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Clinical social workers’ involvement in and adoption of managed mental health care technology

Angelotta, John Walton, Ph.D.
Case Western Reserve University, 1994

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CLINICAL SOCIAL WORKERS' INVOLVEMENT IN AND ADOPTION OF MANAGED MENTAL HEALTH CARE TECHNOLOGY

by

JOHN WALTON ANGELOTTA

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

Thesis Advisor: Dr. Richard L. Edwards

Mandel School of Applied Social Sciences
CASE WESTERN RESERVE UNIVERSITY
May, 1994
CASE WESTERN RESERVE UNIVERSITY

GRADUATE STUDIES

We hereby approve the thesis of

JOHN W. ANGELOTTA

candidate for the Ph.D. in Social Welfare degree."

(signed) (chair)

Claudia J. Coulh

Vallay Bingham

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CLINICAL SOCIAL WORKERS’ INVolvEMENT IN AND OF ADOPtION OF
MANAGED MENTAL HEALTH CARE TECHNOLOGY

Abstract

by

John Walton Angelotta

Contemporary clinical social work practice has been in the process of being radically altered by the proliferation of what has become known as managed mental health care technology (MMHC). To date there is not an empirical basis for determining the extent to which clinical social workers have been involved with or have adopted MMHC. The present study investigated the degree to which clinical social workers have adopted MMHC, and attempted to identify reasons why that technology has been accepted or rejected. Adoption patterns were conceptualized in terms of Rogers' (1962; 1971; 1976; 1986) Diffusion of Innovations theory. Thus, the major question of this study was: Does clinical social workers' perceived involvement with ("adoption of") MMHC have a differential relationship with the diffusion of innovations adoption characteristics"perceived relative advantage", "perceived compatibility", and "perceived complexity"?

To assess adoption of MMHC, this research asked subjects to respond to a mailed survey. Participants were selected randomly from the 1990 Register of Clinical Social Workers. Subjects selected the degree to which they perceived themselves to be involved with MMHC. Their responses served to place them in one of four groups ranging from not involved to very involved. A one-way analysis of variance (with four
levels of the variable, "involvement") was performed for each of the three measures of the perceived adoption characteristics.

Forty-four percent (N = 950) of the total sample (N = 2139) returned usable questionnaires. Slightly more than 80% (N = 763) of the sample had some degree of involvement in MMHC. Eighteen percent (N = 169) of the sample indicated that they were very involved with MMHC. Likewise, 18% (N = 169) of the respondents indicated that they were not at all involved with MMHC. The results of the ANOVAs affirmed each of the hypotheses advanced. As expected, the perceived diffusion of innovations characteristics "relative advantage" and "compatibility" were significantly positively correlated with "degree of involvement". Likewise, "complexity" was significantly negatively correlated with degree of involvement. The fundamental findings of this research are that a significant number of clinical social workers have indeed adopted MMHC, and those who have tend to view MMHC as providing them with a greater relative advantage and compatibility, and less complexity. The present study has implications for practice, policy and organizations.
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CHAPTER ONE
INTRODUCTION

Statement of the Problem

Contemporary clinical social work practice is in the process of being radically altered because of changes in the greater mental health service delivery system. The change is due to the proliferation of what has become known as "managed mental health care". Already, this model of service delivery has substantially changed the way mental health services are delivered. So much so that Strom (1992), commenting on clinical social workers' attempts to expand further into the private practice arena, stated, "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 (p.399)". A review of the relevant social work literature, as well as the literature of related professional groups, reveals that in addition to there being a reason for social workers to be alarmed by the ramifications of managed mental health care as it relates to practice, they should also be alarmed by the dearth of social worker discussion of the various facets of managed mental health care that have direct bearing on practice and the profession.

To date, there is not an empirical basis for determining the extent to which clinical social workers have been involved with or have adopted "managed mental health care technology". This research is concerned with the extent to which clinical social workers have been involved with and have adopted managed mental health care technology, hereafter referred to as MMHC.

Since the mid-1980s there has been a revolution in the way mental health care services are delivered in the United States (Austad & Hoyt, 1992; Bennett, 1993; Bloom, 1990; Cummings, 1986; 1988; 1991; Giles, 1988; Lazarus, Beutler&
Norcross, 1992; Sederer & St. Clair; Staton, 1989; Zimet, 1989). The predominant, largely private, "fee-for-service" model of mental health care service delivery, is rapidly being diminished and replaced by managed mental health care (MMHC). The evolution of managed mental health care has also significantly affected the, heretofore, alternative models of mental health service delivery: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs), (Abrams, 1993; Bennett, 1993).

The professions of psychiatry, psychology, a disciplinary mix of employee assistance professionals, and, to a far lesser extent, social work, psychiatric nursing, and clinical counseling, have addressed the growth of managed mental health care. They have done so in their respective professional journals, newsletters, conferences, practice committees, and in their official policies, and practice standards. Austad & Hoyt (1992), both psychologists, assert that today's managed care providers are shaping the way psychotherapy will be delivered in the future. According to psychiatrists Sederer & St. Clair (1990), "Psychotherapy is being redefined by the patients' experiencing managed care treatment. Managed health care, through prepaid health care delivery systems and utilization review organizations, is perhaps the greatest trend in modern health care (p. 1142)." Masi (1989), a social worker, reports that MMHC represents an "...excellent opportunity for the social work profession (p. 2)." Edwards (1990), also a social worker, states that managed mental health care requires the understanding and involvement of social workers.

A review of the literature shows almost universal agreement that MMHC has had a profound impact on the way service is being delivered and will be delivered. Many scholars and practitioners have taken the position that solo/fee-for-service practice has been inexorably altered, and not to its benefit (Benedec, 1991; Hartmann, 1992; Moldawsky, 1990; Schreter, 1993; Shulman, 1988; Sharfstein, 1988; 1990;
In the first of two articles, Moldawsky (1990) took a minority view and asserted that solo practice was alive and vital. His assertion was based on the results of his 1990 survey (the only empirical report of its kind on MMHC's adoption) of psychologists in New Jersey. The results were overwhelmingly affirming of solo practice's vitality. However, three years later a second survey indicated a serious and significant decline in solo practice in the same state (Moldawsky, 1993).

In the first report, he asserted that MMHC had been taken too seriously by psychologists in solo practice. In the second report, the tone changed dramatically. Whereas the former report had been upbeat and optimistic, the second one was somber and conveyed a very bleak prognosis for the continuation of solo practice.

Even though a large number of mental health care professionals and experts testify to the revolutionary effects of MMHC (Appelbaum, 1993; Austad & Hoyt, 1992; Bennett, 1993; Blackwell & Schmidt, 1992; Bloom, 1990; Budman, 1992; Cummings, 1986; Giles, 1991; Lowman, 1991; Moldawsky, 1990; 1993; Schulman, 1988; Zimet, 1989), there is not a consensus with respect to its being a better, more rational, effective, equitable, or a more viable model of mental health service delivery. The lack of consensus applies to both within and between groups of mental health professionals.

The debate on the relative impact of MMHC has been well discussed in the psychological and psychiatric journals. Regarding the psychologists, there is a group of proponents of MMHC (Austad & Hoyt, 1992; Bloom, 1990; Cummings, 1986; 1988; 1991; DeLeon, VandenBos & Bulatao, 1991; Haas & Cummings, 1991; Kisch & Austad, 1988; Richardson & Austad, 1991; Wellner, 1990; Zimet, 1989), and surprisingly few opponents, at least in the refereed journals (Moldawsky, 1988; Shulman, 1988). This is not to suggest that the majority of psychologists are enamored with MMHC. It is probably the case that most practicing psychologists
would have preferred to continue with the fee-for-service model, a model that was generally very amenable to the needs of the private practitioner. However, psychologists have recognized the revolutionary change in service delivery, and have opted to be proactive and shape the direction of the revolution by getting involved in and adapting to the change. Among the psychologists, there is a third group composed of those who evidence mixed feelings about MMHC. This group has serious reservations about a number of MMHC issues and the ramifications of full acceptance of MMHC in its current form. This group has not opted to adopt MMHC technology in its entirety. However, they are likely to adopt MMHC to the extent that they are working through its problems, and are striving to change with it, as well as change MMHC (APA, 1993; Broskowski, 1991; Bugental & Bracke, 1992; 1993; Herron, 1992; Lazarus, Beutler, & Norcross, 1992; Lowman, 1991; 1992; Newman, 1993; Stern, 1993; Strupp, 1993; Tanney, 1989). As a professional group, psychologists have probably done more than any other professional group to articulate the issues germane to MMHC. The concerns with MMHC have been conscientiously studied by a number of psychologists, and the issues debated in their professional journals and forums.

Like psychology, within psychiatry there are a number of proponents of MMHC (Abrams, 1993; Bennett, 1993; Blackwell & Schmidt, 1992; Feldman, Hill & Goldman, 1991; Giles, 1991; Goldstein, 1989; Lazarus, 1993; Paley, 1993; Patterson, 1990; Rodriguez, 1988; Sabin, 1991; Schuster, 1991; Staton, 1989; Tischler, 1990; Vispo, 1993). Likewise, there are a number of psychiatrists who battle the encroachment of MMHC into their practice domain (Appelbaum, 1993; Benedec, 1991; Borenstein, 1990; Fink, 1993; Hartmann, 1992; Melnick & Lyter, 1987; Sederer & St. Clair, 1989; Sharfstein, 1988; 1990, 1991; Shore, 1992; Vartzopoulos & Vartzopoulos, 1991; Westermeyer, 1991). Unlike the psychologists, where there is a
fair number who fall into the "mixed feelings group", the psychiatrists have just a few
(Dorwart, 1990; Thompson, Burns, Goldman & Smith, 1992).

Like the psychologists and the psychiatrists, the employee assistance
professionals have addressed MMHC. However, there is a significant difference
between the former and the latter groups' stance. The EAP articles are more
testimonials to how EAP practitioners have and should get involved with MMHC.
There is a "business" quality to the discussion that is void of deeper professional issues.
Most notably absent from the discussion is a debate of the ethical issues, as compared
to the treatment given in the psychological and psychiatric publications. This may be
attributable, in part, to the EAP articles coming through trade magazines, as opposed
to refereed journals. Over the past five years, a number of articles have appeared in
the major employee assistance publications, i.e., The ALMACAN (subsequently
named the EAPA EXCHANGE), Employee Assistance, and The EAP Digest (Cagney,
In May 1988, a special issue on managed health care was published in The
ALMACAN (Yandrick, 1988). It featured articles on a number of MMHC issues,
including such topics as components of a comprehensive MMHC system, MMHC in
relation to internal and external employee assistance programs, and a managed care
reference guide. Similarly, the July/August 1988 edition of The EAP Digest was
devoted to MMHC (Watkins, Hearle, Benigna, Goren, & Sims, 1988). In March,
1989, The ALMACAN featured another special section on "PPOs and the Spectrum
of Treatment" (Yandrick, 1989) In July 1990, Employee Assistance presented a
special issue on Managed Care: EAPs and employees (Roman, Googins, McKinney,
Fedorka & Francek, 1990). Throughout 1990 to the present, articles have continued
to appear in EAP publications. In addition, the Employee Assistance Professional
Association published a pair of monographs on EAP Standards and EAP’s relationship to managed care (Yandrick, 1990).

Surprisingly, psychiatric nursing journals were devoid of any significant attention to its relationship with MMHC, even though most major MMHC companies employ a number of psychiatric nurses. With respect to clinical counseling and MMHC, one article (Foos, Ottens & Hill, 1991) appeared on the revolutionary effect of MMHC on the mental health field. The authors made recommendations about how clinical counselors can establish a professional base in the new MMHC system.

As a professional group, clinical social workers also have not paid enough attention to the revolution in mental health service delivery caused by MMHC. In comparison to their psychologist and psychiatrist colleagues, they have neglected to keep abreast of the issues, especially as it relates to the vitally important area of their professional publications. There are only a few exceptions to this. There have been some significant references to MMHC in the NASW NEWS, the National Association of Social Workers' monthly publication. However, the commentary is generally unremarkable, with the exception of Edwards'(1990) treatment of MMHC and his concern for its effect on the social work profession. Also, a three part piece on MMHC appeared in the NASW NEWS (Landers, 1992a, 1992b, 1992c). Yet, the piece lacked depth and perspective. A number of the conclusions drawn were either misleading or erroneous. Strom (1992) produced the only MMHC relevant article to appear in a refereed social work journal. Strom addressed the impact of MMHC and social workers' development of private practice. Although not published, Masi (1989) provided the Board of Directors of the National Association of Social Workers with a "White Paper", entitled, "Managed Mental Health: State of the Art and Implications for the Social Work Profession". Fortunately for social work, the NASW Delegate Assembly, recently approved a policy statement on managed care in general, with
special reference to managed mental health care (NASW, 1993). In this policy statement on managed care, social workers provide a brief background and census of the issues, as well as make a statement on managed care. The policy adopted includes a position on managed care standards, social work's role in managed care, and advocacy required by social workers.

Because managed mental health care has had such a profound impact on mental health service delivery, and because the nature and extent of clinical social workers' involvement in it is empirically unknown, this research effort was mounted to determine the extent to which clinical social workers are involved in MMHC, and have adopted MMHC technology. If they have adopted MMHC, the question is: Why have they adopted it? If social workers have not adopted MMHC, the question is: Why not?

Summary of the Research

This research examines the extent to which experienced clinical social workers, the majority of whom were in a full or part-time private practice in psychotherapy, were involved in, and have adopted managed mental health care technology. Several constructs, "relative advantage", "compatibility" and "complexity", derived from E. M. Rogers "diffusion of innovations" paradigm (1962; 1971; 1976; 1983; 1986), were utilized to explain adoption or rejection of MMHC. It was hypothesized that the extent that clinical social workers' perceived a "relative advantage" to adopting MMHC, the extent that they perceived adoption of MMHC as "compatible", and the extent that they perceived MMHC as not very "complex", would be positively related to their degree of involvement with MMHC and would, therefore, make them more likely to adopt the new technology. Additionally, a number of social work practice variables, e.g., "years in practice", "theoretical orientation", "ability to work
effectively in a problem-focused model", etc., as well as demographic characteristics, were examined.

**Conceptual Framework**

The nature and extent of clinical social workers' involvement and adoption of managed mental health care technology can be conceptualized within the context of Rogers (1962; 1971; 1976; 1983; 1986) diffusion of innovations theory. In particular, this theory provides a set of constructs that enable an understanding of why some clinical social workers have adopted MMHC and others have not.

Diffusion of innovations theory concerns itself with communications and social change. According to the Rogers model (1962; 1971; 1976; 1983; 1986) there are three successive steps inherent in social change. The steps are invention, diffusion, and consequences. When a new idea or technology is shared by members of a social system, the consequence, or effect of adopting or rejecting the new idea is change in the social system. Therefore, communication creates social change. For instance, the introduction of MMHC has created a significant increase in patient referrals for some practices, and for others, a significant decline. As providers experience and discuss these effects, their practices change. Those who have adapted to the changes have benefitted to some extent, or at least they have been able to maintain a practice, whereas most of those who have not adapted have had to struggle. If the effect of the innovation reaches the magnitude of that which MMHC has had on the service delivery system, then the system has been changed by the consequences of the innovation's diffusion through it.

