EVALUATION AND PAYMENT OF MENTAL HEALTH COUNSELING CLAIMS

Issues for Crime Victim Compensation Programs

National Association of Crime Victim Compensation Boards

150256

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This project is supported by grant number 90-MU-GX-001 awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The Assistant Attorney General, Office of Justice Programs, coordinates the activities of the following programs, offices, and bureaus: the Bureau of Justice Statistics, National Institute of Justice, Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions expressed in this document are those of the author and do not necessarily reflect the official position or policies of the Department of Justice.

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INTRODUCTION

In December 1982, the President's Task Force on Victims of Crime wrote the following:

> Property damage and physical injury are readily apparent, easily understood consequences of violent crime. The psychological wounds sustained by victims of crime, and the best means of treating such injuries, are less well understood.

A decade later, the mental trauma suffered by victims, and the therapy necessary to effectuate recovery from it, are still far from being fully understood. While there is widespread recognition that those who survive criminal violence may suffer acute psychological effects requiring professional care, a number of difficult issues remain that complicate the efforts of crime victim compensation programs to provide resources to assist in the recovery process. This report attempts to explore these issues and to describe approaches that programs may consider in determining how best to meet their responsibilities to support effective counseling for victims of crime.

Historically, nearly all the state compensation programs have been authorized to cover mental health counseling, and currently, all of the programs consider it a compensable expense. This support was reinforced by Congress' passage of the Victims of Crime Act of 1984 (VOCA), which conditioned receipt of federal grant funds upon payment for counseling as an allowable expense. Recent years, however, have seen a dramatic increase in applications from victims seeking reimbursement for counseling expenses. One state, for example, reports that nearly half of its applications include a request for coverage of counseling. The increasing rate of reported sex assaults and child sexual abuse, the development and acceptance of post-traumatic stress disorder as a legitimate psychiatric diagnosis, the recognition by rape trauma centers that many of their clients required long-term counseling, and the emergence of a mental health profession focused on treating crime-related trauma have all contributed to a growing use of mental health counseling as a means of recovery from victimization.

It is not surprising, then, that compensation programs are spending an increasing proportion of their dollars to pay for mental health services. Nationwide, compensation programs' awards for counseling have increased from $8.1 million in 1987 to $48.1 million in 1991, a figure representing more than 20% of the programs' budgets, according to figures gathered from state compensation programs by the Office for Victims of Crime in the U.S. Justice Department. This growing demand comes at the same time that coverage by private insurance plans and public medical assistance is declining. Programs are struggling with the reality that they have become primary payers for a complex, and generally unanticipated, health-care demand.

Victim compensation programs are governed by statutes that charge them with determining the reasonableness of the compensation sought, as well as its relation to criminal injury. In cases involving physical injury, simple review of the diagnosis and subsequent treatment usually serves to provide a clear sense of whether an injury was caused by a specific act of violence, and whether a standard and reasonable course of medical care has ensued. Mental health, however, is vastly less well-defined. The standardization of credentials, diagnoses, and treatment protocol available in the medical world are less clear cut in the mental health field. Philosophical and clinical differences, as well as the relative newness of the field, make it difficult to find norms or standards against which to evaluate the reasonableness of a particular practitioner's approach, and the consequent cost of care.

Questions that compensation programs frequently struggle with include the following:

- Is there a direct relationship between a particular crime and the ensuing psychological injury? What diagnoses accurately describe psychological injury for victims?

- How do preexisting conditions--either psychological conditions or simply "life circumstances"--affect the trauma suffered by the victim, as well as the length

and type of treatment offered? Can the amount and cost of treatment provided for victimization-related psychological injuries be separated from that provided for preexisting conditions?

- How much treatment is reasonable? When is a victim's recovery achieved? How can this be determined in individual cases?

- Which practitioners are qualified to provide treatment? What training is necessary to ensure their qualification?

Compensation programs have been striving to improve their ability to evaluate mental health claims through increased self-education, the development of peer review boards and expert consultation systems, and the promulgation of rules and standards attempting to fix criteria for mental health treatment. A number of programs have consulted closely with mental health professionals in their states to discuss how the program can best work within its resources to support adequate counseling.

Yet, in general, most state programs express increasing concern at the rising costs for treatment whose justification, duration or effectiveness may be difficult to assess. They believe strongly that they have a responsibility to ensure that good quality mental health treatment is provided to victims; they also know that they must protect scarce public funds against claims for ineffectual or unnecessary treatment, or treatment unrelated to criminal injuries and their effects.

To provide information and guidance to its members on the many complex issues surrounding the evaluation and payment of mental health counseling claims, the Association named a Mental Health Task Force in 1990. Task Force members were drawn from programs diverse in size, structure and location, and each had extensive experience with the issues to be considered.

Since its formation, the Task Force has spoken and consulted with a number of therapists and reviewed literature relating to mental health counseling for crime victims. Compensation programs provided information regarding how they evaluate mental health claims and allocate resources to cover counseling expenses. Some of these programs themselves had embarked on collaborative efforts with therapists in their own states to explore mental health issues and to formulate appropriate procedures and policies. While acknowledging that it would be impossible to consult with all the many individuals with experience in providing mental health counseling for victims, the Task Force believes it has gained a great deal of information and been exposed to many differing perspectives.

The Task Force hopes this report will help programs to understand better the complex issues surrounding provision of mental health counseling to victims, so that they can develop their own strategies for effectively evaluating counseling claims. The Task Force does not claim that it has resolved the many issues that programs encounter in this area; it simply hopes that it has shed light on some of them, and that this report will serve as a basis for further examination by individual states.

The Task Force does not believe it appropriate to recommend that all compensation programs follow a standardized approach to payment of mental health counseling claims. The Task Force points out that many of the issues regarding length of treatment, preexisting conditions, and provider qualifications do not lend themselves to easy answers. While this report attempts to set forth the Task Force's assessment of existing knowledge and experience on these issues, there are many matters that remain open to varying interpretations. Just as importantly, states have varying resources for both claims payment and administration, and each must determine the appropriate ways to allocate those resources to meet the needs of the victims it serves.

At the outset of this report, the Task Force believes it important to declare that there can be no question about the crucial need that many victims have for mental health counseling, or the great value of the work dedicated therapists perform to aid in those victims' recovery. We affirm our deep respect for the results therapists achieve daily in relieving the psychic suffering that numerous victims endure. We hope that all who read this report do so with the firm knowledge that it is intended as a constructive contribution to a continuing effort to find appropriate ways to support victims in their recovery from violent crime. We believe that compensation programs, mental health professionals, victims and their advocates must continue to work together to ensure that victims are assisted as fully as possible.

Section 1

BASIC CONCERNS OF COMPENSATION PROGRAMS

Programs not only have a mission to provide resources to assist victims in recovering from the effects of violent crime. Programs have a responsibility to ensure that statutory requirements and rules are met prior to making payment for any crime-related expense for which reimbursement is sought. This responsibility extends to all categories of expense, not simply to mental health counseling claims.

All programs share basic requirements for eligibility. The victim must sustain a physical or mental injury caused directly by the crime; the expenses for which the victim seeks payment must be only for treatment for injury caused by the crime; the treatment must only be as intensive and extend as long as necessary to effectuate recovery; and the expense must be reasonable. The claimant has the responsibility to provide appropriate documentation or proof to establish that these requirements are met.

The primary issues faced by programs in considering counseling claims, in essence, involve the application of these basic requirements to this particular category of compensable expense. Specifically, programs must attempt to evaluate the following with regard to coverage of counseling expenses in any particular case:

- Is the victim seeking treatment for a serious condition arising from a crime, rather than from some other cause?

- Will the treatment be directed to remedy the crime-related injury, rather than some preexisting or unrelated condition?

- Is the mode of treatment used to relieve the condition recognized as effective?

- Will the treatment be provided within a reasonable length of time and at a reasonable cost?

- Is the provider of the treatment qualified to render the treatment?

What makes the evaluation of basic compensability requirements so problematic with regard to mental health counseling claims are the following:

- The lack of agreement within the mental health profession over ways to treat mental and emotional conditions, and the absence of a well-established standard length or course of treatment for victims suffering from those conditions;

- The therapeutic problems inherent when a victim suffering from a crime-related mental problem also presents a prior or non-crime-related condition deserving of treatment (substance abuse, other psychiatric condition, other non-clinical problems); and

- The difficulty, in some cases, of establishing that a mental health problem is caused by the crime, and not wholly or partially by some other condition, factor or event that existed or occurred prior to the crime.

To some degree, these issues are not unique to mental health counseling. Victims who have been physically injured also may have prior physical conditions that complicate treatment. An infirm person, for example, or someone with a preexisting physical problem, may sustain a more serious bodily injury, and require more treatment, than a more healthy person victimized in the same manner. But for most physical injuries, there appears to be much more standardization with regard to treatment procedures and expected outcomes. In other words, most victims with a particular physical injury will undergo a standard type of treatment that can be expected to cost within a certain range. And it is usually more readily apparent that a particular physical injury has resulted from a specific act of violence, rather than from some other cause.

Programs are understandably concerned when counseling claims are received for types of victimizations that on the surface might appear similar, but involve treatment of significantly varying lengths. One

adult victim of a rape committed by a stranger may request compensation for a few weeks of therapy, while another victim of a similar crime may seek payment for many months, even years, of treatment. Of course, programs know that not all stranger rapes are the same, and that different individuals will respond differently to trauma and therapy. But there appears to be little concrete guidance, other than the professional perspective of the treating therapist, for programs to make use of in their efforts to evaluate whether treatment of extended length is necessary or effective.

As demand for victim-compensation dollars grows, programs are more and more concerned about whether they will have sufficient resources to meet the needs of all the victims seeking financial assistance. Programs find themselves having to scrutinize carefully their expenditures in every expense area, including mental health counseling, to ensure that scarce funds are spent appropriately.

It is important to emphasize that basic statutory requirements of crime-relatedness and reasonableness of cost, and the basic concerns of compensation programs relating to conservation of precious funds, apply to all categories of expenses, not just mental health. Subsequent chapters of this report will attempt to examine specific mental-health issues within the context of these basic requirements and concerns.

Section 2

MENTAL INJURY AND DIAGNOSIS

One of the first tasks faced by a compensation program in evaluating a mental health counseling claim is to confirm that a mental injury related to a criminal event has occurred. To do this, programs should have a working knowledge of the effects of victimization and the diagnoses used to describe the conditions and problems victims suffer. An informed program can interpret information provided by therapists more readily, and can feel more confident about whether the claim satisfies statutory requirements for payment.

That a victim would suffer emotionally in the aftermath of violent crime or abuse is to be expected. The victim's personal integrity, trust and safety have been violated, perhaps in a particularly vicious way. Many victims will suffer some disruption, the seriousness of which will depend on the seriousness of the crime. Some victims may lose a night of sleep, or feel depressed or anxious for a short time. Other victims will have much stronger reactions, sometimes rising to the level of a severe psychological condition.

While a full discussion of diagnostic issues is far beyond the scope of this report, the material presented in this section is offered to provide some general knowledge, and to serve as background to a number of concerns addressed in other sections. This information can only be considered a layperson's primer, and is not intended as an exhaustive or technical exegesis of the complex issues touched upon. At most, it is a starting point for programs that wish to pursue more detailed information.

Mental Health Effects of Crime

It is widely accepted that crime can traumatize victims and their families. Mild-to-severe psychological effects, disruption of family and social relationships, and difficulty in returning to normal behavior and thought patterns are not unusual in the aftermath of violent criminal injury. While many victims appear able to recover within a short period of time and exhibit few symptoms of acute distress, evidence indicates that other victims may be affected long after the crime. According to professionals, the emotional and psychological response to victimization will vary widely according to the type of crime, its severity, and the unique personality and life situation of each individual victim.

What most victims of severe violence or abuse experience is usually described as "a normal reaction to an abnormal event." In other words, the severe psychological reactions some victims have to criminal violence are not strange, and do not indicate they are "sick" or "crazy." Victims are usually ordinary people who, having been exposed to a profoundly distressing event, are behaving in understandable and expected ways.

Professionals often speak of three stages through which many victims of extreme personal violence progress following a criminal event.[1] These are the following:

- ***Stage 1:*** This is the acute crisis phase, where the victim may be in a state of shock, disbelief, denial, and/or temporary paralysis. Terror, rage, anxiety, and/or a feeling that "this can't be happening" may be experienced by the victim. Overwhelming fear and stress may make it impossible for the victim to function normally. This stage may last anywhere from a few minutes to a few months, according to some experienced observers, but many expect that for most victims the acute crisis will pass within a few days or weeks, especially if the victim receives prompt intervention.

- ***Stage 2:*** The victim is sometimes described as having an "open wound" during this post-crisis stage, as the victim adjusts and copes with life after the crime. Victims can continue to feel anger, depression, and/or grief; they also may experience agitation, restlessness, insomnia, nightmares, uncontrollable crying, humiliation, loss of identity and self-respect, guilt and self-blame, erosion of trust in others, and even rejection by others. The victim may have persistent and intrusive recollections of the crime ("It's the first thing I think of in the morning"; "I'll see something and it will all come back to me"), and be unable to concentrate on normal activities. Some victims may suffer perceptual disturbances, including flashbacks, hallucinations, illusions, and "dissociative" problems (a complex reac-

tion involving loss of awareness and/or alteration of self-identity, which at its most severe becomes multiple personality disorder). Some victims will exhibit aggressive or suicidal behavior, or may abuse alcohol or drugs. Problems with sexuality and relationships may be experienced. These reactions may be affected dramatically by the degree of support the victim receives from family and friends, as well as from law enforcement and service programs. The length of time that this stage lasts is widely variable.

• *Stage 3:* The victim's long-term reaction comprises this stage. Physical and emotional symptoms brought on by the violence, such as nightmares, phobic fears, and overwhelming anger usually have abated, but the victim's outlook on life may still be profoundly affected, and important relationships may be troubled. The victim may still feel a sense of irretrievable loss, sadness, and may be unable to "come to terms" with the crime. Some of these larger issues may never be satisfactorily resolved, and some victims may suffer difficulty the rest of their lives. Others will make adjustments necessary to carry on, and may even feel new strengths.

Therapists emphasize that every victim is unique, of course, and each will have an individual reaction to whatever trauma has befallen them. One person may survive an assault and experience little stress; another may be severely affected by the same type of crime. It is natural to assume, however, that crimes involving a high degree of trauma or personal violation, such as rape, sex assault, attempted homicide, aggravated assault, and child sexual abuse will result in greater degrees of emotional disturbance, which may be severe enough to require mental health therapy.

Diagnostic Categories

When a victim seeks treatment, a therapist must first determine what the victim's mental condition is, so that appropriate treatment can be provided. Using various assessment and evaluation tests and techniques, the therapist identifies the specific symptoms from which the victim is suffering (the "presenting condition"), and relates them to particular causes, if possible. The therapist then may make a diagnosis, using standardized criteria.

While some psychiatrists contend that a truly accurate diagnosis requires a thorough clinical evaluation of all relevant physical, mental, and social variables, as a practical matter therapists not possessing medical degrees may not undertake extensive testing of victims. Instead, they may rely upon what the victim tells them about the victim's emotions and behavior, as well as prior life events and trauma that could affect psychological response. If diagnostic uncertainty persists, some standardized psychological tests can be useful. While non-physician therapists are not qualified to perform medical tests, they should be alert to potential mental effects of physical trauma, particularly to the head, and refer victims to doctors when a physiological basis for a psychological condition is a possibility.

In making diagnoses, therapists of all disciplines generally use diagnostic categories recognized and described in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. First published in 1980, the manual is now in its revised third edition, and commonly is referred to as *DSM-III-R*. The manual is the "Bible" for the mental health profession, and provides specific criteria that must be met to apply a particular diagnosis in individual cases. The *DSM-III-R* diagnostic categories are almost universally used and accepted in the health care industry to establish the need for treatment.

The *DSM-III-R* is comprehensive, covering all types of mental disorders. While nearly all psychological symptoms have been seen in victims of violent crime, this discussion will focus on those disorders that are most usually associated with mental injury brought on by criminal trauma. These disorders are thought to be "episodic" in nature, that is, traceable to specific episodes or traumas, as opposed to an underlying personality or physical disorder, and susceptible to treatment that can bring about full or nearly full recovery.

