In recent decades, insurance companies in the United States have made efforts toward including managed care organizations (MCOs) in an effort to streamline services and reduce costs associated with healthcare (Bachrach, Guyer, Meier, Meerschaert, & Brandel, 2018), including mental health services such as counseling. This trend has become especially evident in state Medicaid systems (Yamaki, Wing, Mitchell, Owen, & Heller, 2018; MacDonald-Wilson, Schuster, & Wasilchak, 2015). Specifically, MCOs are independent companies that work on behalf of the health services industry and insurance companies utilizing a managed care ideal, and function as a mediator in the patient-provider relationship. This mediation, from state Medicaid agencies, involves the attempt to balance access to quality care and overuse of healthcare systems (Schneider, 2018; Yamaki, et al., 2018).

Managed care is intended to make services more accessible and affordable to those who need it. Socioeconomic inequality factors play a huge role in poor mental health outcomes (Platt, Stace, & Morrissey, 2017). The societal, healthcare, and resource costs for mental health is widespread. Macintyre, Ferris, Goncalves, and Quinn (2018) report that on a global scale, mental health and substance disorders make up approximately one-fifth to one-third of years living with a disability. However, many mental health providers are plagued with denied service claims, leading to frustration and unwillingness to work with MCOs (Schencker, 2017). MCOs were adopted to help managed care companies navigate the demand for access to services, while controlling distribution and insurance reimbursement costs (Schneider, 2018; Yamaki, et al., 2018; Braun & Cox, 2005).

There are varied reactions in the helping professions regarding the effectiveness of managed care. Managed care is thought of negatively, particularly with reimbursement, when brought up amongst mental health providers, stirring reservations about its use in practice (GAO,

2018). Compounding the issue, MCOs continue to consume provider's time by implementing practices outside of the counselor's control, such as plan policies, plan requirements, disease- or treatment-specific limitations to coverage, legal mandates, contract language, and peer reviews (Papatola & Lustig, 2015). Additionally, ethical dilemmas can arise when working with MCOs for client care in the counseling profession. It is important, then, that counselors utilize tools available to them – ethical decision-making models – to navigate these dilemmas as they arise. The purpose of this article is to present ethical dilemmas present while working with MCOs for client care, introduce one example of an ethical decision-making model to use, and discuss implications for research and counselor educators.

Ethical Dilemmas When Working with MCOs

MCOs can have tremendous impact on ethics in the counseling profession. Ethical or moral dilemmas arise in the counseling profession when there appears to be more than one correct course of action, however, neither provides a concrete solution (Freeman, Engels, & Altekruse, 2004). Often, ethical codes are at odds with MCO policy and procedures (Cohen, Marecek, & Gillham, 2006; Gibelman & Mason, 2002). Ethical codes are the counseling profession's guiding principles, and therefore are often used in informing responsible practice and resolution of ethical dilemmas (Cottone & Tarvydas, 2016). However, only 31% of respondents in Danzinger and Welfel's (2001) study reported that they consulted the American Counseling Association's (ACA) *Code of Ethics* to help with ethical dilemmas while working with MCOs. Often times, gray areas found within ethical codes provide little guidance on ethical solutions.

MCOs abide by a strict structure of requirements that providers must follow in order to gain reimbursement for services (Papatola & Lustig, 2015). A survey of providers found that about 75% of participant's clients receiving services were covered under managed care (Danzinger &

Welfel, 2001), and that number is likely to have increased. While studies have found that many providers strive to meet MCO expectations, agreement is hard to find on managed care's effectiveness in the mental health setting (Braun & Cox, 2005). Other studies from social work show that perceptions of professional competence when working with MCOs has a statistically significant correlation to burnout (Acker, 2010). Therefore, it remains unresolved as to how the counseling profession addresses ethical dilemmas related to MCOs, and how it can educate future counselors on working effectively with MCOs. A discussion of a potential ethical dilemma follows.

