice of masters-level psychologists. In some states, certification has been used as an intermediate step with the eventual goal of licensure.

2. Should masters-level psychologists attempt to work within existing professional and legal frameworks to achieve certification and/or licensure, or should a new framework be created? Creation of a new framework is desirable in terms of establishing a professional identity and having appropriate control by our profession over the certification/licensure process. However, the time and financial cost of setting up a whole new system should not be underestimated. It is also a concern that many states who already license masters-level practitioners may be uninterested in creating a new classification which they see as duplicating existing professional categories.

CONCLUSION

There is no question that accreditation and licensure offers great potential for improving the quality of service to the public, as well as establishing a stable niche in the workplace for our graduates. As such, discussion of these issues is of the highest importance. However, the importance of accreditation and licensure goes beyond even these vital concerns. The decisions we make in regard to these issues will define the basic identity of the masters-level psychologist; what they have in common with other professionals and how they are unique. These decisions should be made with care, as they will affect the character of the discipline for many years to come. We should be willing to take the long view and work one step at a time toward our goals, perhaps accepting something we see as second best as a steppingstone toward our eventual objective, while attempting to formulate a unique vision and purpose for our graduates.

WHERE ARE THE MASTER'S PSYCHOLOGISTS?:
THE IMAGE OF MASTER'S TRAINING IN PSYCHOLOGY

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Recently, as part of my attempt to create a master's organization in Ohio, I went looking for Master's Psychologists -- I couldn't find any. When I contacted the American Psychological Association I discovered that their membership list does not include Master's Psychologists, and they would not discuss a master's organization. When I went to the licensing board of my state, I discovered that Master's Psychologists are not licensed or certified in Ohio. When I searched through the professional titles in the phone book I could find no listing for Master's Psychologists. However, in my quest I did find a profusion of counselors, LPC's, LPCC's, CCDC's, EDS's, LISW's and the dreaded Ph.D.'s.

As we all know, Master's Psychologists cannot hold full membership in the American Psychological Association, be licensed in most states in the United States, and are not allowed to call themselves psychologists. Instead they must settle for the title "Psychological Assistant" or some other demeaning and less descriptive term. And yet we know also, that there are about 80,000 Master's Psychologists in the United States. In the U.S. each year about twice as many psychologists graduate with master's degrees as do with a doctorate. We know that about half of the direct mental health, client contact is provided by master's people, and about 80% of the contact with targeted groups, such as the chronically mentally ill, is provided by master's level people.

Recently, the APA was able to track down some of our master's people by working from lists of alumni provided by departments and from their APA Associate Memberships. A survey of those people indicated, in general, that they were a highly satisfied group. I am here to report that that is not the state of affairs I see, certainly not the way it is in Ohio. If master's people are satisfied, it is with their self-knowledge of the quality of work that they do each day. It is certainly not with their profession, and the way they are treated in the workplace.

We also know that many master's level people, in order to survive and practice, move into related fields such as counseling. They eventually develop professional affiliations and commitments which are not in psychology. Often, reluctantly and resentfully, they give up their professional identity as psychologists.

So what is the image of master's people? I submit that mostly they do not have

one. They are an invisible group. For nearly 50 years it has been a group passed over, ignored, discriminated against, and in general, shoved to the back of the bus. There is only one way to change the image of Master's Psychologists -- allow them to create their own. To do this they must be given access to and membership in their profession. It is time that Master's Psychologists were empowered. So the overarching question is "How do we empower master's people?" This empowerment is tied to the other issues which are being discussed at this conference -- the issues of licensure, title, and organization. Steps to facilitate licensure, to develop and appropriately descriptive and positive title, and to organize Master's Psychologists will serve to create an image for master's people. Thus, the issue of image becomes three subquestions, all related to legitimizing and empowering Master's Psychologists:

I. Licensure

It is no longer a question of "Should Master's Psychologists be licensed?" If master's level psychology is to survive -- and it is clearly in the public interest that it should -- Master's Psychologists must be licensed. It is encouraging to see the recent successes in states such as Vermont and Arkansas. How can we turn the individual state initiatives into a national initiative? Or perhaps less strongly, how can we coordinate at the national level the efforts which are currently being undertaken at the level of states? NAMP has recently adopted a model licensing law, but NAMP and CAMPP must decide how they wish to be involved in licensure.

