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The effect of insurance reimbursement on services by social workers in private practice

Strom, Kimberly Jean, Ph.D.
Case Western Reserve University, 1993

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THE EFFECT OF INSURANCE REIMBURSEMENT ON SERVICES
BY SOCIAL WORKERS IN PRIVATE PRACTICE

by

KIMBERLY JEAN STROM

Submitted in partial fulfillment of the requirements
for the Degree of Doctor of Philosophy

Thesis Advisor: Wallace J. Gingerich, Ph.D.

Mandel School of Applied Social Sciences
CASE WESTERN RESERVE UNIVERSITY
January, 1993
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GRADUATE STUDIES

We hereby approve the thesis of

______________________________
KIMBERLY STROM

candidate for the Ph.D.

degree.*

Signed:  ______________________
        (Chairman)

______________________________
Richard S. Edwards

______________________________
Jack Singer

______________________________
Gregory Fink

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THE EFFECT OF INSURANCE REIMBURSEMENT ON SERVICES
BY SOCIAL WORKERS IN PRIVATE PRACTICE

Abstract

by

Kimberly Jean Strom

As health care costs have increased, so too have the number of restrictions placed by insurers on reimbursement for mental health services. With the growth in vendorship for social workers, those in the mental health field are increasingly confronted with the challenge of how to provide appropriate services within the parameters of what will be reimbursed by the third party. These sometimes oppositional forces create a number of philosophical, clinical and moral predicaments. Such dilemmas are likely to be most acutely felt by social workers in private practice, for whom clinical decisions have direct personal fiscal ramifications. Decision making under the pressure of such competing values can be most easily understood using concepts and terminology derived from the field of ethics.

In order to better understand these phenomena and their prevalence, an exploratory study was conducted using a sample of 540 social workers randomly selected from a clinical register. Subjects were sent a nine page, 53-item
questionnaire which contained questions on demographic and practice characteristics, experiences with third party payors, the perceived impact of the third party, the actual effect on practice decisions and actions, and the amount of quandary experienced when deviating from legal, ethical, or clinical norms. Phone interviews expanding on the survey were conducted with a subset of respondents.

As a result of the survey and interview findings, it appears that involvement with third parties varies, and the payor's effect on practice is related to the level and type of restrictions employed. Practice effects were found in the clientele selected for treatment, the diagnoses assigned, the length, frequency, and modality of treatment, and the collateral services rendered. Practitioners also evidenced ethical and personal dilemmas as a result of reconciling practice decisions with third party parameters.

These findings hold significant implications for policy development, social action, education, and expanded research. They also offer an expanded understanding of the current status of private practice and the challenges facing workers in that domain.
DEDICATION

To my parents, Morton and Jean Strom.

Never underestimate the importance of being there.
ACKNOWLEDGEMENTS

I have often joked that my acknowledgements would take up more space than the text of this work. Indeed, many people deserve credit for their contributions, and acknowledgement here is but a small part of the tribute due them. My heartfelt gratitude goes to the following:

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Chapter One

Introduction

To date, social workers have been conveyed vendorship status by 26 states and the District of Columbia. Such recognition affirms their right to receive direct reimbursement from third-party payers for the provision of certain services, chiefly psychotherapy. With legal regulation for social workers now in place in all 50 states, and private practice an ever-growing enterprise, social workers must now take a look at how such advancements might affect the services they deliver. Principal among these effects are the parameters placed by third-party funding sources on the nature of reimbursable activities. As health care costs rise, and mechanisms are implemented to contain these expenditures, clinicians must contend with the presence of a third-party in the treatment process. One such impact might be the pressure to structure treatment decisions— for example, the type, length and focus of treatment— to conform with what is reimbursable by the payor.

This pressure is not specific to private practitioners, or to any one professional group. As has been noted, "In accordance with the old adage that he who pays the piper calls the tune, it is becoming clear that the carriers are demonstrating an increasing power to control the kinds of services offered in
institutions dependent for their survival on the income derived from insurance sources" (Chodoff, 1987, p.1144). However, several conditions make the phenomenon, as it exists for social workers in private practice, ripe for study.

- Social work is relatively new to the fee-for-service model of service provision. The private, entrepreneurial model of service provision is also quite new to the profession. Neither entity is wholeheartedly embraced within the social work community, resulting in a lack of dialogue and guidance about how these new market realities may shape practice.

- Social workers are also new to the arena of third-party payment and the concomitant restrictions it imposes on who and what is "insurable". Such restrictions may conflict directly with long-held tenets of social work, such as the importance of engaging in social action, or taking a person-in-environment approach to problem resolution.

- The profession of social work represents a long history of interest in social policy. The issue of affordable health care and the reasonable containment of health care costs represents one of the most significant public policy issues of the day. Policies which sanction social workers' autonomy and which regulate or affect their payment for services provide an acute example of the interface between larger systems efforts and the ramifications for service providers and
recipients. As such, it represents one issue in which vastly different segments of the same profession share a common interest and goal.

Finally, "Independent social work requires business decisions. In independent practice, a linear link must exist between service and income" (Whittington, 1988, p.83) in order for the autonomous social worker to practice as a self-supporting professional. Private practitioners must often make choices about which activities to engage in based on "bottom line" considerations. When the receipt of funds from a fiscal third party is tied to certain requirements, to what length will the private practitioner go to accommodate these demands in his or her treatment decisions and activities?

Such dilemmas have received more attention in the literature of the psychiatric and psychological professions, due in part to their lengthier experience as approved providers. On their part, there has been no small amount of concern displayed, with some calling it a "crisis" (Rodriguez, 1989), and pronouncing the solo practice of psychotherapy to be an "endangered species" (Duhl & Cummings, 1987). Without preparation for the changes being forged by third party payers, social workers may find themselves breaking into private practice at the very time that the setting itself is becoming extinct. More importantly however, an understanding is needed about the nature and extent of dilemmas practitioners are experiencing, and the efforts they are making to resolve them. Such findings have
ethical and regulatory ramifications as social workers are included in "freedom of choice" legislation and as competency or quality assurance measures are built into licensure laws. They might also inform the content in social work education, particularly the preparation of those who will enter private practice. An awareness of the effects of cost-containment strategies may also have ramifications for the policy decisions which shape future health care funding plans.
Chapter Two
Context of the Study

The study detailed here was designed to gather empirical data about the nature and extent of the dilemmas experienced by social workers receiving third party payment for the provision of treatment services. Central to our exploration of this issue is an understanding of the forces which have shaped the reimbursement system, and how the resulting structure can conflict with the ways in which social workers provide services. Potential areas of impact encompass the populations seen for services, the types of problems qualifying for treatment, an altered worker-client relationship, and the type of services rendered.

Restricted Reimbursement

Currently, social workers throughout the United States are receiving payment for their services through third parties, typically insurance companies, or through some prepaid or managed care arrangement. With vendorship, such compensation may be received directly. In states without vendorship, social workers may still be working under reimbursement guidelines if they see clients under the supervision of an approved provider. Whatever the efficacy of this system for all concerned, it is now in the process of certain change, as the costs of health care, and mental health care in particular, are rising.
Many contend that it is unrealistic to insure mental health in the same way as medical and surgical services. They assert that the two are not comparable, in that the costs and effectiveness of mental health interventions are harder to measure than those for health problems, and that the goals of treatment, and even the definition of mental illness itself, are based on largely subjective criteria (Flynn & Sullivan, 1987, p.3). Others put it more boldly. "Mental health is not insurable. To insure a risk, there needs to be some event over which people have no control, but which can be actuarially predicted. And there needs to be some objective way to determine what payments are appropriate to restore 'wholeness'" (Wenzel, 1986, p. 3).

Efforts to mandate certain types and levels of insurance coverage, while a temporary boon to services and those who provide them, may ultimately be escalating the process toward increased restrictions on services.

State laws requiring employers to offer insurance coverage for mental health care, as well as other services, have long been a controversial subject. As cost-containment pressures grow, state policy makers are beginning to realize that mandated benefits may, in fact, increase health care costs by promoting use of mental health services, as well as giving incentive to large employers to self-insure in order to avoid such mandates (Flynn & Sullivan, 1987, p.6).

Traditional third party coverage was in the form of fee-for-service plans, such as Blue Cross/Blue Shield. Based on indemnity policies, these plans are
essentially "bill payers", dispensing payments to vendors who have provided professional services of the sort covered in their policy. While payments may be limited to certain conditions, or to "usual and customary rates", the retrospective payment mechanisms and fee-for-service structures of traditional insurance plans contain few incentives for cost management. One response to this has been the move toward "managed care". The term "denotes a wide range of organized delivery systems that attempt to balance access, quality, and costs. This balancing act is accomplished by shifting economic risks from the payers to the patients and/or the providers" (Sharfstein, 1990, p.965).

As managed care has expanded, so has the terminology which accompanies it. Briefly, health maintenance organizations (HMOs) provide specified health services at a fixed cost to the consumer using either a "closed panel" or "open panel" of providers. The latter is sometimes referred to as an Independent Provider Plan (IPP). Staff on a closed panel may be paid through flat salary, or on a fee-for-service basis. A low copayment for HMO members, and coverage of preventive services is intended to promote wellness and the prevention of more serious (and costly) illness. Prospective Payment Organizations (PPOs) buy care from selected providers usually at a discounted rate, sometimes with a percentage of fees held until the end of the contract year. The incentive for providers to participate is the potential for an increased or more reliable volume of clients.
In a variation of the IPP, the IPA (Individual Practice Association) allows consumers to choose independent providers, but holds back a portion of the fees from providers, whom it may reimburse on either a capitated or fee-for-service basis. "'Capitation' refers to a fixed monthly or annual payment according to the number of persons covered by the managed care plan; payment is unrelated to the service provided" (Richardson & Austed, 1991, p.53). As such, the provider bears the risk of cost overruns if the services needed outstrip the amount for which he/she was retained. Conversely however, he or she may fare well financially, if utilization is low. For primary care physicians in IPPs or IPAs, capitated payment may serve as a disincentive for referrals to mental health specialists in that the costs of that care may be deducted from the physician's capitation fee (Jewett & Thompson, 1989, p.9).

As the field of managed care has developed, endless permutations ("hybrids") of the model have developed. By and large though, the essential concepts remain the same, and the differences stem from the way they are packaged under various managed care contracts.

One or more of the following limitations is usually used in attempts to contain costs: increasing the patient's share of treatment costs (raising copayments); limiting dollars available per insured per year (total cost cap); limiting treatment to conditions falling into certain diagnostic categories (prospective payment schemes); limiting treatment by number of episodes, or in inpatient settings, length of stay (treatment-episode limits); limiting treatment to specific approved techniques; and limiting treatment through
requiring prior approval by "gatekeepers" (pre-authorization) (Haas & Cummings, 1991, p.46).

Even standard insurance carriers are developing increasingly more sophisticated, and stringent, review and reimbursement procedures. "At one point, the primary users [of managed care] were self-insured programs. Today, Blue Cross/Blue Shield programs, small group health plans, CHAMPUS, Medicare and Medicaid are all expanding their use of managed care concepts. A survey done by Health Insurance Association of America revealed that 47 percent of employees were in conventional unmanaged programs in 1987. It's 1990 survey revealed that only 5 percent were in conventional unmanaged plans; 38 percent were in HMOs, PPOs and point-of-service plans, and 57 percent were in managed fee for service plans" (NASW, 1992a, p.2).

In support of the move toward more managed care, Wenzel sums up the corporate position, saying, "mental illness, and indeed, most chronic conditions do not conform to the requirements of an insurable risk. Therefore, they need to be administered not with an insurance plan, but with a managed budget" (1986, p.3). In fact, recent news reports indicate that mental health care case management has become a thriving industry in and of itself (Adler, 1990).

The growth of cost containment measures is captured in a 1991 New York Times article.
In 1982, 43 percent of employers' health plans had more restrictive coverage for mental health problems than for other ailments; by 1988, the figure was 71 percent, a Department of Labor study shows. The plans typically limited psychiatric hospital stays to 20 or 60 days, versus a minimum of 120-and often no limit at all-for other illnesses....In 1982 [outpatient] therapy visits were already subject to limits in 84 percent of plans. By 1988 that was true of 95 percent (Goleman, 1991).

Finally, while restrictions exist, it is clear that coverage for mental health and substance abuse treatment endures in benefit plans.

In a national survey of 304 managed health care organizations, Levin et al. (1988) found that 97% of surveyed HMOs offered some type of mental health coverage in their basic benefit, 79% offered 20 sessions of outpatient care, and 67% offered some type of substance abuse benefits. Levin et al. also found that over the 10 year period from 1976 to 1986, both mental health and drug and alcohol treatment benefits remained constant, with a median outpatient therapy benefit of 20 sessions per member per year and inpatient benefits of 30 days per member per year (Richardson & Austed, 1991, p.52-53).

However advantageous third party coverage is for those in need of service, the various forms of cost containment they employ bring about a variety of dilemmas for those endeavoring to provide services under them.

**Areas of Conflict**

From the outset, some in the social work profession have been ill at ease with the prospect of privately delivered services. Levenstein (1964) traces its growth as "a deviant subculture". Merle (1962) found it "a basic contradiction in
terms to speak of the 'private' practice of 'social' work" (p.12). The advent of vendorship has done nothing to diminish these concerns. Hans Falck's 1984 editorial "A Loud and Shril Protest" aptly sums up such consternation. "...[Social work] schools have opened the door to private practice, to third party reimbursement, to limited private practice, taking the cream off the top as far as fee paying clients are concerned, leaving the masses of the poor, the chronically ill, the multiproblem families to find help and support through underfunded community agencies" (p.4). Nor has time softened the degree of debate. A recent "Point-Counterpoint" debate in the *Journal of Social Work Education* (Specht, 1991; Barker, 1991a) and a volley of letters to the editor of *Social Work* (for example, Brandt, 1990; Karger, 1989; Winkler, 1990) stand as evidence that feelings still run high about the place of private practice in social work and social work education.

Whatever the history within the profession, it is clear that an outcome-oriented/payor-driven system only serves to intensify these philosophical incompatibilities. Referring to the "industrialization of social work practice", Fabricant (1985) addresses some of the effects of an increased emphasis on production and efficiency. The results, including decreased opportunities for decision making, fragmentation, specialization, and a narrowed mechanistic response to complex human problems all fly in the face of familiar social work
approaches. Such reductionism is not limited to social workers swamped by the bureaucracy of public welfare offices or mental health clinics. The dependence by private practitioners on third party funds may similarly narrow their range of choices and activities. And, unlike agency employees, there exists no administrative infrastructure or policy-making body to insulate the private practitioner from these dilemmas or the ramifications of the choices made.

Where might difficulties arise when third party forces meet clinical judgments and professional values? These conflicts may be seen as falling into four basic categories—eligibility for services, the types of problems qualifying for treatment, the changing worker-client relationship, and the type of services provided.

**Eligibility for Services**

Some attention has been given to the developing stratification in overall health care in the United States. As a result of scarce resources and increased efforts to exclude from coverage those who are likely to be heavy users of services, "...our health care system, never a paragon of equality, is becoming more sharply stratified. Lester Thurow and Uwe Reinhardt each see three tiers: one for people on government assistance, another for employees of corporations, and another for the wealthy who can afford the private health care market" (Morreim, 1988, p.22).
In the mental health field as well, the type of payment system may dictate the services available to individuals in need. "A survey by Lange, et al. (1988) found that all of the HMOs in their study claimed to permit continuation of treatment beyond the maximum number of allowable visits. Alternatively, clients may be transferred to the public sector at the outset of treatment, or when benefits have been exhausted if adequate care cannot be provided within the restrictions of the managed care system (eg. 20 visits per year). In capitated systems, a financial incentive exists for such transfers" (Richardson & Austed, 1991, p.57).

Such dual systems of care are in direct contradiction with social work's heritage of inclusiveness and appreciation for all populations. Yet, insurance coverage by its very nature is available only on a work-conditional or husband-conditional basis (Arches, 1984). Risk management tends to further exclude from coverage those who have chronic or severely debilitating illnesses. "With current economic constraints [the severely mentally ill] are at risk for being under-treated. The lack of depth in insurance policies, that is, the lifetime limits on coverage by days of care per episode of illness or on visits per year, will inevitably cause problems for these patients and their families" (Sharfstein, Dunn & Kent, 1988 p.64). As a result of third party payment considerations, the pool of reimbursable clients to be seen in private practice will likely lack many children, the elderly, people in poverty and minorities as well as the more severely impaired (Taplin,
1987; Borenzweig, 1981; Lehman, 1987; Sharfstein, et al., 1988). For some, this list would constitute the very populations which social work should be most inclined to serve. Even a history of successful mental health treatment may render one ineligible for future coverage should they ever have occasion to change insurance plans (Barker, 1988a).

Even those who carry coverage for mental health services present potential providers with a dilemma if the nature of their problems is such that the limits on service appear inadequate to meet their needs. "If a plan limits treatment, it is both clinically and ethically problematic to offer services to inappropriate cases (e.g., those who would deteriorate under the proposed treatment limits). However, there is much debate about which cases are inappropriate" (Haas & Cummings, 1991, p. 48).

While practitioners debate the problems and characteristics most amenable to restricted forms of treatment, third party payors will increasingly protect themselves through other methods, most typically, by "limiting eligibility for services to particular diagnostic categories (e.g., the plan doesn't cover situational adjustment disorders or the plan doesn't cover personality disorders" (Haas & Cummings, 1991 p. 49).

**Problems Qualifying for Treatment**
While social work has prided itself on offering an alternative to the "medical model" of problem identification and treatment, increasing affiliation with the insurance industry forces a resurgence of that model. "The companies and government programs that provide the benefits for their subscribers, being in the health insurance business, must operate on the basis of some definition of illness even though the definition is likely to be covert, rather than clearly formulated" (Chodoff, 1978, p.1142). Chodoff, a psychiatrist, acknowledges the difficulty of placing complex personal or emotional difficulties into narrow categories. From the social work perspective, Arches argues that the establishment of a label (in DSM terminology) as a prerequisite for reimbursement inappropriately changes social problems (in need of structural solutions) to medical problems in need of "cure" (Arches, 1984). Despite concerns about the potential damage in applying labels to clients, the social work profession is now involved in a payment system that demands such labels, and uses them in reimbursement decisions.

The fact that some common types of problems are not recognized for reimbursement may lead clinicians to affix certain diagnoses for the sole purpose of attaching insurance funds. A 1991 New York Times article on fraudulent practices among mental hospital chains noted, "Deliberate misdiagnosis and changing dates of service are among the most common types of all medical insurance fraud, according to the Health Insurance Association. But proving a
diagnosis was altered to increase insurance reimbursement is often extremely difficult, particularly in psychiatry, where definitions are vague" (Kerr, 1991, p. 20).

In a study of the prevalence and causes of deliberate misdiagnosis, Kirk and Kutchins surveyed clinical social workers about their diagnostic practices. Among the findings- Fifty-nine percent said that Axis I diagnoses (the major mental disorders) are used for insurance purposes when clinically unwarranted. Seventy-two percent of the respondents are aware of cases where more serious diagnoses are used to qualify for reimbursement. At least 25 percent of the respondents to these two questions indicated that the practices occurred frequently. Since reimbursement is rarely available for family problems, it is not surprising that 86 percent are aware of instances when diagnoses for individuals are used even though the primary concern is in the family. The majority of respondents said that this occurred frequently (Kirk & Kutchins, 1988, p.230).

While it may be in the clients' best interest to tap into that financial support, it may also be that, "the delicate fabric of the psychotherapeutic relationship, which depends on the honesty and integrity of the therapist, may be damaged in the atmosphere of collusion between the participants in making such diagnoses only to secure reimbursement" (Chodoff, 1978, p. 1142-1143).

Kirk and Kutchins conclude that those who engage in intentional misdiagnosis and their professional colleagues have failed to acknowledge the consequences of such a practice, however it may be rationalized. They
characterize it as an inherently deceptive and manipulative act, which not only corrupts the individual client-practitioner relationship, but ultimately the entire profession's pact with society to perform in an unbiased and ethical fashion (Kirk & Kutchins, 1988).

Ultimately, duplicity in diagnosis may also be leading to more intense scrutiny on the part of funding sources. Those carriers which have moved away from reviewing strict diagnostic labels in approving claims have done so in favor of requiring even more in-depth information about the nature of the problem and the goals and course of treatment. As a consequence, social workers may experience challenges to the clinical relationship and significant alterations in the type, length, and focus of care they can reasonably provide.

**Changing Therapeutic Relationship**

In examining the physician/patient contract in light of DRG-based reimbursement, Morreim states, "no one will be more affected by cost containment than the physician. The insular relationship in which the physician was able, ideally at least, to use his own best medical judgement to further exclusively the best interests of his patient, is quickly dissolving into a complex network of entwining and sometimes conflicting obligations" (1988, p.20). While the parallels with current reimbursement dilemmas are clear, one might assert that because the
concept of relationship is so central to the service itself, cost containment measures jeopardize mental health services all the more.

In some managed health care plans, representatives of the funding source may become involved from the outset of treatment, informing the therapist about what will constitute appropriate (reimbursable) services. Increasingly, reimbursement systems are characterized by "utilization management", defined as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case by case assessment of the appropriateness of care, prior to its provision" (Institute of Medicine, 1989, p.17). In short, it introduces a third party into the treatment relationship. Zuckerman (1989) delineates the consequences of this, stating that it ultimately "removes from the exclusive domain of the patient and therapist the ability to mutually arrive at the direction and goals of the psychotherapy and independently review their progress" (p.122). "It becomes a system in which the therapeutic relationship involves three people, and as such, all of our accumulated knowledge of how to develop, understand, and utilize the therapeutic alliance becomes obsolete" (p.122).

When the fiscal third party asserts its right to know what it is paying for, issues of trust, loyalty and privacy arise for both the practitioner and the client. For example, with the intrusion of the payor, commonly held parameters about
confidentiality are challenged, as extensive information must often be disclosed to "justify convincingly the need for continuing treatment" (Enoch & Sigel, 1979, p.9). As a consequence, clinicians can no longer assure clients that things said in the context of the therapeutic relationship are protected.

