

A Summary Report of the Cost-Effectiveness of the Profession and Practice of Marriage and Family Therapy

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Abstract This purpose of this paper is to provide a summary of the cost-effectiveness research for the profession and practice of marriage and family therapy. Studies based on four sources of data were considered: (1) a western United States HMO covering 180,000 subscribers; (2) the Kansas State Medicaid system with over 300,000 beneficiaries; (3) Cigna, a large United States health insurance benefits management company with more than nine million subscribers; and (4) a marriage and family therapy training clinic in the western United States serving approximately 300 individuals and families a year. Results from the studies support the potential for a medical offset effect after couple or family therapy, with the largest reduction occurring for high utilizers of health care. The studies also show that covering family therapy as a treatment option and marriage and family therapists as a provider group is not associated with significantly higher treatment costs. An application of cost-effectiveness methodology to medical family therapy is also considered.

Keywords Cost-effectiveness · Family therapy · Medical offset · Health care utilization · Medical family therapy

Introduction

Results from studies conducted within established medical systems and over 15 years demonstrate that family therapy is an effective and relatively inexpensive modality of psychotherapy treatment (e.g., Crane and Payne 2011). In addition, as a group of independently licensed treatment providers, marriage and family therapists provide care that is as cost-effective as other mental health groups (Moore et al. 2011). These providers also

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are associated with less therapy dropout, suggesting that patients are receiving at least average care (e.g., Hamilton et al. 2011). This article is an update and expansion of Crane (2008), which reviewed studies through 2007 that dealt with family therapy as a treatment modality but did not summarize the findings regarding marriage and family therapists as a mental health discipline.

The paper is organized into two major sections. The first section presents a summary of the results for the 22 studies that make up this body of research. Within each subsection, studies are presented in chronological order according to where the data were collected. The second section briefly touches on summary themes in the data and limitations, and provides information on future directions for research including how this information can be used in advocacy efforts, especially as it relates to medical family therapy (MedFT).

Findings from HMO Data

The first group of studies was derived from data gathered at a western United States Health Maintenance Organization (HMO) serving 180,000 subscribers and focused on “medical offset effect” (defined as the reduction in other health care services use after the provision of psychotherapy). Although this phenomenon had been well demonstrated for individual therapy, very little information previously existed specific to marriage and family therapy (MFT).

Paper charts for mental health and general health care were available for three discreet periods: (a) 6 months before the start of therapy; (b) 6 months after the start of therapy, and; (c) between 6 and 12 months after the start of therapy. A sample of 292 participants was selected from those who had used individual, couple, and family therapy services. Because of the archival nature of the data, little demographic information was available. However, it was able to be determined that the average age was 30 years and the sample was largely made up of middle income and Caucasian individuals. Therapy type was the independent variable and outpatient care was used as the dependent variable in the studies. Participants were further separated into groups according to five different therapy types: (a) marital/couples therapy; (b) family therapy identified patient (FTIP); (c) family therapy other patient (FTOP); (d) individual therapy, and; (e) a no therapy comparison group.

Study One (Law and Crane 2000)

The first study was an attempt to apply medical offset research methods to MFT specifically. When the three time periods were compared, it was found that there were significant reductions in health care use. In particular, those who participated in family therapy ($n = 172$) were found to have reduced health care use by 21.5 % 1 year after psychotherapy started, compared to a 10 % reduction for those who had individual therapy ($n = 60$). Additionally, the family therapy participant who was not the identified patient (FTOP) group ($n = 60$) also showed a reduction of 30 % in health care use after 1 year. This finding was notable because this group of participants was not the focus of therapy, suggesting that family therapy may produce a medical offset beyond just the identified patient. However, because this finding is unique to this study, further research should be conducted to verify this possibility. No study is known to have attempted replication of this finding at the present time.