A. What can be done to facilitate licensure?
B. What would licensure for master's level people look like?
C. What role will NAMP and CAMPP play in state and national licensing efforts?

II. Title

It should be apparent that my favorite title is "Master's Psychologist." The people we are talking about here, you and I, are psychologists, and we have a master's degree. But perhaps there are other titles which may be considered.

A. Can we agree on a title which will recognize Master's Psychologists as psychologists?
B. What title is appropriate?

III. Organization

NAMP was organized in November of 1993 and is growing rapidly. With NAMP we have an organization which is specifically designed for Master's Psychologists. But what is still evolving is the role which NAMP will play in furthering Master's issues. And we should not opt entirely out of participation in

other organizations. We should continue to pressure the APA and other organizations to further empower Master's Psychologists.

A. What advice can we give to NAMP about the role it should play in furthering the image of Master's psychologists?
B. How can we work with other organizations?
C. What should our stance be with APA? Should we try to convince them or should we go our own way? Is anything to be gained by working with APA?

In summary, Master's Psychologists have no image. Organized psychology has not allowed them one. But that does not have to be viewed as entirely negative. It means we have the opportunity to construct an image, but it will take extraordinary effort. We first must seize control of our identity -- we must wrench ourselves free of the stranglehold of the APA, licensing boards, and Ph.D. practitioners. We must quit asking and begin telling.

MANAGED CARE AND MENTAL HEALTH: AN ALLIANCE?

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The purpose of this paper is to present the issues surrounding the role of managed care in mental health service delivery. The first part of the paper will focus on the inception of managed health care and the viability of its continued existence. The latter part of the paper will focus on the impact of managed care on mental health service delivery in this country. Issues, such as, a) available mental health treatment options and service needs, b) skills and efficacy of service provision, c) accountability and evaluation, and d) ethics will be discussed.

While there may be disagreement as to the efficacy of the managed health care system in providing quality mental health services to consumers, there is little disagreement that managed health care is here to stay (Bloom, 1990; Newman and Bricklin, 1991; Broskowski, 1991; Haas and Cummings, 1991; and VandenBos, 1993). Most have noted that the rise of managed care came as a response to the exponential rise in health care costs across the country, and the consequent desire (or need) to contain such costs. As can be expected, the health care scenario and its proposed reforms are quite complex, and can be defined and assessed using various perspectives.

Regardless of the paradigm used to assess health care delivery, several facts exist. The first is that 15% of people in the United States do not have health insurance. The second is that the rise in health care costs have averaged 3% to 4% higher than the national inflation rate for the past several years. In addition, the rate of health care costs for the government has increased faster than any other category, including military or Social Security (VandenBos, 1993). This leads to the third fact, that Americans consume more health care services than allocated taxes and insurance premiums can cover. For example, in 1992, the expenditure for health care exceeded the revenues from public and private funding by $225 billion (VandenBos, 1993). It is predicted that by the turn of the century, health care costs will represent 15% of the Gross National Product (Broskowski, 1991). These financial trends, although alarming in and of themselves, become exacerbated when viewed in the context of the 35 million Americans not covered by private insurance or state/federal programs, of the exorbitant spending patterns of the United States on health care (much higher than any other country), and of the low ranking of the country on overall health compared to the rest of the world. There is very little argument that reform is necessary.

The debate, of course is how to contain costs. The managed health care system

seems to be the most prevalent cost containment program utilized in the country today. Austad, Sherman, Morgan and Holstein (1992), Newman (1991) and Bloom (1990) reported that managed health care programs serve approximately 50 million people. No doubt, this number will grow. Thus, the issues we face in health and mental health care in this country should be viewed through the lens of a managed health care paradigm. As noted by Haas and Cummings (1991) the era of mental health fee-for-service delivery is coming to an end.