Another relationship issue raised by the involvement of third party payers is the heightened potential for symbiosis and an intensification or disruption of transference - countertransference issues (Enoch & Sigel, 1979; Zuckerman, 1989). What of the client who loses his/her coverage in the process of treatment, or whose services are no longer approved for payment? The practitioner involved is "faced with a moral dilemma of his own economic needs versus client needs" (Paradise, 1983, p.16). Even efforts to 'work out an arrangement' can still prove disruptive to the treatment process, and in fact, may also result in sanctions from managed care plans for being a "problem provider" (Zuckerman, 1989) or charges of fraud from insurance companies (Psychotherapy Finances, 1991a). Mcrreim (1988) has even coined the term "poaching" to refer to the practice of providing continued services to those who have used up their benefits, because when this is done, the resources of time, service or energy are thus less available for other patients' use.

Services Provided
Threats to the therapeutic relationship are not the only clinical challenges with restrictive payment systems. Whether overt or covert, pressures exist to conform treatment to the financial parameters set by the funding source. Paradise notes that "Short-term treatment models have become attractive to some practitioners because length of treatment coincides with the amount of insurance benefits available in a calendar year" (1983, p.16). Through annual "recredentialing" of providers, some managed care companies now 'weed out rebels and reward team players' among the therapists they reimburse. This process involves scrutiny of the provider's credentials and their brief therapy performance. "PPOs want providers with impressive service profiles—that means providers who show strict adherence to short-term therapy" (Psychotherapy Finances, 1991b, p.1). Others have also cited a rise in group treatment due to its ability to tap larger revenue sources (Enoch & Sigel, 1979). Clearly, both brief and group approaches have well established places among accepted forms of intervention. But the choice to use either modality should be based on their therapeutic - not economic - value.

As the definition for a "reimbursable treatment episode" is narrowed, so may be clinicians' choices about what services they can afford to provide for their clients beyond the 50-minute hour. Essential activities such as supportive phone contacts, school or home visits, advocacy or collateral contacts, may need to be abandoned as economically unfeasible. Of all the helping professions, those
trained in social work may feel this bind most acutely. Given the demonstrated importance of such actions throughout the profession's history and literature, their loss may be all the more critical.

While he or she may feel some pressure to tailor treatment to available funds, at least with some insurance plans, the choice still rests with the therapist. With managed health care, "certification of the problem" and development of the plan for treatment may be done by the third party's case manager. While these individuals may themselves come from the mental health disciplines, and while they may contend that they are as eager for quality care as they are for cost-effectiveness, there is still no denying their impact on the clinical process (NASW, 1992a; Haas & Cummings, 1991; Richardson & Austed, 1991). For example, on examination of a case, the reviewer might approve payment for "five sessions of family therapy" with further approval to be determined at the end of that time. Does the clinician in this case become a mere technician, carrying out the mandate of someone with fiscal, but not personal responsibility for such actions? With the wide variety of approaches available in the mental health field, how should the ideal form of intervention be chosen? Even among seasoned practitioners, one could surely find several valid routes to the same therapeutic end. What does it mean for a clinician to carry out the route determined by another who may not share the same educational or theoretical grounding?
A similar scenario arises around the use of inpatient care. Whatever one's work setting, it is likely that at some point they will encounter a client who, in their judgement, needs to be in a secure setting such as a hospital. However, strict limitations on the reimbursement of inpatient mental health care may severely limit the availability of this resource. Its higher cost, the fact that lengths of stay for psychiatric hospitalization can be four times that of general hospital care or surgery and the history of misuse of this resource for controlling behavioral, rather than true psychiatric problems, have all combined to make inpatient care the least desirable alternative from a fiscal standpoint (Adler, 1990, p.27). While such reticence is understandable, who takes responsibility for the decision not to hospitalize a suicidal patient, when provider and payer disagree about its necessity? In reporting the finding of a recent court case, Tischler states, "Even in the face of pressure to comply with actions by external review organizations that may have adverse financial consequences, clinicians remain ultimately responsible for decisions affecting patients" (1990, p.971). The resulting double bind, however, has received too little attention, both in terms of determining the actual prevalence of such dilemmas and in guiding workers on their resolution.

While material in the literature and anecdotal accounts offer information about the areas of difficulty, as yet social work lacks a framework through which to better understand this phenomenon and empirical data to understand its
magnitude. The following sections will outline such a framework, and describe a method used to study the issue and its impact.
Chapter Three
Ethics and Clinical Decision Making

The literature on social work values and ethical decision making offers a rich theoretical foundation for this research. As Reamer states, "...Our professional decisions must be justified ultimately by statements (implicit or explicit) that a particular decision is right or wrong for specific reasons, and has consequences which are good or bad. The very use of terms such as right and wrong and good and bad, to represent professional preferences and values lead us in the end to ethical concepts and ethical issues" (1982, p. 31-32).

"Ethics (from the Greek root ethos, meaning custom, usage or habit) deals with what action is morally right, and how things ought to be. General ethics clarify the obligations that are owed by anyone to anyone. ...Professional ethics are a codification of the special obligations which arise out of the acceptance of a specific role position, that of a professional" (Loewenberg & Dolgoff, 1985). As defined in the Social Work Dictionary, "ethics" refers to "A system of moral principles and perceptions about right versus wrong and the resulting philosophy of conduct that is practiced by an individual, group, profession, or culture" (Barker, 1991b, p. 77).
The philosophical approaches to ethical decision making can be seen as falling largely into two categories. *Ethical absolutists* or *deontologists* hold that certain kinds of actions are inherently good or bad, right or wrong. *Ethical relativists* or *teleologists* maintain that actions are not inherently good or bad, but are justified based on the context in which they were made and on the consequences which result. Of this group, *utilitarians* such as Bentham (1948) and Mill (1957) would assert that the targeted outcome should be the "greatest good for the greatest number." Conversely, *ethical egoists* would hold that the preferable outcome should be that which benefits oneself, regardless of the consequences for others (Loewenberg & Dolgoff, 1985, p.32). Despite our profession’s reliance on the foundations provided by moral philosophy, Imre argues that

... there is an intellectual tradition in philosophy characterized by various rules of logic and reasoning about how one clarifies assumptions and argues for a particular perspective against other alternatives. Practice demands, however, pose a different kind of problem. Often with little time for reflection, decisions must be made immediately within a very specific context" often with grave consequences for all concerned (1989, p. 20).

In fact, many practice decisions are confounded by the competing values and loyalties which characterize social work situations (Loewenberg & Dolgoff, 1985). Each incident requires a range of considerations; the well-being of the
client, societal pressures and dictates, resource limitations, the worker’s abilities and preferences, etc. Additionally, the decisions and actions of social workers are guided by the value base established within the profession. These core values are promulgated through the educational process and enunciated in the profession’s code of ethics. As Timms notes in his book on the subject, "Whatever one’s understanding of social work, 'values' are given a central place in social work activity both in the exposition and in the justification of social work. Second, values, despite their agreed importance, have not been given the sustained and critical treatment warranted" (1983, p.107). While Timms’ work goes on the address the latter situation, and to offer an examination and historical analysis, his original point is well taken. Despite the frequency with which values are referenced, social work values are broad, ambiguous, and variously defined, and on the whole, they remain general enough to allow for a broad range of action. For example, Abbott summarizes the primary values as follows, "..(1) respect for basic rights, (2) sense of social responsibility, (3) commitment to individual freedom, and (4) support of self-determination" (1988, p.25). The Council on Social Work Education’s Curriculum Policy Statements for Master’s Degree and Baccalaureate Degree Programs in Social Work Education enunciate "the values and principles that must be infused throughout every social work curriculum."

These are listed as:
- Social workers' professional relationships are built on their regard for individual worth and dignity and are furthered by mutual participation, acceptance, confidentiality, honesty, and responsible handling of conflict.
- Social workers respect people's right to make independent decisions, to contract for services, and to participate actively in the helping process.
- Social workers are committed to assist client systems to achieve access to needed resources.
- Social workers strive to make social institutions more humane and responsive to human needs.
- Social workers demonstrate acceptance for the unique characteristics of diverse populations.
- Social workers are responsible for their own ethical conduct, for the quality of their practice, and for seeking continuous growth in the knowledge and skills of their profession (CSWE, 1991a, p.6)

However, as broad moral preferences are translated into behavioral imperatives, through such forms as a professional code of ethics, the potential for ethical conflict becomes more apparent. Such items as, "the worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgement required for the performance of professional functions" and "the social worker should avoid relationships or commitments that conflict with the interests of clients" (NASW, 1990, p. 3-4), can clearly present workers with dilemmas when striving to "do the right thing" in regard to their clients, whatever the practice setting. As stated earlier, the environment created in private practice with the involvement of third party payors, presents further complications.
The study conducted was not intended to test or advance knowledge regarding ethical theories, nor was it designed to judge the ethical behavior or level of moral development among individual practitioners. Rather, the field of ethics (and by extension, the ethical and value foundations of social work) provides a framework for understanding how dilemmas are created and what choices are made to resolve them.

The practitioners under study are often faced with a choice between the dictates of their clinical knowledge and professional values and the fiscal and business incentives posed by the third party payor. Thus, the study conducted had three purposes: 1) to explore how and to what extent reliance on a fiscal third party creates ethical dilemmas for social workers in private practice; 2) to ascertain what adjustments individual workers make to decrease the gap between their needs and their clinical judgements and the restrictions of the third party, and 3) on what basis or through what processes they make those adjustments.
Chapter Four

Related Research

The impact of the fiscal third party on clinical decision making has received little systematic investigation (L. Foster, personal communication, May 1, 1992; S.A. Kirk, personal communication, September 8, 1991). Much of what has been written is anecdotal or incidental to other findings. Therefore, it is necessary to look to these related investigations for what they can contribute to the questions at hand.

Studies which undergird the present research come from three major, though not totally discrete, domains. The general field of ethics offers studies on social workers' values, choices, and mores when faced with complex situations. These studies focus on the elements of ethics and ethical dilemmas. The literature on decision making offers insight into the processes used to resolve dilemmas. Finally, research on the effects of cost-containment in health care, and in mental health specifically, offer information on the strategies used to accommodate these pressures. Each area represents a component of the questions investigated in this study.
Ethics

Much of the literature in ethics offers case descriptions or philosophical discussions to highlight the nature of dilemmas faced by social workers. Other material offers readers direction based on interpretations or applications of codes, legislation or court cases, such as Tarasoff (see, for example, Seelig, 1987; Barker, 1988b, and Schwartz, 1989). Relatively little scientifically structured research appears to be available in this area. However, several studies do help to validate and inform the research under examination.

In a study of 58 clinical social workers from one region of the country, Conrad administered a number of specially developed scales to identify ethical issues occurring at each phase of the psychosocial process, and to ascertain what dilemmas caused the greatest conflict. While few of the reported areas of conflict relate to those contained in the proposed study, the existence of strong conflicts around "discharging clients regardless of treatment needs due to policy and funding constraints" (1988, p.607) is relevant. A similar phenomenon may exist for private practitioners whereby they must curtail services due to limits on reimbursement. In Conrad's findings, this is characterized as a role conflict between the professional's orientation to service and the organization's emphasis on efficiency. However, one might extrapolate from this that for private practitioners, the same conflict exists, but the roles are both ascribed to the
worker—there is no organization to blame. Thus, the conflict remains, but it is internal to the practitioner.

Of particular use in the Conrad study is her operationalization of the term 'ethical dilemma', which is used synonymously with ethical conflict or ethical issue. It refers to a situation in which the practitioner is faced with a doubt about how to act in relation to personal and/or professional values, norms and obligations. It implies two competing goods, for example, the right of a child vs. the right of a parent (1988, p. 604).

Green and Hansen (1989) surveyed the prevalence of 16 ethically challenging situations among 202 randomly selected clinical members of the American Association of Marriage and Family Therapists (AAMFT). They also explored the degree of consensus among respondents as to how such situations might be handled. It is worthy of note that these vignettes included a mix of dilemmas, involving not only value questions, but practice questions as well, such as "treating the entire family if one member does not want to participate". This again reinforces the breadth of dilemmas which may be subsumed under the ethics rubric.

Of special interest in this study was the finding that the dilemma entitled "payment for services" was experienced by 80% of the respondents. It was also one of two issues where the respondents’ choice for resolution was in conflict
with the group’s code of ethics- in this case, that of social responsibility. "Subjects rejected the idea of continuing therapy at no charge when a family can no longer afford their services. They preferred to wait to get paid when the family could better afford it" (Green and Hansen, 1989, p.157).

Some of the issues which have been categorized as ethical dilemmas, such as integrity when assigning diagnoses have been studied. In studies of the diagnostic practices of psychiatrists (Sharfstein, Towery & Milowe, 1980) and social workers (Kirk and Kutchins, 1988) each reported patterns of intentionally inaccurate diagnoses.

Sharfstein, et al. (1980) used two studies, one of mental health benefit utilization data and another of anonymous practitioner reports to compare the use of certain diagnoses. They conclude (from inconsistencies between the two studies) that data submitted to insurance companies were often inaccurate. Diagnoses submitted tended to be less severe than the condition warranted due to psychiatrists’ concerns about confidentiality and the stigmatizing nature of a more severe diagnosis. While they hypothesized that more severe diagnoses might be submitted to ensure third party coverage for services, the results indicated this to be a rare occurrence.

Using a 10% random sample from the NASW clinical register, Kirk and Kutchins (1988) surveyed social workers about the diagnostic practices they had
observed. Utilizing the responses "occurs frequently", "occurs occasionally" and "unaware of any occurrence", subjects were asked to respond to statements such as, "A diagnosis for an individual was used even when the primary problem was in the family system", and "An Axis One diagnosis was made for insurance purposes even though it was clinically unwarranted". As discussed earlier, the researchers found patterns of "over-diagnosis" for the purpose of qualifying for reimbursement, and, like Sharfstein, et.al., they found incidents of "mercy diagnosis" to minimize the danger of leaks in damaging information or detrimental effects of labeling. Because their study asked for practitioners' awareness or observation of such practices, it is difficult to determine how closely that approximates the actual occurrence of such acts, and it complicates the possibility of inquiry into motivations and rationales for such behavior.

Smith, McGuire, Abbott & Blau (1991) surveyed 102 mental health practitioners on the reasons used to resolve professional ethical conflicts in an attempt to validate previous findings that clinicians "would often do less than they believed they should do to resolve ethical dilemmas" (p. 235). Subjects were given 10 ethical conflict vignettes and eight rationales to use in indicating what they should do in given situation and what they likely would do. Vignettes included situations with both legal and nonlegal ramifications. One scenario involved inappropriate diagnosis and insurance fraud. Among the rationales available were:
upholding the law, upholding a code of ethics, "it just feels right (intuition),
upholding personal standards, financial need, fear of legal reprisal, and protection
of reputation. Responses were given an ethical choice score (ECS) based on the
consistency of the actions selected with APA ethical principles. While overall ECS
scores were higher for "should" responses than for "woulds", a significant
difference (p<.01) between the two was found on three items, including the one
on inappropriate diagnosis and insurance fraud. Overall, the researchers concluded
"that there is often a discrepancy between what clinicians know to be the ethically
preferred course of action in dealing with professional-ethical dilemmas, and their
stated willingness to implement this ideal" (Smith, et al., 1991, p.238). Their study
addresses not only the specific areas of conflict examined in this research, but also
the ethical dimension of the problem. While Smith et al. provide no information
on the specific rationales used to justify actions on the "inappropriate
diagnosis/insurance fraud" vignette, they do report "that for situations in which
clinicians indicate they would violate what they should do in response to an
ethical dilemma, they will do so primarily for personal or situational reasons,
rather than reasons based solely on formal professional codes" (Smith, et al., 1991,
p. 238).

Finally, Berliner (1989) offers a review of the 292 allegations of unethical
conduct filed with NASW Chapter offices between 1979 and 1985. While he
breaks the items down by category of complaint, he does not explain what actions constitute each category, thus limiting his report’s usefulness for the development of research questions or comparisons. With regard to private practitioners, he notes that they are underrepresented as respondents, but that most of the sexual misconduct cases involved those in private practice. While it does not illuminate the existence of other forms of impropriety, it does allude to the possibility that private practitioners are subject to more autonomy and fewer institutional controls (Berliner, 1989, p.70).

**Decision making**

As with the field of ethics, much of the published information on decision making is of a conceptual or descriptive nature. Much of the quantitative research addresses predictors of outcomes. For example, Hutchinson (1988) uses multiple regression to offer a model of factors which lead to removal of a child from an abusive home. Similar studies cover decision making in situations such as adolescent pregnancy and terminal illness. Few studies address clinical decisions of the type to be explored in this study.

Holland and Kilpatrick (1991) note that "although much attention has been directed toward developing theories of ethical choice, surprisingly little is known about how social workers actually define, respond to and resolve such matters" (p. 138). Consequently, they used in-depth interviews with 27 social workers to
develop a framework of the ethical dimensions of direct practice. The result was the elucidation of three key dimensions of competing values. In the first, the focus of decisions, the range is between emphasis on the ends or goals sought to an emphasis on means or principles. The second dimension involves an orientation toward individual autonomy vs. one toward mutual and group responsibility. The final dimension involves the locus or source of decision-making authority, which may range from reliance on internal instincts or judgements to compliance with external rules, norms, or laws (Holland and Kilpatrick, 1991, p.140). The researchers found respondents’ positions to range along each continuum. While such results are hardly surprising, this study and the resulting framework may be relevant in suggesting questions for, and ways of interpreting, the decisions and actions of private practitioners. It is also worthy of note that none of the subjects made reference to their profession’s code of ethics as a guide for their decision making.

In another examination of decision making, Dobrin (1989) administered the DIT (Defining Issues Test) to 213 social workers as a means of exploring male and female differences in ethical judgement. The DIT does not utilize social work-specific situations, but offers general vignettes to examine "the structure of a person’s moral philosophy by focusing on the rationale used in reaching moral decisions" (Dobrin, 1989, p. 452). As such, the DIT measures the "cognitive
component of ethical decision making". Among his findings were a significant, but unanticipated difference between men and women and a greater difference between men and women in private practice. In both cases, men's scores were lower than those for their female counterparts. Dobrin offers few insights into the meaning of such findings, but attributes their existence to potential differences between those studied and the general population (in which scant gender differences have been found on previous administrations of the DIT).

Woody (1990) offers an explication of the components of ethical decision making by putting forth a model in which dilemmas in clinical practice are resolved using five "decision bases". These resources for decision making include theories of ethics, professional codes of ethics, professional theoretical premises, sociolegal considerations and the therapist's personality and character. She suggests that each of these factors is weighed as a competing viewpoint when perplexing situations occur. For example, when contemplating the report of child sexual abuse after a perpetrator's disclosure of it in treatment, sociolegal ramifications, the therapists' character, and his/her theoretical premises come into play in determining which course of action carries the least risk. Although used for case analyses, this model has not been studied or empirically applied. Still, it offers an excellent example of how clinical decision making is derived from the field of ethics.
In decision-making theory (Janis & Mann, 1977), conflicts are resolved on a cost-benefit basis. The outcome is determined "by the individual’s assessment of the positives and negatives accruing to him- or herself and significant others as a result of actions and choices. For any given decision, the individual tends to balance the estimated costs against the benefits" (Walden, Wolock & Demone, 1990, p.68). Using decision-making theory as a theoretical base, Walden and his associates used conflicts that typically pitted clients’ interests against organizational, collegial or societal mandates; for example discovering that a colleague had recorded home visits which never took place. Hypothesizing that affiliation with a particular type of organization would affect one’s choices about how to respond, the authors presented twelve vignettes to MSW students, hospital social workers, and child protective services staff. Respondents then selected their responses/actions from options which had been classified as "system-oriented", "client-oriented", "combined", or "deferred/non intervention".

Some support was found for the original hypothesis, with workers proving more likely to select system-oriented responses when faced with decisions involving their type of setting. Respondents who were supervisors tended to select system-oriented options more often than did line workers. However, the authors’ supposition that MSW students, with no organizational affiliations, would be more likely to make client-centered decisions was refuted. There are numerous
methodological and sampling weaknesses in the study. As the authors' note, "inferring behavior from hypothetical scenarios is somewhat risky. In real situations, people may not act as they say they would" (p.74). Nevertheless, the model used in the study sheds additional light on the processes social workers use in decision making. "A cost-benefit approach to decision making appears to provide a useful paradigm for understanding the choices that practitioners make in the face of ethical conflicts. Professional norms, supported, it can be hoped, by external sanctions, seem to be a critical aspect of the decision-making process. For our respondents, a middle-range position between the client and the organization was the predominant choice" (Walden, et al., 1991, p.74). How such findings would translate into the realm of private practice is unclear. The issue of organizational affiliation for the worker might become even stronger when decisions made in practice have direct, and at times exclusive, bearing on the practitioner. When the "benefits" to be calculated impact directly on the social workers' livelihood, the decision making matrix likely becomes more complex.

Clearly, scarce attention has been paid to the process and resources for decision making, particularly of the type contained in this research. Those studies which do cover clinical decision making don't account for financial incentives or the clinician's needs or well-being as a factor in practice decisions. While this particular type of ethical and practice dilemma appears not to have been widely
addressed in the social science literature, neither has there been extensive material on the effects of restricted reimbursement on service delivery.

Cost containment

Much of the literature on cost containment and service utilization comes from the medical field and the hospital and insurance industries (Frank and Lave, 1985; Wells, et.al, 1987; Levin, 1987/88; Sharfstein, et.al, 1988). In these, cost containment may not only be characterized by reimbursement restrictions, but also by cutbacks and by public funding regulations such as the use of Diagnosis Related Groups (DRGs). Such studies also tend to take a broader view of the phenomenon, addressing it not at the individual level, but at that of the institution or population as a whole. Many of the studies which do address the practitioner's response to cost containment come from the field of psychiatry. Despite these differences, such research provides a foundation for that being conducted on a more narrow topic and population.

Sharfstein et al. (1984) reviewed the findings of three 1982 studies on the impact of third party cutbacks on the treatment provided by privately practicing psychiatrists. One study, of 400 northern California psychiatrists, found them treating a higher-than-expected number of severely disturbed Medicaid patients, and at a lower per-unit cost than public clinics. No information is given about the
effect of cutbacks on the treatment provided or on the nature of treatment itself. For example, "treatment" which constitutes simple medication review and management might be expected to be delivered at higher volume, making services to the severely disturbed profitable, even at lower-than-desirable reimbursement rates. The two other studies were done with 52 and 158 respondents respectively, from the region’s psychoanalytic and psychiatric societies. These asked for a comparison of their services and practices following a cutback in the Federal Employees Health Benefit program. Among the reports were decreased practice hours and volume of patients, reduced fees, fewer visits and changes in treatment modalities. "The most significant adverse effect for patients has been the decreased availability of intensive psychotherapy (including psychanalysis) for adults and children. Anecdotal evidence is already present of increases in hospitalization, in premature termination of treatment, and in shifts from potentially curative treatment to more palliative treatment" (Sharfstein et.al., 1984, p. 481). The authors conclude that further studies are needed to determine the extent of such effects. They also raise concerns about the ethical and fiscal dilemmas posed by such changes, stating that psychiatrists can adjust or find new sources of income, but it is the patient in need of service who will suffer.