Williams, Rice & Rogers (1988) point out that the diffusion of an innovation follows a process where "...(1) an innovation, (2) is communicated through certain channels, (3) over time, (4) among members of a social system" (p. 11). The new idea diffuses at a differential rate within the social system as a function of how the
innovation is perceived by its members, especially in terms of the following five
diffusion of innovations characteristics: relative advantage, compatibility, complexity,
observability, and trialability.

For Rogers' (1962; 1971; 1976; 1983; 1986), an innovation can be anything -
an idea, a practice, a technology or product. Moreover, the innovation does not have
to be objectively new. What matters is the beholder's perception of the innovation
and, more important than the innovation's newness, is the formation of a favorable or
unfavorable opinion about it.

Rogers (1963; 1971; 1983; 1986) posits two "channels" through which the
innovation is issued: mass media and interpersonal. The mass media channel is best
suited for stimulating a general awareness of an innovation, whereas the interpersonal
channel is best suited for influencing an individual to take a favorable or unfavorable
stance towards the innovation. Diffusion of MMHC technology is being channeled to
social workers mostly by way of the interpersonal channel because of its direct impact
on them in their practices. Generally, social workers encounter MMHC in their direct
practice with patients as it relates to treatment authorizations. As a result, discussion
is generated among social workers and opinions about MMHC formulated.

Considering that there has been relatively little discussion of MMHC in professional
social work publications, the most appropriate mass media social work channel is
being under utilized. In contrast to social workers, psychologists and psychiatrists
have learned of MMHC technology through both the mass media and interpersonal
channels. This is evident in the numerous publications in their journals on the subject.

The third part of the diffusion paradigm is concerned with "time". More
specifically, this aspect concerns the time it takes an individual or a group to adopt a
new technology, i.e., their relative "innovativeness". However, it must be stated that
time is not a major consideration in this research effort. MMHC technology is being
imposed on the service delivery system (Dorwart, 1990; Moldawsky, 1993; Schreter, 1993; Zimet, 1989). In effect, as MMHC technology becomes more firmly entrenched, it matters less whether or not providers favor it or not. It is growing because the payers are insisting on it. In effect, unless providers forsake insurance reimbursement, and some have, they have been forced to become involved in MMHC, even if it is with reluctance.

The final piece of the diffusion paradigm to consider is the "social system". According to Williams, Rice & Rogers (1988), a social system is a set of interrelated units that have common goals and objectives towards which they work. The units may be micro (individuals) or macro (groups) in scope. Also, the social system has a structure, i.e., a manner of doing things in a regular and predictable way. This research effort concerns itself with the clinical social work system, more specifically the mental health/psychotherapeutic part of clinical social work.

While this study examined the diffusion of innovations attributes "relative advantage", "compatibility", and "complexity", the attributes, "observability" and "trialability" were not included in this study. These characteristics were not included because it was judged that the difficulty inherent in operationalizing them was not going to be offset by the information obtained. Nevertheless, in diffusion research it has been shown that an innovation is more likely to be adopted if it can be tried in a less than "all or nothing" proportion (LaBay & Kinnear, 1981). Similarly, if an innovation's results are more observable, then it is more likely to be adopted (LaBay & Kinnear, 1981).

As compared to diffusion of innovations research to date, where "adoption" of the innovation served as a dependent variable and the adoption characteristics served as independent variables explaining adoption, this research takes a somewhat different approach. In contrast to previous diffusion research, where adoption criteria had been
fairly easy to define and data on adoption were relatively readily available (Musmann & Kennedy, 1989), adoption criteria for MMHC were not clear nor were data on adoption so readily available. Even though there are some well formulated definitions of MMHC (Bennett, 1990; Bloom, 1990; Cummings, 1986; Shulman, 1988), there is still considerable disagreement around aspects of the definitions. For instance, some see MMHC in very negative terms. Sharfstein (1990) limited it to inpatient utilization review, and also called it "mangled care". Similarly, Moldawsky (1990) referred to managed care as "rationed care". However, not everyone saw MMHC in a negative fashion. Bennett (1993) defined MMHC as a service delivery system that was rapidly changing and developing into a more viable and equitable delivery system. Bennett's definition of MMHC encompassed three phases of development for example, where utilization review was only one of the most rudimentary elements. Still others described MMHC as if it were an extension of the traditional staff model HMO (Richardson & Austad, 1991). As a consequence of the broad range of meanings attributable to MMHC, as well the perceived degree of difficulty inherent in obtaining data on adoption, the decision was made to operationalize the concept of adoption in terms of the respondent's perceived involvement with MMHC. Further, instead of attempting to construct a causal model in which the attributes predicted adoption, a less ambitious, yet productive, correlational analysis was designed. This study advanced several hypotheses around perceived involvement's correlation with the three adoption characteristics.

**Overview of the Study**

To assess the extent to which Clinical Social Workers have adopted managed mental health care technology, this research required subjects to respond to a mailed survey questionnaire. A standard nonexperimental, single cross-section survey design was employed. Participants in the study were selected randomly from the 1990
Register of Clinical Social Workers (NASW, 1990). Subjects were asked to select the
degree to which they perceived themselves to be involved with MMHC technology.
Their responses served to place them in one of four groups: 1) not involved with
MMHC; 2) minimally involved with MMHC; 3) fairly involved with MMHC; and 4)
very involved with MMHC. The "perceived level of involvement with MMHC" served
as one of the primary variables in the study, along with the three characteristics of
adoption of a new technology, the other major variables of interest. The adoption
characteristics were: 1) relative advantage, 2) compatibility, and 3) complexity. Three
scales were constructed specifically for this research, each measuring one of the
adoption characteristics. A one-way analysis of variance (with four levels of the
variable, "involvement") was performed for each of the three measures of the
perceived adoption characteristics, i.e., relative advantage, compatibility, and
complexity. Finally, the questionnaire included demographic items, as well as items
that elicited information about the respondents' work context and managed mental
health care experience.

Justification for and Nature of the Study

Because of the radical changes in the mental health service delivery system
produced by the widespread imposition of the MMHC model, it can be argued that
clinical social workers cannot afford to be uninformed about its nature and operation.
This research was conducted to provide an empirical understanding of clinical social
workers' understanding and adoption of the technology, as well as to provide a
rudimentary explanation of why they have become involved, to the extent that they
have. To date there have been no published studies on the extent to which clinical
social workers have been involved in MMHC. Moldawsky (1990; 1993) has
conducted some research on psychologists' involvement with MMHC. However, both
of the Moldawsky studies were conducted with very limited samples, both were atheoretical, and both were simply descriptive reports.

The actual consequence of being poorly informed about the changes in the service delivery system have a bearing on the profession, the individual clinical social worker, and most importantly, the client. On the level of the profession, even though the National Association of Social Worker's Delegate Assembly has approved a managed care policy (NASW, 1993), it is one that has not been sufficiently discussed by the general membership, and its discussion has been especially lacking in the scholarly social work journals. It is a concern that such a policy could be developed without there having been a discussion of the key issues in the professional journals, as has been the case in psychology and psychiatry. In particular, it is difficult to understand how the Clinical Social Work Journal has not carried articles about MMHC, when so much is being written about it in the related disciplines of psychology and psychiatry.

On the individual social worker level, there are consequences to being uninvolved with MMHC. Some social workers will simply not ever elect to be involved with MMHC because they have no desire to conform to its requirements of brief treatment and utilization review. However, if they fail to understand MMHC's basic tenets and practices, they will be unable to offer informed opinions on its bearing on colleagues, patients and, more generally, the field. Should social workers fail to learn more about the very basic assumptions underpinning the new service delivery model, including its reliance on the theory and practice of brief psychotherapy, then social workers will persist in practices that run contrary to the new technology and their potential important roles in it.

On the level of consequences to clients, poorly informed policy makers and clinicians run the risk of not providing proper treatment to individuals. The
consequences of not providing any treatment, or not enough of the right kind of treatment, range from continued suffering that may have been ameliorated through proper intervention, to, in extreme cases, physical abuse or death through suicide.

With these considerations in mind, several things were attempted in this study. First, MMHC's evolution to date was reported. Particular attention was given to explaining the differences between the several models of mental health service delivery. Second, the ground for the MMHC model was explained, i.e., cost-offset, and brief psychotherapy as the most parsimonious approach to adequate treatment. Third, this research attempted to provide several types of empirical data, including the degree to which clinical social workers perceive themselves to be involved with MMHC; the extent to which clinical social workers are employed by MMHC companies; the extent to which clinical social workers have actual contracts with MMHC companies; whether or not clinical social workers feel they can work effectively in a "focused" treatment format; and other important questions. Finally, several scales were constructed that relate to the diffusion of innovations constructs of relative advantage, compatibility, and complexity. These constructs provide a richer understanding of why clinical social workers may be more or less involved with MMHC. It is theorized that those who perceived themselves as more involved with MMHC will show a significant and positive correlation with greater relative advantage and compatibility, and a significant and negative correlation with greater complexity.

Because of the scope of this research, namely, a very large national sample of clinical social workers, the mailed questionnaire survey design was thought to be the most suitable and expedient way to obtain the necessary information.

Limitations of the Study

Even though the survey design employed was adequate for the purpose of answering the research questions, and even though the sample contained a large
random sample of respondents, some significant research limitations remain. First, since this was a nonexperimental research design, causation cannot be inferred. Second, among the threats to the research's validity is the extraneous variable of history. Since this survey collects data at only one point in time, it is impossible to determine how clinical social workers may respond upon a second administration. It is likely that their involvement and rate of adoption or rejection is subject to significant change due to many things that happen over time, not the least being the MMHC model's rapid growth. This effect was reported by Moldawsky (1990, 1993). In the space of three years, between the first and second of his surveys, the results changed significantly. In the first study, psychologists reported that MMHC had very little impact on them. In the second study this changed significantly. The first survey concluded on a very optimistic note. The results clearly indicated that psychologists' perceptions of their private practices in New Jersey had not been negatively impacted by MMHC. The results indicated that private practice was thriving. Upon an analysis of the results of the second survey, the conclusion was that psychologists' perceptions had changed significantly. Numerous respondents indicated that their solo practices had experienced a significant decline in referrals due to the growth of MMHC.

Another limitation of this study is the population from which the sample was drawn. The sample of respondents was restricted to only those clinical social workers who appeared on the Register of Clinical Social Workers (NASW, 1990). Hence, those clinical social workers, who were not registered, and who may or may not have been adopters of MMHC, were excluded from the sample. This group accounts for a larger group of clinical social workers than those who were included in the register.

Finally, even though subjects were selected randomly, there remains the bias of self-selection. Borg & Gall (1983) have identified a number of factors which cast some doubt on generalizing from a sample of volunteers to a population from which
the sample was drawn. Accordingly, they report that volunteers tend to be: female, higher social class, more intelligent, more unconventional, less authoritarian, more Jewish than Protestant, and more Protestant than Catholic, to name a few.

**Importance of the Study**

By arriving at a better understanding of the extent to which clinical social workers perceive themselves to be involved with MMHC, and by gaining some additional insight into the nature of their involvement, appropriate measures can be taken to better inform social workers about the changes occurring in the mental health service delivery system. One desired effect of communicating the results of this study would be that it facilitate clinical social workers' intensifying the debate of the salient professional, clinical, and ethical issues in its professional journals and forums. A positive consequence of such a debate would be more informed opinions on MMHC.

Another reason for conducting this study is that it is a fact that clinical social workers have been involved in MMHC's development and practice. For those of us who have been in the MMHC practice arena, it is well known that some of the pioneers of MMHC organizations have been social workers. For example, the founders of two of the oldest and largest MMHC organizations, Personal Performance Consultants, Inc. and Human Affairs International, Inc., were social workers. It would be important to better understand the reasons why some clinical social workers have decided to adopt MMHC technology and why others choose to remain uninvolved, or less involved.

The results of the present study would be expected to provide a better understanding of the role of MMHC and the practice of clinical social work. Current literature has failed to provide a clear measure of the degree to which clinical social workers are involved in MMHC. Further, the current literature does not reflect the degree to which clinical social workers have found MMHC to be a good fit with their
practice. The study of such factors as advantage, compatibility and complexity should shed light on how clinical social workers feel about MMHC, and their reasons for adoption or rejection of MMHC.

A better understanding of clinical social workers' involvement in and attitudes towards adoption of MMHC would also have valuable implications for social work policy. For example, broad acceptance of MMHC would call for considerably more study of MMHC by policy makers and academicians than is currently reflected in the literature. Similarly, if the results indicate a rejection of MMHC by clinical social workers, then the need for alternative models of service delivery would be obvious.

The results of this study should have significant implications for MMHC organizations. A better understanding of present and potential mental health care providers would enable MMHC organizations to better select, recruit and train providers.

Finally, the results of this study will provide additional support for the utility of the Diffusion of Innovations Theory (Rogers, 1971; 1983; 1986) to understand the proliferation of mental health service delivery systems. The extent to which Rogers' adoption characteristics correspond with clinical social workers adoption of MMHC will provide evidence of the appropriateness of the model.
CHAPTER TWO
LITERATURE REVIEW

The Evolution of Managed Mental Health Care

In order to facilitate an understanding, of the current practice of MMHC, this chapter addresses several things. First, an attempt is made to distinguish MMHC’s defining characteristics from those of other models of mental health service delivery, most notably, the traditional fee-for-service model, and the HMO, PPO, and IPA models of service delivery. Second, the point is made that the growth of MMHC has been driven by a need to contain dramatically increasing health care costs. Third, the assertion is made that the impetus behind the movement to contain costs was on the part of business, not the provider community. Fourth, it is argued that the business communities desire to contain costs created a need that was addressed by entrepreneurial providers, who developed a model of service delivery that took the "bottom line" of business into consideration. Finally, in juxtaposition to the first four points, managed mental health care is defined.

The Fee-for-Service Model

Since MMHC is largely a blending of the various service delivery models, it is easier to define MMHC by first defining the other models of mental health service delivery. The predominate form of service delivery has been the "fee-for-service" model. Bloom (1993) referred to it as "unregulated care from private practitioners (p. 110)." This model is comprised of private, for profit practitioners, operating on their own, in solo practice, or on their own, with other solo practitioners. Some of these practitioners may incorporate, but many band together in what is typically called "a loose association". A "loose association" is an entity which is just what its name connotes. It lacks the legal definition, of for example, a corporation. Usually, a loose
association is designed with maximal individual provider autonomy in mind. As such, the members of the association practice in a manner that they deem appropriate, with some consideration of how others in the association may feel, but not necessarily with a legal agreement to practice in a specified manner. Members of a loose association often reflect similar practice orientations, ideas on organizational size, growth, and administrative concerns. The hallmark characteristic of a loose association is that its members typically share "agreed upon expenses", such as rent, office supplies, and secretarial service. In this kind of arrangement providers keep 100% of their collections for services rendered, after the agreed upon shared expenses have been deducted.