Study Two (Law et al. 2003)

This study focused on “high utilizers” of health care ($N = 65$) within the larger Law and Crane (2000) sample. Little research has shown whether this population reduces health care use after psychotherapy, despite accounting for a disproportionate amount of costs. High utilization was defined as four or more health care visits during the first 6 month period. After therapy, those who received individual ($n = 22$), marital ($n = 15$), or family therapy ($n = 28$) all reduced health care use by about 50 %. The reductions in health care use were statistically significant at -57 % for the FTOP patients. The largest reductions of -50 to -57 % were seen among those who participated in some form of conjoint therapy. Individual therapy also produced a large and statistically significant reduction of -48 %.

Study Three (Crane et al. 2004)

This exploratory study examined the relationship between therapist characteristics (such as age, experience, gender, and profession) and the medical use of their clients. The sample consisted of 197 clients who received services from 13 providers, which included: (a) marriage and family therapists ($n = 4$); (b) psychologists ($n = 2$), and; (c) clinical social workers ($n = 7$). The average age of the therapists ranged from 37 to 47 years old, and the average years of experience ranged from 8 to 14 years of practice. Logistic regression was used to analyze the data and the results supported the argument that psychotherapy in general contributed to reductions in health care use more than specific therapist characteristics or provider type. However, this study should be replicated with a larger sample for each of the provider types before drawing firm conclusions.

Study Four (Crane and Christenson 2008)

Most offset studies combine various types of health care use into a single outcome variable such as “outpatient visits,” which has the potential to mask patterns in reductions within specific sub-types of health care use. In this study various types of outpatient care (e.g., health screening, illness visits, laboratory/X-ray, and urgent care) utilized by the 292 participants in the original Law and Crane (2000) study were separated out for analysis. Similar to the findings by Law et al. (2003), the most prominent reductions over the three time periods were found for high utilizers who participated in MFT. For these participants there was a 78 % reduction in urgent care visits, a 56 % reduction in laboratory/X-ray visits, and a 68 % reduction in health screening visits when T1 was compared to T2.

Findings from Kansas Medicaid Data

The second source of naturally occurring data was from the Kansas Medicaid system. Medicaid is a program funded by federal dollars intended to provide health care to lower income children and families. Medicaid is administered at the state level and is one of the largest providers of health care to children in the United States.

Study One (Crane et al. 2005)

The first use of this data was a longitudinal, retrospective study that looked at health care costs associated with treating conduct disorder in Kansas. The youth in this study

($N = 3753$) received comprehensive services (e.g., case management and pharmacological intervention), along with one of three types of therapy: (a) in-office family therapy ($n = 164$); (b) in office-individual therapy ($n = 3086$), and; (c) in-home family therapy ($n = 503$). The participants were mostly males (81 %), Caucasian, (73 %), and had an average age of 14.4 years. The cost of health care use for a period of two and a half years after therapy was available for each participant. Over the two and a half year follow-up period, the cost of health care was \$16,260 for the in-office individual therapy group, \$11,116 for the in-office family therapy group, and \$1,622 for the in-home family therapy group. These findings showed that, compared to health care costs for the individual therapy group, those who received in-office family therapy were 32 % lower and those who received in-home family therapy were 85 % lower. Accordingly, it appeared that when family therapy is included in treatment, there does not appear to be a resultant increase in costs.

Study Two (Christenson et al. 2012)

Kansas Medicaid data were used to develop two structural equation models relating to the cost of treating patients ($N = 164$) diagnosed with schizophrenia. The participants were mostly males (55 %), Caucasian, (90 %), and had an average age of 30 years. The first model was based on the extant literature (e.g., Lindström and Bingeors 2000) and included only limited direct effects for family intervention (e.g., reductions in hospitalization costs). The second model reflected both direct and indirect effects (e.g., reducing hospitalizations by increasing medication compliance), and was shown to be a better fit to the data when the AIC for both models was compared. This second model showed a significant indirect relationship between family intervention and general medical costs that accounted for a savings of \$586 for each “session” of family intervention provided. The total indirect effect of family intervention on costs was a savings of \$796 for hospitalizations and \$580 for general medical use for each session of family intervention provided.

