(In press: The Newsletter of the European Family Therapy Association)

The Costs of Providing Psychotherapy: Individual versus Family Therapy

D. Russell Crane*
Scott H. Payne
Brigham Young University

Abstract: The cost of treatment provided by mental health professionals varies across health care systems. In this study of one large health care system, the costs and rates of recidivism for individual versus family therapy psychotherapy was considered. Across nearly four million cases, all mental health professions and DSM diagnostic groups, family therapy is associated with the lowest costs and lowest rates of recidivism.

Method

Design

The study used a retrospective, longitudinal design. As such, it is an example of effectiveness research- meaning that it sought to investigate the effects of psychotherapy in a "real world" setting as practiced by practitioners in a representative health care delivery system. No theoretical "model", treatment manual or approach to treatment was considered. Instead, therapy as it is delivered by a wide range of providers was the only consideration. The definition of individual or family/relational therapy was provided solely by the mental health provider by the procedure listed on their submitted claim form.

Subjects

The subjects of this study are drawn from one of the leading health care insurers in the United States: CIGNA Health Care. CIGNA manages thirty seven health care plans, serving over nine million subscribers. Four years of data (2001-2004) and almost 5 million psychotherapy medical claim entries for the clients in these health care plans were included in this study. Each entry represented one reimbursement claim filed by a mental health care provider. These claims contained a unique non-identifiable identification number for each client, age, the date of treatment, the state where the service took place, the current procedural code (CPT) for the procedure, the primary DSM IV diagnosis, the therapist's license type and the dollar amount of the claim.

Procedure

Data for all psychotherapy charges billed for individual or conjoint therapy were available. The claims lines were classified under one of the following two current procedural terminology (CPT) codes: individual therapy (90806) or family/relational therapy (90847).

DSM diagnoses for each claim were also included. DSM IV diagnostic categories were summarized into twelve groups: anxiety & PTSD, mood disorders, disruptive behavior, substance use & abuse, dissociative disorders,

sexual disorders, schizophrenic and psychotic disorders, and eating disorders. In addition, the additional diagnoses of adjustment disorders, relational problems, and "other" were included in the study. Over 60% of all claims were submitted for the diagnoses of anxiety, mood and adjustment disorders.

Since the contract amounts paid to different provider types are fixed by CIGNA, comparison on the cost of providing therapy by professional discipline was not meaningful. Instead, the primary dependent variable used was Episode of Care (EOC). EOC is defined by CIGNA as a treatment that is continuous. It begins on the date of the first billed psychotherapy service and ends when the individual has had no activity (no claims, administrative and/or clinical) for 90 days. The number of EOC's per patient in ranged from 1 to 34. Over 85% of all therapy was concluded with the first course of treatment. As a result, only the first EOC for each patient was considered in the present analysis.

Data Cleaning

The raw claims data received from CIGNA contained more than five million claims (490,418 unique individual cases) for the period from 2001-2004. Almost one million claims were eliminated for the study. These consisted of claims that were for more than one treatment session, claims with inaccurate service dates, or for patients who saw more than one type of licensed professional, etc..

Therapists

The final data set consisted of 3,997,173 sessions involving therapists of one of six professional types: licensed professional counselors, doctors, master's nurses, master's social workers, marriage and family therapists (MFT's), or psychologists.

Analysis

For the purposes of the present study, all diagnoses and all professional disciplines were combined for descriptive analysis

The final data set also included a 90-day recidivism time frame across all four years. Applying this 90-day relapse timeframe, the initial calculations grouped all data by client ID and profession type. The initial calculation grouped all sessions by episodes of care, resulting in a table that includes one episode of care per entry (N = 587,759). Additional calculations produced data on the average cost per Episode of Care by CPT code and by therapist type. Finally therapy "success" and "recidivism" were calculated. Success was defined as only one EOC per person in the four years of data. Recidivism was defined as the presence of a second (or more) EOC for the same person over the four years of available data.

Research Question

Question: Are there differences in the cost and outcome individual therapy only versus family therapy only versus therapy that combines both types of treatment?

Table 1 Cost of services and recidivism by therapy type

Therapy Type	Total Number of Persons in EOC 1	Total Number of Persons requiring a Second EOC	Average Number of Sessions in First EOC	Estimated cost for First EOC	Recidivism Rate	Success Rate
Individual Therapy Only	366,545	58,858	6.81	$333.99	16.06%	83.94%
Family Therapy Only	68,407	9,640	4.44	$216.56	14.09%	85.91%
Mixed Therapy	55,466	6,752	5.53	$268.09	12.17%	87.83%
Total	490,418	75,250			15.34%	84.66%

Results

These simple descriptive statistics demonstrate that overall, any form of psychotherapy is relatively effective with at least 84% of patients demonstrating success in just a few treatment sessions.

Second, psychotherapy as provided in this health care system is relatively brief and low cost.

Third, including family/relational therapy in treatment is associated with using 35% less psychotherapy overall. The most expensive form of psychotherapy is individual therapy either alone.

Finally, the lowest rate of recidivism is associated with treatment that is a combination of individual and family therapy. No patients who received this form of psychotherapy were seen in a subsequent episode of care by the same provider type.

Discussion

The results of this study demonstrate that family therapy is a cost effective form of psychotherapy. In fact, using family therapy alone in treatment is associated with the fewest number of treatment sessions, lowest cost overall and second lowest recidivism rates across all disorders and all professional disciplines.

The psychotherapy supported by the CIGNA behavioral health system is relatively brief and low cost. It is not possible to determine if the average number of sessions for the first EOC is a result of an official or unofficial "cap" on the number of sessions provided by the plans. Some of the thirty seven health care plans have upper limits of care, others do not. Since the identity of each specific health plan was not available, it is not possible to determine if the results are driven by treatment limits. However, even if treatment limits existed, the average number of sessions required for care should not be lower simply because family therapy is a covered benefit. No policies exist in CIGNA to limit the number of sessions available for family versus individual therapy.

Overall, recidivism was relatively infrequent with a maximum of 15% of patients requiring a subsequent episode of care. The lowest rate of recidivism was found for those patients who experienced a combination of individual and family therapy. Their rate, at 12% , suggests that the combination of individual and family

therapy is a powerful intervention and that can have long term effects. The second lowest rate of recidivism (and produced at the lowest cost) was for those who experienced family therapy alone. This suggests that family therapy alone is the most cost effective form of psychotherapy.

Finally, these results suggest that involving families in psychotherapy is an important component of care. Every effort should be considered to invite and involve other family members in treatment. In addition, supervisors and policy managers who are considering the inclusion of family therapy within their treatment options can proceed with adding this service. There should be no additional costs for doing so. In fact, there is a significant probability of identifying coast savings if family therapy is provided.

Authors Note

*D. Russell Crane, Ph.D., Professor of Marriage and Family Therapy, School of Family Life, Brigham Young University, Provo, UT 84602 USA. Scott H. Payne, M.S., is a graduate of the same program. For additional information see: www.RussCrane.com, or email: RussCrane@byu.edu.