There is another type of fee-for-service provider group, the institutional provider, that is larger in scope than either the solo provider or the loose association of solo providers. The primary institutional providers are the psychiatric and chemical dependency hospitals. Institutional providers typically hire an array of employees representing the mix of professional disciplines, administrators and business personnel. The operative term here is "employ". Institutional providers also encompass a group of providers, most often psychiatrists, who may or may not be employed to some degree by the institution. These providers perform services in the hospital. After doing so, they bill the patient and/or the patient's insurance company for services rendered. In addition, the hospital also bills the patient and/or the insurance company for separate hospital charges.

Aside from the over-arching structure of the typical fee-for-service arrangement, the fee-for-service structure has a number of defining characteristics. For instance, the fee-for-service model is known for having a micro, rather than a macro focus (Shulman, 1988). The therapeutic contract is between the provider and
the patient, without any implicit or explicit agreement to consider the needs of a third party insurance company, or at a greater level, the needs of the community in which the provider and the patient reside. Sabin (1991) emphasized that the contract is only concerned with the individual patient and provider. According to Haas & Cummings (1991), this model is further characterized by the provider's authority and responsibility to determine the type of therapeutic intervention, the level of its intensity, the frequency of its administration, and the extent to which the intervention will endure. Further, to a greater extent, this model considers therapeutic resources as unlimited. Moreover, until recently, it has been the expectation that reimbursement from the patient's health insurance company would be forthcoming without any question of medical necessity occurring (Austad & Hoyt, 1992; Bennett, 1993). Additional characteristics that define the model include the following: the provider's ability to close-off the intake of patients, to specify types of patients that would or would not be seen, to set his or her own fees, and to determine when and where service is provided. Finally, the fee-for-service model is characterized by minimal paperwork demands and administration, as well as less provider to provider collaboration.

In many respects, some of the strengths of the fee-for-service model engendered problems (Bennett, 1993; Bloom, 1990; Cummings, 1986). To the extent that the fee-for-service model allowed for maximum provider autonomy, it also promoted the most costly types of treatment, escalating fees, and in some instances minimal quality and administrative control. Considering these problems, the health maintenance organization (HMO) evolved as an alternative to the more prevalent model (Bloom, 1990; Vispo, 1993).
The Traditional Health Maintenance Organization (HMO)

In contrast to the fee-for-service model there is the "health maintenance" model of mental health service delivery, or more simply, the HMO. Historically, the HMO has been a self-contained entity that provides comprehensive medical and surgical care for a prepaid, annually fixed price (Bloom, 1990; DeLeon, VandenBos & Bulatao, 1991; Vispo, 1993). It was not until more recent times that the HMO began to provide mental health services (Kisch & Austad, 1988). However, since the Health Maintenance Organization Act of 1973, (PL 93-222), and its amendments in 1976, 1978, and 1981, at least 20 sessions of psychotherapy must be available to a patient, including alcohol/drug treatment, and crisis intervention. Bloom (1990) describes the typical pre-managed mental health care HMO as having a central administration, a salaried staff, and a corporate structure, often not-for-profit. This type of structure is referred to as the traditional "staff model HMO".

The staff model HMO is at the opposite end of the service delivery continuum, from the fee-for-service model. Unlike the fee-for-service model, the HMO is dependent on a salaried staff of professionals, administrators, and business personnel. Whereas the fee-for-service model placed a great value on individualism, the HMO model's ideal is a high degree of teamwork, interdisciplinary communication, and a feeling of esprit de corps among the workers (Bennett, 1993). To the extent that the solo/fee-for-service providers are decentralized, the HMO providers are centralized, often in one primary facility, with strategically located satellites. In this model resources are viewed as finite. There is a greater emphasis on less intensive treatment, most notably, a great effort is expended to treat patients in both a brief therapy and an
outpatient modality. Unlike the fee for service model, there is a disincentive to treat patients in long term or intensive hospital modalities. Since the service is prepaid, more service at higher levels of intensity shrinks the financial resources. Furthermore, since the model employs a fixed number of providers, and because the HMO cannot close its intake, such as its fee-for-service counterpart can, longer term services can create bottlenecks, where fewer patients can receive timely service.

Another HMO characteristic is a therapeutic contract that goes beyond the individual provider and patient, extending to the entire HMO group. In other words, there is both an implicit and explicit provider obligation to consider the individual as well as the group when treating a member of the HMO community (Cummings, 1991; Paley, 1993). This is often overlooked and misunderstood by patients and providers alike. The HMO therapeutic contract also includes upper level utilization review. This means that the patient's provider may have to acquiesce to others on the treatment team with regard to his or her treatment. Such acquiescence might include discontinuing treatment, or modifying it in an unexpected fashion.

Finally, HMOs, unlike the typical fee-for-service practice, have been known to promote education, health, wellness, and prevention. In the HMO model there is a greater understanding that patients are not always cured of their illness. In particular, the mental health service is rooted in a belief that interventions should promote adaptation, not cure (Budman, 1988; 1992).

The earliest HMOs were considered "mavericks" by the medical community, and largely despised (Bennett, 1988). The early HMOs emphasized comprehensive, prepaid care for individuals and their families. DeLeon, VandenBos & Bulatao (1991) provide several descriptions of pioneering HMOs. One example is the Western Clinic
which was founded in 1906, in Tacoma, Washington. The clinic provided comprehensive, prepaid medical care to lumber employees and their families. The care was administered by two physicians who charged the employees 50 cents per individual, per month. The Ross-Loos Clinic is another example of a pioneering HMO. It was founded in Los Angeles County in 1929. Ross-Loos served L.A. County water workers and their families. Kaiser Permanente, the final example cited by DeLeon, VandenBos & Bulatao (1991) was founded by Henry J. Kaiser, during the depression. He and a physician, Sidney Garfield, established a comprehensive medical service for the workers, and their families, who built the Boulder Dam in the Mojave Desert. At the time, Kaiser was motivated to establish an alternative health delivery system because he had been unable to get workers for the dam project. They would not work unless medical services were made available. Dr. Garfield agreed to provide comprehensive services for a fee of five cents per employee work hour. In addition, Dr. Garfield broke new ground by extending his service to include preventive care, most notably education and practices that targeted sun-stroke and heat exhaustion.

DeLeon, VandenBos & Bulatao (1991) report that the HMO model developed further following World War II. At that time, Kaiser went public and established a presence around the country. In 1966, the Harvard Community Health Plan was founded. Since then it has become a major source of both HMO practice standards and empirical research to support the standards (Abrams, 1993, Budman, 1988). During the 1960s, the HMO concept was well received by the Nixon Administration, which was pleased with its promotion of preventive services. In part, because of the Administration's support, The Health Maintenance Act of 1973 (PL 93-222), was passed. Among its requirements was the mandate that companies with twenty-five or more employees, with federally chartered HMOs in their vicinity, had to offer an HMO
option. The Act mandated eight basic services, including outpatient mental health treatment. Under the law, provisions had to be made to offer at least twenty psychotherapeutic sessions to each subscriber per year.

The 1973 Act was amended in 1976, 1978, and 1981. Since 1973, medicare, medicaid, and Champus subscribers have been entitled to an HMO option. Deleon, VandenBos & Bulatao (1991) report that between 1980 and 1990 HMOs have grown significantly, from covering approximately 9 million subscribers to covering approximately 39 million subscribers. Similarly, there were 236 HMOs in 1980, and by 1990, 612 chartered HMOs.

The PPO and the IPA

In addition to the fee-for-service and health maintenance models of service delivery, two additional models of mental health service delivery need to be mentioned. These are the preferred provider organization (PPO) and the independent practice association (IPA). According to Bloom (1990), the PPO is a self-limiting group of private practice providers. PPOs may be provider-driven, and contract directly with employers, insurance companies, and managed care companies.

One of the defining characteristics of the PPO is that its providers discount their fees for service in return for a steady flow of referred patients. Another characteristic has been the relative absence of utilization review. However, this has changed dramatically in the last couple of years (Bennett, 1993). Historically, the traditional PPO provider more resembled a fee-for-service provider than either a staff model HMO provider or a MMHC provider. Under the developing managed PPOs there is significant U.R.. As compared to the old PPOs, the new managers are demanding compliance with brief psychotherapy practices. The desired compliance is
thought to require U.R. case-management. A final defining characteristics of the PPO is that the subscriber draws from a list of providers when seeking service. Unlike the HMO, which also has a list of providers, the PPO patient can go outside of the network's list of providers. The penalty for going out of the network is a reduction in the rate of reimbursement, which can often be quite significant.

A major criticism of the traditional PPO model is that there is little disincentive for the provider to limit the units of service provided. When this is the case, then the cost of care goes up because of the increase in service units. Note that many solo practitioners would argue that there are disincentives to providing unlimited service, not the least of which would be one's professional code of ethics, and heavy sanctions for unethical behavior, including the lose of one's license to practice. Nevertheless, the unmanaged PPO has essentially the same cost problems as the traditional fee-for-service model. Finally, and without explicit documentation for this statement other than this researcher's significant personal experience in the field, it appears that some providers criticize the PPO for its failure to provide a steady flow of patients even with discounted fees. In practice, the provider discounts his or her fees for patients seen, but receives very few patients. It has been the case that providers resent this because other, nondiscounted patients could have been seen. This criticism applies to the traditional PPO, and to a lesser extent the managed PPO.

According to Paley (1993), "The independent practice associations is as the title suggests, an affiliation of community physicians serving the HMO patients in their separate office locations. p. 7." Typically the providers, who are not necessarily physicians as Paley stated, are under a capitation agreement with the payers of the service. IPA groups are more similar to the staff HMO model. However, IPA
providers do not generally have to submit to extensive utilization review. Again, they are as their name suggests, more independent.

**The Increasing Cost of Health Care**

The cost of health care is one of the most talked about subjects in the present day United States (Vispo, 1993). Much of the discussion stems from the common knowledge that as many as 37 million citizens are without any health care coverage whatsoever. Many more are without adequate coverage (Vispo, 1993). For instance, there are those who need treatment for specific problems which are often excluded from their health insurance plans. Others remain unable to get necessary care because they have reached their annual or lifetime caps on coverage (Califano, 1986; Hartman, 1992). Still others are denied coverage because their problems are deemed preexistent conditions, and beyond the scope of coverage. Whatever the reason for inadequate coverage, it ultimately gets back to the cost of care. Medical care has been beyond the economic means of millions of individuals and businesses for some time, and it is becoming more difficult to finance for those who still have it (Benedec, 1990).

With respect to total U.S. expenditures on health care, Rodriguez (1988) reports on data provided by the Health Care Financing Administration for the years 1929 through 1983. Health care expenditures between 1929 and 1960 increased by a factor of seven, from 3.6 billion dollars to 27 billion dollars; the cost tripled between 1960 and 1970, from 27 billion dollars to 75 billion dollars; and continued to escalate between 1970 and 1983. Between 1970 and 1983 health care costs went up by a factor of five, from 75 billion dollars, to over 355 billion dollars. In 1992, the cost of health care was more than 800 billion dollars, or more than twice the cost of care in 1983 (Austad & Hoyt, 1992).
Vispo (1993), citing a July 1992, *Consumer Report* special edition, "Wasted Health Care Dollars", states that more than 817 billion dollars was spent on U.S. health care in 1992. The figure constituted 14% of the 1992, U.S. gross national product. According to the article, 163 billion dollars was spent on administrative costs, the remaining 654 billion dollars was spent on patient care. However, of the 634 billion dollars, 130 billion dollars was spent on procedures that were reported to be "clearly unnecessary". The special edition concluded with the comment that the billions of dollars spent on unnecessary procedures and administration could have provide every uninsured U.S. citizen with coverage.

In the United States, business pays the greatest portion of the health care bill, followed by the government, whose payments are largely through the Medicare and Medicaid programs (Simon, 1989). The cost to business is in medical indemnity and HMO premiums, as well as direct self-insurance payments. In view of the huge increases in health care costs over the years, it is evident that business has had to pay a significantly increasing amount of money on health care insurance. Broskowski (1991) reports on the increasing cost of employee health insurance premiums. In 1984, the average cost of health insurance per employee was $1645.00; in 1985, it averaged $1724.00; in 1986, it averaged $1857.00; in 1987, it averaged $1985.00; and in 1988, it averaged $2354.00. The costs have gone up every year since then to the present. In a 1989 survey, conducted by A. Foster Higgins, a large health benefits consulting firm, it was reported that where overall plan costs went up a significant 18.6% in 1988, the mental health and substance abuse portion of the benefit plan went up 27% that year. Mental health and substance abuse per capita costs increased from $163.00 to $207.00. According to the survey, the mental health and substance abuse benefit amounted to approximately 10% of the total benefit plan cost. Finally, a report issued
by Corporate Health Strategies found that expenditures on inpatient mental health services increased 132% between 1984 and 1989. Similarly, substance abuse treatment in non-specialty hospitals increased 171% in the same period. With regard to specialty substance abuse facilities, costs increased approximately 300% (Medical Benefits Newsletter, 1990).

Some of the Reasons Behind Increasing Health Care Costs

Mental Health and substance abuse care costs have increased steadily over the years. However, the cost of care was given a very significant boost through the 70s and 80s with the failure of the deinstitutionalization movement, which had begun in the 1950s. The increase in health costs was also pushed up by the failure of the community mental health centers program, which had been engendered by the 1963 Community Mental Health Centers Act (Bloom, 1981; 1990; Libassi, 1988). Moreover, during the Republican era of the late 1960s through the mid 1970s, and then again through all of the 1980s and the early 1990s, there has been an emphasis on deregulation and privatization. Because of this, a period of tremendous growth occurred in the "for-profit" specialty hospital chains, and private individual hospitals, as well as the specialty units within established general hospitals. Some of the most popular treatment specialties included alcohol, drug, conduct, and eating disorder treatments. These enterprises were intended to make money for their share holders, and/or bolster the hospital's financial base. These corporations substantially increased the number of available beds. Often these beds were heavily marketed in an effort to stimulate demand (Rodriguez, 1988). Through the mid to late 1980s, hospital care accounted for over 70% of the mental health services delivered (Zimet, 1989).
Rodriguez (1988) attributed the increased cost of mental health and substance abuse care to the following factors: less stigma associated with receiving mental health treatment; a significant increase in available hospital beds; a significant increase in the number of providers offering services; fraud; administrative waste; expensive and clinically unnecessary defensive practices to ward off legal problems; advances in psychopharmacology; and more effective psychotherapies. An examination of these factors leads to the conclusion that the delivery of greater amounts of service was largely behind the increasing cost of care.