Generally speaking, the most frequently diagnosed trauma-induced disorders are post-traumatic stress disorder (PTSD), generalized anxiety, phobic disorder, panic disorder, depression, and dissociative disorder. Specific criteria must be met to diagnose a victim as having any one of these disorders. Some victims may suffer from more than one condition.

A full discussion of all the diagnostic categories that could apply to victims is impossible here. A brief summary of PTSD will be provided, however, since it is the diagnostic category that therapists use most frequently to describe the effects of victimization. A short description of dissociative disorders, particularly multiple personality disorders, also is included.

It is important to note that many therapists believe that a large number of victims who are highly distressed and urgently need counseling do not meet the strict criteria of PTSD or any other diagnostic category. For example, a child victim may have nightmares; feel guilty, fearful and depressed; exhibit low self-esteem; possess poor social skills; and have severely distorted thoughts regarding personal safety, sex, and other important issues, without manifesting enough other symptoms to justify a PTSD diagnosis. Yet without appropriate treatment, therapists say, the child may continue to suffer psychological problems that can become even more serious at a later age. Similarly, adult victims also may have significant problems coping in the aftermath of crime, but their symptoms may not rise to the level of a diagnosable condition according to the strict criteria of the recognized disorders. Some experienced therapists, recognizing the need to designate a reimbursable diagnosis so that the victim is qualified for third-party payment, will strive to apply recognized *DSM-III-R* categories if at all possible.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is the term most widely used by mental health professionals to describe acute responses to violent crime. It was originally developed to characterize the severe combat-stress reactions experienced by returning Vietnam War veterans, but therapists now use it to describe reactions to trauma caused by violent crime, natural disaster, and any other "psychologically traumatic event that is generally outside the range of usual human experience."

PTSD is currently defined by the following criteria:

1. Experience of an unusual event that would be extremely distressing to almost anyone, such as a serious threat to one's life or physical integrity, or that of one's children, spouse, or other close relations and friends.

2. Persistent reexperience of the traumatic event through recollections, nightmares, flashbacks, or intense distress at exposure to reminders of the event.

3. Persistent avoidance of stimuli associated with the event, as demonstrated by efforts to avoid thoughts or activities that arouse recollections of the trauma, loss of memory regarding the traumatic event, markedly diminished interest in significant activities, feelings of detachment or estrangement from others, loss of emotional response, or loss of hope in the future.

4. At least two of the following symptoms that were absent before the trauma: exaggerated startle response, sleep disturbance, irritability or outbursts of anger, hypervigilance, trouble concentrating, or intensification of physical symptoms when exposed to events associated symbolically or in actuality with the original trauma.

This disorder is defined as acute when symptoms appear within six months after the traumatic event and last no more than six months. A delayed form is when symptoms surface more than six months after the trauma, and a chronic form is characterized by symptoms lasting for more than six months.

While therapists have applied PTSD with relative success to symptoms experienced by crime victims, many therapists believe that its criteria only partially fit the majority of crime victims. Some believe that its criteria should be broadened to cover the brief but severe stress reactions that do not, strictly speaking, qualify as PTSD. The next edition of the Diagnostic and Statistical Manual (DSM-IV) is expected to redefine the category, enlarging it to embrace symptoms both more and less severe than currently accepted.

Very little research has been done to show the prevalence or duration of PTSD symptoms in various types of crime victims. This research is extremely difficult to perform, given that victims are very different individuals to begin with, and the circumstances of each crime are highly distinct. Nevertheless, it is generally recognized that PTSD may ensue for rape victims, as well as other victims who have been exposed to severe or prolonged trauma. According to some researchers, PTSD-related symptoms (with the exception of fear and anxiety) decline within three months for rape victims[2], though a relatively large proportion of such victims, estimated at from 33% to 63% by different researchers, will continue to exhibit symptoms that disrupt daily functioning.[3]

Dissociative Disorders and Multiple Personalities

While dissociation and multiple personality disorders are not fully understood, it is possible to provide some description of these phenomena. Both are recog-

nized as diagnostic categories in the *DSM-III-R.*

We all experience dissociation in its milder forms; it is simply an involuntary, natural mechanism in which conscious awareness of the environment is lost because of an absorption in thought or some matter outside of oneself: daydreaming, or reading a book, for instance. But dissociation for trauma sufferers can be of a far different order, involving a serious loss of awareness of self or surroundings, and even, at its most extreme, development of distinct personality states within the individual. The trauma victim who does not remember parts of what happened to him and the person with multiple personality disorders have both dissociated, but the phenomenon is more intense in the latter individual and has more potentially severe consequences.[4]

Dissociation can be a defensive protection against conscious awareness of overwhelming emotions, sensations, thoughts, and negative behaviors, that otherwise would overwhelm and handicap the individual. While useful, in one sense, in allowing the individual to function, dissociation is generally a poor adaptive response, and can become so extreme that it interferes with functioning and development, particularly in children. A victim who dissociates may enter into trance states in response to trauma-related stimuli; perceive surroundings as being unreal; experience a feeling of being unreal or not one's self; and be unable to recall important events or personal information. In more severe dissociation, the victim may perceive that a separate part of the self has not experienced the actual traumatizing event, or that only a part of the self experiences unacceptable emotions related to the trauma.

Victims diagnosed as having a multiple personality disorder appear to have developed two or more separate and distinct personalities, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self. According to the *DSM-III-R*, at least two of these personalities recurrently take full control of the person's behavior. While multiple personality disorders are extremely rare, they are more likely to occur among those with histories of severe, repeated trauma experienced as life-threatening, who have adopted habitual dissociative responses to stress, and who have not previously received adequate professional care. Child victims of prolonged abuse whose therapeutic needs have been neglected may be particularly susceptible to multiple personality disorder.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. Since the *DSM-III-R* diagnostic categories are widely accepted by the mental health profession and the health insurance industry, compensation programs also can use them as a basis for establishing the existence of mental injury caused by crime. Programs can expect to see claims from victims who are being treated for PTSD, anxiety, depression, dissociation and other disorders found in the *DSM-III-R.* In addition, since many therapists say that some victims may suffer severe mental problems and are in need of treatment, even though their symptoms may not rise to the level of a *DSM-III-R* diagnosis, programs also should also consider payment for them. As a practical matter, since most therapists nearly always use diagnostic categories or approximations thereof, few claims will be received that on the surface do not present a diagnosed condition that could result in compensable expenses for treatment.

2. Programs also may be able to assume that, in general, the seriousness of mental injury is related to the gravity of the crime. When a victim has experienced either intense or repeated violence, placing the victim's health or life at risk, a greater likelihood exists that a serious injury can occur. Different victims will have widely varying reactions to types of trauma, however, depending on their own perceptions of the event, as well as their own personality and psychological makeup. Primary crimes that result in PTSD or other major mental conditions are rape, sex assault, and any offense involving actual or threatened serious physical injury. In addition, programs can presume that children who suffer physical or sexual abuse, particularly when committed by a close relative, or when the abuse is prolonged or involves physical threat or harm, are likely to require some treatment. This does not mean all victims of serious crime will sustain mental injuries requiring treatment. Many will not, and will not seek treatment. But programs will not be surprised to see

a greater percentage of rape victims, child abuse victims, and victims of life-threatening crimes seeking mental health counseling.

3. The Task Force urges programs to provide information and training to staff on mental health issues. Staff should have at least a basic understanding of diagnostic and psychological terminology and concepts in order to make judgments about mental health counseling claims. Training is often available at conferences for victim service practitioners, and mental health professionals also may be available to provide information and training directly to program staff. A good deal of written material on the mental health effects of victimization also exists.

Notes

1.While many victimization experts have written about the three typical stages of victimization, the Task Force notes the important work of Morton Bard, Ph.D., and Dawn Sangrey, authors of The Crime Victim's Book (published by Brunner/Mazel, Inc., New York); Lucy Berliner, M.S.W., of the Harborview Sexual Assault Center, Washington; Dean Kilpatrick, Ph.D., and Benjamin Saunders, Ph.D., of the Crime Victims Research Center, South Carolina; Ann Burgess, R.N., D.N.Sc. University of Pennsylvania; and Marlene Young, J.D., Ph.D., National Organization for Victim Assistance.

2.Kilpatrick, D.G., Vernon, L.J., & Resnick, P.A., "Assessment of the aftermath of rape: Changing patterns of fear," Journal of Behavioral Assessment, 1, pp. 133-148.

3.Burgess, A.W., and Holmstrom, L.L., "Adaptive strategies and recovery from rape," American Journal of Psychiatry, 136, pp. 1278-1282 (1979) (63% estimate); McCahill, T.W., Meyer, L.C., and Fishman, A.M., The Aftermath of Rape (Lexington, MA: Heath and Company, 1979) (33% estimate).

4. James, Beverly, Treating Traumatized Children, (Lexington, MA: Heath and Company, 1989). Ms. James, a clinical social worker, cites work of B.G. Braun in her excellent discussion of dissociative disorders.

Section 3

TREATMENT OF MENTAL TRAUMA

Prior to approving payment for counseling claims, compensation programs must be satisfied that the therapy is directed toward crime-related mental trauma, that it is recognized as effective, and that it is provided at the least intensive level necessary. For example, if once-a-week individual therapy is recognized as sufficient to achieve therapeutic results, then inpatient hospitalization is not justified. Again, these requirements are not unique to the evaluation of counseling claims; they apply across the board to all types of compensable medical expenses.

While programs rarely feel the need to question specific therapeutic techniques, some knowledge of the types of treatment generally provided to crime victims should be helpful to programs in evaluating counseling claims. A familiarity with basic terms employed by therapists, as well as strategies to achieve recovery, will aid program staff in analyzing documentation provided by therapists in support of counseling expenses.

Programs also should understand the uses of treatment plans, and should consider requiring their submittal by therapists in every case for which payment is sought. A treatment plan is essentially a "blueprint" for the therapist, detailing the problems or conditions presented by the victim, the types of treatment that will be employed to address each problem or condition, and the goals of treatment. Therapists use these plans to guide their work, and programs can use them to evaluate whether mental injuries are crime-related and whether treatment is directed specifically toward those crime-related conditions.

TYPES OF TREATMENT

Mental health counseling is provided in a variety of settings. Crisis intervention, individual therapy, group therapy, and family therapy are the primary ways in which treatment is performed.

In addition, therapists use a variety of treatment methods. A number of different stress management and coping strategies can be taught, and "cognitive" and "behavioral" techniques are commonly employed. Psychodynamic and psychoanalytic therapies, though less often used for trauma victims, have some adherents among therapists. Medication can be an important adjunct to therapy for some victims. For children, forms of "play therapy" are often the treatment of choice.

Many therapists treating crime victims share the same general approach and use generally similar treatment "modalities." Yet differences in educational background (psychiatry, psychology, social work), experience, and professional philosophy result in a range of treatment technique or emphasis.

There is no one standard treatment that the mental health profession has recognized as most effective, or that therapists are expected to employ when treating specific disorders. While some studies show that certain types of treatments have been particularly effective in treating specific symptoms or issues, research studies to compare the efficacy of various treatments is sparse. It also remains unclear whether victims suffering from certain disorders, like depression, who do not receive professional care will improve on their own. Still, it is widely accepted that professional treatment certainly should have significant beneficial effect, and will shorten the recovery time for most victims.

The following material provides some background on treatment generally provided to victims. In this discussion, no distinction will be made between "counseling" and "psychotherapy." Some observers believe that no real difference exists between the two, since the nature of the relationship between the counselor/therapist and the person seeking help is essentially the same, and the process that occurs does not seem to differ. It is noted that if the therapist is a medical doctor or psychologist, the term psychotherapy is generally used; when it involves other types of therapists, what is done is often called counseling. While some may quarrel that objectives in treatment, and techniques available, may vary significantly between counseling and psychotherapy, there appears to be no need in this report to make distinctions, and no attempt to do so is intended.

In a complete treatment program, it will not be unusual for some victims to receive some combination of the therapies described below. For example, a rape victim may receive some assistance from a hospital-based crisis center, and then continue with individual and group therapy. Children also may be treated in individual and group settings, and family members may be involved.

Crisis Intervention

Crisis intervention is sometimes referred to as "psychological first aid." It is often provided in emergency rooms or other hospital settings by rape crisis counselors or advocates, or on a limited basis by other mental health practitioners. "Hotlines"--phone numbers that victims can call for advice and support--also can be considered crisis intervention.

Crisis counseling is brief, directed therapeutic intervention that consists primarily of providing support, information, and assistance in immediate decision-making. It aims to stabilize the victim and restore the victim's previous level of functioning as quickly as possible. It often includes expressing regret and displaying compassion, as well as assisting with practical needs. The crisis counselor may help to ensure that the victim is physically safe, and provide referral for medical care and other services and financial assistance.

Crisis intervention may be necessary when victims and their families are in a state of acute disequilibrium following a violent crime, or, in the case of children, the revelation or reporting of the crime. A crisis may also be precipitated at some later point, such as when the offender is released from prison.

Crisis intervention will usually take place in from one to five sessions that occur very soon after the crime. The goals of crisis intervention--stabilization, support, information--usually are achievable by trained personnel within a short period of time. Crisis intervention therapy is not expected to address lingering psychological disturbances produced by the victimization experience. However, many experts believe that crisis intervention is essential to assuring the maximum emotional recovery of the victim, and will make overall treatment shorter and more successful.

Individual Counseling or Psychotherapy

Individual psychotherapy focuses on assisting people in understanding, expressing and changing emotions, thoughts, and behavior that are disturbing or distorted, or that impair normal functioning. It is intended to reduce the acute negative psychological effects of victimization by enabling the victim to alter behavior and thinking that may have been adversely affected by the crime trauma, and by assisting the victim to "come to terms" with the crime.

Therapists working with victims ordinarily target specific abuse-related symptoms, such as fear, nightmares, intrusive thoughts, and difficulty concentrating, and help the victim overcome these symptoms. Therapists also work with victims to overcome depression and self-blame, adjust to difficulties being experienced in work or relationships, and explore "existential" questions. ("Why did this happen to me? Will I ever feel safe again? What should my attitude toward others and the world be?")

Techniques used by psychotherapists include guiding the victim within the safety of the therapeutic setting to reexperience the criminal event in memory and to express feelings associated with the crime. The goal is to enable victims to manage emotions and thoughts related to the crime without undergoing intense anxiety or other negative effects. This is felt to be a healthier adaptation than avoidance, repression, or dissociation.

There is a broad spectrum of psychotherapeutic orientations, and some therapists will employ a variety of techniques focused on modifying thinking or behavior disturbing to the victim.[1]

Stress management and coping techniques are useful in treating common intrusive symptoms like flashbacks, nightmares, startle responses and hypervigilance. Some of these techniques are emotional ventilation, external structuring and problem-solving, stress inoculation training, and relaxation.

Cognitive/behavioral techniques modify distorted thinking and undesirable behavior. In general, "cognitive restructuring" is based on the premise that distorted or unrealistic beliefs may contribute to many emotional

and behavioral problems. Similarly, therapists using behavioral methods believe that a positive change in functioning will affect the way the victim thinks and feels.

Many therapists will use a mix of cognitive and behavioral techniques to work on a variety of symptoms or issues. For example, the victim may have been assaulted while shopping, and now may be extremely fearful of going out to stores; or the victim may have been raped by a brown-haired man wearing a leather jacket, and now experiences overwhelming anxiety when seeing any man with a similar appearance. The therapist will assist the victim to recognize that the act of shopping is not dangerous in itself, and that not all brown-haired, leather-jacketed men are rapists. The therapist may help the victim learn to stop thoughts that are disturbing, or may use a technique called "desensitization," which involves repeated imagining of situations related to the criminal event that are currently stressful but not realistically dangerous, with the objective of reducing anxiety. Self-blame, guilt, shame, distrust of self and others, anger, frustration and sadness are also responses that can be "reconceptualized" with help from the therapist, who may provide accurate information and logical analysis (e.g., you were not responsible for the crime, you can exert control over emotional behavior, you have a right to feel angry). The therapist can help the victim place the event into some perspective, and to "decatastrophize" it. Other techniques include relaxation, stress management training, assertiveness training, anger management training, problem-solving, goal setting, decision making, and sex therapy.

Psychodynamic or psychoanalytical approaches may involve searching for solutions to an individual's current problem through an examination of clues in past experience as well as current behavior. Some experts believe that psychodynamic and psychoanalytic techniques are less appropriate for treating trauma relating to recent victimization, though it may be used effectively with some adult survivors of incest. There is little research or evidence that would indicate that this orientation is better or worse than any other.