Findings from Cigna Data

Data from the behavioral health division of Cigna, a large national health insurance company with over nine million members, were provided for the following nine studies. Cigna initially provided cost data for all psychotherapy services in the United States and Puerto Rico during a 4-year period (2001–2004), producing a sample that included 490,000 unique patients. This majority of the sample was female (60 %), and the average age of participants was 32 years. Recently Cigna has provided additional data, including that from more recent years (2005–2006). Studies one through three, below, present results from the sample as a whole, whereas studies four through nine focus on specific sub-samples within the data (e.g., patients diagnosed with depression).

Study One (Crane and Payne 2011)

Outpatient claims data for almost 490,000 unique patients were used to find the cost of therapy (individual and family) as provided by marriage and family therapists (MFTs), master’s level nurses, social workers, professional counselors (PCs), psychologists, and physicians (MDs). The results showed that family therapy alone was substantially more cost-effective than either individual therapy or “mixed” therapy (a combination of both

individual and family therapy). Overall, 85 % of the patients required only a single episode of care, and services provided by PCs were the least expensive. The 86.6 % success rate and 13.4 % recidivism rate shown by MFTs were the best in those categories among the various providers.

Study Two (Hamilton et al. 2011)

The second study in this series examined dropout rates by provider type, modality (e.g., individual, family therapy) and diagnosis. Administrative claims data for 434,317 patients were examined. Results showed that individuals treated by MFTs had the lowest dropout rates. In terms of treatment modality, the lowest dropout rate was found with individual therapy, and when diagnosis was considered the lowest dropout rate was found among those diagnosed with mood and anxiety disorders. It was also noteworthy that amid the DSM-IV diagnoses, schizophrenia and substance use disorders were amongst those with the highest dropout rates.

Study Three (Moore et al. 2011)

This study was similar to Crane and Payne (2011), but sought to examine more specifically whether having a MFT license affected outcomes in family therapy. The same provider types (e.g., MFTs, MDs, nurses, social workers) and outcome measures were used (i.e., dropout, recidivism, and cost-effectiveness). The final sample included a total of 31,488 men and 36,333 women. Results showed that licensed MFTs again had the lowest dropout rate. MFTs were also more cost-effective than nurses, MDs, and psychologists, but given the similar costs and lower drop-out rates, were less cost-effective than social workers and PCs.

Study Four (Moore 2011)

The sample in this study consisted of 3,315 patients who had participated in psychotherapy for relational problems. These included those with a diagnosis of a partner relational problem (V61.10) or those with a parent–child relational problem (V61.20). The outcomes of interest included total cost, cost-effectiveness, and recidivism. Psychotherapy dropouts (i.e., less than two sessions) were excluded from the analysis. Only services provided by psychologists, PCs, MFTs, and social workers were included due to the preliminary finding that MDs and nurses did not provide conjoint services for these types of problems. Results showed that those who received individual therapy for relational problems did not have a higher recidivism rate than those who participated in family therapy. Findings also showed that couples therapy was a relatively brief intervention that required an average of five sessions and cost approximately \$280 for an episode of care (with recidivism of 8.43 %). These findings lend support to the contention that adding family services as a covered benefit to insurance plans would not be too costly.

Study Five (Chiang 2011)

Cost-effectiveness of family and individual therapy was considered for those diagnosed with schizophrenia. Cigna provided 6 years of data (2001–2006) for this analysis, which included more than 2,000 unique patient claims for outpatient psychotherapy. The outcome measures of interest included recidivism and dropout rates, total treatment cost, and cost-effectiveness.

Results demonstrated that family therapy was more cost effective, largely due to lower recidivism rates and lower total treatment costs. However, family therapy also had higher dropout rates than individual therapy.