Another major contributor to the rising cost of care has been the underwriting policies of the indemnity medical insurance industry. It has, until very recently, encouraged over utilization of health care resources, especially in regard to the most expensive kind, inpatient care (Cummings, 1991; Lowman, 1987; Manning, Wells, Duan, Newhouse & Ware, 1986). Indemnity insurance has had a history of paying for virtually any service rendered by a licensed psychiatrist, psychologist, and more recently, licensed social worker, and/or counselor (in a number of states). Furthermore, a great number of unlicensed providers receive indirect insurance reimbursement by working under the auspices of a licensed provider. Also, somewhat ironically, indemnity insurance often paid for extensive inpatient stays far more readily than, for example, extending outpatient treatment benefits to cover outpatient sessions intended to avert hospitalization (Rodriguez, 1988). It is likely that business' affinity for paying for the more costly hospital stays is a consequence of the erroneous idea that more is better (Zimet, 1989). Further, some have speculated that businessmen in general have viewed service rendered in a hospital as more properly medical, as compared to "talk treatments" delivered in a psychotherapist's office (Zimet, 1989). Prior to the late 1980s, and before utilization review, it was the industry standard to
pay for 30, 60, and 90+ inpatient days, often at per diem costs in excess of $500.00. This practice significantly contributed to health care costs going up. Broskowski (1991) observed that increased cost conformed to the following formula: (service units) x (service price) = cost of the service. If there are few or no disincentives to provide service units, as was the case with indemnity insurance, nor disincentives to lower price, then costs go up. This is precisely what happened. Providers strove to increase their service units, as well as their prices.

The Emergence of Managed Mental Health Care

MMHC emerged as a significant influence on the delivery of mental health services in the mid 1980s. There is a consensus in the literature that its rapid growth and influence was driven by an almost singular desire to contain the rising cost of care (Austad & Hoyt, 1992; Bennett, 1993; Bloom, 1990; Broskowski, 1991; Cummings, 1986, 1988; 1991; Paley, 1993; Richardson & Austad, 1991; Sharfstein, 1988, 1990; 1991; Stern, 1993; Tischler, 1990; Vispo, 1993; Zimet, 1989). The move to contain costs was not initiated by the provider community. Business instigated the change. Business was paying the majority of the health care bill. Bennett (1993) asserted that there was a "revolt of the payers". Heretofore, business had cooperated with the providers and the patients. However, business reached its end-point for paying. In the way of illustration, Broskowski (1991) related that in the late 1980s Blue Cross and Blue Shield was Chrysler Corporation's "largest supplier". It was reported that Chrysler was spending approximately 600 million dollars per year on health care, and the cost of providing care was going up faster than the rate of increasing profits. Health care costs accounted for 7% of the sticker price on a new car ($600 per car). Chrysler, as did other corporations, made a decision to change the way they were purchasing and paying for health care services. Cost-effective strategies were sought.
A number of providers came forward to service business' need for cost containment. Among them were some of the "old guard" providers of alternative mental health service, i.e., Kaiser Permanente, Harvard Community Mental Health Plan, and Community Health Plan. Also, some of the new MMHC organizations, such as, Preferred Health Care, Human Affairs International, Metropolitan Clinics of Counseling, and MEDCO (which as of early 1993 includes the former American Biodyne and Personal Performance Consultants) came forward with their brand of cost conscious mental health service. These provider groups were promoting being well-grounded in the belief that cost containment is a critical consideration in the provision of health care. The proponents of MMHC did not apologize for discussing cost of services. It was their primary lead, enabling them to get their "foot in the door". Once inside, managed care companies promoted business practices such as working within budgets, limiting services to the most parsimonious ones, finite resources, and the need for the provider to conserve resources when designing treatment plans.

In addition to these large corporate providers, a number of solo providers have also come forward, sometimes not fully under a MMHC banner (Patterson, 1990). They have been willing to learn managed mental health care techniques and follow MMHC protocols, including utilization review. Since the mid 1980s, some of these solo practitioners have joined together in groups which maintain both fee-for-service and managed care options. A significant number of these providers have evolved into preferred providers for larger MMHC organizations.
The Managed Mental Health Care Model

Managed mental health care more resembles the former alternative mental health service delivery system, the HMO, than the fee-for-service model. This is due to the model's introduction of what Bennett (1993) called an "executive function". The introduction of a co-decision maker into the treatment process, more or less eviscerates the notion of solo practice, or so it would seem. In the private practice model, the executive has been the sole decision maker. In that model, the best executive of treatment is the trained provider who has actual first person experience with the patient.

Zimet (1989) defined MMHC as encompassing the concepts and strategies of the HMO, PPO, and utilization review organizations. Similarly, Austad & Hoyt (1992) defined the model as any of the methods that attempt to control the cost of service, the utilization of service, and the location and provider of service. Bloom (1990) described the MMHC organization as being very similar to an HMO. The managed care entity provides comprehensive inpatient and outpatient mental health services, including chemical dependency treatment. The services are specified in advance, according to price and amount of service, as well as to whom they will be delivered. Services may be prepaid, on a fixed annual basis, as is the case with traditional HMO product, or they may be delivered per requested need through an organized network of private practitioners who have agreed to certain managed care policies and procedures with referred patients. Broskowski (1991), described managed care as a "variety" of strategies that fall into one of two categories. The first category contains strategies intended to reduce the price of mental health services.
e.g., provider discounts for referrals, and caps on benefits. The second category contains strategies intended to reduce the number of service units provided, e.g., utilization review, and capitation. In a capitated system, the more service provided, then the less profit. These definitions indicate that the main thrust of MMHC is to deliver services that are cost containing, by way of some kind of limiting, external control.

Sabin (1991) expanded on the meaning of MMHC, noting some of the special skills required of its practitioners, many of which originated in the HMO. In the HMOs, policy dictated that attention be given to costs, outcomes, focused treatment, practice guidelines, utilization review, and limited psychotherapeutic resources. Consequently, HMO practitioners developed a number of skills that their fee-for-service counterparts did not necessarily develop. Sabin (1991) called one of these skills "population oriented practice". Population oriented practice balances the need of the individual patient with the need of the group. As has been pointed out, the therapeutic contract in the fee-for-service model is limited to the provider and the patient. In the MMHC model the therapeutic contract is between the provider, the patient, and the members of the group of covered employees or subscribers, the same as it is in the HMO. Population oriented practice distinguishes MMHC providers from fee-for-service providers insofar as the former are routinely expected to maintain greater availability, provide group therapy, have a good knowledge of self-help, including referring to self-help, and a willingness to teach behavioral health care.

Like the skill of "population oriented practice", MMHC requires another skill, which Sabin (1991) called, an "expeditious clinical stance". An expeditious clinical stance is one where the therapist is willing to look at "whatever may work" to solve the presenting problem, even if the intervention does not achieve as high a clinical goal
as the therapist might ordinarily desire. Being clinically expeditious would include, for instance, referring an alcoholic patient to intensive outpatient chemical dependency treatment and self help, directly following a successful two day detoxification period. An example of a less clinically expeditious treatment plan would be, for example, a ten day inpatient stay, following the same successful two day detoxification period. Meeting at least the patient's necessary needs, if not always his or her sufficient needs, is being clinically expeditious.

A clinician cannot be clinically expeditious unless he or she knows the treatment outcome literature. In many instances providers hang on to preferred long term psychotherapeutic methods and treatment beliefs in spite of evidence that shows that less intensive and enduring treatments work just as well (Budman, 1988; Cummings, 1986). In order to be clinically expeditious, the MMHC clinician needs to be aware of treatment outcome research, alternative treatments, and also be skilled in operating in different treatment modalities, especially a brief psychotherapy modality. Such knowledge and skill often helps a provider feel more comfortable in prescribing a less than "ideal" course of treatment (Richardson & Austad, 1991).

The last of Sabin's (1991) essential MMHC skills is twofold, ethical analysis and advocacy. Sabin (1991) highlights the importance of being truthful with utilization review case managers and insurance representatives. It is clearly unethical to lie to these representatives, and doing so seriously compromises the therapeutic relationship even when the patient may encourage the therapist to tell a "just" lie. Often times the provider knows that being honest with a reviewer threatens the continuation of perceived necessary treatment. The therapist needs to know how to properly challenge the authority of a reviewer when such situations exist. Doing so requires skill and finesse. Even though MMHC has been constructed on a philosophy of brief
treatment, in practice reviewers are often unfamiliar with its theory and practice, and press to suppress all forms of treatment, including brief treatment (Bennett, 1993; Cummings, 1988). As a consequence, they often lack the necessary training and experience to recognize situations where treatment should be re-authorized, in spite of treatment exceeding the number of pre-authorized sessions. This applies even when therapy is not beyond reasonable brief standards (Budman, 1988). For example, it is not uncommon to find reviewers challenging requests to continue with patients who are in the midst of an acute major depressive episode, after as few as six sessions (Stern, 1993). In addition to performing one's ethical obligation to challenge negative treatment decisions, challenging reviewers requires advanced level advocacy knowledge and skill.

In addition to the above mentioned definitions of MMHC, and some of the special skills required for its proper practice, Bennett (1993) presents an evolutionary account of MMHC's development. Accordingly, MMHC has gone through three phases of development: the first phase - utilization review, the second phase - provider discounts, and the third phase - network development. By no means does this suggest that MMHC currently, or generally reflects stage three development. Examining MMHC from a developmental perspective provides a way of highlighting where the field has been, and some of the problems encountered and solved.

With respect to the first phase, Bennett (1993) cited the Institute for Medicine's definition of utilization review: UR "...is a set of techniques used on the behalf of purchasers of health benefits to manage health care costs by influencing patient care decisions mainly through case by case assessment of the appropriateness of care prior to its provision (pp. 54 - 55). During the early and mid-1980s, a number of utilization review firms sprang-up. Currently there are over 250 UR firms in
operation (Bennett, 1993). Utilization review firms sell their service directly to self-insured employers and indemnity insurance companies. Full service managed care companies have internal and external reviewers of their own. The theory behind UR states that a considerable amount of the health care dollar is spent on unnecessary procedures, or on fraudulent claims. UR proponents maintain that they can ascertain, with a high degree of accuracy, "medically necessary" care through a process of telephone calls and written communications with providers. The process of utilization review is one of authorizing care before it is given ( precertification/prospective review), during the process of care (concurren t review), and after care has been provided (retrospective review).

Most independent psychotherapists have major objections to utilization review, especially in those instances where they are being reviewed by UR firms with whom they do not have an agreement or contract (Appelbaum, 1993; Sharfstein, 1990). First of all, most of these providers do not consider themselves to be providing fraudulent or unnecessary psychotherapy, and probably are not. Second, most of these providers perceive themselves to have gone through a rigorous process of training and, therefore, not in need of having another party review their decisions from a distance (Moldawsky, 1990; 1993; Shulman, 1988). Among the major provider criticisms of UR are the following: the UR process intrudes on the doctor/patient relationship; it is difficult to determine that which needs to be reviewed; reviewers are poorly trained and inexperienced clinicians; the appeals process is often vague or extremely difficult; and finally, provider challenges are suppressed by the threat of being cut-out of the network. Overall the most severe criticism of the UR process is that it fails to change provider behavior. Providers are forced to look for ways of "getting around it" (Bennett, 1993). In other words, UR does not have the effect of helping providers
learn how to be more cost-effective. Finally, and with the caveat that it has significantly impacted the cost of inpatient care, UR does not work the way its proponents would have the payers believe. With the exception of detecting fraud, the process of utilization review of outpatient mental health care has been empirically demonstrated to be unnecessary. It is unnecessary because most patients finish therapy in a fairly short period of time anyway (Budman & Gurman, 1988; Phillips, 1985, 1988; Richardson & Austad, 1991). In addition to the ascension and cost created by UR, it is likely to have a negative impact on the cost-offset effect of mental health treatment on general medical care utilization. UR is overly concerned with preventing false positives. Its intent is to screen out treatment which is unnecessary, however, its effect is to often screening out necessary care (Stern, 1993).

Bennett's (1993) second phase of MMHC is referred to as the "provider discount" phase. During this phase, preferred providers were identified and extended independent contracts to provide services for referred employees or subscribers. As is the case with the traditional PPO, the managed care preferred providers agreed to reduce their fees in exchange for volume referrals. Managed care added to the PPO concept a layer of utilization review. In the MMHC-PPO organization providers had to agree to outside review. Bennett maintained that this failed because the idea of discounts was naive. The "inexpensive" providers, as Bennett referred to them, were not any less expensive. Very often the providers who were willing to discount their fees were inexperienced and poorly trained. They were willing to take whatever they could get because patients were not coming to them anyway. As it turned out the "inexpensive" providers often took more time and resources, and still failed to get the clinical job accomplished. Moreover, the problem of the traditional PPO, no incentives to cut-down the units of service provided, remained.
One of the pioneering managed care efforts operationalized in the mid 1980s, i.e., the American Biodyne concept of MMHC (Cummings, 1986), is an excellent example of a "second phase" MMHC organization.

The Biodyne model has generated a tremendous amount of criticism (Moldawsky, 1990; Shulman, 1988). However, it has also grown in size and scope to become a national MMHC provider now publicly owned and traded. In 1993 it was purchased by a major health care conglomerate, MEDCO. The Biodyne model is important because it was one of the MMHC trendsetters. At its core, it is a full-service mental health HMO. The major difference between it and the staff model HMO, is that in addition to its employed staff of mental health therapists, administrators, and clerical personnel, it has a national network of independently contracted preferred providers.

Many of the original Biodyne features have been modified or eliminated, yet a good number of its practices are still in vogue, and many of its ideas remain influential. According to Cummings (1986; 1988) Biodyne was owned and operated by clinical psychologists. The expressed reason for creating the Biodyne model was two fold. First, based on Cummings extensive clinical experience and research at Kaiser Permanente, he concluded that there was a better, and more cost-effective way of delivering mental health services. Second, Cummings maintained that, if psychologists did not take matters into their own hands and provide clinical services that also contained costs, the business community would take over mental health service delivery and dictate the way therapy would be provided. Ironically, as Shulman (1988) points out, Cummings developed a large corporation in order to fight the corporatization of mental health service delivery. At one time Cummings (1986)
spoke of having thousands of Biodyne Centers providing psychological services across the entire U.S.

Cummings (1988) stated that Biodyne began by first "throwing out all of the sacred cows". His expressed intention was to get rid of any unproductive treatment or treatment ideologies. What resulted was a treatment approach based on a philosophy of brief psychotherapy, a patient "bill of rights", and a "therapeutic contract" between the patient and the psychotherapist. According to the patient's bill of rights, the Biodyne patient has a right to expect to be free of psychological pain and suffering, to the extent that this is possible, in the shortest time possible, and with the least intrusive amount of intervention. The therapeutic contract states that the therapist will never abandon the patient, and that the patient will never be asked to do something he or she cannot do. In return, the patient is asked to join the therapist in a partnership to make him or her obsolete as soon as possible (Cummings, 1988). What then ensues is a process of brief intermittent psychotherapy that ends whenever the agreed upon presenting problem has been resolved. Patients were told that they could come back into treatment whenever they needed. However, each time they would focus on an explicit presenting problem and work it through to completion. One of the things not particularly emphasized by Biodyne is that there are a number of problems that are not deemed amenable to psychological intervention. Cummings (1988) further emphasized that since a number of therapists are not going to be comfortable with Biodyne's treatment philosophy and methods, only those who were comfortable with it should become Biodyne providers (Cummings, 1986, 1988; Haas & Cummings, 1991).