The term managed health care refers to a variety of programs and incentive systems. It is not the purpose of this paper to delineate and discuss such differences. However, some general points can be made about managed health care that impact on mental health delivery. As noted earlier, the primary objective of any managed care program is cost containment, which can be translated and implemented in various ways. Three categories seem to be targeted to achieve containment goals (Bloom, 1990; Broskowski, 1991). The first is method of payment and authorization, be it by a prepayment schedule, negotiated fee-for-service treatment by selected providers, or an authorized cost effective alternative treatment program. The second category is the liability of financial risk. Who shoulders the burden of costs that exceed the predetermined cost scale for each consumer per each service? Either the managed care program assumes fiscal responsibility, the employer, or in some cases, the consumer directly pays. When the managed care program assumes financial liability, often times they will use mechanisms that limit access and impose criteria for subscriptions (Haas & Cummings, 1991). This selection practice usually leads to a healthier population of subscribers who displays less illness and thus less financial risk. The third category targeted for cost containment is utilization rate. Such practices include, plans that allot incentives to providers to be cost effective, and authorization prior to treatment.

No matter what program design is utilized by the managed health care industry, the pressure to provide quality, effective treatment through a cost containment orientation is a pervasive, presenting condition. Such a condition raises important ethical and service delivery issues that focus on the availability of quality, affordable, and accessible and appropriate care.

As the managed health care industry continues to provide mental health care coverage to more people, mental health professionals are voicing great concern. Primarily, the concern is that the gatekeepers and decision makers of the managed health care industry do not possess an understanding of the mental health orientation and perspectives and lack the vision to move mental health practice forward (Broskowski, 1991; VandenBos, 1993). As noted by Newman and Bricklin (1991), from its inception, the managed health care regulatory systems have provided limited guidelines for mental health service delivery. The Health Maintenance Organization Act of 1973 only includes short-term, outpatient mental health services, for example. The primary thrust of the Act, which has dictated the present managed care practices, is to ensure accountability of quality health outcomes within a cost containment operation. The guidelines are broad and allow

for a myriad of interpretations and methods of operation.

One consequence of the regulatory and practice activities of mental health care within a managed care organization is a forced indoctrination of one enterprise into the structure and practice of another. Thus, lies the core of much debate regarding delivery of mental health services in this country. A prime example of the consequence of such a fit is the lack of standardization across states and within states as to regulations for service provision, including the credentials of providers (Newman & Bricklin, 1991). Some managed care administrators will only hire professionals who are licensed by their professional organizations. Others view provider qualifications based on efficacy and cost savings. Wells, Manning, and Benjamin (1986) have shown that treatment from fee-for-service providers was not more effective than services from managed care providers. However, the managed care services were cheaper to deliver. Thus managed care administrators began to hire providers with master's degrees rather than doctorate level psychologists or psychiatrists (McGuire & Fairbank, 1988).
Most debate about mental health delivery in this country is couched in a trend directed by a diffuse regulatory framework with a sole purpose to provide quality service within a cost containment mind set. Such debate will continue to be argued in light of this managed care backdrop. Thus, the rudiment contention for mental health care in this country is the congruence (or lack of) between mental health care and managed health care operation. Such contention has been expressed through the following issues; the use of time-limited interventions, the exclusion of diverse programs, the accessibility of services to underserved populations, the hiring patterns of mental health practitioners, and the role of mental health professionals within a managed health care setting. Other issues that are salient to the assessment of congruence between mental health and managed health care include; consumer and provider satisfaction, evaluation and accountability of treatment efficacy, and consumer freedom of treatment choice.

As we briefly discuss some of the issues that have been raised concerning the role of managed care in mental health delivery, we should keep in mind two points; a) that the concept of mental health is complex and multifaceted, and b) that the mental health profession has had little success in addressing some of the dilemmas that managed care has been criticized for avoiding.

Most would agree that mental health is a complex, multifaceted phenomenon with no single definition. There is no general consensus as to etiological bases, theoretical understanding of the factors involved or effective methods of treatment. Thus, some of the controversy that surrounds the role of managed care can be attributed to the complexity of the concept of mental health, or mental illness, for that matter. The implication here is that empirical support for concerns raised about managed care may not be easily obtained, due to the intricacies involved in the explication of mental health. Where such evidence can be obtained, conflicting results could arise. The significance of these circumstances can be realized in issues related to the definition of mental health, such as consumer satisfaction,

and provider and treatment efficacy in that they may not be good indicators of the presence or absence of quality care for either managed care or fee-for-service providers.