Study Six (Morgan et al. 2012)

This study looked at the cost of treating substance use disorders for more than 14,000 unique patients with individual and family therapy. Survival analysis revealed that family therapy on average used 2.41 sessions, individual therapy used 3.38 sessions, and mixed therapy used 6.40. When the typical cost of each type of therapy was factored in, the analysis showed that each treatment episode cost \$124.55 for family therapy, \$170.22 for individual therapy, and \$319.55 for mixed therapy. The recidivism rate (i.e., returning for a second episode of care) was lowest for family therapy (8.9 %), mixed therapy (9.5 %) and highest for individual therapy (12 %). Not surprisingly, licensed MFTs used family therapy as a treatment modality three times more than other professionals.

Study Seven (Fawcett and Crane 2012)

The sample for this study consisted of 230 men and 189 women who had received treatment for sexual dysfunction between 2001 and 2006. Differences in outcome (i.e., recidivism, dropout, cost of treatment, and number of sessions) were compared by provider type (i.e., psychologists, social workers, MFTs, and PCs) and modality (i.e., individual, family, or mixed therapy). Overall the results showed that the average number of sessions was seven, and that marriage and family therapists use family and mixed modalities more often than other provider types. Additionally, it was found that mixed therapy had substantially lower dropout rates, suggesting that a combination of individual and family treatment may improve therapy outcomes.

Study Eight (Crane et al. 2012)

The same outcomes used by Fawcett and Crane (2012) were considered for 149 patients with somatoform disorder, both as a complete sample and based on provider type. Initial descriptive statistics for all patients revealed that those with somatoform disorder experienced higher than average recidivism and participated in more sessions (regardless of provider type), while dropout rates were consistent with previous studies (e.g., Hamilton et al. 2011). The analysis also showed that there was no significant difference in terms of total cost or dropouts between the various professions or between masters level versus doctoral level providers.

Study Nine (Crane et al. 2012)

In this study, claims data for 164,667 patients diagnosed with depression were examined. Of interest was whether there would be differences in total cost and cost-effectiveness based on modality or provider type and whether various factors (e.g., age, gender, modality, provider type, etc.) would account for difference in recidivism. Consistent with a number of the studies listed above (e.g., Crane and Payne 2011), the results indicated that MFTs provided services resulted in the lowest recidivism rate. However, contrary to the findings of Crane and Payne (2011) services provided by MFTs in this study were the least costly.

Findings from Training Clinic Data

This research took place in a student training clinic that provides opportunities for clinical training for Masters and Doctoral students at a large university located in the western United States. Students from the marriage and family therapy, clinical psychology, and social work programs served as providers to local individuals, couples, and families who requested psychotherapy services. The data were collected at therapy intake (prospective) and focused on the interrelationships between families and health, with the intent of investigating the potential for a medical offset effect after therapy. Retrospective data were also collected regarding health care use for 6 months before therapy, 6 months during therapy, and 6 months after therapy concluded.

Study One (Jakubowski et al. 2008)

One of the biggest issues with conducting research regarding health care services use and cost-effectiveness is the lack of access to physician medical records. In an effort to address this issue, this study sought to determine if self-reported medical use can be considered an accurate and valid measure in health care research. The sample in this study was 60 % female, 94 % Caucasian, and had an average age of 31 years. Six months of physician medical records for 130 clients were gathered and compared to self-reported medical use for the same time period. Additionally, family members were asked to report on the health care use of their spouse and oldest children for the same period. In both cases medical record and self-reported health care use were found to be highly correlated, suggesting that researchers can substitute self-report for medical records in research efforts. In addition, spouses were reasonably able to report their partner's and their children's health care use, suggesting that only one informant is necessary for health care research on families.