The Biodyne model has changed significantly over the years. Some of the ideas articulated by Cummings (1986, 1988) never materialized. For example, the
promise to never abandon the patient is predicated on the insurance contract not changing, something that has proven to happen frequently. Similarly, other things have changed, such as the fact that Biodyne is no longer run exclusively by psychologists, as was originally touted. Regardless, Biodyne has advanced and continues to advance many of the MMHC developments.

According to Bennett's (1993) analysis, after evolving through the UR phase and the provider discount phase, MMHC evolves into its third phase, which he calls the "network development" phase. Bennett (1993) defines third phase MMHC as a loose association of MMHC savvy individual and institutional providers. Further, it is the union of good clinical and business practices. This association is brought together under the auspices of a single payer, namely the MMHC organization. The MMHC organization contracts with an identified population of either employees or subscribers for specific mental health services. Typically the MMHC organization enters into a capitation arrangement with the business or insurance entity needing the mental health services. Likewise, it is usually the case that the services are delivered through an organized network of independent, fee-for-service providers. The network of fee-for-service providers is neither employed by the MMHC organization, nor are they linked to it through sub-capitation. In other words, the network providers do not take on the risk of providing service to the contracted group. The MMHC entity does. The network provider is solely a provider of service per the request of the MMHC company.

Bennett's (1993) view of the network is such that it is composed of willing providers, i.e., "the right clinicians". Providers who associate with the network do so because they genuinely feel comfortable with the organizational attitude, protocols, and philosophy. Utilizing "the right clinicians", the MMHC entity solicits and trains
providers who are most interested and capable of carrying out its goals and objectives; in contrast to struggling with unattached or reluctantly attached providers. With the right clinicians, the MMHC entity can focus on training them to be more clinically and economically effective.

According to Bennett, the third generation MMHC organization's unique contribution is its ability to shape provider behavior. The organization shapes provider behavior by selecting the right clinical person at the outset, those with a brief treatment orientation and philosophy, including a willingness to be clinically reviewed, a willingness to be overtly supportive of the MMHC process; and an ability to keep patients out of the hospital. Other desirable characteristics include an independent license, and easy patient access to treatment, i.e., short waiting-list, easy intake procedure, etc..

Another way of shaping provider behavior is through monitoring the providers' performance. This is accomplished by reviewing actual performance on an occasional basis, not on a case by case basis, as has been the custom. Finally, provider behavior is shaped by controlling the flow of patients. The primary thrust of third phase MMHC is to free the provider up to perform their function without the usual managed care interference. The goal of MMHC then becomes directing the process of care, not the actual provision of care (Bennett, 1993).

**The Theory Behind Managed Mental Health Care**

In order to meet the business community's demand for cost containment, the new model needed a theoretical ground that exceeded what had gone before it. MMHC had to do more than promise cost containment. The ground for MMHC is twofold. First, MMHC service delivery derives from the assumption that providing
mental health care has a "cost-offset" effect on general medical care (Borus, 1986; Borus, Olendzki, Kessler, Burns, Brandt, Broverman, Henderson, 1985; Burton, Eggum & Keller, 1981; Burton, Hoy, Bonin, Gladstone, 1989; Eggum, Keller & Burton, 1980; Hankin & Oktay, 1979; Jones & Vischi, 1979; Mumford, Schlesinger, Glass, Patrick, Cuerdon, 1984). Cost-offset proposes that, to the extent that mental health specialist services are delivered to people who request help, for whatever reason, their utilization of subsequent general medical service will decline more than if the mental health help had not been provided. The net result of the decrease in general medical service, and the commensurate decrease in the cost of the service, is said to be greater than the cost of general medical care, if mental health care had not been utilized.

The second theoretical ground for MMHC is the proposition that the amount of mental health service delivered, and the level of intensity of the service delivered, should be decreased, in most instances, from the amount and intensity of service typically delivered in the fee-for-service model. Regarding the amount of service delivered in the fee-for-service model, it has been more characteristically long term psychotherapy (Hartman, 1992). However, long term psychotherapy has not been shown to be any more clinically effective, in most cases, than its brief therapy counterpart (Budman & Gurman, 1988; Cummings, 1991). Thus, brief therapy is the ideal of MMHC. Regarding level of intensity, MMHC proponents advance the argument that the least intensive level of intervention is the most appropriate and effective level of intervention. Therefore, advocates of MMHC hold, for example, that inpatient psychiatric, and chemical dependency stays, can be eliminated in most instances, and reduced in the majority of the remaining cases. Historically, inpatient psychiatric care, as well as inpatient alcohol and drug treatment, have produced the
greatest cost in mental health care (Rodriguez, 1988). Kiesler (1982a) reported that as much as 77% of all mental health dollars, including chemical dependency, are spent on inpatient treatment.
The Cost-Offset Ground for MMHC

Bloom (1990) provided an excellent review of the literature on the connection between physical health and mental health. He reported that numerous studies have shown ill health to be significantly related to increased utilization of mental health services (Aronowitz & Bromberg, 1984; Burns & Burke, 1985; Eastwood, 1975; Hankin & Oktay, 1979; Kellner, 1966; Kessler, Burns, Shapiro, Fischler, George, Hough, Bodison, & Miller, 1987; Maricle, Hoffman, Bloom, Faulkner & Keepers, 1987; Regier, Shapiro, Kessler & Taube, 1984; Vaillant, 1979; Ware, Manning, Duan, Well & Newhouse, 1984). Eastwood (1975) found that people with serious physical disabilities used mental health services three times more than those who were healthy. Taube, et al (1984) found that persons with serious psychological problems utilized emergency room services significantly more than "normal" persons, i.e., 30% versus 11%. Hankin & Oktay (1979) found that recipients of mental health services visited their general practitioners twice as often as their non-mental health user counterparts. It is evident that there is a strong connection between the quality of general health and psychological health.

As there is a positive correlation between poor health and higher levels of mental health service utilization, the literature contains a number of studies which demonstrate that mental health and chemical dependency treatment offsets the cost of general medical care utilization. Several studies have made this point in a particularly convincing way. Borus et al, (1985) studied the "offset effect" of mental health treatment on outpatient medical care utilization and charges. A five year, longitudinal survey design was employed to study 400 subjects, all of whom had been given a
mental illness diagnosis during the study's index year, 1978. The group's medical care utilization was studied during the index year, as well as the two year periods before and after. One half of the group (N = 198) received specialist care from a mental health clinician, whereas the remaining subjects (N = 198) were treated by a nonspecialist physician. A retrospective analysis was performed on data routinely collected in the office, such as patient registration sheets, clinical notes, and billing forms. The patients' utilization and charges for medical and mental health services were examined monthly throughout the life of the study. The results of the analysis showed that there was little difference between the groups on their utilization of general medical services, not psychiatric, during the first pre-index year. However, over the balance of the study, the mental health specialist group showed significantly less (p. < .01) general medical care utilization. The nonspecialist treated group showed a 1.55 times greater use of service.

In addition to the reduced medical utilization for the group who received mental health treatment, it was reported that they had a significantly greater number of subjects with severe mental illness, i.e., diagnoses of: schizophrenia, other psychoses, organic brain syndromes, mental retardation, alcohol and drug abuse, and personality disorders. Finally, there was an absolute, although not statistically significant difference between the two groups on the cost of total service delivered to each. The mental health treated group surpassed the nonspecialist treated group by $297.00 per patient, even though the treated group received, on average, seven more total visits to the doctor. The authors concluded that this was to be expected because the treated subjects were sicker, and in need of more treatment than the other group.

In a similar study, Holder & Blose (1987) studied and compared a group of 27,000 randomly selected families who had the experience of having at least one
member of the family in mental health care, with another group of 16000 randomly
selected families who had not had any mental health treatment. Within the former
group, with the commencement of mental health treatment, the total cost of care
dropped for the patient receiving treatment, and continued to drop during and after the
termination of mental health intervention. Additionally, the costs of the untreated
family members also decreased. Regarding the latter group of 16000 families who did
not receive mental health treatment, health care costs remained the same.
Commenting on the study, Zimet (1989) reported that the implications were clear.
Receiving psychological care reduced overall health care costs.

Mumford, Schlesinger, Glass, Patrick, & Cuerdon (1984), reported on the
cost-offset of mental health care on general medical utilization. Upon reviewing the
cost-offset literature, they conducted a meta-analysis, i.e., a statistical procedure for
summarizing results across different studies. They found that the 58 studies supported
the cost-offset hypothesis. Moreover, they corroborated this conclusion by comparing
the results of the meta-analysis with data derived from the federal government's Blue
Cross & Blue Shield claims reported for the period of 1974 through 1978. The data
significantly supported a cost-offset.

The cost-offset data provided an excellent foundation from which MMHC
advocates could justify lobbying business to continue to support the delivery of mental
health services to their employees. Nevertheless, it remained the case that cost-offset
alone did not adequately address the problem of increasing health care costs. Taken
by itself, the cost-offset argument provided a partial answer. Cost-offset alone did not
explain why the MMHC approach would be more effective than the fee-for-service
approach. A number of questions remain unanswered, including: Who needs
psychotherapy? Which interventions are effective? For whom are specific
interventions effective? Which interventions work for what problems? and, How do we know when treatment has worked? (Austad & Hoyt, 1992). To answer these questions it is necessary to examine the second ground for the MMHC model, namely, brief psychotherapy.

The Brief Therapy Ground for MMHC

In addition to promoting the importance of cost-offset, MMHC proponents needed to convince the payers of the health care bill that there was a method for reducing the amount and intensity (the cost) of mental health services. To that end they promoted an understanding of the empirical evidence which demonstrates the effectiveness of brief psychotherapy.

Budman & Gurman (1988) stated that it is difficult to define brief therapy in terms of a number of sessions because the definition is always based on a comparison that can vary. For instance, to a traditional psychodynamic therapist, 50 sessions may constitute a brief treatment experience, whereas a behaviorist or a cognitive therapist may view this amount to be more than the norm or even an excessive number of sessions. According to Budman & Gurman (1988), "What is, in fact, being examined in any discussion of brief treatment is therapy in which the time allotted to treatment is rationed (pp. 5-6)." They prefer to describe brief therapy as "time-sensitive", "time-effective", or "cost-effective" therapy. Stern (1993) defined brief treatment in terms of the therapist's charge to do several things. First, the therapist is charged with the responsibility of helping the patient resolve his or her perceived problem in the shortest possible time-frame. Second, the therapist is charged with the responsibility of being cost-conscious. And third, the therapist is expected to be cost-conscious only to the extent that it does not compromise the care of the patient. Although not a definition,
Koss & Butcher (1986) reviewed the brief therapy literature and found that most brief treatments share a number of common characteristics including: promptness of intervention, early assessment, treatment plan formulated quickly, therapist's use of interpersonal relationship for leverage, therapist's concern for time management, limited treatment goals, directive management of treatment, focus or theme to therapy, ventilation or catharsis, and, flexible choice of techniques.

The effectiveness of brief psychotherapy is open to some debate, especially when forced on clinicians by way of third and fourth party demands. However, there are a number of advocates who assert that brief treatment is appropriate in as many as 75% to 90% of all clinical situations (Austad & Hoyt, 1992; Bennett, 1993; Cummings, 1986; 1988; 1991; MacKenzie, 1989; Stern, 1993). The effectiveness of brief therapy derives from an impressive number of studies which demonstrated its applicability and desirability in a number of circumstances, including cost-conscious environments. Bennett (1993) reviewed the pertinent literature and found that many treatment outcomes were, for all intents and purposes, no different, regardless of the intensity of the intervention. Among these studies, Hayashida, Alterman & McLellan (1989) did not find a significant difference in inpatient, versus outpatient detoxification of mild to moderate alcohol abusers. Whittington (1992) found no significant difference in outcome, when comparing inpatient, residential, and intensive outpatient treatments for alcoholism. Significant differences were not observed when comparing one form of brief psychotherapy with another (Luborsky, Singer & Luborsky, 1975). Significant differences were not noted between groups of severely mentally ill patients treated in day-treatment programs and those treated in inpatient settings (Washburn, Vannicelli & Longabaugh, 1976; Green & DeLacruz, 1981). The difference between long and short hospitalizations was not reported to be significant (Glick, Hargreaves &
Advocates of MMHC point out that the empirical evidence demonstrates therapy to be brief by its very nature. For instance, Koss (1979) found that most patients finished psychotherapy within 6-10 sessions, and 90% complete therapy within 25 or less visits. Budman & Gurman (1988) reported high levels of patient satisfaction within 10 sessions of therapy. Stern (1993) described most therapy as "naturally occurring". He asserted that most patients conclude treatment in a short period of time. Those who stay do so because their problems are not yet solved.

Quantifying psychotherapy does not, in itself, constitute a standard of effectiveness. However, the point needs to be made that contrary to the common understanding, effective therapy is not necessarily long term in nature. In view of the evidence, it may be that long term treatment is often mistakenly applied when its brief, and more cost-effective, counterpart may be more appropriate.

With reference to the number of psychotherapy sessions, and patients leaving treatment, Phillips (1985; 1988) developed the "mental health attrition curve". He found that 50% of all persons who went through a mental health intake process failed to return for a second visit. A declining number of patients leave treatment by the 5th or 6th session (approximately 70%), and only a small percentage of patients remain beyond a 10th session. Phillips stated that these figures relate to all clients seen, regardless of the therapist's theoretical orientation, and whether or not they had a long or a short term focus. These figures were confirmed for HMO patients as well (Budman, 1989; Richardson & Austad, 1992). Other findings affirm Phillips' attrition curve. Several researchers found most patients finished treatment in a similar number
of sessions, e.g., 50% of patients finished in 8 or less sessions, and 75% to 80% of patients in less than 26 sessions (Carr-Kaffashan, 1989). On the basis of 25 years of research data at Kaiser-Permanente, Cummings (1988) reported that most patients (85%) finished therapy in less than 15 sessions, with an average of 6.2 sessions overall. The remaining 15% received longer term psychotherapy.

It is not clear why patients leave psychotherapy in a fairly predictable fashion. Budman & Gurman (1988) related that patients leave therapy after they have experienced some improvement. Those who remain in therapy do so because they need help. Stern (1993) summarized the findings regarding whether or not patients sought help out of "need", "price", "level of insurance coverage", or other demographic variables. "Need" correlated with service use more so than the other variables. Goodman (1986) looked at the question of how much psychotherapy patients needed, and found that the amount of psychotherapy varied. In a meta-analysis of 15 outcome studies, in which 2431 patients were studied, the results showed that patients did not leave therapy until they had experienced some improvement. Approximately 50% of the subjects experienced improvement after 8 sessions, 75% improved after 26 sessions, and 85% experienced improvement after 52 sessions.