The second point, that some of the dilemmas facing managed care today have been in existence prior to the arrival of managed care, can best be observed in the criticism that managed care does not meet the country's mental health needs (Newman & Bricklin, 1991; Elpers, Beverly, Abbott, 1992). While this may be true, it is not new. Unmet mental health needs and underutilization of services has been a documented problem for many years (Shapiro, Skinner, Kessler, Vonkorff, Tischler, Leaf, Benham, Cottler & Regier, 1984). The same can be said for the major ethical issue raised concerning the lack of freedom of treatment choice by consumers in a managed care system (Haas & Cummings, 1991). Such has been the case for consumers in a fee-for-service system as well (Schinnar, et. al., 1992).

One important issue that deserves serious attention is that any delivery system should address diverse mental health needs. As VandenBos (1993) stated, appropriate mental health care must extend beyond the traditional views of service delivery. He further stated that interventions should encompass at least four separate types of approaches, which include; a) prevention, b) short-term treatment, c) rehabilitation therapy, and d) long-term, care. Bloom (1990) proposed that mental health professionals need to develop broader intervention orientations other than clinical to appropriately address the mental health problems of the country.

Such does not seem to be the case in a managed health care program. The trend has been a heavy reliance on brief therapy interventions (Bloom, 1990; Haas & Cummings, 1991; VandenBos, 1993). Austad, Sherman, Morgan and Holstein (1992) surveyed mental health professionals who work within a managed care facility as to the nature of the services they provide. When asked what type of training is most essential for mental health professionals working in a managed care facility, 44% said training in brief therapy. When asked if they were adequately trained for the type of work they were doing, 73% said no. During the course of their stay, 42% changed their direction from long-term to short-term interventions, and 37% changed their theoretical orientation.

The argument is not that brief therapy is ineffective; the argument is that brief therapy is not appropriate for all presenting mental health or illness conditions. MacKenzie (1989) found that brief therapy, while effective for certain populations, does not serve people who cannot effectively engage in verbal discourse, people who have presenting chronic conditions, or people who have either a repeated history or patterns of problematic behavior.

Perhaps the most salient concern voiced is that the managed health care system lacks diverse treatment approaches that would effectively serve special populations including the elderly, minority groups and persons suffering from

severe mental illness (Bloom, 1990; Haas & Cummings, 1991; Newman & Bricklin, 1991; Elpers & Abbott, 1992; VandenBos, 1993). The major barriers facing managed care systems from providing diverse programs seem to be, the cost containment orientation, which is dictated by regulatory guidelines (Bloom, 1990; Newman & Bricklin, 1991), the nature of managed care competition (Bloom, 1990), the marketing practices of managed care programs (Broskowski, 1991; VandenBos, 1993), and the privatization of the public mental health systems (Schinnar, et. al., 1992).

As can be expected, organized psychology has mixed reactions to the managed health care encroachment. Newman and Bricklin (1991) articulated four concerns of organized psychology about managed care, which are; a) the lack of specification of cost containment and comprehensiveness of services for special populations, b) the absence of regulatory mechanisms for managed health care systems to provide diversity of mental heath care, c) the exclusion of regulations that require that psychology be included, and d) the lack of trained personnel, quality assurance systems and the lack of truth in packaging for minority populations. In an effort to place psychology in an advantageous position, the council of representatives of APA issued a policy statement in 1988 concerning the role of managed care in mental health delivery. The basic message of the policy is that psychologists take action on the ethical ramifications that arise from cost containment practices for mental health service delivery and to help assure quality of service. The policy statement urges potential consumers, psychologists and subscribers to appraise managed care delivery systems prior to the decision to affiliate (Newman & Bricklin, 1991; Haas & Cummings, 1991).

Since organized psychology does not speak for the master's level psychologist, what actions should this group of professionals take regarding managed health care? It is not the intent of this white paper to set the direction for master's level psychologists on the managed health care issue. However, there seems to be several areas that may prove to be beneficial to the viability of these professionals. One area may be licensure. Another area may be to capitalize on the unique education and training that master's level psychologists receive. Accountability and evaluation of services rendered by the managed care industry is fundamental to its operation. Psychologists are in the best position to offer such services as evaluators or consultants (Bloom, 1990; VandenBos, 1993). In addition, master's level psychologists have the skills that go beyond the traditional mode of clinical intervention. Such requisite skills will help insure provision of effective, adequate and cost effective care (Bloom, 1990; Broskowski, 1991).

A third area is related to the vitality of the discipline. Psychologists are in the best position to move the knowledge-base and research forward, and to subsequently shape managed care programs with new innovations and technologies based on sound research practices (Haas & Cummings, 1991).