Study Two (Crane et al. 2010)

Although a significant number of researchers have investigated factors that predict health care services use for individuals, almost no researchers have attempted to ascertain the impact of systemic influences. Two studies were conducted to investigate predictors of health care use among persons seeking help for relationship problems. In the first study the dependent variable was children's health care use, and the independent variables were derived from a series of biopsychosocial measures administered to their parents ($N = 60$) at intake. Best subsets regression was used to determine the variable that accounted for the most variance in children's health care use. The results of this analysis showed that parents' marital cohesion and life satisfaction were the strongest correlates, and accounted for 46 % of the variance in health care use. In this model, a decrease in parent life satisfaction was associated with an increase in health care use by the child.

Study Three (Christenson et al. 2011)

The second study investigating correlates of health care use focused on a sample of adults seeking services for relationship problems and included 110 participants. The sample in this study was 66 % female, 96 % Caucasian, and had an average age of 31 years. Given the dramatic reduction in health care use by high utilizers following therapy (Law et al. 2003), a subsample of these participants were selected out for analysis as well ($n = 40$).

For the complete sample, the two variables that accounted for the most variance were “informational support” (i.e., the availability of advice and guidance) and “somatization.” “Hostility” (e.g., having an urge to break things) was the strongest correlate for health care use in the high utilizer group. Interestingly, hostility accounted for as much as 36 % of the variance in health care use in the model for high utilizers. The findings of this study suggest that targeting certain psychosocial variables may promote greater reductions in health care use after therapy.

Study Four (Christenson et al. 2012)

Similar to Law and Crane (2000), this study considered health care use for 56 participants across three time periods (i.e., 6 months before therapy, 6 months after the start of therapy, and 6–12 months after). Descriptive statistics showed that the sample was largely homogeneous in terms of race (96 % Caucasian). Annual income was diverse, however, ranging from \$2,500 to over \$100,000. When health care use from the first time period (T1) was compared to the second 6 months (T2), MFT participants showed a significant (44 %) decrease in health care use. There was also a slight uptick in health care use during the third 6 month period (T3); however, from T1 to T3 there was still an overall decrease of 33 % in health care use. In addition, when biopsychosocial factors (e.g., behavior control, relationship satisfaction, and perceived criticism) were included in the analysis, participants who reported an improvement in general family functioning after treatment showed a significant 58 % decrease in health care use from T1 to T3, while those who did not improve in this regard showed no decrease in health care use.

Additional Findings Related to MFTs

In conjunction with the effort to argue for coverage of MFTs under Medicare, there was a need to demonstrate how much this additional coverage would add in terms of costs to the program (Christenson and Crane 2004). Trends in health care use expenditures for Medicare were determined for a historical 3 year period. These trends were then used to make future projections for how the inclusion of MFTs as providers would affect the bottom line. Using established methods for estimating costs (including both induced costs and the substitution effect), it was determined that the true costs of including MFTs as providers would add less than \$3 million per year to the Medicare budget. When compared against the entire Medicare budget, services provided by MFTs would account for less than .0015 % of total spending.

Morgan and Crane (2010) identified and reviewed eight cost-effectiveness family-based substance abuse treatment studies. The purpose of this review was to move past the limitations of considering clinical outcomes alone, instead focusing on the cost-effectiveness of family-based interventions and providing summary information across studies. The eight articles reviewed in this study were published between 1991 and 2006, and covered treatment for alcohol and substance abuse among both adolescents and adults. The outcomes for each study varied, though all studies included common indicators such as number of days sober and improvement in psychosocial functioning. The most relevant finding from this review was that despite encouragement from the research community to conduct cost-effectiveness analyses, to date few studies have done so in relation to substance abuse treatment. However, Morgan and Crane (2010) also showed that among

studies with comparative data, three of the five studies showed that family-based treatment was more cost-effective than individual therapy.

Given the increasing amount of research showing that family therapy is an effective form of treatment (and sometimes the preferred intervention), Crane et al. (2010) deemed it prudent to investigate how much training each of the major mental health provider types receive in this modality. Content analysis was used to determine how much family therapy training is required in the standards for the six core mental health provider types (Psychiatry, Psychiatric Nursing, Clinical Psychology, Professional Counseling, Social Work, and Marriage and Family Therapy). Results for each of the 50 United States revealed that overall MFTs have three times more required systems-based coursework than any of the other professions and 16 times more face-to-face therapy hours required for licensure.