The above description of typical therapeutic techniques is not intended to be definitive or exhaustive; it is offered only to provide some sense of the therapist's task and approach.

Individual therapy is traditionally provided on a once-weekly basis, though it is not uncommon for more sessions to be provided, particularly in the early stages of treatment. It is not considered necessary or normal for a patient to be hospitalized in order for individual therapy to take place.

Play Therapy

For young children, individual treatment is often conducted with some elements of play therapy, since children are usually less able to express themselves through language, and because they are thought to process experiences through play and activity more than through thought. Play therapy is widely accepted within the mental health profession as effective, and is usually the treatment of choice for children too young to articulate effectively in the standard adult "talk-therapy" format. Play is the vehicle of communication between the child and therapist, and allows the child to enact those things for which she does not have words, as well as to express unconscious feelings.[2]

A typical child therapist's office may be filled with toys, or with large soft bats that children can use to express anger or aggression. As in individual therapy for adults, the therapist's role is to enable the child to manage negative feelings arising from the victimization, and to discourage or remove distorted perceptions of self and the outside world. Either the therapist or the child may set up play interactions that allow the child to reexperience an event or relationship in a different way and with a more positive outcome than that of the original event.[3] Play therapy is most often conducted on a once-weekly basis.

Group Therapy

Group therapy is based on the idea that individuals who suffer from a similar concern can help each other resolve certain aspects of the problem. Sharing with others in a similar situation can help victims feel less isolated or stigmatized by their victimization. Members of the group learn successful strategies for coping, and gain hope that their lives can return to normal, since others have experienced the event and are showing progress.

Group therapy is widely used for both adult and child victims. One problem experienced by therapists, however, is the difficulty of putting together a group composed of victims that are "at the same place" in the recovery process. Those that may be more distant in time from the criminal event than others may have

progressed beyond the point where the sharing of similar experiences can benefit all members of the group.

Typically, group therapy is conducted on a weekly basis under the guidance of the therapist. Group members are encouraged to express their thoughts, emotions, and experiences, and to respond to what others say. Some groups are established for a specific number of sessions, while others are open-ended.

Family Therapy

Therapy involving family members of "direct" victims may have several different purposes. First, family members may be brought in by the counselor to be informed and educated about the aftereffects of victimization, so that they can provide helpful support to the victim. Second, therapy can be provided to family members to treat their own symptoms or problems created by the criminal event. Finally, the family itself can be the target of therapy, when faulty family dynamics are themselves causing or exacerbating the individual victim's problem.

This last objective is the focus of what is normally called "family therapy" within the mental health profession, the idea being that an individual's problems are substantially influenced by the organization of the family unit and the interactions among family members. When the goal is primarily to provide effective support for the actual victim, involvement of the family in treatment may not technically be "family therapy," since the therapist is not truly attempting to change faulty family-behavior patterns. Rather, the goal is to provide information about what the victim is going through, and to encourage support for the victim. In addition, family members may have a need to express their own feelings and reactions in a professional setting, and be counseled to some degree, in order that progress can be made with the actual victim. The therapist may explore the reactions of family members to the crime to ensure that those reactions are not impeding the work being done with the victim.

Family involvement is most often sought when the victim is a child. In that context, inclusion of family members in therapy can have multiple purposes. The capacity of the parents and family to be supportive of the victim significantly reduces the level of victim distress. Parents also may be necessary to carry out or sustain certain therapeutic interventions outside of the therapist's office. In addition, parents and nonvictimized siblings are known to have increased psychological distress themselves that may deserve some attention, if only to enhance the recovery of the child who was the subject of the crime. Therapists also say it is not uncommon for a child's abuse experience to evoke psychological distress related to an unresolved victimization experience in a parent.

Finally, where children may again be living with an offender, family therapy is considered an imperative to ensure physical and emotional safety. However, treatment that includes offenders with victims raises a host of very difficult issues beyond the scope of this article. It should be noted, however, that many therapists view such treatment with extreme disfavor, particularly in spousal abuse situations.

It should be noted that therapy targeted primarily at the effects of the victim's experience on other family members or otherwise "close" persons, may or may not be compensable under individual state law. In about half the states, family members who are "co-victims" or "secondary" victims are eligible for at least some amount of compensation for their own mental health treatment. Other states are not authorized to pay for this treatment, however.

Inpatient Hospitalization

Hospitalization is <u>not</u> necessary unless the victim is suicidal or a threat to others, or cannot function to take care of himself or herself. Hospitalization, particularly for extended lengths of time, is a radical medical management option, not a therapeutic strategy or technique. It is not necessary to hospitalize a victim simply to perform therapy or treat crime-related symptoms and conditions, unless the victim is dangerous or cannot survive unaided outside the hospital setting.

The goal of inpatient treatment is to stabilize the individual so that he or she is no longer a danger to self or others, and/or to provide custodial care until the victim is able to function and care for self. These limited goals can be achieved in anywhere from a few days to a few weeks, depending on how serious the problem is. Again, inpatient treatment is <u>not</u> necessary to treat the majority of symptoms from which victims suffer, such as nightmares, intrusive thoughts, anxiety, or depression not rising to suicidal behavior. When a victim is stabilized--no longer a threat to self or others, and able to care for self--the victim should be dis-

charged, and further therapy can take place on an outpatient basis.

"Day treatment," performed in all-day blocks of time without hospitalization, also is relatively rarely called for as a therapeutic option, since few victims either require or can tolerate the intensity of treatment that it implies.

Psychotropic Medication

Psychotropic medication may be used by psychiatrists in treating a wide range of disorders. Recent research shows that violent trauma can induce chemical changes in the brain, and that disorders like major depression have biological components. Appropriate medication can enable a victim to recover from debilitating mental conditions, like depression, or to alleviate symptoms such as insomnia, impaired concentration, and startle reactions. When these conditions or symptoms are improved, other types of treatment that were hindered previously can be successfully employed.

Medications prescribed by psychiatrists for conditions or problems victims could experience can include antidepressants, anti-anxiety drugs, anticonvulsants, beta blockers, and anti-psychotics. This report cannot examine the efficacy of these drugs. While they may have many uses, the majority of victims will not be prescribed medication, if only because most of them will not be under the direct care of physicians. However, non-physician therapists should be alert to signs that medication may be called for, and should refer victims to doctors for an appropriate evaluation.

It should be noted that no medication is recognized as a remedy for PTSD itself. As mentioned above, however, certain drugs may be effective in treating specific PTSD-related symptoms.

Alternative Therapies

According to some experts, certain types of treatment should not be utilized as either the primary or sole means of treatment. While therapy involving art forms (painting, dance, drama) can be particularly helpful for individuals with impaired speaking, hearing, or reading skills, or for children or others who have difficulty connecting feelings with words, it is not adequate in and of itself, some experts say. Instead, it may be used as an adjunct to other, more accepted therapies, and as a way to open up communication between the victim and the therapist.

Native American Traditional Healing

American Indians have practiced traditional healing methods for thousands of years. While a full discussion of the many types of healing performed by and for Native Americans is not possible here, it should be emphasized that traditional healing is fully recognized as legitimate in Indian culture, and its effectiveness has been demonstrated over many centuries.

While each of the hundreds of individual tribes in North America practices its own traditions, researchers have described a number of similarities. Indian healing practices are based on Indian spiritual beliefs, and are closely tied to religious customs. Wellness is defined as harmony in mind, body, and spirit, which are interconnected. Disharmony within or among these elements may create illness, and the task of the traditional healer is to restore the harmony necessary to health. Ceremonies, such as those performed in "sweat lodges," herbal medicines, and other means unique to each of the tribes are performed and provided by "medicine men" and other healers recognized by individuals and tribes as qualified to provide this assistance.

TREATMENT PLANS

Many therapists make use of treatment plans to guide their work with individual victims. The treatment plan is essentially a blueprint for providing therapy to an individual victim. The treatment plan describes the symptoms, problems or conditions for which the victim seeks help. It may evaluate what symptoms relate to the crime as opposed to some other cause, and describe significant factors that may influence the claimant's recovery (e.g., lack of family or community support, preexisting conditions). It sets specific goals for the therapy, such as improvement in self-esteem, amelioration of nightmares, or management of negative feelings resulting from the crime. It describes modes of treatment that will be used to achieve the specific goals. It may or may not set time frames to attain each goal; many therapists insist that it is impossible to predict in advance how quickly individual victims will progress in therapy. In any event, it is generally <u>not</u> a forecast that a specific result will be obtained within a set length of time. Rather, it is a plan of attack, against which the progress of the victim in therapy can be measured.

The treatment plan can be a valuable tool for compensation programs as well. In reviewing treatment plans, programs can see specifically what conditions the therapist is focusing on, and whether those conditions relate to the crime. The plan provides a means for for checking progress toward the goals and objectives set for the therapy.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. While there are no enforceable standards regarding what treatment must or should be provided by mental health professionals in treating crime victims, there is general consensus among many practicing therapists about effective modes of therapy for victimization injuries. Programs generally would be unwise to make any effort to dictate that any particular type of treatment be provided or avoided, absent clear evidence regarding its unusual, unnecessary, or destructive nature. Focus instead must be on whether the treatment is directed toward crime-related symptoms and issues, and whether the therapy produces results.

2. Programs are urged to consider requiring claims for mental health counseling to be documented with mental health treatment plans completed by the therapist. The treatment plan should detail symptoms and diagnoses; preexisting conditions as opposed to crime-related injury; the type of treatment to be used to deal with each symptom or problem; and the goals for each type of treatment. [A sample treatment plan is included in the appendix to this report.] At a minimum, treatment plans should be required in cases involving extended or extraordinary treatment.

If treatment plans can be reviewed by programs shortly after the beginning of therapy, decisions may be made about issues such as the portion of treatment directed toward crime-related injury so that victims and therapists know how much could be covered by the program. If this is not practical, because requests for coverage may be received or evaluated after the completion of therapy, the treatment plan still can serve as an aid in the program's evaluation.

3. A special note: Programs are urged to accord full respect to healing systems traditional to Indian cultures. When Native American victims prefer healing methods used effectively for thousands of years, programs are encouraged to support such practices.

Notes

1. Courtois, Christine A., Ph.D., Healing the Incest Wound (New York: Norton & Company, 1988).

2. O'Connor, Kevin John, The Play Therapy Primer (New York: Wiley & Sons, 1991).

3. Ibid., p. 100.

Section 4

CRIME-RELATED INJURY AND PREEXISTING CONDITIONS

Compensation programs are authorized only to pay for treatment of crime-related injuries. When victims are physically injured, it can be relatively simple to determine whether medical care is directed toward healing specific injuries arising from the crime. But mental health treatment can be more complicated, as the first sections of this report have indicated. It may be difficult to discern what aspects of the victim's post-crime mental state are entirely due to the effects of crime, as opposed to a preexisting or unrelated condition or problem; and it may not be easy to focus treatment exclusively on those symptoms or problems caused solely by the victimization itself.

Nevertheless, most therapists will evaluate a victim seeking treatment to try to determine as precisely as possible the conditions or problems that are disturbing the victim, as well as the causes that may have brought them about. In doing so, the therapist should be able to gain a fairly complete picture of what symptoms or issues are directly related to the crime, as opposed to some other basis. Most of these symptoms and issues can be specifically addressed by the therapist and patient, so that some separation of treatment for crime-related injury and preexisting problems and conditions can be made.

Still, therapists emphasize that victims are "whole" individuals. A seriously traumatic event will affect many facets of a person's life. To "heal" the victim fully, some therapists contend, it may be necessary to deal with a number of issues that relate to the individual's past and current life. While many therapists believe strongly that it is possible--and necessary--to focus counseling primarily on the victimization and its aftereffects, most agree readily that other aspects of this "whole" person will come up in therapy. Indeed, since part of the therapeutic mission may be to explore ways to function positively in a world that seems very different after the crime, a person's "life"--family, relationships, work, etc.--may necessarily be a subject for examination.

Few victims are likely to have a history of clinically significant psychiatric problems prior to being victimized. We can assume this because the incidence of serious mental illness in the general population is small, and crime can occur to anyone, at random. But some victims will have emotional or behavioral difficulties that precede the criminal event, such as abuse of alcohol or drugs, or stemming from other problems or circumstances, such as dysfunctional families. And while treatment for alcohol or drug abuse will be different from therapy for crime-caused mental problems, treatment of a victim with a history of a depressive disorder that has been made worse by the trauma of crime, or of a victim whose prior family relationships have created problems that are affecting the victim's reaction to the crime, will not lend itself so easily to a clear distinction between therapy focused on preexisting conditions and issues and that which is directed toward crime-related symptoms.

This difficulty is not one found simply in the mental health arena; as an example, if a bone already weakened by age or some preexisting trauma or infirmity is subjected to a blow, it may break, while a stronger bone may simply be bruised. Should the compensation program pay only for the amount of therapy that would be required to heal a strong bone? Probably not, but if the reason the bone broke so easily is because it is cancerous, the program might feel no obligation to pay for a course of care to cure the cancer, which is completely unrelated to the criminal injury. Similarly, programs will have an understandable concern when underlying conditions (prior family problems, substance abuse) appear to be a main object of therapy.

It also should be noted that, unfortunately, a significant proportion of the population has been victimized at some time during their lives, and that these prior victimizations may affect treatment for the current crime-related injury. Some estimate that as many as a third of the female population, and 10% of males, have been sexually abused before the age of 18. An individual may never have sought treatment for prior crime-related trauma, and treatment for the newest victimization may necessarily have to involve emotions

or issues raised by the prior crime(s). Again, this is not to suggest that compensation programs must cover counseling for prior victimizations, but practically speaking, the therapy for current crime-related trauma may also necessarily address the mental aftereffects from that which happened previously.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. Programs should expect therapists to perform thorough evaluations of any victims they treat, in order to determine as precisely as possible which presenting conditions are caused by criminal victimization, and which problems preceded or are unrelated to the crime. The therapist also should be required to detail the approach that will be taken to deal with each of the victim's problems that are the object of treatment. Programs can then make better determinations about what portion of the treatment is directed toward crime-related injury as opposed to that which focuses on other or prior conditions.

2. Programs can insist that they will pay only or primarily for treatment directed toward specific objectives in healing crime-related problems. When treatment is clearly intended to achieve other goals, programs can feel justified in refusing payment. When a therapist believes that treatment of crime-related mental injury requires therapy for other, preexisting problems, or that those preexisting conditions have been exacerbated by the crime, the program may face a more difficult question.

3. A recommendation from section 3 of this report is repeated: Programs are urged to consider requiring claims for mental health counseling to be documented with mental health treatment plans completed by the therapist. The treatment plan should detail symptoms and diagnoses; preexisting conditions as opposed to crime-related injury; the type of treatment to be used to deal with each diagnosis or problem; and the goals for each type of treatment. If treatment plans can be reviewed by programs shortly after the beginning of therapy, decisions may be made about issues such as the portion of treatment directed toward crime-related injury so that victims and therapists know how much could be covered by the program. If this is not practical, and requests for coverage are received or evaluated after therapy is well underway or substantially complete, the treatment plan still can serve as an aid to the program's determinations.

Section 5

LENGTH OF TREATMENT

In general, compensation programs have a responsibility to ensure that the cost of services being paid for is not excessive. This means that the program must determine whether treatment is provided at a more intensive level or extensive length than necessary to achieve the recovery of the victim. While this is not always an easy task when evaluating physical-injury treatment, it is even more daunting when looking at mental health counseling, given the difficulties surrounding diagnosis and treatment of mental injuries, the effect of preexisting conditions or "life circumstances," the lack of standardization in treatment approach, and the wide variation in expected outcomes.

It is obvious that each victim is a unique individual, that each crime is different, and that the degree of trauma suffered by individual victims will vary. Likewise, the speed with which the victim recovers will depend on a number of factors, including the victim's pre-crime mental health and personality; the presence or lack of support from family, friends and community; and the treatment methods and skill of the therapist.

Because of these individual variations, no standard length of treatment has been established by the mental health profession for any type of victimization or any particular mental condition. No research studies demonstrate conclusively that a certain amount of treatment will or should achieve specific results for particular types of victims or conditions. While some therapists report that most of the victims they treat recover substantially within generally similar lengths of time, they also report that significant variations from the norm are extremely common, and that it would be impossible to predict the course or duration of therapy for any individual victim before therapy has progressed significantly.