Geis et.al. (1985) addressed the disproportionately large number of psychiatrists who have been sanctioned because of fraud or abuse of government
medical benefits programs. Most reported psychiatric fraud takes place against Medicaid, yet relatively few psychiatrists will participate in that program because it so severely restricts psychiatric services. Although the authors offer several rationales for the overrepresentation of psychiatrists among sanctioned physicians, they also conclude, "Psychiatrists may also cheat more than other doctors because they find the benefit system particularly unresponsive to what they consider to be their fiscal due. Among those apprehended, a common self-defense is that what they were doing was worth so much more than the government was paying that they felt justified in adding time to their bills" (Geis et al., 1985, p.234).

In a report on the preliminary results of a survey of 1200 outpatient mental health providers who currently contract with managed care companies, *Psychotherapy Finances* (1991c) reports that 42 percent stated that managed care had a negative impact on patients and providers, and 27 percent reported a positive effect. Twenty-five percent said that the impact was neither negative or positive. The study findings were based on a twelve percent response rate, and have not been fully detailed. The researcher, Oss, reports that the final results should be available in 1992. At that time, more relevant information may be gleaned about the study, its results, and the presence of social workers in the sample.
Newman and Bricklin (1991) report on a 1987 survey among mental health practitioners who subscribe to Behavior Today. In that research, "86 percent of respondents believed that quality of mental health care suffers when provided through managed care" (p.26). The most frequently cited cause for this concern was the limits placed on number of sessions, noted by 79 percent of respondents. "Other major complaints expressed included increased paperwork (67 percent of respondents), the gatekeeping system (55%), decreased flexibility in the treatment approaches allowed (47%), and the long wait for reimbursements (46%). Approximately two thirds of respondents specifically objected to physicians and nurses with insufficient training and qualifications in mental health acting as gatekeepers" (p.26). Advantages of managed care were noted as well. These include increased client flow, less need for practitioners to do marketing, assistance in stability in fluctuating marketplace and increased income/cash flow. While clearly related to the issues under study here, the design and sampling methods leave the findings of this research open to question.

A qualitative study by Martin Lakin offers what may be the closest approximation to the research conducted in this study. While not focusing on social workers, or even private practitioners specifically, Lakin interviewed approximately 100 psychotherapists on "four broad topics: general areas of ethical concern; colleagues' practices; recollections of personal equivocal conduct or
experiences of unethical practices; and ideas and recommendations for preventative measures" (1988, p.3). Lakin's interviewees represented a range of mental health disciplines, practice settings, years in the field and were diverse in terms of age and gender, although they were drawn from only one region of the country. He found that their ethical concerns varied by the types of therapies they specialized in and their practice settings. For example, private practitioners were more concerned with "money matters" than those in public settings. Among the most directly relevant themes which emerged from his interviews were, "The limits of confidentiality: the interests and rights of spouses, parents and other 'third parties'" and "Financial arrangements with clients and insurers" (1988 p.5). Specifically, when it came to financial issues, Lakin noted a difference based on the discipline of the interviewee. He found social workers - whether in private or institutional arrangements - to be "invariably more sensitive to the hardships worked on individuals and their families from the expense of psychotherapy" (1988, p. 19) Lakin acknowledged that this may change as social workers increasingly move into the private sector.

Interviewees addressed directly the impact of the fiscal third party on their practices, expressing concern about the ethical implications of deceiving the payor, "even though they seem to believe it is apparently common practice" (1988, p. 21). With specific regard to diagnosis, Lakin found that many therapists were
troubled by the requirement to provide a certain level of diagnosis for reimbursement,

but most rationalize their 'shading' of diagnosis as being in the interest of the patient, and blame the insurance companies for forcing the deception. Besides the fraudulence of this practice, no matter how defensible, there is also the conveyance of a curiously amoral attitude to the patient. Is not therapy crucially concerned with uncovering the multiple self-deceptions and dissemblings patients practice on themselves and others? Therefore, doesn't this undermine the basic authenticity of the therapy relationship itself? (1988, p. 21)

The contributions of this research rest in its direct examination of the issue under study, although it occupies a relatively small segment of the range of ethical dilemmas examined by Lakin. No other studies reviewed examined both the specific issue of the fiscal third party's impact and the various issues imbedded within that. Likewise, the methodology employed, and the comments which emerged provide guidance for the study detailed here.

Overall, research related to the question of how fiscal third parties affect treatment decisions is just that-related. Elements must be drawn from studies for what they can add to this new area of inquiry. The research cited here indicates that ethical dilemmas and service considerations do arise from the involvement of third parties and that often the decision about how such problems should be handled is situational or utilitarian in nature. Other studies point to the greater vulnerability of private practitioners. Due to the autonomy inherent in their
positions, people practicing independently are subject to a range of pressures and options not experienced by agency practitioners. The general scarcity of empirical research on this topic in the social work field might be attributed to the relatively rapid escalation in cost-containment, its having taken longer to affect clinical social work services, particularly in private practice, or the sensitivity inherent in the issues involved. Yet it is apparent that the need exists for research into the third party-practice decision dilemma. The available literature offers ample substantiation of the problem and methods for its examination, but no data on its prevalence. This suggests, then, that a survey of people in private practice would be the most useful means for uncovering the extent of the problem.
Chapter Five

Questions for Study

Because little prior research has been conducted on the issues to be investigated, it would be premature to generate hypotheses around these phenomena. Rather, an exploratory, hypothesis-generating study was called for, to clarify relationships among these issues and lead to the development of measures to examine them in the future.

As a result of historical developments, related research, and current dialogue on the topic, four questions emerged for examination in this study.

1) To what extent does reliance on a fiscal third party create ethical dilemmas for social workers in private practice?

2) How are practice decisions affected by the reimbursement parameters set forth by a fiscal third party?

3) How do private practitioners resolve these dilemmas? What rationales, processes, or guides are used to help them arrive at their decisions?

4) What factors are associated with the occurrence of ethical dilemmas?

Additionally, current information was needed on the characteristics of private practitioners, and the nature of their work. No recent studies provided this
material, and it was necessary for understanding and interpreting the data supporting the research questions.

The derivation and intent of each of these questions will be discussed independently.

1) To what extent does reliance on a fiscal third party create ethical dilemmas for social workers in private practice?

As an empirical examination of the difficulties posed by third parties, this study sought to uncover the prevalence of dilemmas when social workers in private practice are faced with reimbursement restrictions. Precise definitions of these concepts include:

**Third party payers/Fiscal third party:** Insurance plans, HMOs, PPOs or company self-insurance programs which provide some or all of the payment for an individual enrollee’s procurement of covered services. This definition also includes public insurance programs, such as CHAMPUS, Medicaid and Medicare.

For the purposes of this study, such "services" consist of those for mental or emotional problems and for the treatment of chemical dependency. "Reliance on" such plans is characterized by the percent of the practitioner’s caseload utilizing such payment for treatment.

**Ethical dilemmas:** Instances in which the practitioner’s practice decisions are characterized by a conflict between his/her beliefs, preferences or clinical
judgement and the reimbursement parameters placed by a fiscal third party around that practice. For example practitioners might have to choose between offering the course of treatment dictated by their training and current knowledge, but find that the reimbursement will not cover that form or length of service.

**Social workers:** Those people possessing an MSW or the equivalent from a CSWE accredited program. (The MSW is the recognized degree for this form of practice. Without it, even those with doctoral degrees in social work may not be sanctioned to practice. And, while in many states, experience is needed beyond the receipt of a degree in order to practice autonomously, this is not evenly regulated. Nationally, some MSWs with no post-graduate experience may be able to engage in private practice.)

**Private Practice/Practitioners:** Those social workers who engage in autonomous, for-profit social work practice (providing at least individual, conjoint, family or group assessments or psychotherapy) either as their primary or secondary work setting. Primary setting is defined as either the social worker’s only work setting, or the one in which he/she spends the majority of his/her work hours, while secondary refers to that in which the social worker spends the second largest percentage of his/her work time, but at least 5 hours per week.

A group private practice is distinguished from a for-profit agency by the direct relationship between the social worker’s provision of services and the
reimbursement for those services, as found in the former setting, but not the latter. Individuals working in a group private practice would thus be appropriate for inclusion in the study. While social workers can also provide consultative and other services under the private practice model, the scope of those would not apply for third-party reimbursement.

2) How are practice decisions affected by the reimbursement parameters set forth by a fiscal third party?

This is a more explicit derivation of the first question. Practice decisions refer to those choices made by social workers in private practice about who to accept as clients, what diagnosis to assign to each client, how long to provide treatment to that client, and what form that treatment should take. [The assigning of a diagnosis refers to that done for legal or reporting purposes, such as to the third party payer. "Form of treatment" refers to the use of individual, conjoint, group or family modalities, or of specific methods such as task-oriented or behavioral interventions.]

Reimbursement parameters are the conditions set forth by fiscal third parties, in the form of insurance coverage type, levels, or reimbursement criteria. Such parameters may be contained in either prospective or retrospective reimbursement systems, and may also be conveyed through preferred provider agreements or the use of utilization review or case management systems.
3) How do private practitioners resolve these dilemmas? What rationales, processes, or guides are used to help them arrive at their decisions?

The research on ethics and ethical decision making offers some insight into the rationales and resources used when therapists are confronted with conflicting values. However, with few exceptions (Smith, et al., 1991; Lakin, 1988), these have not included cases where the dilemma involved the practitioner’s livelihood or other such personal outcomes. Thus, less is known about these issues. Because the purpose of the study was not to test models of decision making or ethical choices, the questions in this area were broadly drawn, and were intended primarily to uncover the resources and processes used by practitioners (and conversely, those not used).

4) What factors are associated with the occurrence of ethical dilemmas?

Because this topic has not been researched before, there is little foundation for suppositions about any demographic or practice characteristics and how they might relate to the experience of difficulties with third parties. Again, baseline information is needed in this area.

This is believed to be the first study to ask social work practitioners directly about the effect of third party payors on their services. As such, the study separated the larger issue into four related questions. For each, direct, precise
questions were developed to solicit information advancing the knowledge about this phenomenon. Because this was an exploratory endeavor, an effort was made to make areas of inquiry as inclusive as possible and to allow for a high level of respondent explanation and feedback.
Chapter Six
Research Design and Methodology

The following sections detail the methodology and procedures used to examine the prevalence of third party impact on services by social workers in private practice. A mailed questionnaire was developed, tested, and administered to a randomly selected national sample. Telephone interviews were conducted with a subset of respondents to examine further the exploratory research questions. Throughout, care was given to protect the rights and anonymity of the study’s subjects.

Sample

A cross-sectional survey was utilized to address the exploratory research questions. A 53-item, nine page questionnaire was mailed to a random sample of 540 individuals on the NASW Register of Clinical Social Workers (1991). The register is a voluntary national listing of some 16,000 names. Individuals listed on the register must pay $100 in annual fees (above their regular NASW dues), and must submit evidence of meeting the following basic criteria:

- A master’s or doctoral degree from a school of social work accredited by the Council on Social Work Education;
- Two years of post-master's clinical social work practice under the supervision of a master's-level social workers (or the equivalent in part-time work, computed at 1,500 direct client contact hours in a period of not less than two years);
- Membership in the Academy of Certified Social Workers (ACSW), or a state license that requires an examination (NASW, 1991a, p. vi).

By definition, individuals on the register are eligible for and likely to engage in some form of clinical practice. This property made it a suitable population from which to draw, despite the fact that listing on the register is voluntary, and thus eliminated some individuals from possible inclusion in the sample. In selection of the register, other options were ruled out as being unreliable or unfeasible (state licensure lists), too broadly drawn (NASW general membership) or too narrowly drawn (other clinical listings, or insurance provider lists) to fully capture the issues under examination.

No distinction was given to those individuals who were listed on the register as private practitioners. Because the study contained no supposition that the phenomena being examined would differentially affect full vs. part time practitioners, or those for whom it is a primary or secondary work setting, the entire population on the register was used to provide as inclusive a sample as possible.

For a one-sample problem, in an exploratory study such as this, an n of 166 is needed to estimate population parameters within 10 percentage points with
a 99% confidence interval (Lemeshow, et al., 1990, p.94). Thus the sample size of 540 was chosen with the intent of producing 166 useable questionnaires (30% of the sample). Response rates for other studies with this population (Kelley & Alexander, 1985; Kirk & Kutchins, 1988) have been over 30 percent, but for this study, a greater number was needed because the sample was expected to contain some people who would not meet the requisite criterion of engaging in private practice at least five hours per week.

Survey Instrument

As noted in Chapter Five, the development of the questionnaire (Appendix I) was guided by the four exploratory questions underlying the study. Comprehensive information on the characteristics of respondents' private practices was also required to provide data on the current status of private practice, and to serve as a backdrop against which the exploratory questions could be examined and interpreted. The contents of the questionnaire incorporated selected items from instruments used in previous studies (Kirk & Kutchins, 1988; Lieberman, et al., 1988). Additional items specific to this study were developed based on review of the literature and discussions of the issue with over a dozen private practitioners.

The questionnaire contained items addressing respondents' demographic characteristics, their degree of involvement in private practice, information on the
characteristics of their practice and their experience with third party payers. Measures of the effect of the fiscal third party on treatment decisions included questions about the frequency of specific incidents where clinical decisions or actions were compromised, questions on the degree of quandary felt when faced with certain decisions, and a question about the procedures used to make decisions in light of conflicting values.

**Pre-Test Procedure**

Prior to dissemination, the survey instrument was pre-tested with nine private practitioners from two geographic regions across the country who were conveniently available to the researcher. These individuals represented a mix of ages, lengths of time in private practice, genders, and involvement in practice as a primary or secondary work setting. The subjects were mailed the draft questionnaire and asked to complete it and then respond to 10 accompanying feedback questions (Appendix III). Feedback was obtained in person, in writing, by phone, and often through a combination of these means. As a result of this feedback, several questions were eliminated because they were found to be cumbersome (for example, a breakdown of caseload by diagnostic category or client income level) and contributed little to the investigation. Others were reworded for clarity.
Based on the input from pretesters, a decision was made to ask for actual numbers rather than percentages, when inquiring about respondents' caseload characteristics. For example the final questionnaire asked how many clients are male, rather than what percent. It was believed that this would be less open to skewing by estimation and result in greater accuracy. Questions distinguishing "number of clients/individuals" from "number of cases" were added in recognition that those numbers could vary greatly for respondents seeing a large number of couples or families. A question about the act of "under-diagnosing" clients to prevent them from the stigma associated with some diagnostic labels was added at pre-testers' recommendations. As a result of the pre-testing procedure, the final document was shortened, clarified and simplified.

Procedure

The 540 individuals selected were mailed a pre-coded questionnaire, an explanatory cover letter and a stamped addressed return envelope. Three weeks after the initial mailing, a follow-up letter was sent to all non-respondents asking for their assistance in completing the questionnaire. Approximately six weeks after the initial mailing, a full packet consisting of a cover letter, questionnaire and return envelope was sent to the remaining nonrespondents. Because of the complexity of the instrument and the time frame for follow-up letters, it was
difficult to ascertain how response rates were related to each of the researcher's prompts.

Interviews

Because the subtleties inherent in the ethical decision making process might not be captured through the questionnaire format, a sub-sample of respondents \( N = 9 \) was chosen for follow-up phone or personal interviews. It was expected that interviews would result in deeper, more illustrative information to complement or clarify the quantitative findings. Because the returned questionnaires yielded ample commentary in both volume and depth, interviews were structured to allow some follow-up into issues raised by the questionnaire as well as inquiry into items not raised on the original instrument. As such, questions for the interviews (Appendix II) were based on those in Section B of the questionnaire, but were further developed after initial analysis of the survey data.

The respondents to be interviewed were selected based upon their responses to the original questionnaire. Replies were generally categorized as reflecting high, medium, and low levels of difficulty with reimbursement restrictions. Three respondents were then chosen at random from each group and contacted about their willingness to participate in follow-up questioning. One of
the individuals contacted declined to participate due to time constraints, and another subject was chosen to replace him.

Protection of Human Subjects

The protection of human subjects was ensured through the following measures:

In an introductory letter (Appendix IV) and in directions for completing the questionnaire, the general purpose and focus of the study was shared with those being surveyed. There were no hidden agendas in the research protocol as designed. The names of all subjects were kept on a master list where they were linked with a study identification number to allow for follow-up with non-respondents. The master list was destroyed after the date for responses had passed. This step was taken to ensure respondents’ security from sanction should published results of this study reveal findings of fraud or other censurable offenses.

Individual interviews were structured to offer similar protection to participants. Interviewees were contacted by an affiliate of the researcher, who explained the purpose of the phone interview, and read each a statement listing their rights as a research subject (Appendix V). Those who proceeded to speak
anonymously to the researcher were considered to have provided informed consent.

Finally, no participant in the study will be identified in any reports on the findings of this research.
Chapter Seven

Findings

Sixty percent (337) of the subjects sampled returned the completed questionnaire. Ten questionnaires were returned by the postal service as undeliverable, and ten were returned uncompleted or were not useable for other reasons. This is a higher rate of return than similar mailed surveys to this population (Kelley & Alexander, 1985; Kirk & Kutchins, 1988). However, a larger than expected proportion of the sample (160 responses) failed to meet the screen criterion of engaging in private practice at least five hours/week. Of those individuals, 11 percent responded that they were retired, 19 percent were in private practice less than five hours per week, and 66 percent were not involved in private practice for other reasons. The remaining 157 cases formed the basis for the study's findings.

For those who responded, the questionnaire represented a substantial commitment of time, trust and information in order to be thoroughly completed. It was recognized in the development of the instrument that a certain level of detail was necessary in order to obtain sufficient information to meet the objectives of the study, although it might well result in less responses.
Originally 166 subjects were desired in order to make estimates at the 99% confidence level. However, the 157 qualifying responses are well above the number needed (96) to estimate prevalence among the population within 10 percentage points, with a 95% confidence interval (Lemeshow, et al., 1990, p.94). Therefore additional sampling or further follow-up with the initial sample was not essential and was not conducted.

Characteristics of Respondents

Respondents came from 41 states and the District of Columbia. No responses were received from Arizona, Idaho, Indiana, Kansas, North Dakota, Oklahoma, South Carolina, Utah or Vermont. The greatest number of responses came from California (9.6%), Massachusetts (10.8%), and New York (14.6%). As displayed in Table 1, over two-thirds of the respondents were female and 32 percent were male. The mean age was 49.4 (s.d.= 8.86, range 29-73). The sample was predominantly caucasian, with less than four percent representing racial or ethnic minorities.

Seventy-two percent of the respondents engaged in private practice as their primary work setting and 28 percent maintained it as a secondary work setting. As reflected on Table 1, 54 percent of the sample characterized their reliance on income from private practice as "essential". The percent of household income
derived from private practice ranged from 1 to 100 percent, with a mean of 42.2 percent (s.d.= 29.21).

Those in one wage-earner households reported getting a mean of 59 percent of their income from private practice. For those in two income households
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (n=153)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 30</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>31-40</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>41-50</td>
<td>67</td>
<td>44</td>
</tr>
<tr>
<td>51-60</td>
<td>47</td>
<td>31</td>
</tr>
<tr>
<td>61-70</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>&gt; 70</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sex (n=155)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>68</td>
</tr>
<tr>
<td>Race (n=154)</td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>149</td>
<td>97</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic American</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>American Indian</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Family's Total Income (n=148)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 25,000</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>25,000 - 39,999</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>40,000 - 59,999</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>60,000 - 79,999</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>80,000 - 99,999</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>100,000 - 119,999</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>120,000 - 139,999</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>&gt; 139,999</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Number of Wage Earners (n=154)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td>Two</td>
<td>110</td>
<td>72</td>
</tr>
<tr>
<td>Extent of Reliance on PP Income (n=155)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential</td>
<td>84</td>
<td>54</td>
</tr>
<tr>
<td>Important, But Not Essential</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>Helpful, But Not Essential</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>Negligible Contribution</td>
<td>11</td>
<td>7</td>
</tr>
</tbody>
</table>
the mean was 36 percent. T-test comparing the two means indicate a significant
difference at the p< .001 level (t = 4.12, df = 89). Sixty-two percent of those in
one-income families earned between $40,000 and $80,000, but four respondents
in that group earned more that $100,000 per year. The annual income was
naturally much higher for two-income households, with almost one-fourth of that
group earning more than $140,000 in 1991.

The location of respondents’ practices was rather evenly divided between
urban (46%) and suburban (45%), with only nine percent reporting that they
located in rural settings. Three practitioners reported having two practice sites in
different types of communities (e.g. rural and suburban).

As indicated in Table 2, respondents evidenced extensive experience in the
field, with a mean of 19.37 years since the receipt of an MSW (s.d.= 8.10), a
mean of 17.47 years in full time social work practice (s.d.= 7.77), and a mean of
12.59 years in private practice (s.d. = 6.86), either as a primary or secondary work
setting.
Table 2
Respondent Experience

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Since MSW (n=155)</td>
<td>19.37</td>
<td>8.10</td>
<td>4-45</td>
</tr>
<tr>
<td>Years in Full Time Social Work (n=153)</td>
<td>17.47</td>
<td>7.77</td>
<td>0-42</td>
</tr>
<tr>
<td>Years in Private Practice (n=156)</td>
<td>12.59</td>
<td>6.85</td>
<td>2-35</td>
</tr>
</tbody>
</table>

Because there are no published demographic characteristics of persons listed in the Register, it is difficult to check the representativeness of the sample based on the characteristics of the population. As has been done in other studies of this type, the available alternative is to compare the results with those obtained in previous research on this population.

The findings on gender, age, and time in post-MSW practice are very close to those drawn from the same source by Kirk and Kutchins (1988), but the percent of minority respondents (four percent) is much lower than theirs (twelve percent). Jayaratne, et al. (1988) reported gender, age, ethnicity, and years-since-MSW statistics which were comparable with this study, using a sample of private practitioners from the general NASW membership directory. Just over 44 percent of their private practitioners earned more than $45,000 and over half of the respondents charged between $51 and $75 an hour. Given the time elapsed since
it was conducted, that study's findings do not seem to differ greatly from those described here.