Themes and Implications

At the present time there is an overall consensus that family therapy interventions are effective for a wide range of presenting problems (e.g., Sprenkle 2012; Stratton 2011). Overall, these types of interventions seem to be clinically effective and the studies within this review demonstrate that they are cost-effective as well.

Despite showing good clinical results, there has been an overall inattention to costs when considering outcomes. This is especially troubling given that public and private discourse about the current health care market is dominated by cost considerations (Christenson and Crane 2004; Cummings et al. 2009). Similar to medical offset research (Law et al. 2003), family therapy as a treatment procedure (and MFTs as a discipline) has not yet fully realized the importance of demonstrating cost-effectiveness and how related findings may benefit market share. Cummings et al. (2009) (approaching the issue from the perspective of psychologists) argue that psychologists' unwillingness to address costs has led to "a precipitous decline in their practices and in their incomes" (p. 32). Individual psychotherapy practitioners have awoken to this reality and have pushed to improve conditions for reimbursement (e.g., Kessler 2008). Unless there is a commensurate and concerted effort to likewise show that MFT services are cost-effective, MFTs risk at best becoming marginalized in the health care market, and at worst becoming irrelevant.

The research conducted by Crane and colleagues has sought to address this significant gap in the literature. As noted in the introduction, the above outlined research shows that services provided by MFTs are not very expensive to provide, and may be less expensive than services provided by other professionals (e.g. MDs, psychologists) without any significant increases in recidivism or dropout. Additionally, family therapy appears to be associated with reductions in other types of health care use following therapy, especially for those who are considered high utilizers. Furthermore, MFTs are uniquely qualified to provide the couple and family services that have demonstrated effectiveness. Taken on whole, the evidence presented here supports the argument that family therapy (as a distinct treatment modality) is a cost-effective means of delivering quality services to patients and that MFTs (as a distinct profession) are cost-effective providers of psychotherapy.

However, despite the consistency of results across the studies, there are limitations that should be considered in reflection. Data presented here are archival, longitudinal, and retrospective (with the exception of the training clinic data). The strength of these data is that it is possible to investigate treatment as it occurs in the "real world" of health care delivery, as opposed to studies of tightly controlled laboratory studies of manualized

treatment. However, these data have their own weaknesses in that many other factors, such as the availability of various mental health providers, can be uneven. Some patients may have limited choice in what professional groups are available to them.

In addition, some patients may not be aware of differences in the professional training of the mental health disciplines, or may select providers based on unclear expectations about what to expect. In these cases, one may be “comparing apples to oranges,” but in the world of health services research, one must use the data that are available. In addition, there is no evidence that any of the results presented here are inherently biased for or against any treatment modality, or for or against different professional groups.

Additionally, because the data from our HMO source, Medicaid and Cigna are archival and based on claims reporting, it is impossible to link clinical outcomes as typically measured (e.g., using standardized assessments) to cost data. Recidivism is one method for evaluating clinical outcomes, but not returning to therapy could also be related to dissatisfaction or with higher levels of treatment severity as with a remission of symptoms. In any case, although high dropout rates can be a driver of low cost therapy, they almost certainly are not a good measure of clinical improvement or relief of human suffering.

Accordingly, cause and effect relationships cannot be determined from these data and interpretations of the value of services by different provider types should be made with caution. Of course, the opposing view (as highlighted above) is that real world demonstrations of cost effectiveness are important because they represent what happens within naturally occurring mental health delivery systems. It is expected that this debate will continue into the foreseeable future.