Length of treatment also will depend substantially on the goals of treatment. Is recovery defined as symptom reduction, i.e., relief from nightmares, depression, intrusive thoughts? Or is it defined as a restructuring of attitudes and thoughts that have been distorted by the trauma of criminal violence, and a full assimilation of the painful experience of the crime into the victim's "life view"? Is crisis intervention that enables the victim to function again at work and home, however mentally scarred, sufficient, or is treatment more of a continuum from immediate crisis to a final "coming to terms" with the crime's meaning to the victim's life?

This lack of certainty regarding treatment length is a vexing problem for many compensation programs. It would be much simpler if some relatively clear standards existed for evaluating the reasonableness of treatment duration in each individual claim. Essentially, however, programs are left to rely primarily on the therapist's assessment of when treatment is finished, which in turn is presumably based on the victim's own feelings regarding his or her recovery. While this situation is not inherently different than the program's necessary reliance on medical opinions of a victim's recovery from a physical injury, based on the victim's self-assessment, there appears to be a qualitative difference in the amount of "hard evidence" of recovery. An X-ray can determine when a broken bone has healed, but no comparable test of mental recovery is usually available--though there are some standardized tests to measure depression and other disorders, and some would argue that the victim's perception of recovery from symptoms is "hard evidence."

While on the surface it may seem to make sense simply to take the professional opinion of the therapist regarding the necessary length of treatment, programs express considerable frustration over the wide variation in treatment lengths for victims who seem to have suffered substantially similar trauma. One therapist completes treatment with a ten-year-old child abused by a stepfather within a year, while another therapist treating a similarly-aged victim of the same crime insists that treatment must last three or four times as long. Programs are left to wonder whether the inconsistency is due to the individual talent or approach of the therapist, the possibility that non-crime-related conditions are being treated, or even the profit motive of the therapist. This is <u>not</u> to raise suspicions about the vast majority of therapists, but rather only to admit candidly that the wide variation in treatment length seen by

some programs can give rise to such concerns.

Programs also are aware that nearly all major medical insurance plans and public health benefit programs incorporate limits and caps on the total number of counseling sessions covered, the total cost of therapy, and/or the fees charged for each session. In addition, most compensation programs limit expenditures in other major cost categories, such as funerals and lost wages, and require that medical procedures be performed at a "reasonable" cost; the programs may believe it is consistent with overall program operation to set limits in the mental health area as well.

With a duty to protect scarce public funds, as well as a mission to provide resources to assist in victims' recovery from crime-related injury, programs seek assurance that treatment in individual cases will neither extend longer nor cost more than is necessary. While no definitive standards for treatment outcomes exist, programs can use the expectations of therapists, the limits used by other third-party payers, and their own experience in handling claims to guide them in their consideration of the reasonableness of treatment duration.

Factors Affecting Treatment Duration

Therapists say that many factors will affect the length of treatment in individual cases. Among these factors are the following:

- The type and severity of the crime;
- The mental disturbance or condition that results;
- The personality and character of the victim, which may depend at least partially on the presence or absence of prior and existing mental conditions, problems, and trauma, including previous criminal victimizations;
- The degree of emotional support from family and social relationships;
- The period between onset of mental disturbance and beginning of treatment;
- The goals of treatment; and
- The orientation and skill of the therapist.

It seems obvious that a brutal, life-threatening victimization could result in more severe emotional trauma than a "less serious" crime. Therapists also explain that a victim's response to emotional injury will depend to a significant degree on many factors that either predate or are subsequent to the crime itself. To speak of one extreme, a victim with a serious preexisting mental illness, or a history of substance abuse prior to the victimization, may have more difficulty in recovering than a relatively healthy individual. And someone who gains the support and help of caring friends and family may recover quicker than someone who is isolated or castigated. How soon therapy begins after the crime also may have an effect on treatment duration, since mental problems may be more firmly entrenched and difficult to heal if they are not dealt with promptly.

What goals therapists and victims set for treatment, and how recovery is defined, will substantially affect any discussion of treatment length. If recovery is determined by whether the victim's immediate mental crisis is stabilized, and whether the victim can function at work and home, then a few sessions of crisis intervention may be all that are necessary. If recovery is defined as relief of other symptoms normally susceptible to effective treatment, such as nightmares, intrusive thoughts about the crime, and fear and anxiety, a significantly longer period of therapy is usually necessary. And treatment can extend even further if the victim and therapist seek to explore fully the larger, "existential" questions involving the victim's attitudes and outlook toward life, and how the crime affects other aspects of the victim's relationships and experience.

It should be emphasized that many therapists maintain that no victim ever fully recovers. Specific symptoms caused by the crime should abate and disappear, these therapists say, but the experience of crime is something that stays with the victim forever. "Full recovery," then, may be an elusive goal, and cannot be the criteria for setting an end to treatment. Instead, therapists choose to measure success by whether crime-related symptoms are alleviated, and emotional and cognitive problems improved. For example, the victim's fears of going out are in control, or the victim can once again interact comfortably with family, friends, and work associates. Still, while the resolution of specific issues serves as a clear marker of progress toward "termination" of therapy, some therapists report that the clearest indication of recovery is simply whether the victim "feels better."

Individual cases do have ending points, therapists say, but again, many therapists aver that it is impossible to predict when a victim will reach the goals set for treatment. Each victim's progress toward those goals will be highly individual, and it is impossible to know in advance how long recovery will take for any one victim, much less for victims as a whole, according to many professionals.

The therapeutic approach and skill of the clinician also will play an important role in how quickly victimization-related symptoms are alleviated. Evaluating the effectiveness of individual therapists is extremely difficult, however, given the lack of standardization in treatment approach, and the immense difficulties in assessing the individual victim's injury and responsiveness to treatment.

Experience and Expectations of Therapists and Programs

While therapists emphasize that no safe prediction can be made about the duration of treatment for any individual victim, the experience of therapists leads most of them generally to expect certain results within specific lengths of time. For example, some therapists believe that the majority of adult rape victims will attain most of their recovery within six months to a year, given proper care. (Some therapists also believe that brief intensive therapy will show results within a matter of weeks, while still others say that recovery will take several years for many victims.)

These expectations depend to some degree on the victim's specific diagnosis, i.e., depression, PTSD, panic disorder, or other disturbance. Some therapists believe that a major depressive episode, without serious complications, will resolve within three months if medication and psychotherapy are combined in treatment; if psychotherapy alone is used, six-to-twelve months of treatment may be required. Panic disorders, depending on their severity, may be resolved within three months, or may take more than a year to treat. Treatment required to effect recovery from PTSD is highly variable because of multiple individual and environmental factors, as well as the absence of any efficacious medication. Nevertheless, many therapists report substantial recovery of victims with PTSD within three-to-twelve months.

For children, variations in type of victimization, age and development will have a profound effect on treatment length. A four-year-old abused repeatedly by her father will have different therapeutic needs than a teenager fondled once by a stranger. In addition, the most effective treatment may not necessarily be continuous. Children may have some difficulties immediately following a victimization or its discovery, and then, much later, exhibit other symptoms or face other problems traceable to the criminal trauma. The child victim of parental sex abuse may experience severe difficulties at the onset of puberty, for example, or when divorce and remarriage bring a new father figure into the home. Many therapists contend that these later difficulties are just as deserving of treatment as the problems faced by a child immediately after victimization.

Nevertheless, some child therapists have an expectation that a period of 24 - 52 weeks of active treatment (usually once a week) will show significant results in the bulk of child molest cases (though many believe that further treatment may be necessary at later stages of the child's development). A small amount of educational work with non-offending parents and siblings to aid the victim can increase the likelihood of substantial recovery by the victim within this time frame, some therapists believe.

Compensation programs themselves develop certain expectations regarding length of treatment, simply based on the average treatment duration of the claims received. For example, one program that studied its mental health claims found that the vast majority of them were for treatment lengths below 50 weeks. Programs also expect that "minor" crimes, where the victim has not been placed at great risk of bodily harm, will result in little or no need for mental health treatment, while rape victims and child victims will need more professional help.

Insurance Industry Standards

It would be impossible to describe all of the many different coverages for mental health counseling contained in private medical insurance plans, or in various public benefit programs. In private plans, the contract between the insured and the insurer controls mental health benefits, with the amount of coverage depending on the money paid by the insured. It is certainly true, though, that most private plans and public programs place limits on the amount of mental health counseling for which individuals can receive payment, and some plans pay nothing at all for outpatient counseling.

A common feature of private plans is a dollar limit on the amount of mental health benefits that can be paid. A typical plan may offer $2,500 for mental health coverage, which may be renewable each calendar year in which the individual is enrolled in the plan. Many plans will limit mental health coverage only to inpatient hospitalization, however. Plans that cover outpatient counseling often require significant copayments by the insured, frequently as much as 50% of the therapist's charges.

State and federally supported public health programs also vary significantly, depending on available resources and priorities. A not atypical state Medicaid plan might cover 26 sessions, at 50% of normal charges.

Inpatient Therapy (Hospitalization)

Since psychological distress must be extremely severe for hospitalization to be warranted, it would be impossible to estimate the length of time inpatient treatment should last. Hospitalization is not required or justified for the vast majority of victims, however, and programs should strictly scrutinize its use. It is possible to imagine that a victim of prolonged and severe violence might require a period of care within a hospital setting; it also must be recognized that the purposes of inpatient care (patient stabilization and safety) are not necessarily those of psychotherapy, and that psychotherapy should generally proceed on an outpatient basis as soon as the victim no longer poses a threat to self or others.

Options for Compensation Programs

Compensation programs face several choices with regard to the question of whether the duration of treatment in any individual case is appropriate and cost-effective.

- Programs can examine each case wholly on its own merits. While certain expectations may be present (e.g., the program may regard claims for treatment beyond a certain length as excessive), no formal or written limits or guidelines are used to evaluate the length of treatment in individual cases.

- Programs can set caps, maximums, or limits on the amount of counseling for which the program will pay. Caps currently in use in some states range from 16 weeks to 52 weeks, with several programs setting a limit of six months. Some programs may opt for setting monetary limits, with an average of about $2,000 - $2,500 found in a number of states. These limits are based usually on what the program perceives is the amount of therapy necessary to assist most victims to achieve substantially full recovery. The caps also may reflect the program's available resources and its assessment of how much it can allocate to pay all the claims for mental health benefits that it receives. States can set absolute and inflexible limits, admitting of no variation, or they may choose to allow the therapist to justify continued treatment beyond those limits in extraordinary cases.

- Without setting absolute limits, programs can establish expectations that treatment generally should be complete within certain standard ranges, through the documentation and justification required of the therapist. For example, a program may require treatment plans at the outset of therapy, progress reports at predetermined intervals, and written explanations based on sufficient grounds for treatment extending beyond a specified duration. While each claim is examined on its own merits to see whether treatment of any duration is justified, the timing of the documentation requirements creates expectations for both the program and the therapist that coverage of treatment beyond a certain length of time will require more extensive justification by the therapists, and will be carefully scrutinized.

Standard limits on treatment can serve to promote provision of sufficient mental health treatment for most victims. By setting reasonable ranges or limits, programs acknowledge that a certain length of treatment is generally acceptable, and remove some element of doubt about counseling provided for the large majority of victims. In other words, program staff is basically made aware that serious questions need not be raised about the counseling provided in individual cases, so long as it remains below a certain limit. Programs concentrate their attention on those cases that are clearly extraordinary, rather than challenge "average" claims.

Inflexible or absolute caps or limits have the advantage of eliminating some of the need for program energy and resources to be expended on difficult questions surrounding complex claims. If a claim is for treatment beyond a certain length, the program simply denies coverage for the excess above the limit. Knowing that mental health costs in any individual case are capped also may enable the program to project more accurately its total costs for awards. Programs can better budget for all contingencies, if their experience

allows them to estimate the number of counseling claims it probably will receive in any one year.

The disadvantage of an inflexible cap, of course, is that exceptions cannot be made when extraordinary cases of legitimate merit present themselves. The program can become subject to criticism from those who believe it is failing to meet its responsibilities to meet the needs of severely injured victims. Other potential disadvantages are that average claims may tend to "expand" toward the maximum limit, and program staff may lose some interest or incentive in scrutinizing whether the maximum payment is justified in an individual case, since the exposure of the program in any one claim, as well as overall, is relatively controlled.

Flexible limits--those that the program can raise given appropriate justification from the therapist--confine most claims within defined boundaries, but allow programs to retain discretion to meet legitimate needs in those unusual cases where particularly lengthy treatment is requested and adequately supported. Since special justification is required for lengthy treatment, therapists will understand that such treatment will be examined closely by the program. Still, each time a request for coverage of therapy beyond the limit is received, the program must spend significant time evaluating whether the extensive treatment is justified, and may have to consult with professionals (peer review) to make this determination.

Programs that set flexible or inflexible time limits may wish to make exceptions for treatment of a non-continuous nature justified by the appearance of symptoms and problems at a time after the conclusion of the initial course of treatment. Child victims may be in particular need of such consideration. One alternative worth considering is allowing coverage for a certain number of sessions, without requiring that the sessions be used within any specific time period. The disadvantage of such an approach is the administrative burden it may place on a program to keep claims "open" for unknown periods of time.

Setting limits obviously is an issue freighted with many implications for victims, counselors, and programs, and must be approached carefully. On one level, of course, the mental health of individual victims may be affected, depending on the amount of counseling that can be covered. On another level, it's a simple dollars-and-cents issue for both the therapists and for the programs; the therapists' livelihoods depend on these payments, and the programs' ability to serve as many victims as possible within its budget also is at stake.

Given the serious nature of these issues, a number of programs have consulted closely with mental health professionals in their states, either informally or by establishing advisory committees. These contacts are valuable to the programs in their understanding of how they can serve victims' mental health needs, and also help create understanding among the mental health profession of the programs' statutory requirements and need for accountability, as well as the programs' fiscal restraints. A further discussion of such advisory committees is found in section 8.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. This report does not recommend that every state should adopt a set time limit or range, or a maximum cost cap, on the amount of mental health counseling that can be paid for. Nevertheless, if they wish to do so, programs should feel justified in using the expectations and experience of therapists, insurance industry practice, and their own practical knowledge of the needs of victims as seen through applications and awards, to establish such limits and ranges.

2. Programs must determine whether they will establish a standard limit or range that is flexible, so that exceptional cases requiring more treatment can be paid, or whether a maximum cap should be enforced. Programs also must determine whether, and how, they will countenance claims for treatment of a non-continuous nature, i.e., that resumes at some later time after an initial ending point.

3. States that wish to adopt standards are encouraged to consult closely with therapists and other interested parties prior to establishing policies governing their evaluation of counseling claims. Formal advisory committees, discussed later in this report, are one means to debate and resolve issues related to limits.

4. Programs are urged to scrutinize carefully any requests for inpatient treatment. Hospitalization is not required or justified for the vast majority of victims, but rather only for those who pose a serious risk to the life and health of themselves or others.

Section 6

CONFIDENTIALITY

Some counselors keep detailed notes of what was said or done in individual treatment sessions, as an aid to them in performing and evaluating therapy. A number of programs require submission of these notes as a record of treatment. These programs believe that a review of the notes not only confirms that therapy is taking place (that reimbursement isn't being requested for sessions that the victim did not attend), but also can help them determine whether therapy is directed toward crime-related mental health problems rather than toward conditions unrelated to the crime trauma itself.

In signing their applications for compensation, victims explicitly authorize programs to obtain all records relating to treatment for which reimbursement is sought. Programs thus are granted permission to obtain session notes. But while victims may waive the confidentiality of their treatment records when they submit claims, many victims and counselors express serious concerns about the release of session notes. This is understandable, since the notes may document communications between the victim and the therapist of matters and thoughts that the victim regards as extremely private. While functionally these mental-health treatment records are no different than X-rays and other medical records of physical-injury treatment, it is not surprising that victims and therapists have far more concerns regarding the confidentiality of records of mental health therapy than victims and doctors do regarding other medical records.

Therapists point out that to achieve progress in therapy, discussion of highly personal matters is required, and victims may be reluctant to "open up" if they fear disclosure of their statements to outside parties. This concern is not simply a general desire for privacy on the part of the victim; it extends also toward possible exposure of the records to parties outside the compensation program, such as defense attorneys who may seek to obtain them through a subpoena. It also has been pointed out that where compensation programs are operating in small cities or towns, claims-examining staff may know the victim or people who may be mentioned by the victim in therapy.