A recent analysis conducted by NASW (1992b) on the segment of its membership listing mental health as their practice area is also useful for comparison, although it reflects a broader sample by including agency-based practitioners and those at all educational levels. That analysis reflected 72.8 percent females and 28 percent males. The median age range was 41-45, and the greatest number of members were in the "6-10 years of experience" category. Definitional incompatibilities make further comparisons between the two studies fruitless. Comparisons cannot be drawn with other recent studies on private practitioners due to dissimilar questions/categories (Brown, 1990) or different population parameters (Lieberman, 1988).

The findings in this study on fees and third party involvement parallel those in the most recently reported fee and practice survey conducted by *Psychotherapy Finances*. An average of about 60 percent of clients have third party coverage, which represents a three percent decrease from the year before. Twenty percent of the 456 social workers responding reported getting 80 percent or more of their income from third parties. The median fee charged by social workers was $75.; the median for all practitioners was $80. When asked about the effects of managed care on therapy practices, 40 percent of all therapists
responded, "Reduced my patient load", 50 percent said "It reduced my practice income", 44 percent reported more disallowed claims; 37 percent said it "changed my therapy approach", and for 52 percent it meant "shortened length of therapy" (Psychotherapy Finances, 1992, p.3). Such findings further confirm the presence of third party considerations in practice situations.

In sum, these findings are compatible with information available from similar studies. Although other factors affecting generalizability will be addressed in the "implications" section, it should be noted here that extrapolations from the data should be made with caution, to allow for any unknown but possibly confounding characteristics inherent in the sample.

**Practice Characteristics**

Respondents reported working an average of 24.45 billable hours per week in private practice (s.d. = 14.22), and having a mean total caseload size of 25.13 (s.d. = 19.39). For those in private practice as their primary setting the average number of billable hours/week was 31.6 (s.d. = 11.8) and the mean total caseload, 32.0 (s.d. 19.68). For those having a private practice as their secondary work setting, the mean billable hours were 9.7 (s.d. = 4.1), and the average caseload 11.3 (s.d. = 6.53). T-tests comparing the means of the two groups indicate a significant
difference between primary and secondary setting on these items at the p<.001 level for caseload (t = 9.78, df = 150) and billable hours (t = 16.94, df = 148).

The mean fee for 50 minutes of individual psychotherapy was $75.77 (s.d.= 14.92). The mean fee for couples therapy was $78.28 (s.d.= 17.06), and for families, $78.79 (sd = 17.73). The fees for other services are indicated on Table 3. The question on fees for group therapy did not clearly indicate that the charge for the individual (not the entire group) was intended. Some fees respondents reported for this category highlighted the possibility of error in understanding the question. Therefore, answers to this of over $100 were eliminated from consideration due to the possible misinterpretation of the question. Still, findings for this fee may be flawed due to lack of clarity in the question.

Table 3

Respondents’ Customary Fees by Service

<table>
<thead>
<tr>
<th>Fees</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual psychotherapy</td>
<td>75.77</td>
<td>14.92</td>
<td>26-150</td>
</tr>
<tr>
<td>Couples therapy</td>
<td>78.28</td>
<td>17.06</td>
<td>26-150</td>
</tr>
<tr>
<td>Family therapy</td>
<td>78.79</td>
<td>17.73</td>
<td>26-150</td>
</tr>
<tr>
<td>Group therapy</td>
<td>39.80</td>
<td>15.25</td>
<td>10-90</td>
</tr>
<tr>
<td>Diagnostic evaluation</td>
<td>81.51</td>
<td>22.08</td>
<td>35-225</td>
</tr>
<tr>
<td>Case consultation</td>
<td>78.14</td>
<td>27.15</td>
<td>20-250</td>
</tr>
</tbody>
</table>
T-tests indicated that significant differences in fees existed between those in primary and secondary settings (p<.01). Those in primary practice charged an average of $77.82 (s.d.= 15.68), for individual treatment compared to $70.56 (s.d.= 11.37) for "secondary" private practitioners (t = 3.2, p = .002, df = 107). "Primary" practitioners charged a mean of $80.35 (s.d.= 18.13) for couples, while those in secondary practice charged a mean of $73.00 (s.d.= 12.7) (t= 2.73, p = .007, df = 101). For family therapy, primary practitioners charged a mean of $81.06 (sd = 18.77), and "secondary" practitioners charged $72.29 (sd = 13.25) (t = 2.78, p = .007, df = 92).

As indicated in the sample questionnaire, respondents were asked to supply the actual number of their clients or cases in answer to certain questions. Because total caseload size for the respondents ranged from one to 120, these numbers had to be converted to percent of total clients or caseload (depending on the question) in order to meaningfully reflect the item being measured. The means were then calculated based on the percent of caseload, and used here to report client characteristics, payment mechanisms, and practice effects of third parties.*

* Calculations of percentages by category (not individual respondent) were also done. These did not differ substantially from those calculated by other methods. The greatest difference was 3 percentage points on two items of more than 20 percent.

The figures presented are more consistent conceptually with the intent of the study - to ascertain the percent of a practitioners caseload having a certain characteristic, and average that across practitioners.
These figures thus represent the presence of those individuals or attributes in the average practitioner's caseload and only indirectly refer to the clients themselves.

Table 4

Average Caseload Percentages

Using Various Payment Mechanisms

\[ n = 149 \]

<table>
<thead>
<tr>
<th>Payment Mechanism</th>
<th>Mean percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Full Rate</td>
<td>52.6</td>
</tr>
<tr>
<td>Uniform Sliding Fee Scale</td>
<td>7.1</td>
</tr>
<tr>
<td>Reduced Rate, Case by Case</td>
<td>19.0</td>
</tr>
<tr>
<td>Rate Pre-neg. Under Contract</td>
<td>17.1</td>
</tr>
<tr>
<td>Free Treatment</td>
<td>3.1</td>
</tr>
<tr>
<td>Barter Arrangement</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Respondents reported accepting a variety of payment mechanisms for services (Table 4). In 52 percent of the average practitioner’s caseload, clients pay the therapists’ full rate. Seven percent pay by a uniform sliding fee scale, 19 percent pay an individually negotiated reduced rate, and 17 percent pay a rate pre-negotiated under their third-party contract. An average of three percent of cases
were reported as free care, and less than one percent received services through barter or other means. Eighty percent of the respondents reported having no cases in which they were providing services for free, however, 70 percent reported at least some cases in which they were providing services for a reduced rate. No empirical data was available on the extent or circumstances of fee reductions, although comments on the questionnaire indicated:

The better practitioners get a good rep and have sufficient caseload without taking the more restrictive third parties. They don’t then have time for free cases, or the aggravation of troublesome third parties.

My only conflict (with a third party) was the fact that the patients could have used more treatment than they were covered for and when necessary I referred the case to a charitable agency for more treatment after I had exhausted the time I set aside for community service at very little reimbursement for needy patients.

If the third party payment and client co-payment don’t cover my fee, I usually don’t accept the case.

Knowledgeable referral sources do not give names of private practitioners unless the client has insurance or can pay a certain amount out of pocket.

My tendency has been to reduce my fee for clients who cannot pay out of pocket, but there is a limit to this, as I need to earn money too!

For those in private practice as their primary work setting, the largest percent of time (\(m = 78.42\), s.d. = 19.14) was spent in the direct provision of
psychotherapy. As noted in Table 5, the remaining percent of time is spent in administration (m = 6.1, s.d. = 10.58), supervision of other professionals (m = 3.48, s.d. = 5.138), and in case consultation, teaching, conducting workshops, and voluntary public service (each of which had a mean of less than three percent).

Table 5
Percent of Time Spent on Various Activities by Those Whose Practice is a "Primary" Setting

<table>
<thead>
<tr>
<th>Percent of Time Spent</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Psychotherapy</td>
<td>78.420</td>
<td>19.140</td>
<td>10-100</td>
</tr>
<tr>
<td>Case Consultation</td>
<td>2.620</td>
<td>7.900</td>
<td>0-70</td>
</tr>
<tr>
<td>Supervision of other Profess.</td>
<td>3.480</td>
<td>5.138</td>
<td>0-25</td>
</tr>
<tr>
<td>Administration</td>
<td>6.100</td>
<td>10.580</td>
<td>0-70</td>
</tr>
<tr>
<td>Teaching</td>
<td>2.380</td>
<td>6.190</td>
<td>0-35</td>
</tr>
<tr>
<td>Conducting Workshops</td>
<td>2.150</td>
<td>4.107</td>
<td>0-20</td>
</tr>
<tr>
<td>Voluntary Public Service</td>
<td>2.090</td>
<td>4.811</td>
<td>0-25</td>
</tr>
<tr>
<td>Other (some admin. tasks</td>
<td>2.239</td>
<td>5.370</td>
<td>0-30</td>
</tr>
<tr>
<td>reflected here</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Respondents were asked to indicate which approaches they were trained in originally and which they currently employ. The practitioners indicated a wide variety of theoretical orientations used, and a lesser array in which they were originally trained (Chart 1). Psychodynamic or Psychoanalytic theory was reported used by 83 percent of the respondents, systemic by 53 percent, and cognitive/behavioral by 62 percent. While respondents selected only an average of 2.6 theory bases as a result of their original training, they reported utilizing an
average of 4.2 theoretical bases today. The theories "gaining" the most adherents from original training to the present day are task-centered and cognitive/behavioral, which increased 33 and 38 percent, respectively. Yet, as one respondent noted,

While managed health care is on its way here, it has not hit in full force. My training and expertise is in long-term psychodynamic psychotherapy and to the extent that I can, I plan to continue with this modality if it fits the client’s needs and not to change because this may not agree with third party payers. This may necessitate reducing fees, which I already do. I have great concern about the inappropriate use and recommendation for brief therapy when longer term work is indicated. My concern is primarily for the client, but as well for the clinician and the profession. The bombardment by the promoters of brief therapy instills a false (I believe) expectation that we should be able to treat effectively conditions such as borderline personality, substance abuse, childhood sexual abuse in 10 sessions. How ludicrous! And how dangerous!

In one instance, theoretical orientation was found to be related to whether private practice was a primary or secondary work setting. Task-centered treatment was used by 41 percent of the respondents who maintained a private practice as their primary work setting as compared to 63.3 percent of those in it as a secondary setting. T-tests indicated that this difference was significant at the p<.02 level (t = 2.55, df = 80).

Finally, practitioners reported using the following theories which were not originally specifically listed on the questionnaire: transactional analysis, solution-
focused brief treatment, imagery, hypnotherapy, existential theory, functional theory, the chemical dependency disease model, psychodrama and neurolinguistic programming.

Caseload Profile

A picture of who is being served by autonomous practitioners can be drawn from information provided by respondents about the composition of their caseloads (Table 6). The answers from each respondent were converted to "percent of caseload" and averaged to yield a composite portrait of the caseloads of these respondents. Females in the average caseload outnumber males by almost 2 to 1. Over half the clients seen are between the ages of 19 and 39, and less than three percent are under age six or over age 65. The clientele is predominantly caucasian (m = 89.4%), with African Americans constituting 4.2 of the cases, Hispanic Americans 3.6 percent, and Asian/Pacific Islanders comprising 1.1 percent.

By occupation, professionals and semi-professionals make up nearly the same proportion of cases (m = 25.5 and 27.1 percent, respectively). The three occupations least represented in practitioners’ caseloads are unskilled laborers (m = 4.3 percent), craftspersons (m = 3.8 percent), and the involuntarily unemployed (m = 3.8 percent).
Table 6
Client Demographic Characteristics
Percent of Average Caseload

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>36</td>
</tr>
<tr>
<td>Female</td>
<td>64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 6</td>
<td>1.1</td>
</tr>
<tr>
<td>6-12</td>
<td>5.8</td>
</tr>
<tr>
<td>13-18</td>
<td>7.1</td>
</tr>
<tr>
<td>19-39</td>
<td>51.3</td>
</tr>
<tr>
<td>40-65</td>
<td>32.1</td>
</tr>
<tr>
<td>&gt; 65</td>
<td>1.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>89.4</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1.1</td>
</tr>
<tr>
<td>African American</td>
<td>4.2</td>
</tr>
<tr>
<td>Hispanic American</td>
<td>3.6</td>
</tr>
<tr>
<td>American Indian</td>
<td>.4</td>
</tr>
<tr>
<td>Other</td>
<td>.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>25.5</td>
</tr>
<tr>
<td>Semi Professional</td>
<td>27.1</td>
</tr>
<tr>
<td>Clerical</td>
<td>9.6</td>
</tr>
<tr>
<td>Manager</td>
<td>5.6</td>
</tr>
<tr>
<td>Craftsperson</td>
<td>3.8</td>
</tr>
<tr>
<td>Unskilled Laborer</td>
<td>4.3</td>
</tr>
<tr>
<td>Not in Work Force by Choice</td>
<td>6.8</td>
</tr>
<tr>
<td>Student</td>
<td>12.6</td>
</tr>
<tr>
<td>Unemployed</td>
<td>3.8</td>
</tr>
</tbody>
</table>

No information was requested about the make up of caseloads by diagnostic category. In part, such a question would have made the questionnaire
more cumbersome to complete, but additionally, given the vagaries of diagnostic practices, such results were envisioned to be of little use.

Involvement of the Third Party

The construct "involvement" includes both the reliance of practitioners on third parties and other ways in which the third party might exert itself in the treatment relationship. As noted in Chapter 5, "reliance" specifically refers to the percent of the practitioner's caseload utilizing third party payment for treatment. As a measure of this, respondents were asked to list the number of their clients paying through certain mechanisms, including managed care, CHAMPUS, Federal Employees Health Benefits, commercial insurance, Medicaid, Medicare, vouchers or contracts, and out of pocket funds. The percent of cases paid primarily through third parties (even if client co-payment was required) was separated from those paying out-of-pocket only, or receiving services through barter or free care.
Table 7
Average Percent of Caseload Using Various Payment Sources

<table>
<thead>
<tr>
<th>Payment Source</th>
<th>Mean Percent</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care (HMO or PPO)</td>
<td>17.2</td>
<td>0-91</td>
</tr>
<tr>
<td>CHAMPUS</td>
<td>4.3</td>
<td>0-70</td>
</tr>
<tr>
<td>Commercial Health Insurance</td>
<td>36.0</td>
<td>0-90</td>
</tr>
<tr>
<td>FEHB</td>
<td>1.3</td>
<td>0-33</td>
</tr>
<tr>
<td>Medicare</td>
<td>2.8</td>
<td>0-100</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.2</td>
<td>0-100</td>
</tr>
<tr>
<td>Voucher or Contract</td>
<td>3.1</td>
<td>0-89</td>
</tr>
<tr>
<td><strong>Total Third Party</strong></td>
<td><strong>65.9</strong></td>
<td></td>
</tr>
<tr>
<td>Out of Pocket only</td>
<td>29.9</td>
<td>0-100</td>
</tr>
<tr>
<td>Barter</td>
<td>.4</td>
<td>0-9</td>
</tr>
<tr>
<td>Free Care</td>
<td>1.7</td>
<td>0-50</td>
</tr>
<tr>
<td><strong>Total Other</strong></td>
<td><strong>32.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

As illustrated on Table 7, 65.9%, or two-thirds of the average caseload utilized some form of third party for payment. Only 6.9 percent of respondents had no clients paid for through third party funds, and several of those indicated that this was a result of their refusal to take clients with third party payment attached, due to the potential difficulties involved. As might be anticipated a
significant difference (p < .001) was found when I-tests were conducted between "primary" and "secondary" practitioners on the mean number of cases utilizing third party funds. For the former group, a mean of 21 cases were affected (SD = 15.5) compared to a mean of 7.39 for the latter (SD = 6.8) (t = 7.33, df = 140, p = .000).

The percent of clients paying for services out of pocket can reflect those who had no coverage, those whose therapist declined third party payment, and those who had coverage but chose not to use it. In response to a question about the latter, for the average respondent, 11 percent of his/her clients chose to pay for services in order to avoid the strictures accompanying third party payment. While 42.9 percent of the respondents had no clients selecting this alternative, 57 percent did, and for one respondent this was true of her entire caseload of 48 clients. Several respondents commented that they felt this was the case, but had no means of knowing how many of their clients chose to self-pay despite the fact that they had third party coverage.

While one measure of third party involvement is the percent of cases to which such funds are attached ("reliance"), "involvement" taps the much broader presence of third parties, as it considers their role in dictating treatment, not simply paying for its provision. One measure of third party involvement examined the role of the fiscal third party in determining the specific treatment modality of
services provided. Respondents reported that this was true for a mean of only 5.3 percent of cases. Seventy-one percent of the private practitioners reported having no cases with this restriction, while for two respondents this was true for 75% of their caseload.

A second indicator of third party involvement was assessed using a question on the number of current cases where prior approval of the treatment plan was required by the third-party before payment for services was allowed. On average, 17.3 percent of respondents’ cases required prior approval of the treatment plan. While 34 percent of the respondents had no cases where this was required, for one individual this was required for his/her total caseload.

Given that almost two-thirds of the clients seen by the practitioners surveyed utilized third party funding, the degree of reliance, at least for some respondents, was substantial. However, while the level of third party involvement is high, it is also recognized that the reimbursement conditions and level of individual case attention can vary greatly among different payors. This contention is supported in the responses to the latter two measures. Yet the presence of a third party funding source can affect clinical practices in more subtle ways than dictating treatment outright. The following section addresses these more indirect or delicate effects.
Effect of the Third Party

Third party reimbursement can affect clinicians in two essential ways. The third party can have a felt effect, by its very presence, or it can have a more direct impact on the behaviors and actions of the practitioners. In the first situation, the social worker’s perception of the effect of the third party is tapped. The dilemma is presented to the practitioner. In the second, the practitioner’s actions in response to the third party are measured as the dilemma is then acted upon. Therefore, one could feel the pressure of the third party, but not succumb to it by altered treatment practices. Similarly, for various reasons, one could experience no effect, and therefore not feel compelled to deviate from whatever one’s standard clinical practices are. Finally, one could sense various pressures from the payor and choose to respond to them by adjusting diagnostic and treatment decisions accordingly.

In this study these two areas of impact were measured through different methods corresponding to two different sections of the questionnaire. Table 8 indicates the six questions having to do with pressures which might be exerted by the third party on the provider. A category partition scale was used, with respondents assigning a 1 ("None") to 5 ("Great") rating of impact for each situation. On two of the items, respondents reflected particularly high levels if impact. On the 'extent to which you feel pressure to adjust treatment to maintain
third party contracts' 29 percent of the respondents reported moderate to high impact. On the extent to which reimbursement guidelines are a consideration in the choice of diagnosis, 39 percent indicated moderate to high impact.

A scale measuring the construct "Impact" was developed using four of the six questions. Detailed information on the process of scale construction is available in Appendix VI. Scores on the "Impact" scale were used to measure the perceived impact of third party payors on practice. Thus, a score of 4 on the impact scale indicated no effect by third party payors on practice, and 20 indicated great impact. The mean score resulting from the study was 10.57 (s.d. = 4.49). Chart 2 illustrates the distribution of scores. The findings on this are rather evenly spread across the scale, with several "peaks" occurring at the indication of "no impact", "very little" and "some impact". From this skewing to the right, it appears, that third party payors exert only a modest influence at this point on the practice experiences of respondents.
Chart 2

Distribution of Scores on Impact Scale

N = 142
Table 8
Perceived Impact of Third Party
Number (and Percent) of Respondents

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Very Little</th>
<th>Some What</th>
<th>Mod</th>
<th>Great</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent does the acceptance of third party funds create dilemmas for you when making case decisions?</td>
<td>33(21)</td>
<td>37(24)</td>
<td>42(27)</td>
<td>21(13)</td>
<td>19(12)</td>
<td>5(3)</td>
</tr>
<tr>
<td>To what extent do you feel pressure to adjust your treatment decisions in order to maintain providership under PPO or HMO contracts?</td>
<td>36(23)</td>
<td>35(22)</td>
<td>27(17)</td>
<td>17(11)</td>
<td>28(18)</td>
<td>14(9)</td>
</tr>
<tr>
<td>To what extent do you depend on referrals from managed care to maintain your caseload?**</td>
<td>54(34)</td>
<td>37(24)</td>
<td>26(17)</td>
<td>17(11)</td>
<td>13(8)</td>
<td>9(6)</td>
</tr>
<tr>
<td>To what extent has the presence of third party payors in a case had a negative impact on the development of a treatment relationship?</td>
<td>43(28)</td>
<td>44(28)</td>
<td>31(20)</td>
<td>19(12)</td>
<td>14(9)</td>
<td>6(4)</td>
</tr>
<tr>
<td>To what extent do you feel the involvement of the third party negatively affects the overall quality of treatment you can provide?</td>
<td>33(21)</td>
<td>37(24)</td>
<td>42(27)</td>
<td>21(13)</td>
<td>19(12)</td>
<td>5(3)</td>
</tr>
<tr>
<td>To what extent are the guidelines for third party reimbursement a consideration in your choice of diagnosis?**</td>
<td>24(15)</td>
<td>31(20)</td>
<td>37(24)</td>
<td>34(22)</td>
<td>26(17)</td>
<td>5(3)</td>
</tr>
</tbody>
</table>

** = Item eliminated in development of Impact Scale
As stated earlier, a second component of "impact" has to do with respondents' actions in light of third party parameters. Therefore, a set of six questions inquired about the number of current cases in which certain actions were taken as a consequence of third party involvement. A set of four additional questions asked for information on other practice effects experienced over the past year.