Examples of Ethical Dilemmas in Practice

Confidentiality

One of the biggest hurdles for providers in terms of ethical clinical practice with MCOs is the concept of confidentiality. Forty percent of respondents in a study on ethical dilemmas and MCOs report that confidentiality was a specific ethical dilemma encountered (Danzinger & Welfel, 2001). Cottone and Tarvydas (2016) define confidentiality as the client's right to have information within the counseling session remain private between the client and counselor. Confidentiality applies to any communication of personal information; including any recording that may have occurred, counselor notes and documentation, or when information is shared between providers with client consent. Confidentiality is a crucial part of the therapeutic alliance, as it establishes one of the foundational cornerstones of the counseling profession – trust (Kress, Hoffman, & Eriksen, 2010). Standard B.4.e. from the ACA's *Code of Ethics* (2014) specifically addresses releasing client information, stating that the counselor is responsible for making sure that receiving parties of confidential information understand the confidential nature of those records. However, as a non-employee of the MCO to which the information is released, counselors

cannot be in control of where the information goes, who has access to it, and how the MCO stores or destroys the records (Danzinger & Welfel, 2001). Essentially, once the information is sent off to the MCO for review and approval of services, the counselor has no authority to dictate what happens to it afterwards, nor can the counselor ensure that confidentiality is upheld.

Diagnosis

Tying into confidentiality is another issue, specifically regarding diagnosis. Kress, et al. (2010) note that diagnosis, which centers around the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., DSM-V; American Psychiatric Association [APA], 2013), already conflicts with the counseling professions holistic nature by adhering to a disease-model. This applies to mental health providers since a specific diagnosis mandates the type of intervention services that are reimbursed under MCOs (Braun & Cox, 2005). An accurate diagnosis is important in developing a unique and effective treatment plan, which is developed specifically for each individual client (Kress, et al., 2010). The ACA's *Code of Ethics* (2014) section E.5. Diagnosis of Mental Disorders, focuses on the importance of providing an accurate and appropriate diagnosis based on symptoms present, cultural impacts, historical or social biases, as well as refusal of diagnosing if it imposes harm on the client. However, diagnosis is a requirement for reimbursement by nearly all third-party payers (Eriksen & Kress, 2005; Braun & Cox, 2005). Braun and Cox (2005) report that many counselors and clients come to an agreement about using an inaccurate diagnosis to receive reimbursement and continue services. This is a significant ethical dilemma, conflicting with ACA's *Code of Ethics.* Not only does doing so expose the counselor to ethical repercussions from licensing and ethics boards, but the client may inadvertently be exposed to more harm. This harm could include being labeled, increased stigma,

and difficulty obtaining other insurance with a pre-existing condition (i.e., mental health diagnosis) (Kress, et al., 2010).

Goodman (1997) argues that the diagnosis mandate by MCOs for reimbursement creates two ethical dilemmas: 1) MCOs require a diagnosis that implies there is a specific issue before seeking mental health services, and 2) diagnosis must show that future services are necessary in order for continued care under MCO guidelines. The problem then becomes that preventative services are more likely to be denied under MCO coverage. Additionally, if a diagnosis changes to reflect a more stable or less severe symptomatic state, continued services may not be covered, even if the client and/or counselor feel as though continued services are warranted for stability (Goodman, 1997).

Braun and Cox (2005) note that most MCOs deny coverage for "adjustment disorders, for disorders typically requiring long-term counseling, and for diagnostic codes that bear exclusively Axis II status" (p. 427). However, Axis I disorders are generally accepted, unless the problem is identified as a V Code (Braun & Cox, 2005). While the current *DSM-V* does not use the Axis system, this provides a general picture of which diagnoses are covered versus not. It also provides an example of justification MCOs may use in denying certain diagnoses on service claims. Counselors could then be faced with the dilemma of misdiagnosing or inflating a diagnosis to fit MCO guidelines so that clients may receive covered services. However, counselors may not understand the negative impact of doing so. Clients may not understand the nature of certain diagnoses and how those diagnoses may carry unexpected repercussions or cause harm (i.e., denial of future insurance coverage or higher rates, stigma or labels associated with mental illness diagnosis, etc.) (Braun & Cox, 2005).

Recommendations for Practice: Using an Ethical Decision-Making Model

Danzinger and Welfel (2001) found that counselors were not utilizing ethical codes to help inform ethical decision making when it involved working with MCOs. This could lead to ethical violations with practicing counselors, as the ethical codes are guiding principles for ethical practice. The ACA's *Code of Ethics* (2014) standard B.3.d. states that counselors only disclose information to third-party payers when appropriate consent has been given by the client. Standard C.6.b. also states that counselors provide "accurate, honest, and objective" (p. 9) information regarding professional activity to third parties, including insurance companies or MCOs (ACA, 2014). However, the ACA's *Code of Ethics* does not provide specific guidelines to follow if there is a conflict between MCO requirements and ethical standards.