Therapists regard it as a professional obligation to guard the privacy of treatment records unless required by law to divulge their contents, and indeed, statutory doctor-patient and counselor-client privileges require such confidentiality in many states. Some therapists would view any effort by compensation programs or other parties to obtain session notes as a potentially serious violation of the victim's trust, and say that they would resist release of their notes.

While some programs report that session notes are useful in establishing whether treatment is related to problems arising directly from the crime rather than to issues that pre-existed or are unrelated to the crime, other programs believe that the notes are relatively useless, since program staff lack the professional expertise to evaluate how therapy is performed, or whether what transpires in a session is contributing in some manner to the recovery of the victim from a criminal injury. Some programs that use other forms of documentation to evaluate the crime-relatedness and effectiveness of therapy (treatment plans, progress reports, and other verification forms) feel little need to review session notes, even if they feel some obligation to request them and keep them on file.

Any program that seeks and obtains session notes should be able to guarantee their confidentiality. Statutory confidentiality applying to doctors and counselors would extend to the programs that receive their records, and many compensation statutes themselves have provisions prohibiting the release of information obtained from victims. While most programs should have no difficulty in assuring that they can maintain the privacy of sensitive records, some report that defense lawyers and other outside parties have demanded disclosure under freedom-of-information or "sunshine" laws, or through subpoenas issued in legal actions. It is incumbent upon each program to understand how state law affects its ability to protect the confidentiality of the information it receives, and to be able to give assurances to victims and therapists that sensitive records will not be released.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. No recommendation is made concerning whether programs should require submission of session notes or other working documents specifically describing the content of therapeutic activity. It is noted that programs may expect considerable resistance from some counselors to provide such records, and that victims have an understandable concern that the records of counseling sessions should remain private. Programs may wish to consider other means to determine issues regarding crime-relatedness of injury and treatment, including treatment plans and progress reports that will describe work toward specific objectives rather than detail the content of individual sessions.

2. Programs should strive to ensure the confidentiality of whatever records are received regarding counseling claims, through whatever statutory protections available. Statutory provisions to accomplish such protection are in place in a number of states; examples are included in the appendix to this report.

Section 7

PROVIDER QUALIFICATIONS

Compensation programs have a legitimate interest in paying for treatment performed only by qualified providers. If victims receive good treatment, they are more likely to recover. In turn, programs are less likely to waste valuable resources for therapy that achieves little or, at worst, is harmful to the victim.

Since state laws and licensure requirements vary regarding who may perform counseling or psychotherapy, it is not possible to define for all programs whom they should regard as qualified. For example, in some states no licensing or specific educational background is necessary in order for someone to offer services as a counselor, while in other states a specific degree and license is mandatory. Of course, state compensation programs may be free to set their own standards for the types of therapists that are eligible for payment, but this may be difficult if their standards vary significantly from requirements generally prevailing in the state.

Therapists come from widely varying educational backgrounds. The three major categories of therapists are psychiatrists, psychologists, and social workers. A fourth category may consist of "counselors" who do not possess the educational training of members of the above three categories, but nevertheless have some qualifications to treat victims for emotional problems. Social workers are by far the most numerous type of therapist, followed by psychologists and then psychiatrists. Based on their training and experience, therapists from each category may have somewhat different approaches to treating victims. Currently, there is no extensive research information regarding the relative effectiveness of treatment provided by these various types of therapists.

A psychiatrist is a medical doctor who has had four years of medical school, one year of internship, and at least two years of approved residency training in general psychiatry. Child-victim specialists will have a two-year fellowship in child and adolescent psychiatry that includes supervised experience in a range of therapies and settings.

A clinical psychologist is a Ph.D. with approximately five years of graduate training, including a year of internship and several half-year programs of supervised clinical experience. Most states also require post-doctoral experience for licensing.

A social worker should have a masters in social work (M.S.W.), having spent two years in a graduate program of classes and field work. Several years of postgraduate experience may be required for a state license.

Other types of counselors vary from state to state, and may include marriage and family counselors and clergy. These individuals may or may not possess the degrees mentioned previously, and they may or may not be required to meet licensure requirements.

In Indian cultures, traditional healers have usually learned the customs and techniques of healing over many years of study and practice. With hundreds of separate tribes in this country, each with their own traditional ways and beliefs, it would be impossible and inappropriate to prescribe requisite qualifications for traditional healers. In many tribes, "medicine men" and others who perform traditional healing ceremonies are known by reputation in the community, without any formal identification or "licensure" by the tribe or the state.

States often require that mental health practitioners be licensed, certified, or registered by the state. Licensure is designed to protect consumers by ensuring that practitioners have met minimum requirements for the general practice of their discipline. Licensing boards also usually establish procedures for accepting and investigating complaints about professional practice or conduct, and may establish minimum continuing education requirements for licensees.

Specialized training on the treatment of trauma and victimization-related disorders is not generally required by state licensing authorities in order for therapists to treat victims. A number of therapists who treat victims believe that specialized training and experience is

extremely important in order for treatment to be performed effectively, however.[1] There are many continuing education training opportunities to assist therapists of all disciplines in developing this specialized expertise. Some therapists have suggested that compensation programs could play a leadership role in improving therapist qualifications by encouraging or supporting continuing education programs focused on treating victims. At least one compensation program is considering requiring specialized expertise as a prerequisite for receiving reimbursement.

In remote, rural areas, licensed mental health therapists may be unavailable. While programs must remain concerned about the quality of care wherever it is provided, some programs may wish to consider reimbursement for counseling provided by non-licensed counselors with sufficient expertise, if the alternative is for victims to be without help, or if obtaining licensed care involves traveling long distances. It may be possible for compensation programs to work with victim service programs and therapists to improve access in rural areas to qualified care, or to at least provide adequate supervision of counseling provided by unlicensed counselors.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. Effective counseling can be provided by psychiatrists, psychologists, social workers, and others with specialized counseling qualifications. In states where mental health providers must be licensed to practice, state compensation programs should feel justified in restricting compensation payments to treatment provided by counselors with licenses. Some states also may wish to include those who are working to obtain such licenses.

2. With regard to Native American healers, the traditions of individual tribes should be respected with regard to who is qualified to provide treatment. Programs are urged to explore these issues with appropriate tribal representatives and service providers.

3. Programs are encouraged to explore ways in which specialized training on victimization-related disorders can be provided to counselors. Programs may also wish to consider ways that access to qualified counselors in rural areas can be improved.

Notes

1. The International Association of Trauma Counselors, Inc., was formed in 1989 by some therapists to establish certification standards and to provide specialized training on treatment of traumatic disorders. For further information, contact the IATC at 638 Prospect Ave., Hartford, CT 06105; (203) 232-4825.

Section 8

APPROACHES TO EVALUATION AND PAYMENT

The factors that may make mental health counseling claims more difficult to evaluate should justify programs in establishing appropriate policies and procedures to ensure that statutory requirements for payment are met. The approach a program takes may depend in part on its resources, both in terms of staff to evaluate claims and funds available for awards; it also may depend on the relative volume and complexity of the mental health claims the program receives.

Each individual claim must be evaluated on its own merits, of course, to see whether it meets statutory requirements. In addition, programs may wish to establish standard expectations, or set ranges or limits, by which these individual claims can be assessed. Programs also may want to make use of the expertise of mental health professionals, individually and in advisory groups, to evaluate claims and help define appropriate standards.

Because of varying circumstances in different states, it would be impossible to recommend any one "best" strategy to employ in evaluating mental health counseling claims. Each program must develop for itself the policies and procedures that will enable it to meet its responsibilities. There a number of means to facilitate claims evaluation that programs are currently using, however, and states may wish to consider them in fashioning their own approaches. Some of these methods and approaches have been discussed in previous sections of this report. Here, an effort will be made to highlight how programs may use a number of these means to establish a sound strategy for the evaluation of counseling claims.

The following are among the procedures that can be used to facilitate the evaluation of mental health counseling claims:

- Requiring documentation from therapists, in the form of treatment plans, progress reports, and/or session notes, to ensure that a compensable injury exists, that the injury was caused by the crime, that treatment is geared to treating that injury, and that treatment is effective.

- Establishing standard ranges or lengths of treatment within which either all or the majority of treatment should occur. These standards either may be flexible, allowing for exceptional cases to receive payment for treatment beyond the standard length, or they may be inflexible, admitting of no exception.

- Setting expense limits, either for hourly rates paid for certain types of therapists (counselors, psychologists, psychiatrists), or for total maximums allowable for mental health treatment.

- Obtaining review of complex or unusual cases by qualified consultants to determine the need for and efficacy of treatment, as well as its length and cost (peer review).

- Requiring preauthorization for unusual or extraordinary treatment, such as inpatient treatment.

- Consulting on a regular, formal basis with advisory committees composed of mental health experts, victim representatives, and other interested parties to gain input on technical and public-policy issues that affect the development of sound administrative policies and procedures regarding support for mental health counseling for victims.

Evaluating Individual Claims

The types of documentation that programs can consider using to help ensure that providers of mental health treatment are performing services that meet statutory provisions for payment include the following:

- *Treatment plan:* A comprehensive treatment plan describes in advance of treatment or shortly after its beginning the following: diagnosis of victim's injury or disorders; goals of treatment to deal with the specific diagnosis and presenting symptoms; the type of treatment that will be used to reach the goals set forth.

- *Progress report:* A progress report describes, at intervals, the recovery being made in therapy by the victim, and monitors progress toward goals set forth in

the treatment plan. Remaining symptoms are identified, and the need for continued treatment is substantiated.

• *Treatment session notes:* These are notes, reports, and other work products made by the therapist during treatment that describe the sessions with the victim.

The above documentation can be either through forms provided by the program, or through reports and records generated by the therapist.

One program has developed the following strategy for reviewing individual claims, which makes use of all of the above forms of documentation:

- Submission of a treatment plan within 30 days of beginning therapy.
- Submission of a progress report after 90 days of treatment.
- Submission of a new treatment plan if therapy has not been completed within six months. The treating therapist also is required to consult with another therapist to discuss the need for further treatment.
- Submission of session notes describing work done in treatment.

To the extent that treatment plans can be reviewed by the compensation program before therapy has progressed too far, victims and therapists are better served by knowing in advance how much treatment can be paid for. Many programs may lack the capability to review documentation early in treatment, however, and in such circumstances the evaluation of the claim may occur after the therapy is complete or well underway. The treatment plan can still be useful, however, because it details the types of conditions treated, and serves as a means for determining whether the treatment was crime-injury related.

The sensitivities and concerns expressed by victims and counselors toward providing notes or other written records detailing specifically the content of therapeutic sessions have been noted in a previous section of this report. No further discussion is necessary here, other than to emphasize that programs seeking such documents may expect to meet some resistance, and should be prepared to provide whatever assurances are possible that the notes will be kept confidential.

Setting Limits and Caps

Section 5 of this report discusses the factors affecting length of treatment, the experience and expectations of some therapists and programs regarding treatment duration, and some of the ways programs can use caps or flexible ranges to control the amount of coverage provided for mental health counseling. While these issues will not be discussed in depth here again, the various options programs have are set forth again here.

The options basically fall into three categories:

• ***Setting maximum treatment-duration or cost caps.*** These caps limit the total amount of counseling for which programs will pay, either in terms of number of sessions, overall time length of therapy, or total dollar amount. The caps may be based on the experience and expectations of therapists and programs for "average" recovery times, or parallel typical coverage of private insurance plans; they also may stem from the realities of the program's budget. These limits relieve program staff and decision makers from disputes with individual therapists over the need for extended treatment, since treatment beyond a certain length cannot be covered. By removing program discretion to allow coverage beyond set parameters, however, the potential exists that individual victims with exceptional needs for extended treatment will not receive full compensation for the optimal amount of therapy.

• ***Establishing standard ranges, with discretion to allow exceptions.*** A program may set an outside parameter of a certain length or amount of allowable treatment, but allow coverage for any treatment beyond that length if justified by special need and appropriate documentation. This allows for exceptional therapeutic needs to be covered by the program, while creating expectations that most therapy should be complete within a standard time frame. Individual claims for treatment of extraordinary length may continue to pose difficulties for program evaluation, however.

• ***Establishing expectations for treatment duration through special requirements for justifying extended treatment.*** The program may not set any limit or standard range, but by requiring special procedures at set intervals, creates an awareness that treatment beyond a certain length is regarded as out of the ordinary and will be scrutinized closely. Submission of a new treatment plan after a set period of time or a certain

number of sessions, a required consultation with another therapist, or mandatory peer review are ways to ensure that requests for extended treatment are carefully evaluated.

We repeat that this report neither recommends nor discourages the establishment of caps, limits, or standard ranges. Each program must evaluate its own approach to mental health counseling claims in light of its own circumstances and resources, and its own assessment of how it can best assist crime victims.

Per-Session Fee Limits

A number of programs employ flat hourly (per session) rates for mental health services, usually scaled according to the therapist's training and/or licenses. For example, programs may pay psychiatrists a certain maximum fee per session, psychologists a fee somewhat less, and social workers a fee scaled down further. These rates will necessarily vary from one region of the country to another, according to general economic conditions and salary levels, as well as local supply of and demand for therapists. It is thus impossible to suggest precisely what hourly fee limitations, if any, should be established by individual states. Programs must consider actual rates charged in the "open market," as well as those reimbursed by insurance companies and other third-party payers. Programs may set limits below fees customarily charged, but must remain cognizant that limits set too far below reasonable provider expectations may result in a refusal by some therapists to treat victims. (Some of the fee limitations in recent use in some states are provided in the appendix to this report.)

Peer Review

A concern frequently expressed by compensation programs is that they lack expertise to make determinations regarding claims involving complex, unusual, or extraordinarily lengthy treatment. This concern is understandable; few compensation programs employ trained mental health professionals as part of their permanent staff or decision-making boards. (Several programs have practicing psychologists or medical doctors on their boards, who review the merits of all mental health counseling claims. Several other programs employ nurses or other medical professionals on their staffs to evaluate counseling and other medical services.)

For programs that lack expertise, claims analysts may face difficulties when they question the need for or duration of counseling in individual cases, or when they voice concern that the counseling is not directed entirely toward crime-related trauma. Essentially, they are questioning the professional opinion of the therapist, who presumably possesses the requisite educational background and licenses to provide appropriate care.

To improve their ability to make sound determinations on counseling claims, a number of programs make use of qualified consultants to review problematic cases. These peer-review systems may involve one mental health professional under contract to the program, or a number of such individuals who are asked to review claims as individuals or in panels. Review may consist only of an examination of treatment plans, notes, and records, or it may involve an independent examination of the victim. In some states, the review is "blind," with the reviewer knowing neither the name of the patient nor the therapist.

It is important for the program to retain the power to make the final decision to approve any claim under peer review; the peer reviewer merely provides a professional opinion on the case, which the program is free to use or reject. Programs must be careful, of course, that competent professionals are used as peer reviewers, since to a certain extent the program will feel obligated to accept the opinions of the reviewing therapist, even though the program retains final decision-making authority. Use of more than one reviewer aids in ensuring that a variety of professional perspectives and abilities are brought to bear on evaluation decisions.

The advantages of professional peer review are apparent. The program's expert is as fully qualified from an educational standpoint as the treating therapist to determine the need for treatment, its objectives, and the effectiveness of the treatment modality being used. While the reviewer and the treating therapist may not agree on these issues, the program at least can base its decision on an independent, sound professional judgment as well as the treating therapist's.

Peer review need not be an expensive proposition. It normally can be accomplished through a review of records and documents, and often takes two hours or less. Fees for this document review should be somewhat less than for actual therapy. And one program reports that it has had a number of therapists volun

teer to help the program without charge in reviewing difficult cases. Since the review process is only necessary in unusual cases, the number of claims that need peer review is usually quite small, some states have found. One medium-sized program found that only 13 claims in the period of a year required peer review.

Preauthorization of Treatment

Victims and therapists probably are better off if they know in advance whether the compensation program will pay for treatment, and how much treatment will be covered. This is particularly true for treatment of extraordinary intensity or duration, such as hospitalization.