Future Directions

Perhaps the most salient issue revealed by this review is what is still lacking in the cost-effectiveness research. Too often research in MFT demonstrates a disconnect between clinical outcomes and costs. Numerous articles are produced to demonstrate that MFT produces changes in psychosocial functioning without providing information on how much the intervention costs to deliver. In fact, a cursory review of the recent 2012 special issue of the *Journal of Marital and Family Therapy* (Volume, 38, Number 1) revealed almost no information on costs in over 280 pages of information about MFT effectiveness and efficacy research.

In order to secure the place of MFT in the health care market, researchers will need to simultaneously evaluate the costs and benefits of the interventions they develop. This is especially true in the case of medical family therapy (MedFT), given the inclination of hospitals and insurance companies to see related services as just “one more thing” (Cummings et al. 2009). To demonstrate effectiveness on this level would require that cost data be collected during the process of conducting outcome research and used to demonstrate cost-effectiveness.

One of the most basic methods of demonstrating cost-effectiveness is to take two interventions with similar outcomes (as demonstrated by effect sizes) and show comparative costs for delivering the intervention. If one is less expensive than the other, with equal outcomes, an argument can be made that the less expensive version is preferable. This method has been used effectively to demonstrate that cognitive behavioral psychotherapy is less expensive than psychopharmacological interventions for panic disorder (e.g., Gould et al. 1995). Cumming et al. (2009) make the persuasive argument that it is high time we

learn the rules of a competitive market place, which dictate that if two products are equally good, the more costly one will soon disappear.

Although a simple comparative method would clearly support interventions that are less expensive to deliver initially, what about those interventions that are inherently more expensive? Fortunately, there are ways to demonstrate that a substantially more expensive intervention produces far reaching effects in terms of cost savings. This has been effectively demonstrated by proponents of Multisystemic Therapy (MST) such as Kleitz et al. (2010), who used cost-benefit analysis to demonstrate that the net cumulative benefit of MST was a savings of \$199,374 to victims and taxpayers (per participant), compared to a cost of \$10,882 to provide the treatment (per participant).

This type of analysis requires that the researcher not only consider the costs associated with providing the treatment, but also factor in the benefits, usually by placing a monetary value on the identified benefits. MedFT research would be a particularly fruitful area to apply cost-benefit methodology. It is not difficult to imagine that cost savings from the medical offset effect, improved adherence to treatment recommendations, increased work productivity, and a decrease in malpractice suits (to name just a few) would far outweigh the costs associated with a collaborative care model. Some research within the field of psychology has already shown that integrated care may be associated with a 20–30 % reduction in costs (beyond the cost of additional services) when a psychologist is included as part of the care team (Cummings et al. 2009). If MedFT intends to grow as a discipline, it will be imperative that researchers show similar benefits.

Advocacy

One final consideration is how policy can be shaped to encourage greater market share for family therapy as a procedure and for MFT as a profession. Two approaches are most often considered in the literature. First, Crane (2008) discussed the importance of having satisfied consumers make the case to insurance companies that the services we provide are valuable. This type of grassroots effort has the potential to raise awareness among stakeholders about what services are in demand and which can ultimately affect decisions about which services to cover. Crane (2008) rightly pointed out, however, that clinicians must use caution and ensure that they are not unduly influencing clients to advocate for the profession. Nevertheless, it can be very helpful for clients to provide feedback about what services work and what they would like to see in their plans.

The second commonly described method is advocacy on the part of practitioners. When a particular service is not covered, practitioners can contact the insurance companies to argue for changes in their policies. Kessler (2008) described a number of examples of practitioners (armed with research) who have encouraged policy makers to modify their policies with positive results. These types of efforts are best carried out when the practitioner has at his/her disposal the evidence that (a) his/her services are as effective (or more) to what is already being provided, and (b) that the services result in cost savings to the system. There are few policy makers who would not be interested in learning how to decrease costs, while also providing high quality services.

Research has made substantial progress on the first part of this argument (though less so for MedFT), and it is time to get started on demonstrating comprehensive cost savings. With this type of evidence available, practitioners will be well-equipped to secure a place in the ever changing health care market.

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