While it is possible that future ethical codes might involve standards relating to resolving such conflicts specifically, current counselors must draw on other avenues to navigate these ethical dilemmas. The ACA provides resources and details ethical decision-making steps to help resolve most ethical dilemmas, and counselors should look to these resources while working with MCOs specifically (ACA, 2014). Forester-Miller and Davis (2016) outline the steps endorsed by the ACA with their ethical decision-making model. These could be applied to a current ethical dilemma involving MCOs in relation to client care. Following is a short case example of an ethical dilemma, with the steps of Forester-Miller and Davis' (2016) ethical decision-making model used to walk through the scenario.

Case Example

Mary is a licensed mental health counselor working in an outpatient setting with her client, Sarah. Sarah is currently experiencing stress related to the breakdown of her marriage and subsequent divorce proceedings. She is covered under the state's Medicaid insurance, which uses

a MCO to provide this coverage. Mary has diagnosed Sarah with an adjustment disorder, since there is no evidence or symptoms of a more severe mental health diagnosis such as major depressive disorder or anxiety disorder not otherwise specified. Mary has received push back from the MCO related to providing services to Sarah, related to the diagnosis of adjustment disorder. The MCO is requiring a different diagnosis to continue covering future sessions for Sarah. Sarah wants to continue with services with Mary, stating that sessions are helping her, but cannot pay out-of-pocket for continued counseling. Mary is unsure whether she should give Sarah a diagnosis of major depressive disorder or anxiety disorder not otherwise specified to get future sessions covered under the MCO.

Applying the Ethical Decision-Making Model

First, Mary needs to identify the problem, taking into consideration whether the issue is ethical or legal in nature. Legal representation should be sought in the event a legal issue arises (Forester-Miller & Davis, 2016). The ethical issue in this scenario is whether Mary should change Sarah's diagnosis so that future sessions are covered, given that Sarah desires to continue seeing Mary and the MCO is stating that they will no longer cover services for an adjustment disorder diagnosis.

Second, Mary should consult the ACA's *Code of Ethics* (2014) and state or federal laws that might apply (Forester-Miller & Davis, 2016). One possible code that would apply would be standard C.6.b. Reports to Third Parties, which states that the counselor provides honest and accurate information, including to health insurance companies (ACA, 2014). Additionally, and possibly more importantly, standard E.5.a. Proper Diagnosis states that counselors "take special care" when diagnosing a client (ACA, 2014, p. 11). For the purposes of Mary and this case scenario, these standards provide the guideline that Mary not embellish or give a false diagnosis

to Sarah simply to continue with services. That doing so may impose more harm on Sarah, unintentionally, and would also be a violation of the counseling profession's ethical standards.

If the codes do not help resolve the dilemma, the third step is to determine the nature of the dilemma. This involves considering the basic ethical principles of autonomy, non-maleficence, beneficence, justice, and fidelity (ACA, 2014). Forester-Miller and Davis (2016) go a step further, urging the counselor to consider the implications for each of the previously mentioned principles, consulting and reviewing current literature surrounding the issue, consulting with other professionals, and reaching out to state and national professional organizations for help.

In Mary's case, she may be breaking autonomy for Sarah by not allowing Sarah to have the freedom of making the choice for diagnosis to cover services. At the minimum, Mary should discuss this potential course of action with Sarah. In terms of justice, Mary would need to consider whether this misdiagnosis of Sarah falls within the notion of treating Sarah differently than she would others. In this scenario, justice may not necessarily apply. Mary could argue that by not inflating the diagnosis, she is taking away a service that would be to Sarah's benefit and well-being, reflecting on the beneficence principle. However, Mary would need to consider how inflating a diagnosis may be opposite of preventing harm and doing what is right. In regard to fidelity, Mary is attempting to honor her commitment to Sarah, by helping her receive services that are covered under her MCO. However, she may not be acting ethically by doing so. Finally, with nonmaleficence, Mary needs to consider how inflating a diagnosis, or giving Sarah an inaccurate one, could cause harm to Sarah in the long-term. Would this inflated diagnosis label her? Would it possibly cause stigma or have consequences that are not easily seen at the outset?

After all implications of the basic ethical principles are weighed and necessary consultation is completed, the counselor is urged to take the next step, which involves coming up with potential

courses of action. For Mary, there are only two potential action steps. The first being to leave Sarah's diagnosis as an adjustment disorder and discuss with Sarah her options for continued services. Mary should also explain to Sarah the MCO's decision and the ethical responsibility she has to not inflate the diagnosis. Or, Mary could choose the second potential action step, which is to inflate the diagnosis so that future services are covered under the MCO. Mary should have a discussion regarding this decision and any consequences with Sarah, too.