There are difficulties with preauthorization; requests for payment approval must be received before or shortly after treatment commences, and programs must make decisions promptly so as not to delay the progress of treatment. (Prompt treatment shortly after the crime may be crucial to the victim's speedy recovery, and may reduce costs overall.) Many programs, with staff already stretched to the limit, will be unable to turn around requests for preauthorization quickly enough.

Given the extremely high cost of inpatient care, however, programs should consider establishing requirements and procedures for preauthorization when hospitalization of the victim is involved. In one state, the program has contracted with a professional company that for a flat fee of $400 performs immediate evaluations of patients recommended for hospitalization. The program has realized a considerable net savings on the cases that were reviewed, in some of which hospitalization was deemed unnecessary. In addition, the doctors in a position to hospitalize patients are aware that their decisions will be scrutinized. In general, preauthorization can be a valuable means to maintain control over expenditures, as well as to keep victims and therapists apprised of whether funds will be available for in-patient treatment.

For outpatient treatment, requiring documentation in the form of treatment plans or other verification, shortly after treatment commences not only gives the program an opportunity to determine whether treatment can be reimbursed; it is also of value in ensuring that therapists are aware of the standards the program is enforcing for crime-relatedness of injury and treatment, and reasonableness of cost. The documentation also helps build the claim file so that proper information will be available for prompt decision making when the claim is evaluated.

Mental Health Advisory Committees

A number of programs seeking to develop approaches to evaluating mental health counseling claims have consulted extensively with therapists in their states to explore issues of mutual concern. Through formal advisory committees, as well as through informal contacts, programs have gained important information on how therapy is provided in their jurisdiction, and have increased their ability to understand and respond to the needs of victims for treatment. In turn, the therapeutic community has learned more about the statutory directives and restrictions under which the program operates, and mistrust of the program's practices has been diminished. The good will created by such efforts has been extremely helpful in winning acceptance and cooperation by the mental health community in the smooth implementation of the policies and procedures developed.

While consultation with individual therapists is invaluable, the program may wish to establish a formal advisory committee that meets regularly to provide input on program policies, procedures, and performance. Thoughtful consideration should be given to the composition of such a committee, and the program should be sure to include representatives of each therapeutic discipline. Psychiatrists, psychologists, and social workers all could be a part of the committee; the program may ask associations of those types of therapists to participate or name representatives. Programs also should consider inclusion of representatives of sexual assault and domestic violence coalitions, victims and victim service providers, and other concerned government agencies.

RECOMMENDATIONS FOR COMPENSATION PROGRAMS

1. While each individual claim must be evaluated on its merits, programs can consider a number of strategies in establishing a cogent approach to covering mental health counseling. These strategies can include requirements for submission of treatment plans and progress reports; setting maximum caps, or establishing flexible ranges or expectations to which exceptions can be made; setting maximum reimbursable hourly rates for therapists; requiring preauthorization for extraordinary treatment; using peer review to scrutinize unusual cases; and working with formal committees of mental health professionals and other interested parties to develop and implement policies and procedures.

2. Each program is urged to work closely with the mental health community serving victims in its state to explore how the program can best serve the needs of victims within statutory requirements and funding constraints. By opening up two-way lines of communication, the program can benefit from the professional expertise of therapists, and can help increase therapists' understanding of the rules and parameters within which the program must work.

Section 9

SUMMARY

This report emphasizes, as it did at the outset, that this is not a conclusive study, dispositive of any, much less all, of the important issues surrounding the payment of mental health counseling claims. If this study serves only one purpose, it should be to raise awareness of significant concerns and issues that programs should consider in developing their policies and practice. While some may disagree with this report's analysis or recommendations, few should quarrel with the need for an ongoing and active examination of the matters it explores. Many crucial questions remain unanswered or only partially explained, and compensation programs should look forward to a continuing dialogue with mental health professionals, victims and their advocates, and other interested individuals and groups.

The following is offered as a brief summary of the content of this report.

Section 1 of this report pointed out the basic concerns of compensation programs in evaluating mental health counseling claims according to statutory requirements. These concerns relate to the need for treatment, its relation to crime-caused conditions, its duration and cost, and the qualifications of providers. While these concerns apply to all categories of expense for which payment is sought, not simply counseling, there appear to be special considerations that make evaluation of counseling claims more problematic than that for physical-injury treatment.

Section 2 provided some background on major diagnostic categories, focusing on Post-traumatic stress disorder (PTSD) as a frequently used diagnosis applied in the aftermath of criminal victimization. While recognized diagnostic categories should establish clearly the need for treatment, programs also were urged to consider coverage for the many highly distressed victims who may not display symptoms that rise to the level of a recognized "disorder." Programs also were urged to provide sufficient training and information to staff and decision makers so that they understand basic terminology, concepts and issues.

Section 3 briefly discussed some of the types or modalities of treatment likely to be used to assist victims. Background was provided on crisis intervention, individual therapy, group and family therapy, play therapy for children, hospitalization and medication. It was pointed out that while therapeutic orientation and approach can vary widely, and there are no enforceable standards within the mental health profession regarding what types of treatment to provide, many therapists employ substantially similar techniques. It was recommended that programs not question individual therapeutic methods unless clearly unusual; focus should instead be on whether the treatment is intended to alleviate a specific crime-related condition or problem. The use of treatment plans to establish crime-relatedness of the condition and the therapy were discussed.

Section 4 examined issues regarding preexisting and unrelated conditions. While it may be difficult to establish precisely what portions of presenting disorders are directly attributable to the crime as opposed to some antecedent event, therapists can be expected to evaluate these matters and often can make some distinctions. Many specific crime-related symptoms can be specifically addressed in therapy. Yet since the trauma of crime may have far-reaching effects on the victim's mental state, relationships, and daily life, treatment may have to involve a variety of issues that may appear less related to the crime. Programs may be wise to allow some leeway to the therapist in managing these complex therapeutic realities.

Section 5 focused on a crucial question for victims, therapists, and compensation programs: treatment duration. There are numerous factors that can affect length of treatment: the type and severity of the crime; the personality of the victim, and the presence or absence of preexisting conditions or other "life problems"; the degree of support the victim receives from family and friends; the orientation and skill of the therapist; and the goals of treatment. While many therapists emphasize the uniqueness of each case, and are reluctant to predict an average course of treatment,

there are, nevertheless, certain expectations that a large majority of violent crime victims will achieve the bulk of their recovery within a roughly similar length of time. Programs that seek to use their own experience, that of therapists, and the standards set by private insurance policies and public benefit plans should feel some justification in setting some controls on length of treatment. Controls can be in the form of maximum caps or flexible ranges. Caps help control costs and remove pressure on program decision makers to question claims for extraordinary treatment duration, but may not allow for coverage of severe cases of clear merit. Flexible ranges allow for exceptional needs to be met, but in doing so create the possibility that staff will need to question the professional opinions of therapists when exceptional treatment seems unjustified. Requiring therapists to submit treatment plans, progress reports, and other documentation is also can help establish an awareness that the compensation program is looking carefully at issues regarding the length and objectives of therapy. It was emphasized that inpatient treatment is a radical medical management technique, and not a standard means to effectuate therapy.

Section 6, on confidentiality, noted that some programs routinely request records of individual therapy sessions, but also pointed out the importance placed by many victims and counselors on protecting the privacy of those records. While some programs believe session notes are valuable in determining whether treatment is related to criminal injury, other programs do not feel qualified to evaluate those records. No recommendation was made concerning whether the notes should be requested; it was pointed out that other documentation, such as treatment plans and progress reports, may serve some of the same objectives for accountability. Programs were strongly urged to ensure that clear statutory and procedural protections would prevent disclosure of the documentation outside the program itself.

Section 7 noted that providers come from different disciplines, and that states have different licensing requirements. It was recommended that in states where licensing is required, compensation programs consider covering counseling only by those with licenses. Programs were urged to give special consideration to coverage of Native American traditional healing, and to explore ways in which access to qualified counseling in rural areas can be improved.

Section 8 described various approaches states can take in evaluating counseling claims. Strategies include requiring treatment plans in all cases, or at least in claims for extended treatment duration, and other documentation; setting caps or flexible limits on treatment duration or cost, or creating expectations for standard treatment ranges through special requirements; using peer review for unusual cases; requiring preauthorization for inpatient treatment; and forming advisory committees of mental health professionals to help develop and implement sound policies and procedures.

APPENDIX

STATE MENTAL HEALTH COST CONTROL RULES

Alabama

Coverage limited to 50 sessions, unless extended by the program because of extreme circumstances. Peer Review Panel reviews claims at the request of the program.

The therapist must be a Ph.D. or M.D. or must be recommended by a Ph.D. or M.D. Masters-level therapists are not required to be licensed. Maximum fees for individual therapy are $70 per hour for licensed counselors/social workers; $80 per hour for Ph.D.; $100 per hour for M.D.; group therapy @40% of those maximums.

Arizona

12-month limit from time of first treatment.

Arkansas

$2,500 limit or six months, whichever comes first, provided that a treatment plan is submitted within 30 days of beginning of treatment.

California

Coverage limited to 50 sessions, unless medical necessity for further treatment is documented. Treatment for 50 additional sessions can be approved. Maximums are $10,000 for direct victims, for surviving parents, siblings, children, spouses, or fiances of homicide victims, and for custodial parents or primary caretakers of minor victims of sexual or physical abuse; $5,000 for other "derivative" victims. Payment in excess of caps may be made "if the claim is based on dire or exceptional circumstances that require more extensive treatment, as approved by the Board.

Treatment must be by licensed psychiatrists and psychologists ($90 per hour maximum); licensed clinical social workers and licensed marriage, family, and child counselors ($70 per hour maximum); registered candidates for licensure under the supervision of a licensed therapist; peer counselors specializing in rape crisis counseling, in conjunction with licensed mental health practitioners. Group/family therapy reimbursement is limited to a maximum of 40% per session of the provider's individual hourly session rate, per individual victim, not to exceed the maximum rates.

Large-scale, pre-qualified providers are eligible for a simplified payment procedure, in which they receive training, and can submit bills without further documentation being required. Auditing will ensure compliance.

Colorado (4th Judicial District)

Coverage limited to 10 visits or payment up to $1,000, whichever occurs first, unless a review of the claim is requested, and information is provided by the therapist on the victim's progress and prognosis. An additional 10 visits or $1,000 may then be approved.

Only licensed therapists are eligible. Any insurance coverage must be utilized.

Delaware

Not to exceed 1 year and total cost of $5,000.

Florida

Limit of $2,500; time limit of 3 years from date of crime is applicable to all expenses, including mental health counseling.

Hawaii

Limit of $3,000.

Idaho

Family members of homicide victims limited to $1,500 per family; family of sex assault victims limited to $500 per person, $1,500 per family.

Indiana

Up to $1,000 if no sliding-scale fees are used; up to $1,500 if sliding-scale fee is applied.

Iowa

Coverage limited to care provided by licensed psychologists, persons with masters degree in social work or counseling and guidance, or a victim counselor as defined by state law.

Non-medical counseling has a maximum benefit of $3,000. Counseling provided by a psychiatrist or under the supervision of a psychiatrist is applied toward the medical maximum of $10,500.

In homicide cases, counseling is covered for victim's spouse, children, parents, siblings, or persons cohabiting with or related by blood or affinity to the victim, with a maximum of $3,000 per survivor and a total of $6,000 per death.

Family counseling is not compensable unless the victim is present in the counseling session and the focus of the treatment is to assist in the victim's recovery. The program does not allow reimbursement for counseling sessions in which the offender is present.

If it is apparent from the treatment plan that treatment is addressing issues not directly related to the crime, the program may pay for only that percentage of treatment which is addressing the victimization.

For victim service agencies, the program pays a maximum of $25.00 per hour for individual counseling and $10.00 per hour for group counseling. Compensation funds cannot supplant federal or state funds granted to victim service agencies. If the counselor's salary is funded in whole or part with grants funds or used as match for grant funds, the salary must be deducted from the allowable reimbursement rates.

Treatment plans are requested in cases when treatment has continued for an extended time period and/or when the cost seems excessive. The treatment plan must include the length of time treatment will continue, diagnosis, treatment goals, and proposed method of treatment including pre-existing conditions.

Indiana

Coverage limited to $1,000 for therapists not using sliding-fee scales; coverage up to $1,500 for therapists using sliding-fee scales.

Kansas

Maximum for mental health counseling of $3,500 for each victim, plus $300 for an evaluation. Family members, including spouse, children, siblings, parents, legal guardian, stepparents and grandparents, of homicide victim are eligible for $1,000 grief-therapy award. Compensation beyond maximums may be awarded provided board finds extenuating circumstances justifying further therapy, supported by documentation.

Inpatient hospitalization is considered only if condition is life-threatening; maximum of 10 days or $10,000, whichever is less; more compensation may be awarded if extenuating circumstances are found.

Maximum of $60 for individual and family counseling in a non-medical setting; group therapy maximum of $40 per hour.

Louisiana

Detailed treatment plan to support request for payment is required from counselor, along with itemized bills which detail specific dates of service.

Benefits are limited to $2,000 and a time cap of not more than six months from date of first visit.

Reimbursable rates are $60 hour for M.S./M.S.W. (L.P.C./B.C.S.W.); $75 hour for PhD/MD (Board certified); and $25 per session for group therapy.

In inpatient settings, payment is allowed for no more than one therapy session per day, group or individual. No occupational therapy or recreational therapy charges are reimbursable. No medication or macrobiotic supplements other than traditional psychiatric medications and analgesics are reimbursable. Payment for all allowable charges will be made at a 50% rate and must be accepted as payment in full.

Maryland

Counseling maximum of $2,000 per claimant.

Minnesota

Limit of $75 per hour for individual therapy, $40 per hour for group therapy. No session limit on parents, spouses, and minor children of homicide victims; 10-session limit for siblings of homicide victims. Parents of sexually abused children may receive 5 sessions.

Mississippi

Limit of $1,000.

Missouri

Coverage limited to $1,000.

Montana

Maximum of $500 per person or $1,500 per family for the spouse, parent, child, brother, or sister of a homicide victim; and for the parent, brother, or sister of a minor who is a victim of a sexual crime for which a person has been charged.

Nebraska

Maximum of $2,000 for licensed therapists.

New Hampshire

Limit of $2,000.

New Jersey

Payment limited to 50 sessions for a direct victim 18 years of age or older on the date of the incident, and 100 sessions for a victim under 18 years of age.

New Mexico

Payment limited to licensed therapists. Advance authorization required for more than 30 sessions.

New York

Payment limited to M.S.W., C.S.W., Ph.D., and M.D.

North Carolina

Payment limited to licensed doctors or those practicing under licensed doctors.

Oklahoma

Mental Health Peer Review Panel consists of one psychiatrist, two psychologists, one licensed social worker, and one licensed professional counselor. All members are volunteers and meet on a monthly basis. Members were found by contacting the various state licensing boards for recommendations. All members have experience treating crime victims.

A form developed by the panel is sent to a therapist if the Compensation Board requests a peer review. All cases are reviewed "blind": therapist names and addresses are inked out.

The panel does not tell the Board whether to decline or award a claim. They simply state various findings of fact. This helps the Board to make an informed decision without swaying them in one direction or another. In each case, the Board has based their decision on the panel findings.

The panel made recommendations on 13 cases in its first 15 months. In the majority of cases, the treatment was found to be reasonable and as a direct result of the crime. There were several, however, that were continued pending further information.

Hourly limits are $110 for M.D., $90 for Ph.D., $75 for licensed M.S.W., $60 for licensed professional counselor or marriage/family therapist, $35 for unlicensed M.S.W. in licensed agency.

Oregon

Statutory $10,000 limit.

South Carolina

Coverage limited to 90 days or 15 sessions, whichever is greater.

Texas

Licensure is required for payment.

Utah

Primary victims eligible for a $2,500 maximum. Secondary victims within a family who witness or are traumatically affected by the violent crime shall be eligible for a $1,000 maximum mental health counseling award. Extenuating circumstances warranting consideration of counseling beyond the maximums may be submitted by the mental health provider after the maximum award has been reached.

In-patient hospitalization shall only be considered when the treatment has been recommended by the victim's physician or mental health provider in life-threatening situations. The program is currently contracting with a private mental health service to do immediate evaluations on the need for in-patient hospitalization, at a cost of $400 per evaluation.