MMHC's grounding in brief therapy is empirical. Most people leave treatment in a relatively short period of time. If brief therapy is viewed as an ideal, refined and encouraged, then its increased promotion should eventually result in a reduction in overall service units, and costs would be contained to a greater extent. Additionally, the reduction in unnecessary service units would not negatively impact the cost-offset effect, because the minimum number of service units would be given with the maximum amount of clinical and cost containment effect.
MMHC's ground in brief therapy is well documented (Austad & Hoyt, 1992; Bennett, 1993; Bloom, 1990; Cummings, 1986; 1991). However, it must also be emphasized that knowledgeable MMHC practitioners are becoming more aware of the need to make the distinction between cost-effective treatment and brief treatment. When long-term treatment is indicated, its use is the most cost-effective. Perhaps the problem is one of definition, as Budman & Gurman (1988) pointed out, the term "brief" is always in comparison to a standard that may vary. The literature reflects a range of about 15% to 30% of patients who require "more intensive", possibly "long term" therapy (Bloom, 1990; Budman & Gurman, 1988; Cummings, 1986; 1991; Haas & Cummings, 1991; Phillips, 1985; 1988; Stern, 1993). Within the MMHC model, its advocates argue, patients can be offered the more appropriate treatment, i.e., longer and more intense treatment than the norm for most mental health concerns.

Some patients are better suited for brief psychotherapy than others. Research shows that there are patient characteristics that are indicative of whether or not the patient's problem can be adequately addressed in brief treatment. Strupp (1992) described three patient characteristics that indicate a patient's suitability for brief psychotherapy. First, at the beginning of treatment, the patient should demonstrate an ability to form a therapeutic relationship. Second, at the outset, the patient should exhibit significant motivation, and a desire to collaborate with the therapist. Third, a patient with a severe character disorder should be considered with great caution. Haas & Cummings (1991), in their review of the literature, cite Burlingame, Fuhriman, Paul & Ogles (1989) criteria for involving a patient in a brief psychotherapy. The patient should have clear focal concerns, with clear onset and time markers for the development of his or her problem, the patient should have a history of some
significant attachment; there should not be a pattern of chronic and extreme anger, psychopathy, organicity, or psychosis; and, the patient should be in perceived distress.

Similarly, MacKenzie (1989) provides "exclusion criteria" for the practice of brief psychotherapy. According to MacKenzie, patients are not amenable to brief psychotherapy if they are incapable of verbal communication (delirious, demented, retarded, and/or psychotic patients); have conditions that exceed that which psychotherapy can resolve (patients with a history of serious suicide attempts, chronic alcoholics, severe obsessive-compulsives, severely depressed and acutely anxious patients); or, if they have extreme character disorders, e.g., borderline. MacKenzie suggests that when considering brief treatment, the psychotherapist should apply the exclusionary criteria first, and then examine whether or not the patient meets any of the inclusion criteria.

**Perceptions of Managed Mental Health Care In the Provider Community**

Managed mental health care has been the source of great upset for many members of the provider community. Sharfstein (1990) referred to managed mental health care as "mangled care". Hartmann (1992), in his presidential-inaugural address to the American Psychiatric Association, described the current era of psychiatry as "unhappy", largely due to the growth of MMHC. He relates that in his official travels around the country, his constituency repeatedly asked him about the encroachment of MMHC on psychiatry, and further confided in him on a number of personal concerns. He summed up their feelings as follows, "I think many psychiatrist hate it, and feel terribly worn down and wasted by it" (p. 1140). Westermeyer (1991) blamed the deaths of seven patients on managed care. In these cases, managed care restrictions precluded a psychiatrist from being in charge of treatment in each of the seven cases, and hence the deaths. Westermeyer argued that the deaths would have been averted had a psychiatrist been in charge. Similarly, Durmont (1990) blamed the suicide of a
medical resident on the harsh and belittling demands of managed care. He reported his
disgust with the imposition of managed care requirements on practice, and likened it to
an assembly line where physicians are forced to do "piecework". Testimonials such as
these, while not typically as harsh, are abundant in the literature (Moldawsky, 1990;
1993; Sharfstein, 1990). Many providers harbor strong, negative feelings toward
MMHC (Moldawsky, 1993; Shulman, 1988)

In contrast, a number of practitioners have expressed favorable attitudes
towards MMHC. Lowman (1991) stated that intelligent clinicians and alert
researchers will see opportunities in MMHC. Cummings (1986; 1988; 1991)
promoted MMHC as a model that will enable the practice of psychotherapy to survive
in an era of cost cutting. Beck & Haaga (1992) found MMHC principles and practices
favorable to cognitive psychotherapy. According to them, consumers and payers of
psychotherapeutic services want to see treatment plans with identifiable goals, and
interventions based on empirical support of their efficacy, as is the case with many
cognitive interventions, e.g., the prescriptive treatment of depression (Beck, 1979).
Commenting on the future of behavior therapy, Giles (1991) and his colleagues found
very little support, until recently, for behavioral treatment. According to Giles,
managed care values treatments which are specific, short term, and have an empirical
basis of support. Zimet (1989) pointed out that MMHC may not be any more
financially constraining than the "free-choice" model. Regarding the "free choice"
model, he remarked that it is not really free, particularly as it relates to outpatient
psychotherapy, where there are often substantial deductibles, co-payments, and caps
on yearly and lifetime benefits. Endorsement such as these provide evidence of
considerable support for the model in some professional quarters.

It is not surprising that the perception of MMHC is fairly well dichotomized in
the provider community. The mainstream, traditionally-educated, solo practitioner has
been significantly affected by the imposition of MMHC on his or her practice. Even if
the provider elects not to be involved with MMHC, either as a preferred provider, or
as a respondent to MMHC's requests, his or her practice is affected by the workings of
MMHC (Broskowski, 1991). For example, some patients who would otherwise seek
the solo practitioner's services do not because he or she is not on the prospective
patient's list of authorized providers. Similarly, former patients who would ordinarily
return to the solo provider should the need arise, do not because their insurance does
not pay. Even if the patient pays the full fee without any recourse to an insurance
benefit, the provider may be negatively impacted knowing that this may impose a
financial hardship on the patient. It has not been adequately established, but it is
logical to assume, that the private practitioners who have not gotten involved with
MMHC have lost patients (Moldawsky, 1993). MMHC has altered the former referral
conduits by restricting whom they would pay (Sharfstein, 1990). Whereas most
patients had standard indemnity insurance in the traditional system, the new evolving
system funnels patients to MMHC providers, and shunts patients away from the stand
alone providers. Although this is not universally true, it is becoming increasingly the
case.

Sharfstein (1990) stated that MMHC has recognized and attacked the very
heart of the traditional model of practice. Accordingly, MMHC has sought to modify
the behavior of physicians who have heretofore been independently organizing and
prescribing treatment. They have been able to accomplish this by implementing
utilization review which has effectively taken on a significant role in the treatment
decision making process. As a consequence, the traditional autonomy and judgment
of the professional has been seriously undermined. In addition to managed care's
intruding on the very heart of the doctor/patient relationship, Sharfstein noted the
futility of the extensive paperwork and "worthless calls" from reviewers. He asserts
that utilization review, which has been unregulated, should be regulated. Finally, Sharfstein points out that UR rests on undocumented claims that it reduces costs. He calls it a "working hypothesis".

Similar to Sharfstein, Schreter (1993) reported that the traditional model, the "biopsychosocial model" of mental health, is under attack. He predicts that MMHC will continue to grow and take control of the service delivery system. More specifically, he predicts a number of trends to continue. First, managed care companies will begin to get out of actually having professional employees provide care. Increasingly managed care companies will select and manage independent practices capable of supplying services to "carve-out" groups of employees or subscribers. Rather than providing the care as they currently do, they will take advantage of, among other things, the use of computers to monitor the performance and adherence of selected providers to their protocols. Providers will increasingly have to know precisely what the managed care company expects, and then deliver it, if they wish to continue the relationship. Second, there will be an increasing regard for fiscal concerns at the expense of clinical ones. Third, control of services will shift from the provider to the payer. Fourth, the focus of therapy will shift from cure to adaptation. Presenting problems will be targeted versus underlying personality and/or neurotic problems. Consequently brief intermittent therapy will continue in its ascendance and long term therapy will continue its decline. Fifth, the movement towards independent providers taking on large portions of a managed care contractor's business will significantly reduce the need for intrusive and external utilization review. The selected independent practices will necessarily set-up their own internal utilization review. Such practices will range in the degree to which they monitor their providers. It is likely that there will be little need for intensive U.R. because the demand for services will be high and the approach will be brief. Finally, Schreter predicts that the
movement towards lower levels of care, including self help will continue, as will the
rationing of treatment, the development of "mega-provider" systems, the emergence of
universal health insurance, and the continued disruption of solo office practice.

Shulman (1988) responded to Cummings (1986) promotion of the American
Biodyne model. His critique brings out a number of good points from the vantage
point of a more traditional psychotherapist. He rejects Cummings assertion that
psychologists have to develop brief, standardized responses to their patient's problems.
One of the points is that much of Cummings' promotion of prescriptive/brief
interventions is predicated on the effectiveness of these interventions in reducing
general medical care utilization. Shulman argues that while it is a desirable
consequence to see general medical costs offset by mental health intervention, it is not
the primary function of mental health intervention to offset medical care costs.
Pointing out that most psychologists do not go into the practice of psychology to
offset medical costs, Shulman suggests most psychologists see their primary function
to be that of reducing psychological and emotional suffering. Psychologists are mental
health specialists not cost-offset technicians.

Another point made by Shulman (1988), regarding Biodyne, is its dependence
on a corporate structure. He asserts that Cummings' advocation of "corporatization"
of psychology as an appropriate response to businesses attempts to control the mental
health service delivery system is an overreaction. Shulman argues that corporatization
of mental health results in the system dictating practice, and this places the patient's
interest second to the corporate interest.

Some of the criticisms of the MMHC model are somewhat mollified by the assertion that it is not for every mental health provider (Austad & Hoyt, 1992;
Cummings (1991) advised that MMHC providers and potential MMHC providers
should not become involved with it unless they know what they are getting into. They recommended that before accepting a MMHC provider contract several things should be clear. First, the specifics of the contract should be understood, as well as the organization's treatment philosophy, UR protocol, and appeals mechanism. Second, providers should avoid plans that put explicit session number limits on outpatient psychotherapy, that skim sicker people from its membership, and those that may erect artificial barriers to suppress service utilization, e.g., waiting lists, excessive copayments, extensive/time consuming intakes with nonmental health personnel, etc. Third, providers were encouraged to participate in plans that provide features such as: training; availability of treatment alternatives if and when benefits are exhausted; education of their subscribers as to the nature of the benefits; and plans that are open to provider feedback.

As important as the preceding advice may be, it is of equal importance to know that, in theory, virtually all MMHC practice is dependent on a thorough understanding of brief psychotherapy, and a willingness to conduct treatment according to brief treatment principles (Blackwell & Schmidt, 1992; Stern, 1993; Strupp, 1992). However, in practice, most MMHC participants know very little about the theory and practice of brief psychotherapy. Not only is this true of the contract service providers that are recruited, but it is also true of most staff members employed by MMHC companies. This is evident if it is considered that there is a relative absence of training in either graduate school curriculums and internship programs (Strupp, 1992). Unless providers are taught the very basics of brief therapy, they will be unable to make informed choices about programs with which they should become involved.

With reference to MMHC/brief psychotherapy training, several authors have stressed the need for more of it. Budman & Gurman (1988) point out that being an experienced therapist does not equate with being an effective brief therapist.
Richardson & Austad (1992) agree, and add that ineffective therapists are not only more costly, but they are not helpful to the patient. They suggest that a result of being incompetent in brief therapy, or reluctantly involved in it, therapists are more likely to inhibit positive outcomes by showing inappropriate upset, by taking out anger on the patient by discharging patients to soon, by not knowing how to revise initial treatment plans where indicated, and by failing to advocate for patients when needed.

Stern (1993), a proponent and teacher of brief psychotherapy, stated his concern about the manner in which he believes virtually all MMHC organizations violate the principle of "therapeutic integrity". According to Stern, this is done by either the overt or covert mandating of brief psychotherapy for all psychotherapy situations. He contends that, even though the proper practice of brief psychotherapy is the most parsimonious and effective treatment approach for the vast majority of outpatient mental health concerns, it should not be universally applied as it has been. Most MMHC organizations mandate brief psychotherapy by one of two methods. One method is having a manifest treatment philosophy of unlimited sessions, but in actual practice rarely authorizing a provider to provide more than five or six sessions per authorization period or in total. A second method, is having a policy of utilization review that rarely sees "medical necessity" in more than five or six therapeutic visits, or effectively in terms of a very limited treatment encounter.

Stern (1993) outlines how at the early, middle, and late stages of therapy, therapeutic integrity is compromised by mandated brief treatment. In the early phase of treatment therapeutic integrity is violated in several ways, including the following: rushing the formulation of a treatment plan; having little recourse to change a hastily formulated or a flawed treatment plan; an atmosphere of pressure that undermines a patient's trust and confidence in the therapist; and an intrusive U.R. process that scares and/or confuses the patient. In the middle phase of treatment, therapeutic integrity is
threatened when, for instance, the client does not cooperate with the therapist by staying on the preordained and inflexible trek to completion of therapy as originally conceived and authorized. In such cases, the therapist often projects her or his own frustration and anger on the patient for making him or her fall behind schedule, or possibly make them look bad to the MMHC authority. In the termination phase of treatment, therapeutic integrity may be compromised by not allowing the patient the opportunity to thoughtfully leave treatment. The result is a therapeutic discharge that is more suited to the therapist's needs than the patient's need.

Perceived Advantages and Disadvantages of MMHC

With the caveat that staff model HMO providers, MMHC entrepreneurs, and most payers (at least at this stage) saw many advantages to adopting MMHC; most mental health service providers were reportedly finding more disadvantages than advantages. This perception has to a great extent been engendered by the way MMHC has entered the provider milieu (Shulman, 1988). It has surfaced in such a fashion as having the capacity to destroy established practices by either disrupting referral conduits, or by reducing payment for services rendered, and/or stopping payment for services heretofore rendered and reimbursed (Appelbaum, 1993; Benedec, 1991; Hartman, 1992; Moldawsky, 1993). Moreover, MMHC has succeeded in interjecting itself into daily office practices (Schreter, 1993), not because it has been invited in, but rather, because reimbursement is not forthcoming unless there is compliance (Fink, 1993).

The extent to which some aspect of MMHC is seen as an advantage or a disadvantage varies considerably with the beholder's orientation. For instance, Patterson (1990), a MMHC provider and vice president of American Psychmanagement, saw the infusion of managed care into traditional solo practice as adding a component of enhanced quality control and unprecedented partnership. In
contrast, Sharfstein (1990) observed MMHC to be a direct intrusion on the autonomy and clinical judgment of the professional. Similarly, but regarding another dimension of MMHC, Blackwell and Schmidt (1992), proponents of brief psychotherapy and MMHC, maintained that in contrast to long term therapy, termination is handled much better in brief therapy. On the other hand, Stern (1993), also a brief therapist, saw termination in a MMHC system as for the most part arbitrary. According to Stern, too often MMHC terminations are more a function of the patient having reached some arbitrary and low limit on the number of sessions, rather than having solved the mental health problem.