The fifth step involves considering the pros and cons of each of the potential courses of actions, noting any consequences (Forester-Miller & Davis, 2016). Mary's first option, to not embellish the diagnosis, is ethical and would avoid imposing any stigma, label, or potential harmful consequence to Sarah. She would also be free from any ethical ramifications that could impact her license and/or professional affiliation. However, the con would be that Sarah would have to find alternative ways to cover the cost of her future sessions, which she may not have access to. For the second option, the benefit would be that Sarah could continue to get services that she desires. However, the cons would be the potential harm to Sarah through stigma or labels, consequences to Mary professionally and/or legally, and the unseen consequences of doing so, which are not apparent at the outset.

The final step, preceding the implementation of the selected course of action, includes three specific steps of consideration when evaluating the plan: 1) justice in the sense of whether you would treat others the same in this particular situation, 2) publicity and whether you would want the selected course of action known to others, and 3) universality in terms of whether you would recommend this course of action to another professional (Forester-Miller & Davis, 2016). Using formal ethical decision-making models to help navigate ethical dilemmas allows the counselor to

discover the best possible course of action, and there are several ethical decision-making models available in addition to the one detailed here.

Research

While research surrounding MCOs effect on the counseling profession has grown with the increase in MCO use, there are still limitations to the type of research available. Much of the literature involving research with MCOs involves providers and the struggle to manage MCO requirements. Specifically, research only focuses on ethical practice in very specific regions of the United States (Willging, Waitzkin, & Nicdao, 2008). Some research has discovered disparities in accessible services covered by MCOs in rural areas. In particular, this has a large effect on vulnerable populations based on race, ethnicity, culture, or socio-economic status (Willging, et al., 2008).

The importance of continuing such research cannot be stressed enough. Danzinger and Welfel (2001) found in their study that 90% of respondents believe that managed care had an impact on their practice, with 60% stating that this impact was negative in nature. Further findings from their study indicate that 60% report that they had changed treatment plans based on managed care "limitations" (p. 143), 46% state that they had terminated or would terminate with clients before they were ready due to managed care limits, and 44% note that they had or would have changed a client diagnosis so that the client would be able to receive additional coverage for services (Danzinger & Welfel, 2001). In general, 75% of respondents in Danzinger and Welfel's (2001) study report that while working with managed care, ethical dilemmas presented themselves frequently.

Implications and Recommendations for Research

Managed care's aim is to have more involvement from clients in their health care to shape the quality of health care services in general (MacDonald-Wilson, et al., 2015). In 2009, Beecher found that using the medical model for diagnosis and treatment of mental health concerns was "limiting" (p. 15), specifically when looking at individuals with schizophrenia. Moreover, in his study, Beecher (2009) found that using the medical model as a basis for services impacts whether mental health professionals (in the study's case, social workers) provide services to these individuals. More research focusing on client insight and involvement in the MCO process as it pertains to mental health services would be warranted, and an important component to informing how providers can advocate on the behalf of the clients utilizing their services (i.e., How has the movement towards MCO involvement affected client perceptions on mental health care? or How has MCO involvement created a barrier in receiving mental health services?). In addition to this area, research focusing on generalizing the use of MCOs across various areas of the United States and populations is needed to provide a broader context of how MCOs are affecting client care (i.e., Are there differences between client care in urban versus rural settings under managed care?). As mentioned above, research could focus on how to help rural areas navigate the challenges of MCO requirements. This could include specific research on clients or providers, and how MCO restrictions affect access to services and the ability to adequately provide services in an area with limited resources (Willging, et al., 2008).

A bigger area that warrants further research in regard to providers in particular, is how providers are resolving ethical issues surrounding diagnosis specifically when working with MCOs (i.e., Are ethical decision-making models effective in navigating ethical dilemmas surrounding MCO involvement with clients?). As Danzinger and Welfel (2001) found in their study, 44% of

respondents note either having done so or being willing to change a client diagnosis to fit MCO requirements for reimbursement. This creates an ethical dilemma and shows that many providers are feeling it necessary to consider acting unethically to provide services for clients. In addition, their study found that one-third of respondents reported that working with managed care negatively affected the therapeutic relationship with the client, which lends support for more advocacy to help produce fewer negative effects on clients (Danzinger & Welfel, 2001). Special care to guarantee confidentiality on the parts of the participants will be crucial for future research, given that many participants may have concerns about either admitting to unethical practice, or admitting to manipulating MCO guidelines and having repercussions due to this participation (Dorfman & Smith, 2002).