Payment shall be made only to licensed therapists or to individuals registered with the state's Division of Professional and Occupational Licensing and working towards a license, in which case they must be supervised by a licensed therapist. Maximum reimbursable rates are $85 per hour for individual and family therapy by licensed psychiatrists and psychologists, and $42.50 per hour for group therapy; $65 per hour for individual and family therapy performed by an L.C.S.W., M.S.W., or marriage and family therapist, and $32.50 per hour for group therapy.

Vermont

Limits of $3,000 total and $60 per session. Payment may be made to licensed psychiatrists and psychologists, certified clinical social workers or mental health counselors; psychiatric nurse clinicians; crisis counselors employed by a recognized crisis counseling agency, provided that the counselor works under the supervision of a licensed psychiatrist, psychologist, or certified clinical social worker. Treatment plans are required.

Virginia

Payment limited to $60 per session for therapists licensed as M.D., Ph.D., M.S.W., L.C.S.W., or L.P.C.

Washington

To qualify for payment, mental health providers must register with the crime victim compensation program and qualify as an approved provider under the program's rules. A masters level degree or above is required.

An initial evaluation report is required with the application for benefits or no later than 30 days from the date of the first treatment. The report must include the preliminary diagnosis and symptoms, proposed treatment plan and treatment goals, and expected length of treatment. It must also include a diagnosis of any pre-existing conditions and their potential effect on the condition resulting from the assault.

When treatment is to continue beyond 90 days, submission of a narrative report is required to substantiate the need for continued care, and must be renewed every 90 days. When the victim requires treatment beyond 180 days, a consultation with a consultant chosen by the attending mental health provider is required to determine and/or establish the need for continued treatment. Additional narrative reports will continue to be required at 90-day intervals. Independent assessments may be ordered by the program to establish a diagnosis or outline treatment rationale, when these are controversial or ill-defined, and to determine the extent and aggravation of any pre-existing condition.

Washington (continued)

Preauthorization is required for inpatient hospitalization; therapy involving a single session of longer than one hour; concurrent treatment; family therapy beyond 12 sessions; electroconvulsive therapy; testing; and day treatment.

Wisconsin

Coverage limited to licensed psychiatrists and psychologists, and M.S.W. and crisis counselors employed by a recognized crisis counseling agency working under the supervision of a licensed psychiatrist or psychologists.

POST-TRAUMATIC STRESS DISORDER

Source: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (Washington, D.C.: 1987).

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives or friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   1. recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
   2. recurrent distressing dreams of the event
   3. sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
   4. intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
   1. efforts to avoid thoughts or feelings associated with the trauma
   2. efforts to avoid activities or situations that arouse recollections or the trauma
   3. inability to recall an important aspect of the trauma (psychogenic amnesia)
   4. markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
   5. feeling of detachment or estrangement from others
   6. restricted range of affect, e.g., unable to have loving feelings
   7. sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response
   6. physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B,C, and D) of at least one month.

Delayed onset if the onset of symptoms was at least six months after the trauma.

STATE CONFIDENTIALITY PROVISIONS

Florida (Fla. Stat. section 119.07 (3)(aa)):

Any document which reveals the identity, home or employment telephone number, home or employment address, or personal assets of the victim of a crime and identifies that person as the victim of a crime, which document is received by any agency that regularly receives information from or concerning the victims of crime, is exempt from the provisions of [the open public records law]. Any state or federal agency which is authorized to have access to such documents by any provision of law shall be granted such access in the furtherance of such agency's statutory duties, notwithstanding the provisions of this section.

Kansas (K.S.A. 74-7316):

The board shall prepare and transmit annually to the governor and the legislature a report of its activities. Such report shall include the name of each claimant, except that in cases involving a sexual offense . . . the names of victims shall be deleted from the report . . .

New York (N.Y. Executive Law section 633):

The record of a proceeding before the board or a board member shall be a public record; provided, however, that any record or report obtained by the board, the confidentiality of which is protected by any other law or regulation, shall remain confidential subject to such law or regulation.

North Dakota (N.D. Cent. Code section 65-13-10):

Confidentiality of Records. All records of the board concerning the application for or award of reparations under this chapter are confidential and are not open to public disclosure. However, inspection of these records must be permitted by:

1. Law enforcement officers when necessary for the discharge of their official duties;

2. Representatives of a claimant, whether an individual or an organization, may review a claim file or receive specific information from the file upon the presentation of the signed authorization of the claimant;

3. Physicians or health care providers treating or examining persons claiming benefits under this title, or physicians giving medical advice to the board regarding any claim may, at the discretion of the board, inspect the claim files and records of persons;

4. Other persons may have access to and make inspections of the files, if such persons are rendering assistance to the board at any stage of the proceedings on any matter pertaining to the administration of this article.

5. Juvenile court records or law enforcement records . . . may only be released to the parties, their counsel, and representatives in proceedings before the board and must be sealed at the conclusion of the proceedings.

Oregon (Or. Rev. Stat. section 147.115):

(1) All information submitted to the department by an applicant and all hearings of the board . . . shall be open to the public unless the department or board determines that the information shall be kept confidential or that a closed hearing shall be held because:

(a) The alleged assailant has not been brought to trial and disclosure of the information or a public hearing would adversely affect either the apprehension or the trial of the alleged assailant;

(b) The offense allegedly perpetrated against the victim is rape, sodomy or sexual abuse and the interests of the victim or of the victim's dependents require that the information be kept confidential or that the public be excluded from the hearing;

(c) The victim or alleged assailant is a minor; or

(d) The interests of justice would be frustrated rather than furthered, if the information or if the hearing were open to the public.

Washington (Wash. Rev. Code section 7.68.140):

> ***Confidentiality.*** *Information contained in the claim files and records of victims, under the provisions of this chapter, shall be deemed confidential and shall not be open to public inspection: Provided, That, except as limited by state or federal statutes or regulations, such information may be provided to public employees in the performance of their official duties: Provided further, That except as otherwise limited by state or federal statutes or regulations a representative of a claimant, be it an individual or an organization, may review a claim file or receive specific information therefrom upon the presentation of the signed authorization of the claimant: Provided further, That physicians treating or examining victims claiming benefits under this chapter or physicians giving medical advice to the department regarding any claim may, at the discretion of the department and as not otherwise limited by state or federal statutes or regulations, inspect the claim files and records of such victims, and other persons may, when rendering assistance to the department at any stage of the proceedings on any matter pertaining to the administration of this chapter, inspect the claim files and records of such victims at the discretion of the department and as not otherwise limited by state or federal statutes or regulations.*

Wisconsin (Wis. Stat. section 949.11 (3)):

> *All hearings shall be open to the public unless in a particular case the examiner determines that the hearing, or a portion thereof, shall be held in private having regard to the fact that the offender has not been convicted or to the interest of the victim of an alleged sexual offense.*

Confidentiality Policies

While statutory confidentiality provisions may carry more weight than mere policy or procedure developed by the program, some programs have used their own rules effectively to protect their files. New Jersey, for example, reports that while it has no specific statutory language protecting the confidentiality of claim records, the Board's policy to protect its records from disclosure has been upheld in state court against motions brought by defense attorneys.

Vermont has developed a policy regarding confidentiality and release of information that reads as follows:

> *Claims for compensation and supporting documents and reports are investigative data until the claim is paid, denied, withdrawn or abandoned. Investigative data means that the information is confidential, i.e., not available to the public or the claimant.*
>
> *After the claim is paid, denied, withdrawn or abandoned, the claim and supporting information are private data on individuals. Private data means that the information is not public, but is accessible to the claimant.*
>
> *Information about the status of a claim (whether all forms have been received, or whether the claim was paid or denied), may be given to claimants, service providers or collection agencies calling on behalf of a service provider, a victim advocate calling on behalf of the claimant, or an elected official inquiring on behalf of the claimant. No details should be given about the case.*
>
> *Information about claim status may be given to the claimant's attorney or family members only with a letter of authorization form the claimant to release information.*
>
> *No information can be given to any other individuals not listed on the claim form without authorization.*
>
> *After the claim is paid, denied or abandoned, the claimant may be given detailed information regarding her or his claim.*

Whatever the means by which compensation programs provide confidentiality to the records they receive and generate, it is important that such protection be available. Programs are then able to assure victims--and the providers that serve them--that sensitive information will not be exposed to public scrutiny. Greater cooperation and ease in obtaining necessary information should be the result.

INITIAL REPORT

Provider Name_____

License or Certification #:

Address:

Phone:

Claimant Name_____Claim #_____

Address:

Phone:

Date of birth:

Date treatment began: Number of sessions to date:

Please provide the following information:

1. Presenting Symptoms (emotional, behavioral, medical)
2. Presenting Symptoms Related to Crime
3. Significant Factors that May Influence Claimant's Recovery
4. Historical Data (preexisting conditions and potential effect on claimant's recovery)
5. Diagnosis (DSM-III-R)
6. Therapy Issues to be Resolved in Treatment
7. Therapy Goals and Methods
8. Frequency and Length of Sessions
9. Estimated Duration of Treatment (if known)

PROGRESS REPORT

Provider Name_____

License or Certification #:

Address:

Phone:

Claimant Name_____Claim #_____

Address:

Phone:

Date of birth:

Date treatment began: Number of sessions to date:

Report Number:_____

Please provide the following information:

1. Identification of Current Symptoms and Changes in Previously Documented Symptoms
2. Diagnosis (DSM-III-R) If Changed From Last Report
3. Present Treatment Goals
4. Evaluation of Progress Toward Treatment Goals
5. Therapy Methods Related to Updated Goals
6. Frequency and Length of Sessions
7. Estimated Duration of Treatment (if known)

Treatment Report

A. TO BE COMPLETED BY THE FISCAL INTERMEDIARY:

1. Case Number _____ 2. State Code _____

3. F.I.: Blue Cross and Blue Shield of S.C. 4. Second Level Reviewer _____

5. FI Reviewers Phone: 1-800-334-0308 6. Date case sent to review _____

7. Patient's DOB: _____ 8. Sex: Male _____ Female _____

9. Patient's Marital Status: Single _____ , Married _____ , Separated _____ , Divorced _____ , or Widow(er) _____ .

10. Date treatment began _____ 11. Date treatment ended _____

12. Number outpatient sessions _____ or inpatient days _____ to date.

13. Treatment Settings:

a. Outpatient
- ____ Therapist's Office
- ____ Hospital Clinic
- ____ C.M.H.C.
- ____ Other

b. Inpatient
- ____ State of County Mental Hosp.
- ____ Other inpatient Psychiatric Facility
- ____ Alcohol or Drug Abuse Facility
- ____ Nursing Home or Extended Care Facility
- ____ Other Residential Setting (Specify) _____

14. Primary Therapist:
- _____ M.D. or D.O.,
- _____ Marriage and Family Therapist
- _____ Psychiatric Nurse Specialist
- _____ Other _____
- _____ Clinical Psychologist
- _____ Clinical Social Worker
- _____ Pastoral Counselor

15. Diagnosis: Use DSM-III Codes Only
Axis I: a. _____ b. _____ Axis II: _____ Axis III: _____

B. TO BE COMPLETED BY THE PROVIDER:

INSTRUCTIONS:

This treatment report is completed at the 24th session of outpatient care or on or before the 30th inpatient day. Subsequent reports may be provided using the Follow-up Progress Summary. If psychoanalysis is the primary treatment modality, then the authorization form for psychoanalysis must be completed.

The patient has signed an authorization to release information as part of the process of filing a claim with CHAMPUS. However, the provider is encouraged to discuss the nature and contents of this report with the patient. CHAMPUS Regulation 6010.8-R does require review of all inpatient and outpatient mental health services by the F.I. to include peer review.

Please respond to all items. Additional documentation, such as a narrative or hospital chart (all or part) may be submitted to supplement the information contained in this report.

NOTE: Accurately completing this form plus providing supportive or collaborative information will expedite processing of your claims. A narrative will not be accepted in lieu of completion of the CHAMPUS Treatment Report.

CASE # _____

1. Diagnosis: Use DSM-III Codes only Mandatory (All axis)

Axis I
a. _____

b. _____

Axis II _____

Axis III _____

Axis IV 1 2 3 4 5 6 7 0
(Circle Appropriate #)

Axis V 1 2 3 4 5 6 7 0
(Circle Appropriate #)

2. Presenting Symptoms:
Describe symptoms (distress) and functional impairments for which patient sought care.

Check severity of patient's dysfunction:

____ Mild. ____ Moderate. ____ Severe

3. Historical Data:
Relevant history for understanding patient's current condition. If patient is less than 18 years old, include significant developmental aspects.

4. Prior Treatment Episodes:
State pertinent medical/psychological information from prior treatment episodes.

Date(s)	Diagnosis	Interventions	Response

5. Mental Status and Psychological Testing:

a. Provide current mental status examination.

b. If psychological testing and asessment was conducted by you, please answer the following questions:

1. Date of test(s) —

2. Name(s) and time spent for each test administered —

3. What questions were to be addressed by this assessment? Please provide sufficient detail.

4. Indicate results, conclusions, and recommendations.

6. Physical Examination: Describe significant results of physician's examination. Include pertinent laboratory examinations, abnormal findings and dates of tests. If problem includes alcoholism, provide the most recent results of neurological, liver function, and other lab tests. Give dates.

7. Evaluate Current Family and Community Support Systems.

8. Using the above data, describe the patient's current condition.

9. Treatment and Interventions:
a. Describe physiological and psychopharmacological treatments (include drug names and dosage).

b. For each treatment modality, (individual, group, family, couples) specify frequency and length of sessions. If you have recently altered the treatment plan or anticipate a change, please explain.

Modality: _____: Frequency: ____ /mo.; Length: _____ mir

Modality: _____: Frequency: ____ /mo.; Length: _____ mir

Modality: _____: Frequency: ____ /mo.; Length: _____ mir

c. If outpatient treatment interventions exceed 2 per week, or if inpatient interventions exceed 5 per week, please explain.

d. Describe the frequency and purpose of collateral contacts, (e.g., contacts with family or significant others) and ancillary services (e.g., educational/vocational).

e. Provide your rationale for the specific level of care being provided (Inpatient and Outpatient).

10. Treatment Goals:

a. Intermediate/Short-term goals. For outpatient, what goals have been set for the next review point? Hospital treatment must end by the 60th hospital day unless a waiver request is granted by Director, OCHAMPUS.

b. Long-term goals. Describe the goals expected to be reached by the end of treatment. Outpatient long-term goals are differentiated from intermediate/short-term (i.e., goals for the next review interval).

11. Termination of Treatment:
What steps have been taken to prepare the patient and family for discharge from the hospital, or termination of outpatient treatment.

12. Estimated duration of treatment :

_____ _____ ___/___/___
Name of Provider (please print) Degree Date

_____
Street

_____ (___)_____
City State Zip Code Phone

STATE OF CALIFORNIA

STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM

MENTAL HEALTH VERIFICATION
VOC MH-A (5/90)

TO BE COMPLETED BY VOC PROGRAM STAFF	
CLAIM NO.	DATE FORM SENT
VICTIM'S NAME	
CLAIMANT'S NAME	
DATE OF INCIDENT	

RETURN FORM TO:

State Board of Control
Victims of Crime Program
P.O. Box 3036
Sacramento, CA 95812-3036

Dear Provider: The Victims of Crime Program has received an application which includes a claim for mental health counseling as a result of the death or physical or emotional injury of the above-named victim. In order to verify the claimed counseling costs please complete this form and return it to the address specified above. Enclosed is a brochure that will provide additional information regarding the Victims of Crime Program. Questions regarding this form should be directed to the Victims of Crime Program at (916) 322-4426.