Table 9
Deviations In Clinical Decisions or Treatment to Conform to 3rd Party Restrictions
Percent of Average Total Caseload
and Percent of Respondents Affected

<table>
<thead>
<tr>
<th>Action</th>
<th>% of total caseload affected</th>
<th>% of respondents affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gave more severe diagnosis than necessary to conform (n=151)</td>
<td>6.1</td>
<td>37.1</td>
</tr>
<tr>
<td>Gave less severe diagnosis than necessary to conform (n=146)</td>
<td>3.7</td>
<td>19.8</td>
</tr>
<tr>
<td>Reported individual treatment to conform when conjoint or family was really provided (n=147)</td>
<td>10.1</td>
<td>53.7</td>
</tr>
<tr>
<td>Selected modality to conform, when another was warranted (n=150)</td>
<td>3.2</td>
<td>22.7</td>
</tr>
<tr>
<td>Selected treatment approach to conform when another was more appropriate (n=149)</td>
<td>5.2</td>
<td>31.5</td>
</tr>
<tr>
<td>Doing fewer collateral contacts/ less advocacy because not reimbursable (n=144)</td>
<td>3.0</td>
<td>18.7</td>
</tr>
</tbody>
</table>
Table 9 indicates the questions and the mean percent of cases reported based on a respondent's total caseload. As illustrated, an average of over six percent of the cases currently seen by respondents received more severe diagnoses than necessary in order to conform to reimbursement guidelines and an average of 3.7 percent were given a less severe diagnosis in order to conform. The greatest impact found was in the reporting to payors that individual treatment services were provided, when in reality conjoint or family services were provided. This occurred in an average of over 10 percent of cases. To lesser extents, the choice of treatment modality, treatment approach, and the provision of advocacy or collateral contacts were affected by third party restrictions (mean percent of 3.2, 5.2, and 3.0 cases, respectively). While unrelated to reimbursement restrictions, one question asked about the practice of underdiagnosing clients to avoid the potentially stigmatizing effects of such labels. In response, 57 of the practitioners reported doing this, affecting a mean of 15.5 percent of all cases.

The figures on Table 9 appear to under-represent the phenomena, however, for two reasons. Because they were calculated based on the total number of cases rather than only those which are third party-paid, the percents are diluted by the inclusion of cases to which the situations do not apply. Percents calculated only on the proportion of cases paid by third parties were generally 3-5 percent higher,
but are not reported here because manipulation of the data in that way left it open to possible inaccuracies.

The questions in the section on practice deviations are also particularly direct, and probe areas in which both ethical and legal sanctions could be brought to bear on respondents. Therefore, it was anticipated that some underreporting of actions was especially likely to occur in response. However, less straightforward inquiries would not have adequately addressed the issues raised for study, and, while possibly presenting a lower-than-actual incidence rate, any figures on prevalence of difficulties are felt to be informative as a first examination of this problem.

The percent of caseload where treatment or diagnostic deviations occurred is only one measure of prevalence. Another is the percent of respondents who had or had not taken those actions with their current cases. Between 6 and 13 respondents did not answer these questions and were excluded from consideration. As indicated in Column Two, Table 9, of those answering, 37 percent reported giving a more severe diagnosis in at least one case to conform to third party parameters. Over 19 percent reported giving a less severe diagnosis in at least one case. Twenty-two percent reported having selected the modality to conform, 31.5 percent reported selecting the treatment approach to conform, and 18.7 percent reported doing less collateral work or advocacy in at least one case, due to
reimbursement restrictions. The greatest number of practitioners were affected by third parties in the practice of falsely reporting the type of treatment provided. Over half of the subjects (53.7 percent) were currently reporting individual treatment to the payor while in actuality providing family or conjoint services for at least one of their current cases.

Using T-Tests, one area of significant difference (p = .011) was found in this section between respondents who had private practice as their primary or secondary work settings. "Primary" private practitioners reported assigning more severe diagnoses than necessary in order to conform to third party restrictions for a mean of 4.4 percent of their caseload, while "secondary" private practitioners reported this for a mean of 10.2 percent of the caseload (t = 2.63, df = 57).

As displayed in Table 10, several of these actions were significantly correlated with the "Impact" scores. While this was not true for situations of over-diagnosis or under-diagnosis to conform to third parties, for four of the items, the greater the perceived impact by the third party, the greater the instances of responding to it by altered treatment practices. The highest correlation (r = .40) was between "impact" and doing less collateral contacts or advocacy, even though this action affected a relatively small number of clients.
Table 10
Correlation of "Impact" Score with Practice Effects

<table>
<thead>
<tr>
<th></th>
<th>r</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gave more severe diagnosis than needed</td>
<td>.06</td>
<td>135</td>
</tr>
<tr>
<td>Reported 1:1 when marital/family provided</td>
<td>.21*</td>
<td>134</td>
</tr>
<tr>
<td>Selected treatment approach to conform</td>
<td>.29***</td>
<td>137</td>
</tr>
<tr>
<td>Selected modality to conform (eg. individual instead of marital)</td>
<td>.18*</td>
<td>137</td>
</tr>
<tr>
<td>Doing less advocacy/collateral</td>
<td>.40***</td>
<td>131</td>
</tr>
<tr>
<td>Percent of cases shortened treatment to conform</td>
<td>.27***</td>
<td>140</td>
</tr>
</tbody>
</table>

* = (p < .05)
*** = (p ≤ .001)

Overall, 83 respondents offered 154 sets of remarks or explanations on areas contained in the study. On one section, they were asked to give open-ended comments in response to the questions on practice deviations resulting from third party involvement. Their statements in this regard were almost more telling than the figures presented, as practitioners described poignantly the nature of their actions and where and how they draw the line in departing from standard practices.

It's all an ugly game.

I have a great deal of worry about the potential misuse of diagnosis by insurance companies. I feel caught between 'needing' to provide a severe enough diagnosis to justify longer term treatment and the implications it may carry with it for the patient.
Marital therapy is seldom covered by insurance and I will enter treatment under one name.

I do not form decisions regarding treatment modality, conformity, or diagnosis based on reimbursement guidelines. I will report a case as individual if the guidelines do not reimburse for group therapy.

I see individuals together; I don’t treat marriages.

None (misdiagnosis) in a clear-cut situation, but I’m sure in a questionable diagnostic situation I’ve chosen the most viable route.

I would never give a more serious diagnosis. That’s unethical and unfair to the client. I do, however, now include every element the client evidences on each Axis of the DSM-III-R, whereas, if not managed care, its one basic diagnosis.

I will not compromise treatment needs for the insurance’s sake.

I allow third party policy just to affect my paperwork to a moderate degree.

I discuss with the client the needs of their treatment and the extent of their insurance coverage. They almost always elect to pay the extra as needed.

Other practitioners noted problems not directly captured by the study questions.

Current UR providers appear to ignore diagnosis- if person is not doing well and making progress then the insurer wants to discharge them. If they are doing well, then the insurer wants to discharge them. I recently was given 5 sessions and told that the case would be "closed-no extensions. No appeals".
One difficulty now is with those who have two different insurances simultaneously... eg. separated families. The responsibility for payment gets tossed back and forth while we continue to see the client. But as a philosophy at this practice we will take monetary risks to help the client.

I’ve heard about blacklisting among managed care firms of non-compliant therapists, which is scary for its potential to damage people’s reputations, especially when the panels share information among themselves.

I do none (of these things) at present, but was in a situation on one case - preauthorization only given for every 2 sessions - had to call a psychiatrist to review progress and treatment plan each time. This process would take 2 weeks, increasing the client’s anxiety.

I feel that quality is affected because confidentiality is ‘out the window’ with the reports required for continued flow of benefits. Some patients feel this is more of a problem for me than for them, and this may be so.

I received a letter today to negotiate ‘transitions’ with my current clients to a new managed care system. I may lose 80 - 90 % of my clientele due to this process.

Some difficulties either arise or are avoided not because of the nature of the third party, but because of the nature and interests of the therapist.

This is an ethical decision on my part. I must do what I think needs to be done or shouldn’t take the case. In some EAP referrals though this can be an issue and then I reject or cancel the contract.

You learn to say what they want to hear, but you don’t have to cheat.

I believe one’s personal attitude has a lot to do with this issue. Some companies are definitely better than others. I have actually
come to enjoy some of the support and feedback I got from some reviewers and established very productive relationships with them.

I find it unethical to do most of the above. I don’t, however, get reimbursed for all my work. As you can tell, I slide my fee and tell my clients that I will be honest with them about what I tell the insurance company. They need to fight the good fight to get their deserved reimbursements.

Part-timers in this area do less third party. They don’t put up with as much. If it gets difficult they’ll write them off. We full timers can’t afford to do that. We find a way to make it work.

I am becoming known for working with what I call ’damaged people’ (severe childhood abuse). These cases are not brief treatment cases. Since I will not abandon these people if their insurance approval runs out, I suffer, but do not believe that I take it out on them. It is certain managed care programs which cause problems. I do many things which are not reimbursable.

I seldom if ever have done advocacy or environmental manipulation.

Because this is my second job - I’m not affected by this - I’m selective and only choose those clients who pay up front regardless or (I take) those who can’t afford and I want to provide care pro bono.

I don’t take cases which would require (collateral work or advocacy), due to this issue.

At times, however, uncompromising standards may shift responsibility or difficulties from the therapist to the client.

(It is the) patient’s responsibility to pay me, ultimately.
I have not padded my reporting. I let the person know ahead of time that the insurance may not approve.

I have a very strong belief that you shouldn’t "cheat" just to get at the money, so I don’t, and if I find myself in such a situation, I do not accept the case, or I terminate.

My service permits me to set my own guidelines and standards. A patient needs to conform their method of payment.

I get the patient to pay if its indicated.

Even others whose actions have been unaffected acknowledge the presence of difficulties and the potential for practice changes as a result.

So far I have been lucky.

I am not a provider for PPO or HMOs because of the severe limitations they impose on treatment which is indicated, the amount of paperwork, and low fees. Not in the patient’s best interest or therapist’s!

For several of the above answers, I answered 0 because I do not make a lot of money - I am a second income- but I would answer differently, as I would be forced to do differently were I single income (i.e. would not be able to do the collateral work I do now for no pay, especially with Medicaid clients).

I would eventually move into full time private practice, but given this situation, I don’t see how I can provide clinical services to persons of financial limitations with third party resources and make a living for myself.

Other questions tapped some larger practice effects of third party involvement. In reviewing their experiences over the last twelve months (Table
11), respondents reported refusing an average of 2.9 percent of the referrals made to them due to the clients' lack of third party coverage. Practitioners indicated that a mean of 1.75 cases had discontinued treatment over the past year because the practitioner did not want to conform to reimbursement guidelines. During the same period, a mean of 9.7 percent of the cases closed had received shortened treatment due to reimbursement restrictions, and in a mean of 8.5 percent of cases, sessions were held less frequently than needed so that third party funds would last the calendar year.
Table 11
Other Practice Effects of Third Party over Last 12 Months
Mean and Range cases and Percent of Respondents Affected

<table>
<thead>
<tr>
<th>Action</th>
<th>Mean</th>
<th>% of respondents affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of referrals refused in last 12 months due to lack of 3rd party coverage (n=153)</td>
<td>2.9</td>
<td>28.8</td>
</tr>
<tr>
<td>Number of cases discontinued in last 12 months because respondent did not conform to 3rd party (n=153)</td>
<td>1.75</td>
<td>29.4</td>
</tr>
<tr>
<td>Percent of cases closed in last 12 months where treatment was shortened due to 3rd party (n=152)</td>
<td>9.7</td>
<td>57.2</td>
</tr>
<tr>
<td>Percent of cases in last 12 months where sessions held less frequently than needed due to 3rd party (n=155)</td>
<td>8.5</td>
<td>62.6</td>
</tr>
</tbody>
</table>

Once again, the number of respondents affected is worthy of note. While only 29.4 percent had clients discontinue due to their refusal to comply with the payor and 28.8 percent had refused referrals due to the clients’ lack of coverage, 57.2 percent closed cases following shortened treatment, and 62.6 percent "stretched out" client sessions to last over the calendar year.

Unlike the preceding section of the questionnaire, three of these questions asked for respondents to give percentages of occurrence, not actual numbers. While care was given in the instrument to alert subjects to the 12 month time
frame of the questions, the fact that percents were required was apparently not clear. Thus, some respondents answered "1", leaving the researcher with the impression that it referred to a case, not a percent of cases. Because there was no way of gauging what some respondents really meant in their answers, the figures given were used, although the resulting data may be artificially low as a result.

The comments respondents shared leave little doubt about the dilemmas attendant to these issues.

Patients wanted me to use their HMO for marital and I won't do that—they were all enraged with me.

My approach to reimbursement is this: My fee is $65 per session. If the client carries insurance that covers my fee, diagnosis and treatment then the client submits my bill for reimbursement. It is his or her responsibility to pay my bill. I will, however, reduce or negotiate my fee if the client’s carrier will not reimburse for my services.

These questions imply an adversarial relationship which I fortunately, I guess, have been able to avoid so far. I have had clients stop services because they would not pay for services beyond what their policies covered, but I am willing to negotiate a cash fee with them if they want to continue.

I often feel I’m being put in the position of lying in order to act in the best interest of my client.

I’m not the typical practitioner - reimbursement is NOT important to me (PP is 1% of income).

It’s frustrating. Many clients cannot enter or continue treatment. Many are deceived by the wording of their medical coverage and
I have to tell them the real story. Many clients cannot see the best therapist for their problem because of reimbursement.

The Personal Struggle

Clearly, contending with the presence and mandates of a third party can be a perplexing and stressful experience. This section examines the resources used by practitioners in making decisions, and the level of quandary experienced when deciding to deviate from ethical, clinical, or legal standards.

In a question on the "procedures used for decision making when faced with conflicts between treatment decisions and reimbursement guidelines" respondents were asked to select from a list of ten options all processes which applied. As portrayed on Chart 3, a variety of methods are used, with "Consulted Colleague" and "Discussed with the Client" being the most prevalent, and "Referred to Written Practice Policy" and "Referred Case Out" among the least prevalent. Less than a third of the respondents reported referring to the profession's code of ethics. Although several of the responses in the 'other' category could have been subsumed elsewhere, additional processes reported include: "referred to a book on private practice issues", "realistically narrowed down the goals of treatment to conform to time and money available", and "I decided for myself what was appropriate and ethical".
When faced with competing demands and pressures, practitioners might choose a course of action for pragmatic reasons, yet still feel discomfort or difficulty in the process. The degree of quandary respondents experienced when acting in discord with ethical or clinical principles was explored though a series of questions using category partition scales. Practitioners were asked to indicate from 1 ("No quandary") to 5 ("Great quandary") the level of difficulty they had in taking certain actions. Respondents were to use category 6 ("Not Applicable") if they never took the action indicated. Significant inter-correlation (p<.001) was found among the items in this section with coefficients ranging from r=.3226 to .6101. A measurement scale was not constructed from these items due to the large number of "not applicable" responses and the consequent lower number of responses per cell.

The results of these six questions are indicated on Table 12. The area in which respondents indicated the greatest quandary was "giving less treatment than needed to conform with reimbursement guidelines" (29.3 percent), yet six percent of the respondents reported no quandary with this action. The action for which the greatest percent described "no quandary" was in reporting individual treatment to the payor when another was actually provided (10.7 percent). This item also had the lowest number of "not applicable" responses, indicating that only 26.7 percent of the subjects did not take this action at some time.
Four items in the "quandary" section were found to have significant (p<.001 - p<.05) positive correlation with Impact scores when this procedure was run eliminating user-missing data. As displayed on Table 13, in situations other than limiting collateral contacts and/or reporting such activities as reimbursable when they are not, the greater the degree of impact experienced by respondents, the greater the degree of quandary expressed when acting in response to those pressures. There were also areas of modest but significant negative correlation between items on the quandary section and three respondent characteristics (Table 14). It appears from these that the greater the respondent's age, years in private practice, and years of full time experience in social work, the lower the levels of quandary encountered.
Processes Used for Decision Making

Chart 3
Table 12
Degree of Quandary Experienced
n = 150

<table>
<thead>
<tr>
<th>Situation</th>
<th>No quandary</th>
<th>Very little</th>
<th>Some what</th>
<th>Mod. quandary</th>
<th>Great</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving more severe diagnosis than warranted</td>
<td>10.0</td>
<td>8.0</td>
<td>12.0</td>
<td>14.7</td>
<td>17.3</td>
<td>38.0</td>
</tr>
<tr>
<td>Selecting modality to conform</td>
<td>8.0</td>
<td>7.3</td>
<td>8.0</td>
<td>17.3</td>
<td>13.3</td>
<td>46.0</td>
</tr>
<tr>
<td>Reporting individual treatment to payor when another was provided</td>
<td>10.7</td>
<td>13.3</td>
<td>12.0</td>
<td>20.0</td>
<td>16.7</td>
<td>26.7</td>
</tr>
<tr>
<td>Giving less treatment than needed to conform to guidelines</td>
<td>6.0</td>
<td>2.7</td>
<td>8.7</td>
<td>14.0</td>
<td>29.3</td>
<td>39.3</td>
</tr>
<tr>
<td>Counting collateral contacts/phontime as reimbursable when it is not</td>
<td>9.3</td>
<td>5.3</td>
<td>2.7</td>
<td>6.0</td>
<td>8.0</td>
<td>68.7</td>
</tr>
<tr>
<td>Limiting # of collateral contacts due to non-reimbursability</td>
<td>8.7</td>
<td>2.0</td>
<td>9.3</td>
<td>7.3</td>
<td>10.7</td>
<td>61.3</td>
</tr>
</tbody>
</table>
Table 13
Correlation of "Impact" with Level of Quandary

<table>
<thead>
<tr>
<th>Quandary</th>
<th>r</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quandary-counting collateral contacts as reimbursable when they are not</td>
<td>.06</td>
<td>46</td>
</tr>
<tr>
<td>Quandary-selecting modality to qualify for reimbursement</td>
<td>.22*</td>
<td>79</td>
</tr>
<tr>
<td>Quandary-reporting 1:1 when marital/family provided</td>
<td>.21*</td>
<td>105</td>
</tr>
<tr>
<td>Quandary-giving less treatment than needed</td>
<td>.27**</td>
<td>86</td>
</tr>
<tr>
<td>Quandary-giving more severe diagnosis than needed</td>
<td>.23*</td>
<td>90</td>
</tr>
<tr>
<td>Quandary-limiting collateral/advocacy</td>
<td>.24</td>
<td>54</td>
</tr>
</tbody>
</table>

* = (p < .05)

** = (p ≤ .01)
Table 14
Correlations - Respondent Characteristics and Levels of Quandary by Situation

<table>
<thead>
<tr>
<th>Situation</th>
<th>Characteristic</th>
<th>Age</th>
<th>Years in PP</th>
<th>Years in SW Full Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving more severe diagnosis than warranted</td>
<td></td>
<td>-.22*</td>
<td>-.10</td>
<td>-.16</td>
</tr>
<tr>
<td></td>
<td>(n=93)</td>
<td>(n=92)</td>
<td>(n=93)</td>
<td></td>
</tr>
<tr>
<td>Selecting modality to qualify for reimbursement</td>
<td></td>
<td>-.27*</td>
<td>-.27*</td>
<td>-.29**</td>
</tr>
<tr>
<td></td>
<td>(n=81)</td>
<td>(n=80)</td>
<td>(n=80)</td>
<td></td>
</tr>
<tr>
<td>Reporting 1:1 when another was provided</td>
<td></td>
<td>-.26**</td>
<td>-.25**</td>
<td>-.21*</td>
</tr>
<tr>
<td></td>
<td>(n=110)</td>
<td>(n=109)</td>
<td>(n=108)</td>
<td></td>
</tr>
<tr>
<td>Giving less treatment than needed</td>
<td></td>
<td>-.10</td>
<td>-.27**</td>
<td>-.22*</td>
</tr>
<tr>
<td></td>
<td>(n=91)</td>
<td>(n=90)</td>
<td>(n=90)</td>
<td></td>
</tr>
<tr>
<td>Counting collateral contact as reimbursable when it is not reimbursable</td>
<td></td>
<td>-.37**</td>
<td>-.38**</td>
<td>-.36*</td>
</tr>
<tr>
<td></td>
<td>(n=47)</td>
<td>(n=47)</td>
<td>(n=46)</td>
<td></td>
</tr>
<tr>
<td>Limiting collateral contacts/advocacy</td>
<td></td>
<td>-.25</td>
<td>-.30*</td>
<td>-.45**</td>
</tr>
<tr>
<td></td>
<td>(n=58)</td>
<td>(n=58)</td>
<td>(n=57)</td>
<td></td>
</tr>
</tbody>
</table>

* = p<.050  
** = p<.010  
*** = p<.001

Finally, respondents’ comments helped to illustrate what contributed to their level of predicament with these situations.

I am very uncomfortable 'defrauding' third party payors, yet get angry that my time is not reimbursable. When a case requires a lot of collateral time, I will discuss it with the client and arrange an out of pocket fee for this time. Even if its minimal, it helps my countertransference!
I don’t limit my involvement, I simply don’t get paid.

You provide the best treatment you can-regardless of anything else.

You have to be comfortable with yourself and confident to make decisions about what you will do-legally and illegally.

I do not compromise my standards or lie because of insurance, although I am tempted.

In situations of great quandary, I wound up not doing it.

I discuss any and all of these decisions with clients and encourage them to take responsibility in the process. I essentially give them the reality and they make the choice with my assistance and input.

I am troubled in all of these situations because I want to be both responsible (to my clients and myself) and ethical and these are not always clear decisions.

In general, I have felt little quandary because I make the choice which is best for the client (in my opinion), an action which has not always endeared me to an agency.

[Giving less treatment than needed] really does upset me the most.

I resent it and hate it.

Additional Reflections

Telephone interviews with the sub-group of respondents offered the researcher opportunities to delve further into questions addressed in the survey, and talk more generally about the issues under examination. Respondents who experienced a high degree of difficulty with the issue particularly seemed to
welcome the opportunity to talk about it, though all nine interviewees were highly conversant with the situation and its practical ramifications. Some of their comments paralleled the findings above. Those which stemmed from items not addressed directly in the questionnaire will be reviewed here.

The individuals interviewed offered particular insights into conditions affecting the impact of third parties and the ability of private practitioners to respond to these challenges.

My greatest problems are in diagnosis. I don't like it. I give the most mundane diagnosis possible...e.g. adjustment reaction, if its not long term. I discuss it with clients as it's their label, and I'll say, "Here are what I see as the choices". If its long term, I try to choose one with less stigma, but sufficient to get services. I don't care. I see it as my part of the insurance game.

I am somewhat isolated when it comes to larger systems change. Some of this is geographic. I'm in regular phone communication, though, with our state organization. The state NASW is really working and keeping me well informed. If I had more time and energy, I'd probably be protesting or doing more. My main responsibility is to stay in touch to take care of my own organization, even though its a minuscule part of the system.