Education

The ACA provides standards on the education of counselors-in-training, specifically in ethics. Standard F.7.e. Teaching Ethics, states that counselor educators must ensure that students are aware of their ethical responsibility and professional standards, implementing ethics throughout the curriculum of the program (ACA, 2014). As trending issues and hot topics continually evolve in the counseling profession, ethical relevance to the current culture of society is important to keep in mind (Pack-Brown, Thomas, & Seymour, 2008). Just like multicultural awareness, ethical ramifications related to current insurance or MCO involvement in clinical practice is just as important a subject to broach with up-and-coming counselors.

According to Smith (1999), 80% of counselor education programs were confident their graduates were prepared for practice in managed a care environment. Similarly, 78.6% of practitioners rated themselves as well prepared to work within the managed care environment (Smith, 1999). Unfortunately, there is a dearth of literature regarding suggestions for counselor

education programs to incorporate managed care systems into their courses. Smith (1999) asked counselor educators and practitioners to provide suggestions in rank order to improve the position of counselors as providers in the managed care organizations.

Smith (1999) notes there is a need to improve the emphasis on time and to teach more about solution-focused approaches. As mentioned before, MCOs have guidelines that stipulate the types of interventions and treatments used for specific diagnoses (Kontosh, 2000); therefore, it is imperative students are educated on how to adapt to MCOs requirements when treating clients. More specifically, development and application of ethical decision-making skills allows students the ability to navigate these requirements. Solution-Focused Brief Therapy (SFBT) is an effective treatment for behavioral and psychological conditions (Gingerich & Peterson, 2013). However, this approach may not be applicable to clients with more severe diagnoses.

Counselor preparation programs can prepare counselors-in-training to effectively work with MCO requirements. To do so, counselor education programs need to ensure curriculum on ethical decision-making models, application of these models to case scenarios, and incorporate ethics related to MCO requirements in ethics courses or vignettes used throughout the program courses. In addition, preparation programs should increase knowledge and skill in administration and management. MCO knowledge and training can be integrated into the internship and other experience. Other courses such as the Diagnostic and DSM course and the Psychopharmacological Effects course work should be expanded and include outcomes-oriented treatment planning (Smith, 1999). Overall, counselor preparation programs could use more information on health care delivery systems, such as MCOs.

Furthermore, the national accrediting bodies such as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) support the inclusion into the curricula

if all required content is addressed. Counselor education programs may choose how much emphasis is placed on other material. Counselor educators are challenged to create courses that meet the guidelines of CACREP while providing counselors-in-training the information required to be successful practitioner's and educators. The improvements listed above can be applied to several required CAREP courses; for instance, practicum, internship, ethics, and diagnosis and treatment planning.

Practicum and Internship

University supervisors can lead discussion on student's experience in the field with MCO's and how their site supervisors interact with the organization. Utilizing role-play and case conceptualization's stimulating limitations and ethical considerations presented through MCO's involvement with a case. According to Danzinger and Welfel (2001), practitioners who were who were confronted with ethical dilemmas sought out help through consultation with colleagues and supervisors. Counselor educators must stay current regarding issues concerning MCO's and the word of practice (Smith, 1999).

Ethics

Counselor educators use the ACA code of ethics a one of many tools to educate students on ethical decision making. Another useful tool is to have a managed care representative involved (Smith, 1999) when developing stimulations. The assignment will encourage students to make ethical decisions while utilizing the code of ethics while gaining a better understanding of their client's rights.

Diagnosis and Treatment Planning

Smith (1999) suggests counselors in training experience focus more one time- limited and solution- focused approaches. Preparing counselors in training with the ability to create treatment

plans using time-limited approach may prevent conflicts with MCO's and to learn when to advocate on behalf of their clients.

Implications and Recommendations for Education

When considering the nature of MCO involvement and the likelihood that they will be a continued stakeholder in the counseling environment, it is important to consider broaching the subject in a counseling program. While many programs have stand-alone ethics courses, it is argued that this is not adequate to cover the complexity of ethics within the counseling profession (Pack-Brown, et al., 2008). As counselor educators, ensuring that ethics is a continual conversation throughout the coursework is essential, and could play an important role in tackling real-world current issues that students will face when they graduate and enter the field, such as working with MCOs (Pack-Brown, et al., 2008).