(1) PATIENT NAME	(2) NAME OF VICTIM (IF NOT PATIENT)	
(3) PATIENT'S RELATIONSHIP TO VICTIM	(4) PROVIDER ORGANIZATION NAME	
(5) NAME OF THERAPIST	(6) LICENSE/REGISTRATION NO.	(7)EXPIRES

(8) CHECK APPROPRIATE BOX FOR TITLE OF LICENSE/REGISTERED THERAPIST (Refer to No.6)

[ ] MFCC [ ] LCSW [ ] Psychiatrist [ ] Psychologist
[ ] MFCC Intern [ ] Associate MSW [ ] Psych. Assistant
[ ] Other (Please Specify):

(9) NAME AND TITLE OF SUPERVISING THERAPIST (If applicable)	(10) LICENSE NO.	(11)EXPIRES

(12) INDICATE PERCENTAGE OF TREATMENT RELATED TO THE CRIME [ ] Percent

(13) IF PATIENT IS NOT THE VICTIM, EXPLAIN WHY HIS/HER TREATMENT IS NECESSARY

(14) SPECIFY DATE INCIDENT-RELATED TREATMENT: BEGAN [ ] ENDED [ ]

(15) DIAGNOSIS (Identify DSM III-R Codes Used)

(16) PROGNOSIS

IN ACCORDANCE WITH GOVERNMENT CODE 13962(b): (1) THE BOARD CERTIFIES THAT AN "AUTHORIZATION TO OBTAIN INFORMATION" SIGNED BY THE CLAIMANT/VICTIM IS ON FILE AT THE BOARD AND CONSTITUTES ACTUAL AUTHORIZATION FOR THE RELEASE OF THE INFORMATION REQUESTED; (2) THE INFORMATION REQUESTED ABOVE BY VOC/JPA MUST BE SUBMITTED WITHIN TEN (10) BUSINESS DAYS FROM THE DATE REQUESTED; (3) THIS IS A VERIFICATION FORM REQUESTING INFORMATION WHICH SHALL BE PROVIDED AT NO COST TO THE APPLICANT, THE BOARD, OR LOCAL VICTIM CENTERS.

(OVER)

[IF MORE SPACE IS NEEDED, PLEASE USE ADDITIONAL SHEETS]

(16a) ESTIMATE TOTAL NUMBER OF TREATMENT SESSIONS NECESSARY TO RESTORE PATIENT TO "PRE-CRIME STATE"

(17) GIVE BRIEF DESCRIPTION OF EMOTIONAL SYMPTOMS BEING TREATED

(18) ADDITIONAL INFORMATION RELEVANT TO THE PATIENT'S TREATMENT AND/OR THIS INCIDENT

(19) MEDICAL INSURANCE COVERAGE	(19a) POLICY I	(19b) POLICY II
NAME OF INSURANCE CO.		
INSURANCE CO. ADDRESS		
INSURANCE CO. PHONE NO.		
POLICY HOLDER'S NAME AND SOCIAL SECURITY NO.		

(20) DOES PATIENT HAVE MEDI-CAL? _____ (21) DO YOU ACCEPT MEDI-CAL? _____

(22) HAVE YOU BILLED MEDI-CAL? _____ (23) PATIENT'S MEDI-CAL NO. _____

(24) IF YOU DO ACCEPT MEDI-CAL BUT HAVE NOT BILLED MEDI-CAL, PLEASE EXPLAIN WHY

(25) EXPENSES INCURRED TO DATE

(25a) EXPENSES	(25b) INSURANCE PAID	(25c) PAID BY PATIENT	(25d) BALANCE DUE
$	$	$	$
(25e) WRITE-OFF	(25f) PAID BY OTHER	(25g) IF PAID BY OTHER, FROM WHOM	
$	$		

**** DECLARATION ****

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING IS ACCURATE

THERAPIST'S SIGNATURE	DATE	TELEPHONE NO.
SUPERVISOR'S SIGNATURE (If applicable)	DATE	TELEPHONE NO.

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR THE VOC PROGRAM TO CONSIDER REIMBURSEMENT FOR SERVICES.

STATE OF CALIFORNIA

STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM

MENTAL HEALTH EXTENDED SESSION VERIFICATION FORM
VOC MH-B (2/90)

RETURN FORM TO:

State Board of Control
Victims of Crime Program
P.O. Box 3036
Sacramento, CA 95812-3036

TO BE COMPLETED BY VOC PROGRAM STAFF	
CLAIM NO.	DATE FORM SENT
VICTIM'S NAME	
CLAIMANT'S NAME	
DATE OF INCIDENT	

Questions regarding this form should be directed to:

NAME OF CLAIMS SPECIALIST	TELEPHONE NUMBER

Dear Provider: The Victims of Crime Program requires the completion of this form for therapy that will exceed 50 sessions. This form must be completed before additional sessions, beyond 50, can be paid. Therefore, if the victim is anticipated to require more than 50 sessions of treatment, please complete this form and return it to the address specified above.

(1) PATIENT'S NAME	(2) NAME OF VICTIM (IF NOT PATIENT)	
(3) PATIENT'S RELATIONSHIP TO VICTIM	(4) PROVIDER ORGANIZATION NAME	
(5) NAME OF THERAPIST	(6) LICENSE/REGISTRATION NO.	(7)EXPIRES

(8) CHECK APPROPRIATE BOX FOR TITLE OF LICENSE/REGISTERED THERAPIST (Refer to No.6)

[ ] MFCC [ ] LCSW [ ] Psychiatrist [ ] Psychologist
[ ] MFCC Intern [ ] Associate MSW [ ] Psych. Assistant
[ ] Other (Please Specify):

(9) NAME AND TITLE OF SUPERVISING THERAPIST (If applicable)	(10) LICENSE NO.	(11)EXPIRES

(12) IF PATIENT IS NOT THE VICTIM, EXPLAIN WHY HIS/HER TREATMENT IS NECESSARY

(13) INDICATE PERCENTAGE OF TREATMENT RELATED TO THE CRIME [ ] Percent

(14) SPECIFY DATE INCIDENT-RELATED TREATMENT: BEGAN [ ] ENDED [ ]

(15) DIAGNOSIS (Identify DSM III-R Codes Used)

IN ACCORDANCE WITH GOVERNMENT CODE 13962(b): (1) THE BOARD CERTIFIES THAT AN "AUTHORIZATION TO OBTAIN INFORMATION" SIGNED BY THE CLAIMANT/VICTIM IS ON FILE AT THE BOARD AND CONSTITUTES ACTUAL AUTHORIZATION FOR THE RELEASE OF THE INFORMATION REQUESTED; (2) THE INFORMATION REQUESTED ABOVE BY VOC/JPA MUST BE SUBMITTED WITHIN TEN (10) BUSINESS DAYS FROM THE DATE REQUESTED; (3) THIS IS A VERIFICATION FORM REQUESTING INFORMATION WHICH SHALL BE PROVIDED AT NO COST TO THE APPLICANT, THE BOARD, OR LOCAL VICTIM CENTERS.

(OVER)

[IF MORE SPACE IS NEEDED, PLEASE USE ADDITIONAL SHEETS]

(16) EXPLAIN WHY ADDITIONAL TREATMENT IS RECOMMENDED

(17) THERAPIST'S OBSERVATION OF ALL CURRENT SYMPTOMS AND PROBLEMS OF VICTIM WHICH SUPPORT THE NEED FOR ADDITIONAL TREATMENT

(18) PROPOSED TREATMENT STRATEGY

(19) ESTIMATE TOTAL NUMBER OF TREATMENT SESSIONS TO RESTORE PATIENT TO "PRE-CRIME" STATE (FROM THE TIME THIS FORM IS COMPLETED)

(20) PATIENT'S PROGNOSIS: (Check One)

[ ] Poor [ ] Moderately Favorable [ ] Favorable [ ] Good [ ] Very Good

(21) CURRENT INTERVENTION

INDIVIDUAL THERAPY [ ] NO [ ] YES	DATE BEGAN	FREQUENCY
FAMILY THERAPY [ ] NO [ ] YES	DATE BEGAN	FREQUENCY
GROUP THERAPY [ ] NO [ ] YES	DATE BEGAN	FREQUENCY
OTHER (Specify) [ ] NO [ ] YES	DATE BEGAN	FREQUENCY

(22) HAVE THERE BEEN CHANGES IN THE VICTIM/CLAIMANT'S REIMBURSEMENT BENEFITS (i.e., HEALTH INSURANCE, ETC.)? [ ] NO [ ] YES (PLEASE EXPLAIN):

(23) EXPENSES INCURRED TO DATE

(23A) EXPENSES $	(23b) INSURANCE PAID $	(23c) PATIENT PAID $	(23d) BALANCE DUE $
(23e) WRITE-OFF $	(23f) PAID BY OTHER $	(23g) IF PAID BY OTHER, FROM WHOM	

**** DECLARATION ****

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING IS ACCURATE

THERAPIST'S SIGNATURE	DATE	TELEPHONE NO.
SUPERVISOR'S SIGNATURE (If applicable)	DATE	TELEPHONE NO.

NOTE: This form must be completed in its entirety in order for the VOC Program to consider reimbursement for services.

MENTAL HEALTH TREATMENT ESTIMATES

MCVRB # _____

The information requested on this form is required by Minn. Stat. 611A.52 Sec. 8 (a) (2) (1)

MINN. STAT. 611A ABROGATES MEDICAL PRIVILEGE (COMMUNICATION OR RECORDS) RELEVANT TO A CLAIM MADE TO THE MINNESOTA CRIME VICTIMS REPARATIONS BOARD.

Claimant's Name _____ Mental Health Practitioner's Name _____
Circle one: M.D. PhD. M.A. M.S. MSW CCDP (Other) _____

Estimated length of continuous treatment: From _____ To: _____
(date treatment commenced) (estimated date of completion or termination)

at an estimated cumulative cost of $ _____

Presenting Complaint: _____

Diagnosis of Record: _____

Please list the goals for this claimant's mental health treatment relative to their victimization. Each goal should be measurable and have a target date of completion.

Treatment Goal	**Method of Accomplishing**	**Target Completion Date**

Please attach additional sheet if necessary.

MENTAL HEALTH TREATMENT PLAN

CLIENT INFORMATION:

Name: _____
(Victim)

_____
(Applicant, if different)

Address: _____

_____

Date: _____

THERAPIST INFORMATION:

Name:_____
Mental Health Center:

_____

_____

_____

Telephone #_____

Credentials:_____

Fed. I.D.#_____

License #_____

Supervised By_____

The Crime Victims Compensation Board is able to compensate only for the percentage of therapy expenses which are a direct result of the criminal incident of _____.

Is the victim's present psychological condition related in whole or in part to the criminal incident? ____yes ____no

If yes, what percentage of treatment deals directly with the psychological trauma of the criminal incident? _____%

Presenting Complaints:

Funtional Impairment (Please describe the effects of the crime on the victim's functioning as it relates to the following areas):

A) Employment:

B) School:

C) Interpersonal Relationships:

D) Emotional/Behavioral:

Diagnosis of Record:_____

TREATMENT PLAN

TREATMENT GOAL: Please describe in measurable, behavioral terms the goals of treatment as they relate to the functional impairment of the victim. That is, describe the specific behavioral, emotional, and/or interpersonal changes to be achieved as the criteria for termination of treatment.

METHOD OF ACCOMPLISHING TREATMENT GOALS: For each treatment goal, please explain the therapeutic approach(s) you anticipate using. If the approach involves other individuals, i.e. victim's spouse, parents, etc., please identify them and explain how their involvement is directly and beneficially related to accomplishing the treatment goal.

TREATMENT SESSIONS: Please outline the number, frequency, and duration of treatment sessions or programs you anticipate will be required to achieve treatment goals. (Example: Assertiveness training program, two family sessions involving husband initially, followed by 15 one-hour individual sessions weekly, followed by 10 group sessions monthly.)

ESTIMATED LENGTH OF TREATMENT PROGRAM: _____ TO _____.

RETURN THIS FORM TO: Crime Victims Compensation Board
700 SW Jackson, Suite 400
Topeka, KS 66603-3757

(Please attach an itemized statement of charges.)

REQUEST FOR EXTENSION OF TREATMENT

CLIENT INFORMATION:

Name: _____
(Victim)

_____
(Applicant, if different)

Address: _____
_____

Date: _____

THERAPIST INFORMATION:

Name: _____
Mental Health Center:
_____
_____
_____
Telephone #: _____
Credentials: _____
Fed. I.D. #: _____
License #: _____
Supervised By _____

DIAGNOSTIC/ASSESSMENT INFORMATION

A. DSM IIIR Diagnosis
(Please provide five Axis Diagnoses, indicating the principal diagnosis.)

Axis I:

Axis II:

Axis III:

Axis IV: (Psychosocial Stressor Rating)

Axis V: Current GAF _____ Highest GAF Last Year _____

B. Current Symptoms:

C. Functional impairment (Please describe the effects of the crime on the victim's ongoing functioning as it relates to the following areas):

a) Employment:

b) School:

c) Interpersonal Relationships:

d) Emotional/Behavioral:

D. Progress made toward the completion of most recent Treatment Plan.

E. Number of times seen by you since last Treatment Plan _____.

F. Updated Treatment Plan (Please describe in measurable, behavioral terms the goals of treatment as they relate to the ongoing functional impairment of the victims. That is, describe the specific, behavioral, emotional, and/or interpersonal changes to be achieved as the criteria for termination of treatment.)

G. Estimated number of sessions needed to achieve treatment goals: _____.

H. Estimated termination date: _____.

RETURN THIS FORM TO: Crime Victims Compensation Board
700 SW Jackson, Suite 400
Topeka, KS 66603-3757

Note: Please attach a copy of the original Treatment Plan submitted to Crime Victims Compensation Board.

DRAFT

INITIAL REPORT

PROVIDER NAME_____ADDRESS_____
_____
PHONE_____LICENSE OR CERTIFICATION #_____
TITLE_____

CLAIMANT NAME_____ADDRESS_____
_____PHONE_____
DATE OF BIRTH_____DATE TREATMENT BEGAN_____
CLAIM #_____NUMBER OF SESSIONS TO DATE_____

1. PRESENTING SYMPTOMS
   A. EMOTIONAL
   B. BEHAVORIAL
   C. MEDICAL

2. PRESENTING SYMPTOMS RELATED TO CRIME
   A. EMOTIONAL
   B. BEHAVIORAL
   C. MEDICAL

3. SIGNIFICANT FACTORS THAT MAY INFLUENCE CLAIMANT'S RECOVERY;

4. HISTORICAL DATA OF PREEXISTING CONDITION AND THE POTENTIAL EFFECT ON CLAIMANT RECOVERY (i.e. family issues, developmental factors, substance abuse, mental history).

5. DSM III -R DIAGNOSIS WITH CODES
   I
   II
   III
   IV
   V

6. THERAPY ISSUES TO BE RESOLVED IN TREATMENT:

7. THERAPY GOALS AND METHODS TO BE USED IN TREATMENT:

DRAFT

CRIME VICTIM'S COMPENSATION

FOLLOW-UP REPORT

PROVIDER NAME_____ADDRESS_____
_____PHONE_____

TITLE:_____

CLAIMANT NAME_____CLAIM #_____

REPORT NUMBER_____(_____DAYS)

1. IDENTIFICATION OF CURRENT SYMPTOMS AND CHANGES IN PREVIOUSLY DOCUMENTED SYMPTOMS.

2. DSM III- R DIAGNOSIS WITH CODES (IF CHANGED FROM LAST REPORT) INCLUDE RATIONALE IN CHANGES.
I
II
III
IV
V

3. PRESENT TREATMENT GOALS:

4 BRIEFLY DESCRIBE TREATMENT PLAN AS RELATED TO THE UPDATED THERAPY GOALS:

5 FREQUENCY AND LENGTH OF SESSIONS:

6. ESTIMATE DURATION OF TREATMENTS, IF KNOWN.

7. EVALUATION OF PROGRESS TOWARD TREATMENT GOALS:

DRAFT

Crime Victim's Compensation
406 Legion Way SE HC-720
Olympia Washington 98504

CONSULTATION REPORT

Claim Number _____ Date of Consult_____

Primary Provider_____
Address and Phone_____
_____
Title_____
License or certification_____

Consulting Therapist_____Include address & phone #_____
_____
Title_____
License or certification_____

Claimant_____Date of first treatment_____

Number of sessions to date_____Date of Birth_____Sex___

1. DSM III-R diagnosis with codes if not listed previously.

2. Current symptoms

3. Historical Data

4. Evaluation of progress of treatment

DRAFT

5. Appropriateness of continued treatment

6. Has the course of treatment followed the standards of appropriate care for the diagnosis?

I have reviewed and discussed the clinical records with the primary provider regarding the case of_____ case #_____, and am_____ am not_____ in agreement with the diagnosis of
AXIS_____
_____
_____

and the treatment and methodology utilized in said treatment. I am in agreement that the progress is satisfactory and the condition being treated is due to the specific condition covered under the Crime Victims Compensation Program. If not in agreement, please so indicate on this form and explain by separate enclosure or list specific narrative explanation on lines provided.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature and date_____

Please make any further comments and recommendations on back of form or append separate sheets, ensuring proper identification on each sheet.