I want to be as sharp as possible with my diagnosis, yet I need to find a way to discuss this with clients. Because of managed care, I feel I can't or shouldn't be as honest with insurance companies as I'd like, yet I'm concerned what kind of message this gives to the client. If it becomes a situation where the client and I are joining together to put one over on the insurance company, it has an effect on treatment. You end up triangulating the insurance company in... The main ethical issue is how to present a balance. If I have to get pre-certification (for services) or certification after one session, it could give the message that 'Big Brother's watching
over us'....How can you present it objectively? You can present it that 'all three of us will put our heads together to get you the best treatment possible under your coverage.' This works until the company refuses to certify because the person's not ill enough!!

The importance of approaching third parties in a non-adversarial manner and developing personal rapport with payor representatives was mentioned repeatedly.

We have an excellent office manager who has personal contacts developed with system representatives, allowing us to obtain a lot of information and guidance informally.

I make sure relationships are good with provider relations personnel and my referral sources. They get to know you over time. You can't view it as adversarial—you won't survive. When they sense animosity, they don't want to deal with you.

I profess my ignorance to provider reps and ask them for information and direction.

However one respondent had developed a particularly aggressive, and by all reports successful, strategy to limit the encroachment of third party scrutiny.

We [six person practice] have patients sign a statement allowing us to advocate on their behalf in order to manage their mental health care needs. We send a letter to the payor stating, 'The patient and I hereby request that the following information be given in order to assist us and our attorney to deal with any difficulties which may arise with medical coverage and payments.' Then we give policy information on the patient and then request the certifying
persons' license number, credentials, malpractice insurance policy
number, their personal attorney and their corporate attorney and
their license to practice medicine. We tell them that any
conversations may or may not be tape recorded should the
information be needed in the future to prepare legal statements. It
makes them squirm!

We have a utilization review mechanism built in within the
practice. (Payors) need to define how what they can do is better,
especially when they are making decisions based on financial
needs, not the patient's needs.

Interviewees also acknowledged that the efforts at increased accountability
for clinical actions were not entirely negative or unnecessary.

On one hand, managed care has made me think through more
clearly what I'm doing, and in that, it has had a positive effect on
my practice. On the other hand, you must fight tooth and nail for
what you need.

We can be a non-credible profession. The field is going to have to
shape up...this business we're in is serious.

As an administrator in my full time position, I see things from the
other side too. They could care less about our treatment concerns.
Their responsibility is to save money. Although sometimes it seems
they spend $50. to save $5., we have our role, and they have theirs.

You can get very casual and loose in private practice. Its good for
me to be responsible, and to firm up my work, records and
treatment plans. So that's the good inside the bad of managed care.

When we get reports or information for charts from other private
practitioners, the material is often worthless. We are developing
training programs and manuals around these things, so that with
good treatment planning and a quality improvement program,
practitioners can meet payors head on and win.
Despite the fiscal ramifications for the provider, it is clear that the effect restrictions have for clients are also a source of pain and despair for practitioners.

Even though I also work in an HMO and understand it from that side, there are people with long-term problems and such payment mechanisms force them to "seal over" these things that they've finally decided to deal with (eg. incest and PTSD). They have tried that in the past (perhaps in past therapy) and it hasn't worked, yet they can't afford to pay for the services on their own.

...mental health is treated so differently from other health concerns....

What happens?? #1 Insurance changes, I'm not a panelist, and I lose them. #2 I start to see them, but discuss paying out of pocket every other visit to attenuate service. #3 I try to structure what I'm doing in treatment so I don't leave them raw and emotionally opened when the money runs out.

Interviewees offered advice to others struggling with the issues, based upon their own experiences.

Be real clear about the contracts you sign. Check them out with both peers and contractors and read them very carefully.

About 5 years ago I got into a local network. Until then, I hadn't realized the extent of their effect. I went to local NASW meetings and training, I began to read all I could, and continued to get into networks. The best experience and knowledge is first hand. Second hand isn't always accurate, and can be fueled by rumor or fear."

If you are going to sign a contract, you have to expect to play by the rules.
Two people paid for by managed care had lots of visits, and then I got notice that for ten more visits, a big review would be required. I discussed it with the clients who then decided to try a period of time without treatment. One client knew exactly how long a hiatus was allowed before she could resume therapy and have it covered without review!

I'm highly computerized and generate my reports more easily that way, which helps. I would not want to move to a totally self-paying clientele. One of my offices is in a working class area, and I would lose some of the diversity in my caseload. As it is I have a sliding scale, and do not reject people because they can't pay $85. Some friends and I have been talking about how to diversify services into areas which are not third party-dependent (eg. groups) rather than narrow our caseloads.

I have been able to negotiate on some of these areas. We said 'no' to insane contracts. We had no time for multiple forms and no need for the clientele. They then renegotiated what we absolutely had to fill out. So, in some situations, you can negotiate, yet you can't be unreasonable. In the same way, I've had success in advocating for clients getting extensions. Yet you need to be clear about your rationale, etc.

Network! I think the nature of social work, even in agencies is to guard one's turf. In private practice, it's a dollars and cents issue. There's no trust. People need to keep communication going. You don't lose clients by this, you gain information and opportunities for consulting. People are so hungry for information, but don't want to share any, when there could be benefits to mutual assistance.

I had two companies that would only pay if given session-by-session updates on what went on in treatment. As a result, the clients dropped the insurance companies and got better coverage.

Get consultative supervision and business training, at least at first.
Social workers ought to practice what they preach... social action is needed, yet undervalued or under-practiced by clinical types. Social work schools are doing students an injustice by not equipping them for this and for [rigorous practice standards].

Do regular billing...if it is consistent, its easier to follow up. Its important to have standardized, computerized procedures.

Subscribe to *Psychotherapy Finances*.

Network. Five people are better than one struggling in isolation. Some people are clear that they won't share. They're honest and say, 'I'm reluctant to give information because this is a gold mine for me.' There is a fear that it will result in slicing up the pie even further.

I had training in community organizing, so I find this joy-fulfilling. Many private practitioners are negative knowledge-bound. They have the opinion that they can’t do anything, when they just need the right tools.

You must set fees high enough (due to those who pay a set percent of fee). It is not good or rewarding to be flexible on these things. Have a clear policy, and then do reductions or write-offs, but don’t be wishy washy. These outfits are computerized and have their own needs too. Take a clear stance.

You need to encourage your clients to be savvy and advocate for themselves. Consumers may be the best hope for change in taking action, to say to their employers that 'this coverage is inadequate'.

I do feel some power via NASW... its a good group in my state on this. They have put a lot of pressure on companies to review their empaneling processes to show what social workers can do.

Finally, those interviewed discussed how the changing marketplace has affected their views of private practice.
Be prepared to take risks- private practice is no longer a safe little cocoon. You have to know why you’re doing private practice. My purpose was giving the type of services I can only give in this way. Now is a crazy time to go into private practice, and people who go into it for money are naive. If I’d thought about it more at the time I did it, I probably wouldn’t have even done it then.

My view of private practice has changed. I was in private practice part time for 8 years. I’ve only done it full time the last year. Over the last 6-8 months, I find myself working harder, doing more paperwork. I would like to be in the position of being able to limit the number of cases from certain carriers, but right now, my practice is not at that point.

Everything is affected by third parties. Private practice is dead. Within the next 3-5 years there will only be a handful of insurance carriers, and people will have to be in a group or agency model to survive.

It makes me anxious about doing this the rest of my life. At one point I thought I would, and even thought my children could. I’m making decent money and getting along now, but I wonder, when will the bubble break?

In sum, the nine interviews helped to confirm the validity of the questionnaire findings. Perhaps more importantly, they put a very personal face on what could seem to be an issue fraught with selfishness, deceit, and manipulation. They also served to reconfirm that the issues involved are complex, and the "answers" obscure.
Chapter Eight

Analysis

In this section, the findings from both the qualitative and quantitative portions of the research will be summarized then analyzed in light of the initial research questions. The strengths and limitations of the study methodology will also be addressed.

Summary

This research offered a current picture of the nature of private practice and the clientele served through that mechanism. Those engaging in private practice appear to be seasoned professionals with a good deal of agency and private practice experience behind them. Nearly one-half of their household income is derived from private practice and over half find the private practice income essential. Virtually all the respondents were caucasian, the average age was 49, and 72 percent reside in two-income households. Only nine percent located their practice in rural areas. The predominant service provided was psychotherapy or counseling and an average of 27 billable hours was reported spent each week servicing an average of 26 cases. The gender of the composite caseload mirrored that of the respondents, with approximately 64 percent of the clients being female.

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Clients tended to be young adults, caucasian, and occupied professional or semi-professional positions. An average of 65 percent of clients used third party funds for their treatment, and another 30 percent used only out-of-pocket funds. Many respondents offered reduced fees, however only 20 percent currently had any cases receiving free care. The latter is particularly interesting to note, in light of concerns raised about exclusivity in who can afford services from private practitioners.

That only nine percent of the respondents had located their practices in rural areas contrasts with the argument made for social worker vendorship that among mental health professionals, that group offers more geographic dispersion, and thus, more access to services for potential consumers (Meddin, 1982).

Although this study focuses on some of the rigors in private practice, it appears that this is by and large a thriving, financially rewarding enterprise, serving a demographically homogeneous population. It is, however, in a state of increasing uncertainty due largely to changes in the market resulting from fiscal third parties.

Examination of Study Questions

The results of the study may be best analyzed using the four exploratory questions which undergirded the study:
1) To what extent does reliance on a fiscal third party create ethical dilemmas for social workers in private practice?

2) How are practice decisions affected by the reimbursement parameters set forth by a fiscal third party?

3) How do private practitioners resolve these dilemmas? What rationales, processes, or guides are used to help them arrive at their decisions?

4) What factors are associated with the occurrence of ethical dilemmas?

The first question creates a context for understanding and interpreting the findings contained in the other three questions, as it captures the multifaceted nature of the issues being examined in this study. It became clear through this research that concepts such as "ethical dilemma" and "reliance" can be reflected in a number of ways. While the definition of "ethical dilemma" used in this study was intentionally broad, it may be that "decisional dilemma" would have been a more accurate term. For example, many of the respondents who reported never deviating in their diagnoses or treatment to comply with third parties noted that it would be unethical to do so. However, those who did report these actions did not comment on the ethics of their actions, though as one acknowledged, "I wish I didn't have to do it, but I do". Thus the extent to which this posed an ethical dilemma for them or just a confusing and troubling decision is unclear. The insights available into this based on the "quandary" section of the research and the
interviews will be discussed under Question Three, but the findings highlight the shortcomings of a strictly ethics-based framework for investigating these issues.

"Reliance" as originally defined, appeared too narrow to capture the phenomenon of third parties’ effect on practitioners. Because they so color the practice environment today, third parties affect even those practitioners who, strictly speaking, don’t "rely" on them for clients or payment.

As with "reliance’ and "ethics", practitioners and third party payors are not monolithic entities, and the diversity within each group prevents the offering of blanket answers where they are concerned. For example, the array of third parties means a multiplicity of types and levels of restriction accompanying reimbursement. Depending on which payors are involved, the practitioner may find them highly compatible with his/her treatment approach or highly demanding both of time and concessions. As one respondent put it,

The commercial insurance companies who do not require prior treatment approval have a negative impact only to the extent that some patients don’t have very much coverage (eg. 25 sessions), and so can’t always stay in treatment as long as they need to. The major negative impact is for the HMOs and PPOs that 1) Spew out enormous amounts of paperwork and guidelines, pay you less and require large chunks of time monitoring treatment and 2) Require prior approval or approval every 6 weeks and pressure you to reduce your fee to fit their reimbursement. The ones that have a bad influence have a very bad influence.
Similarly, the nature of the practitioner and the circumstances of his/her practice affect both the reliance on third parties and the view of ethical dilemmas. Dependence on income from private practice, competitiveness of the market in which practicing, how "established" the practice is, the nature of one's clientele and personal values or preferences all affect the degree of involvement with third parties, the presence of conflict and the methods selected to deal with it. Therefore, what may appear in this analysis as equivocation is in fact a reflection of the amount of variability evident in the prevalence and severity of this problem.

Finally, "prevalence" may be viewed in two ways. In this study, the prevalence of dilemmas and the actions taken in response to them are measured by the frequency with which they occur and by the number of clinicians affected. Each vantage point offers a different sense of the degree of the problem, but each is valid for what it offers to our understanding. For example, in the instance of intentional misdiagnosis, it is important to know how many clients are affected, as well as to know how many clinicians are doing it. Wherever possible in the analysis of the research questions, both views on prevalence will be highlighted.

1) To what extent does reliance on a fiscal third party create ethical dilemmas for social workers in private practice?
The findings indicate a moderate but growing level of involvement with third party payors. An average of over 69 percent of cases were covered by third parties, and only 10 respondents were not involved with them for at least a portion of their caseload. The number of practitioners who expect their involvement to increase in the near future was generally indicated through comments and interviews. The extent to which the viability of private practices would be adversely affected if these funds were not available is probably similarly high. Ninety percent of respondents indicated moderate or great reliance on managed care referrals. Yet 58% indicated little or no reliance, and several practitioners reported having the freedom to draw clear parameters around which third parties they would affiliate with, if any. However, the growth of managed mental health care and an increase in the number of social workers eligible to draw down third party funds through the passage of vendorship legislation may increase the trend toward more involvement and reliance. A number of respondents and interviewees acknowledged concerns that the "situation is only going to get worse".

Those social workers who accept only a narrow range of cases in order to insulate themselves from ethical dilemmas confirm the impact of third parties by the extent to which they will go to avoid them. Whether they came to this decision through any struggle or regret is uncertain. Nor can it be determined if
they see having a highly selective practice as an ethical issue or one at odds with the tenets of the social work profession.

The presence of dilemmas (whether or not they are acted upon) is reflected in the answers to the impact questions and scores on the "impact" scale. While the distribution of scores on the scale indicated limited overall impact, the answers to individual questions demonstrated the levels to which respondents were affected by particular dilemmas.

Twenty-five percent of the respondents indicated that to a moderate or great extent, dilemmas were created by acceptance of third party funds. Twenty-nine percent felt pressure to a moderate or great extent to adjust their decisions to maintain HMO or PPO providership. Another 25 percent reported that third parties negatively affected the overall quality of treatment to a moderate or great degree, and 39 percent said that to a moderate or great extent it was a consideration in assigning diagnoses.

Clearly, in a variety of ways and to a variety of degrees, third parties create dilemmas for practitioners. While it is unclear if these are viewed as ethical or clinical in nature, the practice decisions and actions which result can be seen in the next section.
2) How are practice decisions affected by the reimbursement parameters set forth by a fiscal third party?

Much clearer information is available in response to this question. The study supports the connection between payment mechanisms and the domain of treatment as the decisions and actions of practitioners were affected in the following ways:

• **Who to accept for treatment?** Respondents reported that for an average of 2.9 percent of the referrals they refused over the last 12 months, the reason was because they did not carry third party reimbursement. Over 28 percent of the respondents did this in at least one case. Conversely, comments and interviewee input indicated that some clients are refused or required to self-pay *because* of the type of coverage they carry, and the practitioner’s refusal to accept it. Because no questions were asked about this issue, no figures are available on its prevalence. Information was given on the number of cases discontinued over the past year due to third party strictures and the practitioner’s unwillingness to accommodate them. This occurred for an average of 1.75 cases and was done in at least one instance by almost 30 percent of the respondents.

• **How long to provide treatment?** In 9.7 percent of the average caseload, treatment was shortened due to third party restrictions, and 57.2 percent of the respondents indicated having had to do this at least once in the past 12 months.
• **How frequent will treatment sessions be?** Over eight percent of the average caseload has sessions held less frequently than needed in order to extend benefits. Sixty-two percent of the respondents reported having done this in the past 12 months.

• **What diagnoses are assigned?** Less severe or more severe diagnoses were assigned to conform to third parties in an average of 3.7 and 6.1 percent of cases respectively. Eighty seven respondents (57.8 percent) reported not having done either of these actions for their current caseload, while only 38 percent of respondents indicated that they had never done it.

• **What treatment modality is used?** In an average of 3.2 percent of cases the modality was selected to conform to the third party when another was warranted. Over 22 percent of the respondents reported having done this in their current caseload and 54 percent indicated having done it at some point in time. For 39 percent of the respondents, and an average of 5.3 percent of cases, the treatment modality was directly dictated by the payor before services could be provided.

• **What treatment approach is used?** For an average of 3.2 percent of the cases and 31.5 percent of the respondents, the treatment approach to be used is selected to conform to the third party when another is deemed to be more appropriate. Nearly two-thirds of the respondents reported having at least one case in which the third
party must approve the treatment plan before services can be provided. This affected an average of 17.3 percent of cases.

- **What additional services can be provided?** Over eighteen percent of the respondents reported limiting their advocacy efforts or collateral contacts for at least one current case due to the non-reimbursability of such endeavors. This affected an average of 2.59 cases. When asked about levels of quandary with certain actions, over 38 percent of the respondents indicated having their practice affected this way at some time.

Only 23 respondents reported making no accommodations with their current caseload for third parties, and of that, 10 respondents have no third party-paid cases whatsoever. The others clearly vary in the degrees and ways in which they are willing to accommodate third party restrictions. Through respondent and interviewee comments it also became clear that different strategies are devised to limit the effect of the payor on practice decisions. Through fraudulent reporting, for example, practitioners attempt to avoid altering their practice to suit the payor, and instead, continue their activities as usual and report that they have conformed. Requiring clients to pay for some or all services is another method of avoiding third party strictures. This strategy presumes that clients have the desire and wherewithal to do so, and that the practitioner can risk losing them if they do not.
Not all responses are intended to subvert the payment system. Practitioners also make concessions to restrictions in ways which they deem to be tolerable, if not desirable. Such compromise occurs through focusing only on the client’s immediate problems, limiting collateral contacts or advocacy, and stretching out sessions to fit with annual treatment limits. Such an adjustment can also be seen in the adoption of task-centered and cognitive/behavioral approaches by many respondents.

Finally, should the payor or the coverage levels dictate the closing of a case, the last level of response seems to involve keeping the client on a self-pay basis, advocating with the payor for extended coverage or services, or closing the case, perhaps with referral elsewhere.

Despite the sensitive nature of the questions, the likelihood of under-reporting of practice deviations, and wide variability among the factors which can force altered practice decisions and actions, this study’s findings make it clear that altered practice decisions due to third parties are prevalent both in the number of clinicians affected, and in the number of cases affected. In regard to the latter, three mitigating factors should be kept in mind. While no more than 18 percent of the total caseload was reportedly affected by any of the practice deviations, the interpretation of these figures is affected by the following:
- One-third of the average caseload does not utilize third party funds. Therefore, practice deviations would not be necessary for this segment of the caseload.

- There exists a wide range of restrictions among payors. Therefore, those without strict parameters would not necessitate practice deviations.

- The nature of cases is such that some clients’ conditions would not conflict with third party restrictions. For example, family or marital therapy is not the treatment of choice in all cases. Practice deviations to allow this would only be needed if: 1) family or conjoint treatment were indicated; 2) the reimbursement system disallowed it, and 3) the client(s) intended to use their coverage to pay for services. Therefore, while prevalence for cases was calculated based upon the total caseload, these figures are likely to be conservative due to the parameters that affect when such deviations are necessary.

3) How do private practitioners resolve these dilemmas? What rationales, processes, or guides are used to help them arrive at their decisions?

The actions taken in response to restrictions were addressed in the previous question. This section examines the internal and external processes respondents used to determine their actions or to justify having taken them.

Comments and interviews indicate clearly that some respondents avoid or resolve dilemmas by setting distinct limits: on what payment plans they will and
won’t accept, on what types of problems they’ll treat, on the client’s financial obligation, and on the services they’ll provide without remuneration. Others have a more general sense about what actions are acceptable for them to take, and which are not.

Practitioners used a number of guides for decision making, including consulting colleagues (64 percent), considering what others might do (26 percent), consulting third party representatives (46 percent) and discussing it with a consultant or supervisor (24 percent). Unfortunately, the choices offered didn’t include "I did what I thought was right", as that guide was noted repeatedly in comments and interviews. Other explanations or rationales typically centered on the client, and 82 percent of the respondents discussed matters with the client as one of their decision making processes. In comments, even those behaviors which constitute fraud or otherwise violate professional standards were frequently justified as being necessary to obtain services for the client, conducted in the client’s best interest, and usually done with the client’s informed consent. The effect of such collusion between therapist and client against the third party has been addressed in other works (Zuckerman, 1989), as has the concern about fraudulent practices (Kirk & Kutchins, 1988). It is not that practitioners view such actions as correct, but they are considered an expected part of "playing the game"
or otherwise essential to doing business under third party conditions. Finally, some practitioners did note their own stake in the decisions being made.

I have to live too.

I don’t want to work more hours for less money. I’m deciding now what I’ll do. I advise others against private practice now.

Still other practitioners recognized that the requirements put forth by third party payors are not exorbitant, and they used the perceived fairness of these requests to determine their response.

I don’t consciously hang on to clients, but I think that when the caseload is large, I don’t expend the energy to be focused and shorter-term.

Generally, what they want isn’t unreasonable. But, I have 2-3 long term patients who as a result of childhood traumas have real difficulty in movement and change...their experiences take a lot of redoing. I’m concerned about what their payor will do.. a year isn’t even enough time, much less 10 sessions!

Along the same lines, some "made the best of the situation" by maximizing their knowledge and utilizing the third party for assistance. By not taking a passive role, those involved in legislative or regulatory change, collegial support, and professional education appeared to have a more hopeful outlook regarding the impact of payors on their work.

Respondents did not appear to view these decisions from a predominantly "ethics-based" framework. Only 30 percent reported referring to the code of ethics
as a decision making guide and only four statements out of 154 sets of comments addressed the ethics of practice deviations directly. It appears that when confronted with dilemmas, a situational or utilitarian approach was taken in which the practitioner would weigh the factors, risks and responsibilities for any given situation. As a result some activities were reportedly ruled out as unethical, but often actions were taken for pragmatic reasons despite acknowledgment that the behavior violated accepted standards. The preferred course of action seemed to be avoiding such situations wherever possible, through client selection, requiring self-payment, and having established procedures.