During the academic program, it is important to allow students to have the experience and opportunity to become ethical decision makers, which specifically involves having them acknowledge their "personal cultural biases, prejudices, and stereotypes to their work with clients" (Pack-Brown, et al., 2008, p. 298). Even and Robinson (2013) found that there was a significant difference in the number of ethical violations between counselors graduating from a program that was accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and counselors graduating from those that were not CACREP accredited. Taking this into consideration, counselor educators working in academic programs that are not accredited by CACREP could work towards advocating for accreditation, citing research as a rationale for the need in order to provide better ethical instruction and experience for counselors-in-training.

Counselor education students need to have ample opportunities to work with a variety of hypothetical scenarios to help them sort through these ethical issues and wrestle with the

consequences of their diagnostic decision-making process and discussions with clients. Students can be trained to raise these issues in their meetings with clinical supervisors and to seek out consultation when situations such as these arise. There are many ethical scenarios with MCOs that do not have a clear resolution, but counselors-in-training need to have opportunities to face these problems during graduate school and identify the ethical dilemmas inherent in the scenario presented. Small and large group discussions can help to facilitate reflective practice, and students can desensitize themselves to exploring and perhaps disagreeing with each other regarding the best course of treatment.

Pack-Brown, et al. (2008) also give considerations on how to infuse ethics throughout the counseling education program, which can include MCO specific ethical considerations. First, the authors suggest providing a clear mission statement and objective of the program that includes a strong ethical component. This ensures that any applying student has the opportunity to read the mission statement and to get an idea of the expectations of the program, including ethics (Pack-Brown, et al., 2008). Second, having a curriculum that strongly incorporates ethics, including related to MCO requirements specifically, into each of its courses and makes sure that students gain a good understanding of their ethical responsibility (Pack-Brown, et al., 2008). This includes providing students with experiential learning opportunities that allow them to apply ethical principles, standards, and decision-making models to real-world scenarios, including MCO specific scenarios. Finally, Pack-Brown, et al. (2008) suggest programs consider diversification of faculty and students to allow for a well-rounded inclusion of topics that might not be as well known to specific demographics.

Graduate students in counseling also need to have opportunities to learn to advocate for their clients and for the profession as a whole. Helping counselors-in-training engage in role plays

with simulated MCO representatives might provide them with opportunities to practice their communication skills and rehearse problem solving efforts with an insurance company. Most counselors do not understand that MCO representatives are trained to negotiate and consider the pros and cons of coverage for the client. Often, the MCO may be willing to extend coverage under special circumstances. Rehearsing these kinds of conversations can help promote advocacy skills and potentially obtain extended services while adhering to professional and ethical codes. MCOs are also willing to negotiate the terms of coverage if the business owners are contacted directly about the (sometimes) unfair behaviors of MCO representatives. The MCO may show more flexibility when "their customer" (the business policy purchaser) raises concerns about the coverage limitations. Orienting students to this kind of consultation and advocacy, with permission from their client, can help them understand how systems can be used to advocate for the clients. Finally, counselors can bring these concerns to professional conferences and promote national discussions to expand and enhance revisions to the ethical codes. All the ethical codes have periods for open comment and revision. Counselors need to consider the ways that the profession itself can be clearer on these issues, and advocate for revisions to national guidelines.

When considering the implications of these suggestions in regard to MCOs, counselor educators can ensure that their students have a working knowledge of the challenges that lay ahead of them when they start practicing independently. MCO specific scenarios can be incorporated into class vignettes, giving students access to and experience thinking and making decisions regarding MCO requirements and practice. Specific ethical decision-making models can be introduced to help navigate the dilemma, such as the one explored previously provided by the ACA. Having an academic program that encourages and embraces diversity of faculty and students may also allow for broader experiences related to specific vulnerable populations. These

individuals could provide their experience and background knowledge to the discussion about advocating and working with MCOs.

Conclusion

Managed care and MCOs were established to help control costs and disparity of services in the health care industry. However, many issues have arisen in the mental health field in terms of ethical dilemmas when the requirements of MCO reimbursement contradict professional ethics. Opportunities exist to make use of specific ethical standards found within the ACA's *Code of Ethics* (2014) to consider best practices, additional research to understand counselors' struggles to apply them, and the need for programs to anticipate these struggles within the context counselor preparation programs. Implications for each of these areas were discussed in detail, however, the most compelling implication suggests that advocacy and awareness of ethical dilemmas is a continual issue that counselors should take responsibility to address. This includes decisions made while practicing clinically, conducting research to inform practice and bringing awareness to issues, and while educating future counselors to take active and leadership roles in the further advancement of the profession.

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