A fourth area is for master's level psychologists to take an active role in the

reshaping of the public sector and Community Mental Health Centers in particular, because their role in mental health delivery will change as a consequence of managed care (Schinnar, et., al., 1992).

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THE HUMAN CAPITAL INITIATIVE

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An ambitious framework for research on problems of human behavior has been developed by representatives of psychology's research-oriented societies. Through a series of Behavioral Science Summits convened by APS, over 100 representatives of almost 70 different organizations worked toward "the development of a national research agenda that would help policy makers in federal and other agencies set funding priorities for psychological and related sciences" (APS, 1992, p.7).

This agenda developed within the framework of the Human Capital Initiative, described by the National Behavioral Science Research Agenda Committee as "a sustained, national research effort, to enhance understanding of human development and behavior...to support research relevant to a set of crucial national priorities" (p. 11). Six critical problem areas relevant to psychological science have been identified:

- **Productivity in the workplace**
- **Schooling and literacy**
- **The aging society**
- **Drug and alcohol abuse**
- **Mental and physical health, and**
- **Violence in America**

Both basic and applied research are needed to clarify the best ways to address the challenges of human behavior presented in each of these areas. We need a better understanding of the processes which underly problems of human behavior as well as more certainty about methods which are effective in preventing or alleviating these problems. In the words of Milton Hakel, Chair of the Research Agenda Coordinating Committee, HCI is "the first effort to bring large-scale inter-society collaboration to bear on the identification of research needs...Research alone will not solve the nation's problems, but these problems won't be solved without systematic inquiry and painstaking analysis on a far larger scale than ever before. The time is right for basic and applied research and development that strengthens America's human capital" (p. 3).

The first phase of this effort culminated with the publication of The Human Capital Initiative (APS, 1992), a document which targeted the six critical problem areas and

described them in terms of research in psychology. The second phase, still underway, is the development of specific research initiatives in each of the six

1 Much of the material for this white paper was provided by Milton D. Hakel, Chair of the HCI Research Agenda Coordinating Committee. Dr. Hakel will address the Conference on the implications of the Human Capital Initiative for education and employment of master's graduates in psychology.

areas. These initiatives are developed by individual researchers representing many scientific societies who meet in workshop format to agree on topics and issues. A drafting group then develops a document which presents an overview of problems in the area and of the contributions of psychology to understanding and practice in that area. The document identifies basic and applied research and development which are necessary to move forward toward the solution of human problems in that area. These specific research initiatives are intended to call to the attention of Congress, federal agencies, and the general public some ways in which an investment in psychological research can help to improve the human condition in our society. Two initiatives have been described in special issues of the APS Observer.

THE CHANGING NATURE OF WORK

The first such report, Human Capital Initiative: The Changing Nature of Work (APS, 1993a) dealt with the problem area of Productivity in the Workplace. This initiative discussed five critical questions, each of which was addressed in a chapter that identified relevant basic and applied research needs. The critical questions are:

- How can we make people and technology work well together?
- How can we build organizations in which people will produce their best work?
- How can we train and retrain productive workers?
- How must the workplace change to adapt to the growing diversity of the work force?
- How does the workplace affect worker health? (p. 11).

VITALITY FOR LIFE

A second problem area, The Aging Society, was developed in the report Vitality for Life: Psychological Research for Productive Aging (APS, 1993b). This document recommended four areas for research and funding concentration:

- Health: how to change behaviors which damage health, and to maintain behaviors which promote health, (resulting) in productive aging.
- The Very Old: optimization of the psychological functioning of the oldest-old through both basic research and practical

interventions (to) minimize frailty and disability.

_ Work: how to maximize productivity and maintain productivity into late adulthood, (allowing) us to tap the wealth of older people's experience, wisdom, and expertise.

_ Mental Health: development of better techniques for assessing mental health and appropriately treating mental disorders in older adults, (providing) older adults a better chance to achieve vitality throughout their lives (p. 11).

The report has been presented to the Director of the National Institute on Aging and to selected congressional staff members. It has also been endorsed by 24 agencies and organizations in behavioral science.

OTHER INITIATIVES

Reports of drafting committees for other research areas are now in progress and will appear in special issues of the APS Observer when they are complete.

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