Because of the nature of the measures used, the degree of quandary experienced is more difficult to capture. From 26 to 68 percent of the respondents reported never having engaged in certain practices and therefore the "quandary" questions were not applicable to them. Of those who did take action in response to third parties, it is hard to discern what factors led some to feel no quandary and others a great deal for the same item. As previously mentioned, the negative relationship between the quandary items and age, years in private practice, and years in full-time social work points to these as buffering effects against decisional dilemmas. Precisely how maturity and practice experience help diminish quandary is unclear. It may be hypothesized that these factors contribute to a clearer sense of what actions are and are not acceptable. Thus, the individual may act in
response to third party pressures, but have resolved for him- or herself the appropriateness or necessity of such actions.

While the structure of the measure makes quantification difficult, in general it appears that quandary is greater for those actions which impact on the client (such as giving less treatment than needed) and less for those things which impact on the payor (such as counting phone time as reimbursable when it is not). To whatever extent this is true, it may indicate an assumption by the provider that shortchanging the payor is the lesser of two evils (than shortchanging the client). It may also relate to the practitioners’ affinity for a client, with whom they have a direct relationship, versus the more remote, faceless, payor.

Still, it is difficult to account for reasons why 6 percent of the practitioners would have no quandary giving a client less treatment than needed or why over eight percent would have no quandary limiting needed collateral contacts. The “business’ orientation which emerged through some responses is a possible explanation. In interviews and comments, it seemed that those who view their practice of social work as a business, driven by "bottom line" fiscal considerations, seemed less troubled by the complexities brought by third parties.

In what may be seen as a microcosm of larger society, the emergence of a market ethic, in which venture and entrepreneurship in the for-profit sphere is aspired and esteemed, formed the focus of certain practitioners. In a parallel with
other proprietary services, such as for-profit hospitals, some respondents expressed no qualms in serving a select clientele, turning away those who could not pay, or ceasing services when coverage was no longer available. Whatever regret they may have had about these matters was superseded by economic and business considerations.

Another explanation may lie in the indication that this was a highly experienced sample, with substantial time invested in the field of social work, and in private practice specifically. It may therefore be hypothesized that for some of these practitioners, once a dilemma has been personally confronted, and a course of action chosen, quandary about it is eliminated. Further examination into the causal factors relative to quandary is recommended, based upon the impressions reported here.

In sum, it appears that while a range of supports, processes, and rationales are used, the ultimate decisions and the equanimity with which the practitioner can make them, depends on a highly personalized assessment of the situation and the pros and cons attendant to each course of action.

4) **What factors are associated with the occurrence of ethical dilemmas?**

As the first study of its kind, an attempt was made in this research to accumulate data to aid in generating hypotheses for future research. The study was
not designed to capture the range of moderating factors which affect the impact of third parties on practice decisions. As stated earlier, such items would include the nature of the practitioner, clientele characteristics, and the attributes of the third party. The relationship between some of these factors and practice dilemmas emerged through comments and interviews.

Respondents indicated that ambiguity or flexibility in practice standards affects the level of difficulty experienced. Those who could set and maintain clear practice parameters seemed to experience less pressure from third parties and less likelihood to conform. Those whose clients were able to pay out-of-pocket for services instead of using third party funds (or to augment them when they were depleted) also appeared to have less difficulty. It is not known if practitioners reduced their fees when clients converted to self-pay from using their coverage. That procedure has received increasing attention by payors who view such variable rates (and the failure to collect client co-payments) as fraud (Psychotherapy Finances, 1991c).

Practitioners whose caseloads contained people with extensive problems (stemming from childhood trauma or personality disorders for example) seemed to have a more difficult time, as did those who were trying to build their practices in competitive markets or in regions where social workers were not routinely recognized as reimbursable vendors. Managed care organizations in general, and
some specifically, were noted as being time-consuming to deal with and/or highly restrictive. Some practitioners clearly delineated their difficulties as being with these entities and not with other payors.

Developing relationships with payor representatives appeared helpful to some social workers in their decision making on cases, and in their ability to successfully appeal limitations placed by the payor. Some also believed that their clinical acumen was helpful in this regard, in that they were able to use their knowledge and expertise persuasively. Given this, some were reluctant to delegate these responsibilities to clerical or administrative associates.

Of the factors examined in this study, only one appears to be associated with greater ethical dilemmas and altered practice decisions or actions. Practitioners in private practice as a secondary work setting appear to be more prone to intentional misdiagnosis than do those in it as a primary setting, doing so for a mean of 10.2 percent of their cases compared to a mean of 4.4 percent for primary practitioners. This is especially interesting in light of the fact that they see a significantly lower number of third party-paid cases to begin with. Possible explanations for this include that primary practitioners may have more established procedures, a more reliable pool of clientele, have a greater likelihood of getting caught in fraudulent practices and have more at stake if they do get caught. Prior to this research, one might have held that those in it as a secondary setting are less
likely to engage in such acts because they have less reliance on third party clients
and income. But much is still unknown about the nature of the practices and the
conditions leading to the findings reported here. Perhaps those in primary practice
are more restrictive in who they see and thus don't take couples, families, or
people whose diagnoses don't qualify for reimbursement. Such conditions would
then insulate them from the fraudulent practices reported.

Few significant relationships were found between demographic or practice
variables and "impact", modified practices, or levels of quandary. The absence of
clear patterns, aside from those already noted, indicates that overall these
phenomena are rather well dispersed among different categories of practitioners
and practice types.

Further Observations

As discussed in Chapter Two, ample controversy has existed in the field
of social work about the place of private practice and about its fit with the
traditional missions of social work. The findings of this research may give weight
to some of these concerns. Specifically, beliefs that private practitioners
concentrate their work on the "haves" of society, rather than the "have nots", that
they focus on compliance with unfair practices rather than confronting and
changing them, and that their emphasis is closer to the medical model than to the
The person-in-situation focus of social work all get some validation through this research.

The level of fees, the limited amounts of free care offered, the extent to which co-payment was used to supplement or replace third party payments, and comments which indicated a "bottom-line" orientation by many practitioners substantiate concerns that private services are out of the reach of the poor and those who have coverage, but who cannot afford to supplement it with funds out-of-pocket. This affects not only clients who cannot get needed services, but also the service providers in government or non-profit programs to whom they may turn.

So few questionnaire respondents indicated taking action to force change through larger-systems mechanisms, that this question was incorporated into interviews. Interviewees indicated that a sense of powerlessness and the lack of a social action orientation impedes practitioners' abilities to resist the effect of payors through regulatory or other means. This is a departure from the social work orientation of addressing problems on multiple levels for maximum change potential.

Affiliation with third party reimbursement carries with it acceptance of a medical orientation where individuals are insured and the problems for which they are insured are treated on that level. Therefore, by definition, if a family problem
exists, it is not insurable, however great the need is for remediation. The lack of collateral contacts or client advocacy, as well as repeated references to clients as "patients", reinforce the acceptance by these practitioners of the medical orientation over the broader person-in-environment focus.

What these findings mean in terms of the debate within the profession is unclear. Private practitioners may be most directly affected by third parties (in that their practice decision also have direct financial ramifications) but to some extent all social workers providing services under third party payment are subject to the same stresses and dilemmas. Rather than leading to strife within the profession, such findings point to common areas for action, research and education. These are further developed in Chapter Nine.

This study offers substantial insights into the interface between third party payors and the services provided by social workers in private practice. It captures this phenomenon at a particularly important point in time, during the transition from a relatively open, retrospective reimbursement system (in which social workers are recent providers) to a more restrictive, payor-driven system, with substantial practice implications. In many ways, variations in the range and degree of difficulties practitioners experience may be regarded as phases in the acculturation process, as social workers accommodate or resist a system that increasingly affects the way in which they make their livelihood. To what extent
these findings are part of a developmental process for the private practice of social work will become clear as replications and extensions of this work are conducted in the future. The following sections reflect on and assess the this research from the vantage point of its conclusion.

Re-Examination of the Research

This study represented a first effort at directly determining the prevalence and type of service accommodations made by practitioners in response to third party payment restrictions. It appears that no other study has approached this issue directly with either social workers, psychologists or psychiatrists. Reflection on this experience and the methodology employed yields insights for those researching this in the future.

Strengths

The study's strengths result from several features. Because it is the first to directly inquire about the prevalence of ethical dilemmas, practice deviations, and personal quandary it provides a baseline by which future findings can be measured. The response rate of 60 percent is high for this population and this type of research, thus offering credence to the findings.

The use of both quantitative and qualitative methodologies was important as well. It resulted in hard data on prevalence, as well as informative and
explanatory descriptive material. The time allowed in interviews and the space given on the questionnaire encouraged respondents to share extensively their thoughts and feelings about the issues under examination.

The study allowed for measurement of the breadth of the phenomenon. While "dilemma" was used in the initial questions, the structure of the instrument included a range of ways in which practitioners might be presented with, and react to, hard choices between practice and payment. Indeed, the findings resulting from these questions allowed further development of the concept "dilemma". It became clear that the interface between social workers and third parties leads not just to dilemmas, but in some cases, to action. The results and comments in different sections of the questionnaire indicated that these are separate, but related processes. The decision to take these actions or practice deviations, were, in some cases, accompanied by personal quandary, but again, this is distinct from dilemma experienced or actions taken.

Respondents' comments, their willingness to participate in interviews, and the personal notes written to the researcher indicated the urgency of this issue for practitioners and their receptiveness to the methods used to investigate it. While some respondents declined to answer sensitive questions, forthright explanations by the researcher, the guarantee of anonymity, and the avoidance of passing
judgement about these issues seemed to help increase the response rate and the
candor of the subjects.

While other reflections on the research will be addressed later in the chapter, it is also important to consider the study’s drawbacks.

Limitations

The use of the *NASW Clinical Register* as a basis for selection could be seen as a problem, in that clinicians’ listings are voluntary, and thus may not be representative of the total population of social workers in private practice. However, as noted earlier, this was a difficult population to capture, and other methods had drawbacks which outweighed their potential usefulness.

While the use of the register might yield a more affluent sample, and one which is oriented in the direction of private clinical practice, these appear to be typical features of the population under study, and unlikely to misrepresent the population of social workers in private practice. It could be hypothesized that practitioners demonstrating this level of affiliation with their professional organization might have firmer ethical boundaries or clearer professional guidelines, thus skewing the findings to show a lower than actual rate of ethical dilemmas. While this possibility was taken into account in discussion of the findings, the *NASW Clinical Register* is believed to provide the most nearly representative, available sample from which to select subjects.
While the methodology employed was deemed appropriate in light of the issue under study, survey research has its drawbacks. Every effort was made to increase the likelihood of survey returns, including two follow up mailings to non-respondents. Nevertheless, 40 percent of the questionnaires mailed were never returned. Given the information available in the Register it was very difficult to capture any characteristics of non-respondents which might indicate skewing in the results received. For example, non-respondents could be those having less difficulty with third parties or those more frequently engaged in unethical practices.

As a cross-sectional study, this research captures practices only at a certain moment in time. Therefore it is uncertain whether the picture derived from it represents standard, ongoing practices or some temporary anomaly.

Finally, as with any methodology which relies on self-reporting, the danger exists that responses would be biased by attempts at "socially acceptable" answers. The construction of clear, neutral, questions, the guarantee of anonymity, and an adequate explanation of the study's purpose were intended to mitigate against these effects. Those respondents' who supplied written comments indicated candor in their answers. It could be assumed though, due to the sensitive and potentially censurable nature of the information being sought, that the study's findings underestimate the existence of the phenomena. For example, respondents
evidencing low levels of difficulty with third parties would report otherwise as
they conversed in interviews.

Regardless of how or if I'm being paid, that's not what I'm in
business for. I won't get rich, but these things have no effect on
my efforts. On the other hand, I haven't had anyone tell me to stop
seeing a client. I was always able to work it out with the client. I
try to keep payment and services separate. "Third parties in
general are ok as long as they pay. Managed care is the thorn.
Unless managed care makes me earn less, it wouldn't affect my
choice to be in private practice. What would is emotional burnout,
through time burnout is a problem too. I worked at home 4 hours
yesterday (Sun.) on "justification for treatment" forms.
Interestingly, the one payor who demands the most pays the least.

In addition to the strengths and weaknesses discussed here, several
methodological and conceptual items deserve note for those considering future
research on this topic.

The methodology used, the structure and presentation of the questionnaire
and the combination of personal interviews and survey research all proved suitable
for the task at hand. Among the questions which should be more carefully worded
in the future is that on group fees (Appendix 1, Question A-7). It should be made
explicit that this refers to the fee for an individual receiving group therapy, not the
group itself. The set of questions on the practice effects of the third party over the
past year (Appendix 1, Questions B-33 - B-36) should be made more explicit to
draw the respondent's attention to changes in the unit of measurement (from precise counts to percentages).

Other areas lend themselves to expansion or greater precision in ensuing studies. For instance, the original research questions were broadly framed to allow for the exploratory purpose of the research. But as the findings were developed, other concepts emerged which better defined the issues related to the problem and other areas emerged for specification. As noted earlier, "dilemma" was further specified as "impact", "action" and "quandary". These constructs more clearly reflect the range of issues emerging when practice and payment mechanisms intersect.

As another example, no consideration was given in this study to the structural features of one's practice or other variables which might insulate a practitioner from difficulties. Neither was there a distinction among forms of third party payment and their varying levels and types of restrictions. An understanding of how these affect prevalence of difficulties would be useful in replications of this study. Clearly, the original concept of "reliance" on third party payment was not sufficient to explain the dilemmas experienced, though this relationship might be specifically tested in future research.

While length and complexity are persistent considerations in survey construction, several additional questions might have been useful to expand upon
those already included. For instance, information on the nature and severity of clients’ problems could be compared to the concerns that private practitioners see a less impaired population, and that third parties contribute to this tendency.

Another question might inquire about the use and costs of "sign-offs" by other professionals for social workers in states without direct reimbursement. In these mechanisms, utilization of third party funds carries additional costs for the provider, and may have some effect on the degree of difficulty experienced.

Open-ended or check-off questions could be used to discern the conditions surrounding fee reductions, and the amount of reductions allowed under specific circumstances. A specific question could be asked about personal policies in regard to pro bono services.

The questions on theoretical orientation (Appendix 1, Question A-18 and A-19) could be more precisely stated to reveal the frequency with which practitioners actually use certain theories relative to others. However, this area lends itself to nebulous responses if practitioners are not clear in their command of theory or strong in their awareness of its use.

The study focused on the practitioner’s responses to third parties. An avenue for examination through the practitioners might be the perceived effect of restrictions on clients. Of course, a study examining the direct effects on clients would also be of use. It appeared from the comments that some clients were
undisturbed by third party strictures, while others experienced emotional complications, and still others paid for services directly to avoid the payor altogether. This data would be an interesting complement to that from the practitioners.

In terms of structure, the strengths and weaknesses of category partition scales should be noted. While those used to measure impact and quandary items helped to show relative levels of difficulty associated with particular situations, they were difficult to interpret further, and they provided little insight into the reasons why certain ranks were given. Utilizing open-ended questions with them helped flesh this information out, but due to their drawbacks, future researchers might convert this content into more precise and more easily interpretable questions. If such scales continue to be used, the number or choices for scores could be expanded or given more precise or distinct headings. This, too, would make them more useful.

There was no intent at the outset of this research to construct a measurement scale. That the "impact" scale resulted from four highly correlated items was happenstance. This, then, is an area for future testing and development.

As noted earlier, the issue of quandary remains difficult to assess. An examination into the reasons why individuals do or do not experience quandary when making unethical or illegal decisions are personal and complex. Accuracy
in this area requires honesty and self-awareness on the part of the respondent. As such, an understanding of quandary is difficult to achieve from a pencil and paper survey. Should one want to pursue this line of inquiry, personal and in depth interviews would be recommended, with the aforementioned caveats in mind.

The use of ethics as the theoretical framework for this study must also be revisited. To its advantage, it allowed for broad definition of the concept of ethical dilemmas, and the research which exists related to this topic can be found in the area of ethics and ethical decision making. It is also adequate for capturing the central notion of this study about choices made among competing values or competing goods. Yet ethics also carries with it a moral component, by which some choices are designated good or bad, ethical or unethical. The veracity of subjects’ responses might be affected if the moral tone of this framework is conveyed to them. The issue of right and wrong might also obscure the focus on how choices are made between competing goods, and what processes are employed to come to decisions or actions. A pure decision making model, such as that put forth by Jaris and Mann (1977) might be more useful in this regard. Such a model would be applicable to the types of decisions and considerations under study here, but would not carry the moral inferences of ethical decision making.
In sum, the questions posed for this study and the research conducted offer a foundation for understanding the prevalence of dilemmas, actions and quandaries for practitioners. The findings supply a baseline for assessing changes in the phenomenon over time. The research lends itself to a range of possibilities for future inquiry and knowledge development. And finally, it offers opportunities for response and remediation on issues raised. These items will be addressed in the concluding chapter.
Chapter Nine

Implications

The issue of the interface between third party payors and social work service providers is related to a range of other issues. In as much as this research has advanced the knowledge about this phenomena, so too does it hold implications for a range of other areas. These include expanded research, social work education, social policy and activities of the profession itself.

Research

As is often the case in exploratory research, the findings generated here lend themselves as the basis for future research. It is recommended that future inquiries focus on the following questions:

• Are there any differences in the experiences of social workers as compared with other helping professions?

• Do social workers who only see clients from a certain level of 'wellness' or economic class experience any dissonance with their professional training?

• What might account for observed differences between practitioners working privately as their primary or secondary setting? Are there characteristics of these individuals or their level of engagement in practice which are associated with their
willingness to accommodate or resist the third party? Are these findings replicated over time or through other inquiries?

- To what degree are the difficulties experienced related to any particular form of third party financing? What features are particularly difficult to accommodate? Can these be changed or avoided as cost containment models develop?

- Would educational programs, supervision, or consultation ease the degree of difficulty experienced by practitioners? What might be models for such efforts?

- What individual value bases or decision making frameworks might account for differences in ability to accommodate third party restrictions?

- How does the changing reimbursement system affect practitioners’ feelings about independent practice? Is there evidence of a return to agency practice as a result of competition and restricted reimbursement?

- What is the efficacy of various reimbursement mechanisms? For whom are they most helpful? What alternatives might exist for those whose needs are not well met?

This study’s implications are not limited, however, to the field of future research. As noted at the outset, educational, policy, and professional ramifications abound.
Education

These findings are replete with educational implications, not only for practitioners but for those who aspire to independent practice.

In the area of continuing professional education, it appears a need exists for information about third party payment mechanisms, their advantages and drawbacks for mental health providers, and the responsibilities and challenges which accompany involvement with such systems. Such information would be useful for those who are contemplating a career move into autonomous practice, and practitioners in areas where the infusion of third parties is not yet substantial.

For those who choose to affiliate with managed care entities, training in brief treatment models, the indications and contraindications will be essential. While respondents reflected a broader array of theoretical orientations than they received in their original training, it is hoped that the new knowledge was obtained through relevant, comprehensive courses of study and not picked up in a piecemeal fashion. Admonitions about "quick fix" approaches to continuing education have already been advanced (Edwards & Green, 1983; Davenport, 1992; CSWE 1991b), and it seems particularly necessary for independent practitioners to have a strong grasp of new techniques and an understanding of their appropriate use, especially if they are to debate their use with a payor or utilization reviewer.
Other guidance is needed about ethical and legal sanctions which can arise as a result of involvement with third party mechanisms. The legal and ethical breeches discovered here need attention through education and consultation, but they represent only part of the issue. A range of federal and state legislation affects the parameters in which clinicians and third parties can operate. Additionally, common law, especially that related to liability, holds consequences for the practitioner. For example, recent court cases have addressed the balance of liability between payors and providers should negative circumstances result from shortened treatment. However the actions of the provider in protesting the limitations and/or advocating otherwise appears central to the decision on where culpability rests (Newman & Bricklin, 1991). Practitioners should be equipped with the most current information available, in order to foresee and prevent potential difficulties, and to appropriately respond to them if they do arise.

While it is still unclear how much advocacy clinicians engage in with third parties on behalf of their clients, or what factors inhibit their use of this technique, this, too, is an area for future training. At least one respondent hypothesized that those in direct practice, due to the focus of their work and training, are less familiar with the techniques and purposes of advocacy, and less comfortable with its use. Because such content lends itself well to brief, intensive educational programs, it might be particularly feasible for private practitioners to get such
training. Even for those concerned with the allocation of non-billable hours, this would appear to be time particularly well spent.

Policy

Advocacy on individual cases is not the only area of activism required. Clearly social action is needed on a variety of fronts. This includes reassessing the system of mental health financing in America, shaping the future development of cost containment measures, and addressing the needs of those poorly served or unserved by existing delivery mechanisms.

Activism and change in this area will not be easy. Each situation exists due to a complex course of events, tied in part to our overall national economic disrepair. Yet an understanding of the repercussions of the current reimbursement system should help in avoiding the same as national health care proposals are developed. Likewise, more immediate, practical gains may be made in supporting the regulation of managed care, in assuring that reimbursement systems do not foster conflicts of interest for providers or contain financial incentives for providing inappropriate levels of care, and by assuring that those reviewing service utilization are qualified peers of those whose work they are scrutinizing.

Although it may be more in the realm of professional concerns than policy, attention must extend to providers as well as payors. At the same time as social
workers strive for recognition in vendorship legislation and in reimbursement rates approaching those of other mental health professionals, professional and regulatory policies must be implemented and enforced which hold them to high standards of conduct and ensure the quality of services provided. The amount of variability found in practices, in the interpretation of one’s responsibility to clients and payors, and the limited availability of free care from private practitioners are all areas for investigation and action.

Consequences for the Profession

Social workers, acting both individually and collectively can address many of the issues raised in this study. Formal organizations of social workers, such NASW and the Federation of Societies of Clinical Social Workers, have particular potential to take action on a number of fronts. Implications which lend themselves to action within the profession of social work involve research, quality assurance, guidance in decision making and mutual assistance.

The private practice of social work, by its very nature, fosters isolationism. Even those working in group practices may not have the time for collegiality or the opportunities for consultation. The social work profession’s tradition of ambivalence toward private practice exacerbates this problem, as does the nature of the issues entertained in this study. Because reimbursement demands and
treatment decisions involve issues of professional competence, ethical behavior, business acumen, financial well-being, professional image and reputation, they may receive less attention and dialogue. Whatever the reasons, the passion with which many social workers responded to the questionnaire indicates a unfilled and growing need for guidance, information, mutual assistance, and personal consultation on these issues. Despite the recognition given to NASW by some respondents, other professions are well ahead in their efforts to understand these problems, inform their members about them, and respond to encroachments on practice through lawsuits and legislative strategies (Psychotherapy Finances, 1991b; Goleman, 1991).