Proponents of MMHC report several major advantages (Austad & Hoyt, 1992; Bloom, 1990; Bennett, 1993; Broskowski, 1991; Cummings, 1986; Patterson, 1990; Zimet, 1989). First, patients can be seen by fewer providers because the stay in therapy is much shorter. Stern (1993) asserted that more people are likely to take advantage of brief treatment because there is less stigma attached to it. Several factors account for the lesser degree of perceived stigma. First, brief therapy focuses on the patient's perception of the problem, and in their terms. Second, the therapist adopts a directive, problem solving demeanor that is more readily understood by the patient. And third, patients' strengths are often built upon. They are encouraged to "adapt", rather than seek a "cure". Bennett (1993) observed that an advantage of working in the MMHC modality is the ability to utilize that which the therapist and patient perceive to be reasonable tactics, rather than just individual psychotherapy. For example, therapists are not usually discouraged from performing case management functions. Along the same line, but for a different reason, MMHC has enabled a number of persons to get help who probably would not have gone for help in the past. MMHC programs, especially those which maintain work place employee assistance programs, promote employee case finding. Supervisors and managers are trained in
the rudimentary signs and symptoms of various work place problems, e.g., alcohol, drug, depression, anxiety, and are instructed in how to refer troubled employees and family members to help (Masi, 1989; Zimet, 1989). As a direct result of work-place intervention, an increasing number of workers have received help. This has produced the unintended, yet positive consequence of a progressive breaking down of some of the stigma associated with getting mental health help. The reduction of perceived stigma of getting mental health, and the encouragement of employees to access mental health treatment is perceived as a MMHC advantage.

Just as the traditional HMO providers asserted, proponents of MMHC point out that it enables the greatest good for the greatest number of people (Sabin, 1991). It purports to do this by emphasizing such strategies as brief treatment, education, group therapy, and other "population oriented tactics", i.e., tactics that take into account the individual in relation to the group. As a consequence, MMHC organizations play up the notion that its providers are doing the ethically and morally good thing, i.e., more equitably dispensing scarce resources (Austad & Hoyt, 1992). It seems reasonable to speculate that as managed care continues to dominate the service delivery system its representatives will begin to be seen in a progressively more favorable light than they have been viewed in the past. Likewise, it seems that MMHC has a greater capacity to link the public and private sectors of the mental health service delivery system (Bloom, 1990). Whether or not this will happen remains an open question. But, since the fee-for-service providers failed to accomplish this task, the MMHC proponents have an advantage insofar as they can promote this linkage as an objective and an ideal.

Proponents of MMHC promote other perceived advantages, including greater accountability, outcome based interventions, and a general partnership between the network providers and the managed care entity (Austad & Hoyt, 1992; Bennett, 1993;
Cummings, 1986; 1988). The idea promoted is that members of the network will have greater collegial support. In effect, the members of the MMHC network will be able to depend on each other for support, consult with one another, and generally have a more predictable practice life. In fact, this does seem to have some promise. It is plausible to project that those providers who achieve a steady flow of patients, who are not hampered by intrusive UR, and who can elect to work with interventions that fit the presenting problem, will perceive MMHC as fitting their practice needs.

One of the benefits of MMHC, not discussed in any detail in the literature, is the steady income that a provider can derive by becoming a network provider. Even when it is considered that the provider is likely to surrender a substantial discount for services rendered, the provider is less likely to have his or her bill for services rendered ignored by the MMHC entity, assuming administrative and clinical protocols are observed. In contrast, the problem of having substantial accounts receivables remains for virtually all fee-for-service providers. Some providers are likely to give the discount and worry less about collecting their fee.

There are numerous perceived disadvantages of MMHC. First, from a review of the literature, it is clear that a good number of providers consider MMHC as an intrusive, uncaring, cost cutting process (Sharfstein, 1990; Schulman, 1988). It is primarily those who have directly benefited from its imposition that have positive things to say about it, e.g., the purveyors of MMHC products, such as American Biodyne. Even those who stand to benefit from MMHC's proliferation, e.g., proponents of brief therapy, have had some serious concerns about the way MMHC has been implemented. Most notably, Stern (1993) has observed that MMHC companies have been far too heavy handed about outpatient utilization review. He pointed out how MMHC organizations expend far too much effort on discovering false-positives, i.e., preventing patients who do not need treatment from accessing
treatment, at the expense of making access to treatment easier for patients in need of treatment. One of the most glaring negatives about MMHC is its ignorance of the numerous empirical studies on the attrition rate of patients in therapy (Budman, 1989; Phillips, 1985; 1988), and its insistence on costly, intrusive monitoring of outpatient therapy. Two things are noteworthy. First, the vast majority of people who use mental health services do so because they need to (Knesper, Belcher & Cross, 1988; Watts, Scheffler & Jewell, 1986; Taube, Lave, Rupp, Goldman & Frank, 1988). Additionally, these same patients leave therapy after they have experienced some improvement, and in a relatively short period of time (Budman & Gurman, 1988).

Most patients finish therapy in less than 15 sessions (Phillips, 1985; 1988). Second, intrusive outpatient UR nullifies some of the cost offset of mental health treatment. People who need mental health care may be refused it. As a consequence, they are likely to seek more expensive general medical care (Bloom, 1990). This is clearly a negative and contrary to the expressed, if not practiced, cost containment philosophy of MMHC.

There are some disadvantages of MMHC that have direct bearing on providers. Some providers who have had thriving established practices are suffering some severe economic consequences because they have to discount their rates far below whatever the managed care company could possibly make up with increased referrals. In other words, their practices had been full to the extent that they could fill all of the available hours with preferred patients. In addition, some of these providers who have been able to have associates provide services, especially services that are charged at a discounted rate, are no longer able to do this. In the traditional fee-for-service practice, it was common to have numerous associates billing under a single provider number. Since the advent of MMHC, this is becoming much more difficult to do. For example, most of the large national MMHC companies, MCC, U.S.B.H., MEDCO,
etc., do not allow this practice. They explicitly want contract service providers who are independently licensed (Bennett, 1993; Broskowski, 1991; Patterson, 1990). No longer are they willing to pay a premium to have someone supervise someone else, who is licensed at the independent level, as are now so many social workers.

Another disadvantage of MMHC is the scarcity of qualified trainers and role models (Blackwell & Schmidt, 1992). Budman & Gurman (1988), as well as others (Cummings, 1988; Stern, 1993), have pointed out the importance of specialized training in brief therapy, and in MMHC. It has not been the case that this kind of training has been widely available. As a consequence, it is likely that many therapist, even experienced therapist, will tend to avoid participation in something that is unclear to them.

In addition, many excellently trained and experienced therapists are being cut out of MMHC networks. As compared to more compliant network providers, they are more likely to raise objections and/or concerns about some MMHC decisions which are not in their patient's best interest (Shulman, 1988; Sederer & St. Clair, 1989). In the same vein, experienced and competent providers are having to deal with the pressure of decreased therapist/patient confidentiality, and the struggle to press their patient's interest with overly zealous and less informed case managers (Sharfstein, 1990). Moreover, providers are being kept on the phone for interminable lengths of time. Many providers are upset with the growing need to adapt to each MMHC company's idiosyncratic protocol and administrative concerns. Finally, even if a provider was to provide excellent service to the MMHC concern, there is always the chance of being cut out of it for fairly arbitrary reasons. One of the more common reasons is that the provider's contact in the MMHC organization, one that may have been developed over a substantial period of time, leaves, is transferred, promoted, or otherwise not in a position to refer patients. At that juncture, referrals from the
organization often stop.

Social Worker Involvement in Managed Mental Health Care

Although a review of the relevant mental health care literature reveals very little scholarly activity as it relates to social work and MMHC, especially the clinical, ethical, and potential involvement of social workers in it, several important things point to significant social work interest and involvement in MMHC. Aside from there being so little written about MMHC in social work major journals, it is hard to imagine social workers being uninvolved with, or unconcerned about MMHC. After all, as Goldstein (1993) observed, social workers provide as much as 65% of all psychotherapeutic services. In view of this major contribution to the mental health service delivery system, it does not seem reasonable to conclude that social workers are indifferent to MMHC.

In 1989, The NASW Board of directors commissioned a "White Paper" on the nature and extent of MMHC and its implications for the field of social work. The paper, which was written by Masi (1989), stated that MMHC constituted a "revolutionary" change in the mental health service delivery system, and that it presented "exceptional opportunities for the social work profession". Masi reported that, between October and December of 1988 she conducted a series of 28 face-to-face interviews, and 2 telephone interviews with persons she identified as members of professional associations (including the American Psychological Association, the American Psychiatric Association, the Association of Labor-Management Administrators and Consultants on Alcoholism); employee assistance professional and/or managed mental health care companies (including Human Affairs International, Personal Performance Consultants, Brownlee, Dolan, Stein Associates, American
Psychmanagement, and Preferred Health); major insurance companies (including Aetna, Cigna, the Travelers) and others, including representatives from Towers, Perrin, Forster and Crosby, IBM, the National Institute of Mental Health, and the Institute of Medicine.

According to Masi, the survey methodology consisted of a series of questions which focused on the following areas: general thoughts about MMHC; opportunities for social workers in MMHC; future directions; the identification of legal and ethical issues, and the assessment of training needs for social workers. Following the data collection and analysis, concrete recommendations were offered to the NASW Board of Directors.

Masi covered a number of MMHC issues, among them a description of how MMHC works, how its services range on a continuum, and the unique role of the social work profession in it. She reported that social workers have specialized skills that give them an edge over other types of professionals in providing MMHC services, including experience working with alternative delivery systems and training in counseling. She suggested that social workers have an advantage over psychiatric nurses because the latter lacked the degree of counseling skills social workers have and they were a small sized professional group (psychiatric nurses, not nurses of all specialties) best suited for inpatient work. Similarly, Masi suggested that social workers possessed an advantage over "psychoanalysts", since their clinical methodologies were at odds with MMHC practices. With respect to psychologists, Masi suggested that they were at a disadvantage in MMHC networks because they were not as expert in working with alternative delivery systems. After reviewing the paper, it was clear that Masi saw social workers' uniqueness in MMHC as rooted in their capacity for working within nontraditional systems. Although it was not stated, it
was implied that social workers would be more adaptable in the new delivery system because of their eclectic orientation and training, e.g., counseling, administration, network development, etc.

In addition to emphasizing social workers' special skills which would enable them to take on a unique role in MMHC, Masi briefly commented on the effect MMHC would have on the NASW Code of Ethics, the legal ramifications of MMHC, as well as social worker training issues. Among the ethical considerations, seven key issues were identified:

1. Financial pressure to contain costs could compromise the provision of necessary services, create conflicts of interest, reduce quality of care, and reduce access to care.

2. There exists a significant risk of abuse of power among MMHC providers, EAP providers, insurance companies, and more generally anyone who stands to benefit financially from MMHC.

3. There are serious potential conflicts of interest around authorizing treatment and payment for treatment.

4. Rigid standards of treatment, especially computerized diagnostic systems may prevent individualized care.

5. The increased demand to contain costs may result in the termination of high cost employees.

6. The computerization of records and information sharing regarding patients may compromise confidentiality.

7. There is a good deal of potential for MMHC creating a system of "kickbacks" for referrals (p. 11).

Masi also identified the following potential legal issues: legal challenges to cases denied authorization; antitrust concerns; standard of care concerns; the adequacy of professional liability insurance covering MMHC treatment decisions; and, a potential for labor union-management conflicts. Regarding social work training, Masi pointed
out that short term therapy skills needed to be taught and that there needed to be an increased emphasis on substance abuse education. She also suggested that social workers needed to be better educated in all phases of health economics, need to develop a greater awareness of medical issues, especially the diagnosis of major medical conditions. Further, she maintained that social workers needed to gain a greater familiarity with medications and, more particularly, psychopharmacology, as well as needing to develop negotiating skills, especially as they relate to gatekeeping and dealing with psychiatrists. Finally, she suggested that social workers needed to develop a greater understanding of alternative treatment modalities.

To respond to these ethical, legal and training issues, Masi recommended that the NASW Board of Directors instigate a broad national effort to achieve several goals. The effort she recommended had several components. First, she suggested NASW form a managed mental health care council. Second, she recommended NASW establish a membership information campaign which would sensitize and inform social workers about MMHC. Third, she suggested NASW form a certification system for advanced training if MMHC. And fourth, she recommended NASW form MMHC training institutes.

In the preface to the "white paper", Masi, stated the following: "The profession should be primed to serve a pioneering role in managed mental health and should embrace this opportunity immediately (p. 1)." The paper concluded in the same vein as follows:

(The author) ...has attempted to alert the National NASW Board to a revolutionary new system of delivery of mental health services which will dramatically affect the entire social work profession. The potential for the social work profession is enormous. The profession has a right to expect the Board to exert its expertise and to act immediately before the opportunity dissipates (p. 19).
Several points need to be made concerning Masi’s report. First, the report appears biased in favor of MMHC, business, and employee assistance. Several things substantiate this point. As indicated in Appendix A, Professional Summary, in addition to the author being a Professor at the University of Maryland School of Social Work and Community Planning and an Adjunct Professor at the College of Business and Management, at the same university, the author was President of Masi Research Consultants, Inc. MASI, Inc., was noted as specializing in EAP and Managed Mental Health design, implementation and evaluation. Second, twenty-four of the study's thirty respondents, were either owners or employees of major MMHC companies, major employee assistances companies, and/or major insurance and consulting companies. Third, even though there had been far fewer scholarly articles available on MMHC at the time this report was written, the literature reviewed was almost exclusively taken from EAP trade publications. These publications are inordinately biased in favor of adopting and developing MMHC practices. More critical literature was not reviewed.

In addition to the report's bias in favor of MMHC, the second concern is its lack of caution with regard to its exhortation to the NASW Board of Directors to adopt MMHC practices immediately. Even with Masi's mention of potential ethical conflicts, the report skipped over the ethical concerns in such a fashion that suggested that these concerns could be relatively easily worked out as involvement increased. Although it is important for social workers to be knowledgeable and involved in shaping MMHC, it is probably the case that social workers should take a more prudent course of study of the issues, before rushing to adopt MMHC, as Masi suggested.
In an article in the NASW NEWS, Edwards (1990), in his capacity as President of the National Association of Social Workers, wrote about social workers and MMHC. While seeming to be in support of a number of Masi's (1990) assertions, Edwards presented a more cautious message, making a number of points in the editorial. He observed that social workers were increasingly being called upon to manage costs and reminded readers that social workers have a long history of being in the forefront of change. He also suggested that social workers needed to better understand the current trend toward cost containment and the emergence of MMHC. Like Masi, Edwards stated that social workers were in a unique position to play a prominent role in managed care systems. However, unlike Masi's ebullient account, Edward's remarks were more restrained. He pointed out that even though social workers possessed a core of skills applicable to MMHC, and even with their extensive experience in providing quality services under significant fiscal constraints and their knowledge of alternative delivery systems, there remained a number of serious concerns.