The breadth of the profession’s code of ethics, and its apparent disuse by many practitioners speaks to the need for relevant documents which can guide the actions and choices of private practitioners, especially in regard to the very real pressures of the marketplace. The NASW Guidelines on the Private Practice of Clinical Social Work (NASW, 1991) put forth very explicit instructions for practitioners to follow in situations such as those discussed in this study. Yet members are charged a fee to receive these published standards, and it is unclear how widely the document is disseminated and used.

The peer review of CHAMPUS cases (Jackson, 1987) may provide a viable model for improving and broadening quality assurance within the profession, and
for promoting the use of social workers as payor-affiliated utilization reviewers. Yet, as Jackson noted, there may be "recurrent difficulties" among clinical social workers (p. 217) in their preparation to participate in such a system. Competence in conducting mental-status exams, in diagnostic thinking, in treatment planning and clarification of goals, in precise and clear writing and awareness of current trends in psychotherapy likely remain areas of need. This speaks once again to revisions in MSW curriculum content (Strom & Gingerich, in press) and areas for post-graduate education.

Finally, as funders seek alternatives to inpatient and long-term outpatient care, the door is opened for the development of cost-effective alternatives (Brookowski, 1991; Psychotherapy Finances, 1992). Particularly appealing are services offered in the recipient’s own environment, for example home or school. While this may force a shift in orientation for office-bound private practitioners, it does offer alternatives for the profession of social work to explore and develop. Cost containment is a pressing incentive for social workers to assume the lead in research on practice innovations and in the development of effective treatment models.

The relentless constrictions in health care financing and the dilemmas they cause for private practitioners need not be viewed in a wholly negative light. Many social workers are providing quality services, at reasonable rates, and are
endeavoring to do the best they can by their clients whatever their personal or financial circumstances. Times of upheaval are also opportunities for change and creativity, and while the complexities presented by third party payors are irrefutable, the means available to address them are varied and close at hand.


Appendix I

PRIVATE PRACTITIONERS AND FISCAL THIRD PARTIES STUDY

Please answer all questions as thoroughly and accurately as you can. All replies to this questionnaire will remain anonymous and your input will be most helpful in expanding our understanding of this important and growing issue. For further information, contact Kim Strom, Mandel School of Applied Social Sciences, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio 44106-7164; 216/368-2333 (days); 216/397-9119 (evenings).

Directions: Please put the number corresponding to your answer in the space along the left hand side.

Do you spend at least five hours per week in private practice? (Private practice is defined as "autonomous, for-profit social work practice that provides individual, conjoint, family or group assessments, counseling or psychotherapy.")

_____ 1. No  2. Yes

If your answer is Yes, go to question A-1. If your answer is No, please discuss the reasons behind your choice not to enter private practice.

You do not need to proceed further. Return this questionnaire in the envelope provided. Thank you!

SECTION A - PRACTICE INFORMATION

A-1. _____ What are the first three digits of your zip code?

A-2. _____ In what type of community is your private practice located?


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A-3. _____ Is your private practice a primary or secondary work setting? ("Primary" is defined as either your only work setting, or the setting in which you spend the majority of your work hours. "Secondary" is defined as the setting where you spend a lesser percentage of your work time.)

1. Primary 2. Secondary

A-4. If you answered PRIMARY to #3, what percentage of your work time is devoted to the following tasks: (Total should equal 100%)

1. _____ % Counseling or psychotherapy
2. _____ % Case consultation*
3. _____ % Consultation to/supervision of other professionals
4. _____ % Administration
5. _____ % Teaching
6. _____ % Conducting workshops
7. _____ % Voluntary public service
8. _____ % Other ____________________

*Case consultation refers to work in which you have direct contact with a client. You function as a consultant rather than a primary therapist, and may provide a written report at the request of another provider.

A-5. _____ How many years have you been in private practice, either as a primary or secondary work setting.

A-6. _____ What is the average number of hours per week you work in private practice (both billable and non-billable time)?

A-7. _____ What are your customary fees?

1. $_____ Individual psychotherapy (50 minutes)
2. $_____ Couples therapy (50 minutes)
3. $_____ Family therapy (50 minutes)
4. $_____ Group therapy (1-1/2 hours)
5. $_____ Diagnostic evaluation (50 minutes)
6. $_____ Case Consultation* (50 minutes or more)

*Case consultation refers to work in which you have direct contact with a client. You function as a consultant rather than a primary therapist, and may provide a written report at the request of another provider.
This section (A-8 thru A-18) relates to your current total caseload; please answer all questions. If necessary, refer to your appointment book or files. However, an estimate is preferable to an unanswered question.

A-8. _____ How many cases make up your current caseload? (Count each member of a group as one case. Count couples and families (if the members are primarily seen together) as one case.)

A-9. How many cases receive differential payment rates via the following mechanisms?

1. _____ Full Rate
2. _____ Rate determined by a uniform sliding fee scale
3. _____ Rate reduced on case by case basis
4. _____ Pre-negotiated rates under certain contract or payment system
5. _____ Free treatment
6. _____ Barter arrangement
7. _____ Other ____________________________

A-10. Of your current caseload, how many individuals are:

1. _____ male
2. _____ female

A-11. Of your current caseload, how many individuals are:

1. _____ below age 6
2. _____ 6-12
3. _____ 13-18
4. _____ 19-39
5. _____ 40-65
6. _____ above age 65
A-12. Of your current active caseload, how many individuals are:

1._____ professional (i.e. accountants, attorneys, librarians, physicians, school administrators)
2._____ semi-professional and technicians (i.e. computer specialists, public school teachers, personnel specialists)
3._____ clerical (i.e. bank tellers, cashiers, mail carriers)
4._____ managers (i.e. farmers, small business owners, foreman)
5._____ craftspersons (i.e. artists, bookbinders)
6._____ unskilled laborers (i.e. stock handlers, warehouse workers)
7._____ not currently in labor force by choice (i.e. Women who are currently staying at home, retirees. Do not include children in this category)
8._____ students
9._____ unemployed (not fitting category 7 or 8)

A-13 Of your current caseload, how many individuals are:

1._____ Caucasian 4._____ Hispanic-American
2._____ Asian/Pacific Islander 5._____ American Indian
3._____ African-American 6._____ Other

A-14._____ How many cases require prior approval of treatment plans by a third party before payment for services is approved?

A-15._____ For how many cases does a third party payer determine the specific treatment modality before services are provided?
A-16. How many cases use the following types of funding sources to pay for services they receive from you? (Please choose only one funding source for each client in your caseload. If a family or couple is treated, include all individuals in the unit under the appropriate funding source. Choose the most appropriate funding source, even if co-payments are made by the client.)

1. _____ Managed Care Plan (HMO or PPO)
2. _____ Civilian Health and Medical Program of the Uniformed Health Services (CHAMPUS)
3. _____ Commercial Health Insurance
4. _____ Federal Employee Health Benefits
5. _____ Medicare (even though it may be administered by a private insurance company)
6. _____ Medicaid (even though it may be administered by a private insurance company)
7. _____ Payment by voucher or contract (e.g. from federal, state or local social service agency)
8. _____ Out of pocket funds exclusively
9. _____ Barter (exchange for other services or goods)
10. _____ No sources are used and nothing is paid out-of-pocket for services (free care).

A-17. _____ How many of your current cases have chosen to pay you out-of-pocket to avoid the strictures or repercussions of using third party funds?

A-18. Which of the following approaches do you currently utilize in your private practice? (check all that apply)

1. [ ] Psychodynamic/Psychoanalytic  6. [ ] Ecological
2. [ ] Ego psychology  7. [ ] Behavioral
3. [ ] Humanistic  8. [ ] Cognitive/behavioral
4. [ ] Gestalt  9. [ ] Task-centered
5. [ ] Systemic  10. [ ] Other (please specify) __________
A-19. In which of the following approaches were you originally trained? (check all that apply)

1. ☐ Psychodynamic/Psychoanalytic  6. ☐ Ecological
2. ☐ Ego psychology 7. ☐ Behavioral
5. ☐ Systemic 10. ☐ Other (please specify) ____________

SECTION B - THE EFFECT OF THE THIRD PARTY

Directions: Please use the scale below to indicate your experiences, Note: "Third party payors" refers to insurance companies, or managed care firms, such as HMOs or PPOs who pay you for all or part of your services to clients.

<table>
<thead>
<tr>
<th></th>
<th>1 - None</th>
<th>2 - Very little</th>
<th>3 - Somewhat</th>
<th>4 - Moderate</th>
<th>5 - Great</th>
<th>6 - Not applicable</th>
</tr>
</thead>
</table>

B-20.____ To what extent does the acceptance of third party funds create dilemmas for you when making case decisions?

B-21.____ To what extent do you feel pressure to adjust your treatment decisions in order to maintain providership under PPO or HMO contracts?

B-22.____ To what extent do you depend on referrals from managed care to maintain your caseload?

B-23.____ To what extent has the presence of third party payors in a case had a negative impact on the development of a treatment relationship?

B-24.____ To what extent do you feel the involvement of the third party negatively affects the overall quality of treatment you can provide?

B-25.____ To what extent are the guidelines for third party reimbursement a consideration in your choice of diagnoses?

Please comment on any of the above situations.
This section (B-26 thru B-32) relates to your current total caseload as reported in question A-8. Please answer all questions. If necessary, refer to your appointment book of files. However, an estimate is preferable to an unanswered question.

B-26._____ How many cases were given more severe diagnoses than necessary in order to conform with reimbursement guidelines?

B-27._____ How many cases were given less severe diagnoses than necessary in order to conform with reimbursement guidelines?

B-28._____ How many cases were given less severe diagnosis than necessary to protect the client from stigma or other ramifications?

B-29._____ In how many cases was individual treatment reported in order to conform with reimbursement guidelines (when other treatment, such as conjoint or family) was provided?

B-30._____ In how many cases was the modality of treatment selected in order to conform with reimbursement guidelines, when another form of treatment was warranted (for example, providing individual treatment, when marital counseling might have been more appropriate)?

B-31._____ In how many cases did you select the treatment approach in order to conform with reimbursement guidelines, when you considered another form of treatment more appropriate (for example, providing brief or task-oriented treatment, when your knowledge or experience suggested another choice)?

B-32._____ In how many current cases are you doing fewer collateral contacts or less client advocacy than you normally would because these tasks are not reimbursable?

Please comment on the above situations:
The next four questions refer to your experiences over the last 12 months.

B-33. Of the referrals you have received within the last 12 months, what percent did you turn down because they did not carry third-party reimbursement?

B-34. Over the past 12 months, how many cases did not receive or continue service from you because you did not want to conform to the reimbursement guidelines of their third party?

B-35. In the total number of cases you have closed in the last 12 months, in what percent was the length of treatment shortened to conform to reimbursement guidelines?

B-36. In what percent of cases over the last 12 months were treatment sessions held less frequently than needed so that third party funds would last the calendar year?

B-37. What procedure(s) have you used when faced with conflicts between reimbursement guidelines and treatment decisions? (check all that apply)

1) □ I consulted colleagues
2) □ I considered what other private practitioners might do
3) □ I discussed it with a supervisor or consultant
4) □ I referred to a professional code of ethics
5) □ I referred to a contract with the third party
6) □ I discussed it with the client
7) □ I referred to a written policy for my practice
8) □ I consulted with a representative of the third party
9) □ I referred the case to another agency/therapist in order to avoid conflict
10) □ Other (please specify) ____________________________________________

Please comment on any of the above situations:
The following are situations which practitioners might experience when working with third party payors. In such instances, practitioners may make decisions for pragmatic reasons, yet still feel discomfort or difficulty in the process. Please use the scale below to indicate your level of quandary when making decisions such as these in your own practice. If you never make that type of decision; refer to number 6, "not applicable".

<table>
<thead>
<tr>
<th>1 - No Quandary</th>
<th>2 - Very little Quandary</th>
<th>3 - Somewhat</th>
<th>4 - Moderate Quandary</th>
<th>5 - Great Quandary</th>
<th>6 - Not applicable</th>
</tr>
</thead>
</table>

B-38._____ Giving a more severe diagnosis than warranted in order to qualify for reimbursement.

B-39._____ Selecting the modality of treatment to qualify for reimbursement, when another type would have been more appropriate.

B-40._____ Reporting individual treatment to the payor when another type (such as family or conjoint) was actually provided.

B-41._____ Giving less treatment than the client needed in order to conform to reimbursement guidelines.

B-42._____ Counting collateral contacts/phone time as reimbursable time, when it would not ordinarily be acceptable for reimbursement.

B-43._____ Limiting the number of collateral contacts, or the amount of advocacy, because they are not reimbursable activities.

B-44. Please comment on your experiences in any of the above situations:

SECTION C - DEMOGRAPHIC INFORMATION

C-45. 19_____ What is your year of birth?

C-46._____ What is your gender?

1. Male
2. Female
C-47. _____ What is your racial/ethnic background?
1. Caucasian 4. Hispanic American
2. Asian/Pacific Islander 5. American Indian
3. African American 6. Other (Specify): ______________________

C-48. _____ In what year did you receive your Master's degree in social work?

C-49. _____ Since receiving your Master's degree, how many years have you worked full-time (or its equivalent) in the field of social work?

C-50. _____ How many wage earners contribute to your family's income? (Count yourself as one.)

C-51. _____ What was your family's total annual income for 1991 (include income from all sources, e.g., rental income, investments, child support and alimony, etc.)?
1. Less than $25,000 5. $80,000 - $99,999
2. $25,000 - $39,999 6. $100,000 - $119,999
3. $40,000 - $59,999 7. $120,000 - $139,000
4. $60,000 - $79,999 8. over $139,000

C-52. _____ What percent of this income is derived from your private practice?

C-53. _____ To what extent does your household depend upon your private practice income?
1. Essential
2. Important, but not essential
3. Helpful, but not important
4. Negligible contribution

Thank you for your time and effort in completing this questionnaire! Please return it in the enclosed envelope or to the address on page 1.
Appendix II

Interview Questions

[Each set of questions represents a general area of inquiry. The interviews were structured to allow follow-up inquiry based on the subject's response to any given question.]

1. It appeared from your questionnaire that you had a relatively high (moderate, low) level of difficulty in dealing with third party payors. Do you think this impression is accurate? What factors, skills or attributes do you think might account for this? How did you become knowledgeable about third party payment and how to deal with it in practice?

2. Are there any ways in which you feel your work as a clinician is compromised (or in danger of being compromised) by third party restrictions?

3. How do you handle this personally? What helps guide you in your decision making? What would help? Do you view it as an ethical issue?

4. What concerns do you have about your involvement in private practice, given the existence of third parties? Do you feel its more or less viable? Do you regret the decision to do PP?

5. Do you feel you could effect any change in the reimbursement system? What affects your interest in or ability to do this? Do you discuss these issues with your peers?

6. In closing, are there any statements or questions you would like to raise on this issue? What advice would you have for someone struggling with these issues?
Follow-Up Questions, Questionnaire Pre-test

(Questions were answered in writing, by phone, and/or in person).

1. How long did it take you to complete the questionnaire?

2. Were there any questions you found confusing? Please list the question numbers.

3. Were there any questions you were reluctant to answer? Please discuss why and list the numbers.
   Could you suggest any changes to make them more acceptable, or would you suggest their deletion?

4. On questions asking for the number of clients (for example, in a certain income bracket) would you have preferred to give percentages instead? Which do you feel would have produced more accurate results?

5. What are your general thoughts and feelings about the survey and its contents?

6. Are there any questions which you feel are unlikely to be answered honestly? Please identify the questions, discuss, and suggest any changes.

7. Are there questions you would suggest for the questionnaire which were not included?

8. As a private practitioner, would you find this study useful? How? What other information would you like to know or obtain through future studies?

9. Did the way the questions were asked give a complete, accurate, picture of your practice?

10. Did the questionnaire or the phrasing of questions lead to any biases in responses?

Thank you for your assistance and feedback!!
HELP!
I am a doctoral student in need of your assistance for my dissertation research!

For some time I have been interested in the development of private practice in our field, and I am now doing my dissertation research on what I feel is a compelling issue facing private practitioners—the affiliation with third party payors such as insurance companies, government programs and managed care plans.

You have been selected as part of a national random sample from the NASW Register of Clinical Social Workers. I am asking your assistance in completing the enclosed questionnaire. The information you (and other practitioners nationwide) supply will serve two purposes. It will provide information on the current status of private practice today, and it will supply much needed information about the effect of third party payors on practice decisions.

All responses to this study will remain anonymous. The code number on each questionnaire will be used only for follow up with those who don’t respond after the initial mailing. Once the time for responses has elapsed, lists linking code numbers and respondents will be destroyed.

The survey should take about 30 minutes to complete. Those who have already completed the questionnaire reported that the time spent was helpful to them in personally examining the current state of their practice. Additionally, there is growing concern nationwide about the role of third parties in the provision of social work services. This is an important issue, and one which will achieve more prominence as health care costs increase, and further measures are taken to contain them. Your time and candor in sharing your experiences is vital.
Directions for answering the questions are contained in the survey. When it is completed, simply return it to me in the enclosed stamped envelope. Please feel free to call me at the following numbers should you have questions, need further information, or desire a copy of the final results: (216) 397-9119 (H), (216) 368-2333 (W). Again, my thanks for your assistance.

Sincerely,

Kim Strom  
Ph.D. Candidate, Mandel School of  
Applied Social Sciences  
Case Western Reserve University
Appendix V
Informed Consent Statement for Telephone Interviews

You have been chosen at random for a personal interview as a follow-up to the questionnaire you completed on your experiences with third party payors. You are being contacted by phone to assure your anonymity, and to protect you from identification by the researcher. At the conclusion of this study, the records from this conversation will be destroyed, further preventing you from identification. Your involvement in this interview is strictly voluntary, and your choice to participate holds no negative or positive consequences. Should you decide to participate, you are still free to decline answering questions with which you may feel uncomfortable.

Please take down my name and phone numbers, so that you can contact me, should you have any questions or need further information in the future. (Kim Strom 2556 Warrensville Center Road, University Heights, OH, 44118; (216) 397-9119 (home); (216) 368-2333 (work).)

Given this information and your understanding about the purpose and focus of the study, will you proceed with the interview?

(If yes, begin questions. If no, thank them for their time)
Appendix VI

Construction Procedures - Impact Scale

Item-item and item total correlations were conducted to assess the relationship among items and the degree to which each contributed to the total score on the scale. Cronbach’s Alpha was calculated to estimate the reliability of the total scale. These findings are displayed below.

### Item-Item and Item-Total Correlations for the Impact Scale

\( n = 122 \)

<table>
<thead>
<tr>
<th>ITEM - ITEM</th>
<th>B20</th>
<th>B21</th>
<th>B22</th>
<th>B23</th>
<th>B24</th>
<th>B25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B20 (Dilemma)</td>
<td>1.009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B21 (Pressure)</td>
<td>.5658</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B22 (Dependency)</td>
<td>.3195</td>
<td>.3885</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>B23 (Neg relat.)</td>
<td>.5284</td>
<td>.5602</td>
<td>.1742</td>
<td>1.000</td>
<td></td>
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<tr>
<td>B24 (Quality)</td>
<td>1.000</td>
<td>.5658</td>
<td>.3195</td>
<td>.5284</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>B25 (Diagnosis)</td>
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<td>.3429</td>
<td>.0934</td>
<td>.1574</td>
<td>.3126</td>
<td>1.000</td>
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</tbody>
</table>
ITEM - TOTAL

r=

B20 (Dilemma) .7865
B21 (Pressure) .6852
B22 (Dependency) .3405
B23 (Neg. relat.) .5344
B24 (Quality) .7865
B25 (Diagnosis) .3182

CRONBACH’S ALPHA .81

As a result of these analyses, two of the questions, B22 and B25, were deleted from the scale, and the item-item, item-total and Cronbach’s alpha statistics determined again. These figures are indicated below. The resulting coefficient Alpha of .8657 indicates a highly reliable scale.
Item-Item and Item-Total Correlations
Impact Scale with Weaker Items Removed
n = 124

ITEM - ITEM

<table>
<thead>
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</table>

ITEM - TOTAL

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<th></th>
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<td>B21 (Pressure)</td>
<td>.6305</td>
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<td></td>
<td></td>
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<tr>
<td>B23 (Neg. Relat.)</td>
<td>.5974</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B24 (Quality)</td>
<td>.8295</td>
<td></td>
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</table>

CRONBACH’S ALPHA .87

The "construct validity" of a scale is comprised of both discriminant and convergent validity. As such, the scale must correlate poorly with those variables believed a priori to be unrelated to the concept being measured, and well
correlated to items associated with the construct being measured. As shown below, the desired discriminant validity was indicated. Variables such as community type, age, gender and income were only weakly associated with impact. Correlations between impact and the related issues of "quandary", and practice ramifications are also indicated below. Those areas of correlation provide some evidence of convergent validity. Because they are intended only to measure related but not identical concepts, their use for convergent validity is somewhat circumscribed. Further testing and use of the scale is necessary before the findings reported here can be used without caveat.

Correlation of "Impact" with Demographic Variables

<table>
<thead>
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<th>Variable</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Gender</td>
<td>-.0423</td>
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<tr>
<td>Community type</td>
<td>.0478</td>
</tr>
<tr>
<td>Income</td>
<td>-.0326</td>
</tr>
</tbody>
</table>
Correlation of "Impact" with Practice Effects and Level of Quandary

\[ r = \]

Gave more severe diagnosis than needed \[ .0609 \]
Reported 1:1 when marital/family provided \[ .2168^* \]
Selected treatment approach to conform \[ .2955^{***} \]
Selected modality to conform (eg. individual instead of marital) \[ .1832^* \]
Doing less advocacy/collateral \[ .4054^{***} \]
Percent of cases shortened treatment to conform \[ .2797^{***} \]
Quandary-counting collateral contacts as reimbursable when they are not \[ .0613 \]
Quandary-selecting modality to qualify for reimbursement \[ .2260^* \]
Quandary-reporting 1:1 when marital/family provided \[ .2143^* \]
Quandary-giving less treatment than needed \[ .2798^* \]
Quandary-giving more severe diagnosis than needed \[ .2797^{**} \]
Quandary-limiting collateral/advocacy \[ .2415 \]

\[ ^* = (p < .05) \]
\[ ^{**} = (p \leq .01) \]
\[ ^{***} = (p \leq .001) \]