Among the concerns Edwards identified was what he termed the "decision makers" (the payers) relative lack of knowledge of what social workers had to offer because of social workers' general lack of participation in the business community. Considerable concern was expressed that social workers would go unnoticed by MMHC payers and consequently would be at risk of being left out of the emerging service delivery system. If this were to occur, Edwards argued, then social work's gains in such areas as independent vendership could be lost.

In order to prevent being left out of the new MMHC system, Edwards advocated a number of things. These included a strong effort to become more
knowledgeable about MMHC's legal and ethical issues, more knowledgeable about responding to MMHC requests, increasing efforts to target educational and training needs, and increasing social worker understanding of the ramifications of MMHC on consumer choices, quality assurance, and access. After stating that social work had already been negatively impacted by managed care, Edwards urged social workers to draw on their social work values and skills to formulate an analysis of managed care's short-comings, and further to apply these values and skills to overcome the short-comings of managed care.

Edwards concluded with a review of the steps NASW had already taken with regard to MMHC. They included a program of educating the public about social work and managed care, the development of a NASW task force on MMHC, the development of standards for the practice of MMHC, the initiation of research on MMHC, and the initiation of training sessions on MMHC.

In addition to this article's articulation of some of the key issues regarding social work's relationship to MMHC, and a call to take certain steps in dealing with MMHC, there was a tone of caution and restraint.

Strom (1992) presented the only managed care specific article to appear in a major social work journal to date. The article, "Reimbursement Demands and Treatment Decisions: A Growing Dilemma for Social Workers", was an attempt to put in perspective a number of important MMHC issues, especially as they related to the profession of social work. Strom noted that even though social workers have made major advances in the private practice of social work by gaining legal status in all of the 50 states and the District of Columbia, as well as vendership status in over half of the states, that they may be "...breaking into private practice at the very time that the
setting itself is becoming extinct (p. 398)." She noted that the third party restrictions on practice are of such magnitude that they may make private practice impossible.

In addition to presenting some limited background on the traditional and alternative mental health service delivery systems, Strom points out some of the philosophical, clinical, and ethical issues and conflicts. Among the philosophical issues raised was whether or not social workers should even be involved in private practice. Some social workers (Falck, 1984; Levinstein, 1964; Merle, 1962) believe that social workers should not enter into private practice because it would lead to the abandonment of the poor and severely mentally ill. Strom reported on research showing that social workers in private practice tend to be less concerned about social action and advocacy (Borenzweig, 1981), whereas other research has shown that private practice leads to a better result with clients because it is unfettered by the bureaucratic demands of agencies (Levin, 1976).

Aside from the question of whether or not social workers should be involved in private practice, Strom discussed the issue of MMHC limiting services only to the employed, or to those with employed spouses. In addition, she raised the issue of restricting payment to anything other than psychotherapy with a DSM III diagnosis.

Strom reiterated many of the clinical and ethical concerns raised by psychologists and psychiatrists. These included the following: MMHC entities' effect on confidentiality, on treatment decision making regarding the type of therapy, the length and frequency of therapy, as well as the focus of treatment. Strom was also concerned about the potential interference of the third party reviewers on the therapeutic process. The influence of third party reviewers could lead to the clinician's subordination of the patient's best interest to the interest of the MMHC company.
In addition to the above mentioned articles, MMHC has received some additional attention in the *NASW News*. Landers (1992) presented a series of three articles on MMHC in the September through November editions of the *NASW News*. In these articles, social workers were described as signing more MMHC contracts. However, it was unclear how this conclusion was derived. Landers did not specify "more" in terms of whom or what. According to Landers, with the increased MMHC involvement social workers were also reported to be asking questions, including: Who determines treatment?; Is the provider an agent of the managed care company?; How many sessions are allowed? etc. Landers articles covered some of the rudimentary concerns related to MMHC. Overall, the series failed to provide a broad census of the issues and concerns. On the other hand, it did demonstrate considerable interest on the part of numerous social workers. Throughout the series, social workers were quoted with respect to their involvement with different MMHC organizations, including EAPs. As would be expected, there was a full range of opinions expressed. The upshot of the series was its testimony to social workers' interest and involvement.

Very recently, August 1993, NASW's Delegate Assembly approved a policy statement on managed care (NASW, 1993). The Assembly made it clear that this was a policy on managed care in general, not just MMHC. In the prelude to the actual policy statement, some background information is provided. Several things were stated. First, managed care has come to mean care provided under controlled conditions and generally in accordance with a "medical model", versus a "biopsychosocial model" of care. Second, it was asserted that the rapid growth of MMHC plans was overwhelming the abilities of both providers and consumers of the services. Neither the providers nor the consumers have been able to objectively assess such issues as quality of care, accessibility to care, and other critical considerations.
Third, social workers were cautioned to be particularly aware of the potential harmful consequences of "gatekeeping" in MMHC organizations. The policy stressed that gatekeeping could be used to direct patients to appropriate care, but it could also be used as a way of preventing patients from getting needed help. Fourth, social work roles in MMHC were enumerated including being members of primary care hospital teams and providers of mental health services. With respect to their role in managed care organizations, social workers are expected to assume roles as preferred providers, administrators, consultants, planners and case managers. Finally, it was pointed out that managed care should be considered a neutral concept, neither desirable nor undesirable (NASW, 1993, pp. 169 - 170).

In the "issue statement" of the managed care policy, the Delegates identify the serious risk social workers face with respect to being locked out as providers of professional services. In addition to this concern, the Delegates emphasized a need to develop MMHC standards. Basic standards should include at least the following items: "...universality, portability, affordability, consumer protection and involvement, and requirements for equitable coverage must be included in a national health care policy. In addition, standards for the inclusion of social health care, mental health services, and the availability of social work services are essential in reshaping health care (NASW, 1993, p. 172)."

Regarding the actual NASW policy on managed care, it advocates strategies relating to standards, social work role, and advocacy. Concerning minimum standards for MMHC, the following should be included: a full range of readily available services, safeguards for confidentiality; access to service that meets the needs of special populations; clearly drawn managed care agreements; continuity in treatment, even when benefits are exhausted or transferred; emergency procedures and services; 24
hour access to medical records; basic social work services, including crisis intervention, intervention, assessment, prevention, health education; provision of psychotherapy to individuals, families, and groups, by social workers; readily available complaint and appeals mechanisms; and finally, advisory boards that meet regularly and include consumers of the services (NASW, 1993, pp. 172 - 173).

Social workers play three essential roles in managed care. First, social workers provide direct clinical service. As such, social workers provide a full range of professional services including the diagnosis and treatment of mental and emotional disorders, psychosocial dysfunction, disability and impairment. Moreover, the policy emphasizes that social workers are qualified mental health clinicians. Social worker qualifications include advanced level education and licensing. Second, the social work role in MMHC includes being part of the MMHC staff, e.g., utilization management, network development and management, and operation management. According to the policy, social workers..."use the fundamentals of social work case management that provide a theoretical and technical framework for coordinating mental health and substance abuse benefits with the resources of the family and the community in the best interest of the client" (NASW, 1993, p. 173). The third social work role is that of health care leadership. Social workers have the capacity to develop and implement new service options for their clients and communities.

The final strategy addressed by the managed care policy is advocacy. According to the policy social workers should: insist that social work services be included in managed care plans; promote legislation that will support the standards the managed care policy enumerates; lobby for legislation that mandates professional social work services in all managed care plans, including self-funded plans; promote legislation that requires utilization management to be done by a member of the same
profession; and challenge plans that restrict provider participation and consumer access (NASW, 1993, pp. 173 - 174).

The policy statement concludes by emphasizing the importance for all social workers involved in managed care to work towards promoting that which is in the best interest of the consumer of service.

Applying the Diffusion of Innovations Model to Clinical Social Workers' Involvement in Managed Mental Health Care Technology

There is no way of accurately knowing the nature and extent of social workers' involvement and adoption of MMHC unless an attempt is made to conceptualize it, and then empirically assess it. One useful model for conceptualizing this problem is Rogers' (1962; 1971; 1976; 1983; 1986) Diffusion of Innovations Theory. According to the theory, the adoption of an innovation is a function of its perceived relative advantage, compatibility, complexity, observability, and trialability. This analysis concerned itself only with the first three adoption characteristics. Considering the first excluded adoption characteristic, "trialability", diffusion theory posits that the more an innovation can be tried out in smaller amounts, rather than in its entirety, the greater the likelihood of its adoption. Similarly, considering the second excluded adoption characteristic, "observability", diffusion theory posits that the more an innovation can be observed, then the greater the likelihood of its adoption.

A few reasons account for dropping the later two adoption characteristics. Both trialability and observability were seen as having measurement problems which exceeded their potential contributions to the overall research effort. Also, in a study of the adoption of solar energy systems in the United States (Maine), trialability and observability were unable to distinguish between adopters and nonadopters, even when the other adoption characteristics performed in the manner diffusion theory predicted
(LaBay & Kinnear, 1981). Additionally, both of these constructs were seen as less relevant to MMHC's adoption because, first, in many respects MMHC is difficult to try out. Although it is possible to get involved with MMHC to a minimal degree, generally it is not possible to get involved with MMHC in a large way. In other words, even if one is willing to learn MMHC and accept MMHC patients and/or conditions, opportunities to work with MMHC entities may not be forthcoming. Likewise, MMHC's consequences are difficult to observe. Much of the difficulty in observing MMHC is due to its being a fairly abstract construct.

Based on a review of the pertinent mental health literature, and also the researchers extensive involvement in both the traditional fee-for-service and MMHC models of service delivery, some speculation and tentative conclusions are offered with respect to social workers' perceived involvement and adoption of MMHC. First, MMHC has been imposed on the mental health service delivery system by the payers of the service, i.e., businesses. It is likely that MMHC will continue to grow unless business decides to go back to the fee-for-service system, something, which is not likely to happen in the near future. Second, since a significant, although unknown, number of psychiatrists, psychologists, and social workers, as well as clinical counselors, psychiatric nurses, and a mix of employee assistance professionals have already elected to adopt MMHC practice to some extent, it follows from the diffusion of innovations theory that increasing numbers of clinicians within each of the professions will become more involved in MMHC, especially if they see relative advantage and compatibility increasing with involvement, and complexity diminishing. The result of continuing involvement should be the development of new expectations on the part of both providers and patients, as well as payers. The consequence of growing involvement could be the redefinition of what is appropriate mental health
service, for instance, who should receive what kind of service, for how long, and at what level of intensity. Thus, the system will change.

Also, MMHC is likely to grow and develop if several trends continue to be perceived as productive. One of them, the practice of brief psychotherapy, seems to hold considerable promise for being a viable type of psychotherapy for most people. Another trend that is likely to continue to fuel the managed care movement is the ongoing increases in health care costs. This in concert with the promotion of evidence for a cost-offse: to mental health care on general medical care will probably boost it.

How might there be a relative advantage to social workers for adopting MMHC? It is probably the case that social workers as a group have more to gain from the continued growth of the MMHC than two of its "rival" professions, psychology and psychiatry. As compared to psychology's and psychiatry's stake in the private, fee-for-service model, social work's stake has been markedly less. For the most part, social workers have been operating outside of the private, fee-for-service arena until recently (Strom, 1992). Hence, if the fee-for-service model declines in favor of a model that places a higher value on, for example, masters level providers, then social workers have the potential of faring better than the others (Brookowski, 1991; Patterson, 1990). Over the past forty years, psychiatry and psychology have carved out a substantial place for themselves in the largely private service delivery system. In this system they have grown accustomed to having solo and group private practices that have given them great personal and professional autonomy, as well as generally good to excellent incomes (Bloom, 1990). On the other hand, social workers have been excluded to a great extent from this system, or at the least, less enfranchised. For example, until recent times there have been significant barriers to conducting unsupervised psychotherapy for social workers. Social workers had been,
and are still often required to conduct private practice under the auspices of a psychologist or a psychiatrist. In a MMHC service delivery system this is not the case. In a MMHC system social workers have a very good chance of becoming the preferred providers of general psychotherapeutic services, such as individual, couples, group, and family therapy (Sabin, 1991). This is likely to evolve because outcome research has not shown a significant difference between outcome of psychotherapy as delivered by masters level providers, in comparison to doctoral level providers. In a MMHC system, doctoral level providers, although well suited to provide care, may be increasingly used as specialists (Paterson, 1990). It is logical to assume that MMHC organizations interested in containing costs would be more likely to refer patients to social workers because, in addition to their capacity to perform a quality service, they can be paid a lower rate of reimbursement (Bloom, 1990; Cummings, 1988).

In the event that MMHC continues to grow, it is likely that there will be growth in the utilization of social workers as service providers. As a result, social workers in private practice, as well as agency practice, may be more sought after than psychologists and psychiatrists who generally command a higher fee (Cummings, 1988). Moreover, as social workers fill their potential service hours, their incomes will increase, as will their sense of belonging and status. In a MMHC model, some of the benefits to enfranchised providers include: less worry about the continued flow of new patients; less worry about collecting one's fee, because it is largely paid by the MMHC company; more independent clinical practice; greater capacity to perform nontraditional services and receive reimbursement, such as, family and group therapy; consultation and education; and an opportunity to serve clients not traditionally seen (Bloom, 1990; Bennett, 1993).
In addition to the potential benefits to social workers which are inherent in the MMHC model, there is the opposite potential for those who do not get involved. Therefore, there is an incentive to get involved or suffer the consequences. If the model continues to grow as it has, then social workers who resist it will suffer the effects of continued loss of patients, income and status.

With respect to social work, how might there be compatibility in adopting MMHC practice? For those social workers who have succeeded in carving out successful practices in the fee-for-service and/or agency models, they will continue to suffer some significant compatibility problems, but these are no different than psychologists and psychiatrists. On the other hand, whether established or not, for those social workers who educate themselves in the ways of MMHC, and practice in a professional and ethical fashion, it seems reasonable to speculate that compatibility will increase with increased experience in the model.

As a group, and in comparison to psychologists and psychiatrists, social workers are arguably more likely to be compatible with MMHC practices because they have historically worked under less than optimal conditions. Social workers have a long history of working with less economically and socially advantaged patients than those who had typically presented in a private practice offices (Jayaratne, Davis-Sacks & Chess, 1991, Strom, 1992). Further, social workers have had a history of having to work "in the field", manage significant amounts of bureaucratic requests for paperwork, meetings, and other intrusive requirements that exceed the direct practice of psychotherapy, as well as accommodate the requests of supervisors who might be thought of as being somewhat analogous to third party reviewers (Strom, 1992).
Social workers who have greater familiarity with the distinctions and assumptions which exist between the traditional and HMO models of service delivery, as well as the differences between focused and longer term psychotherapy, are likely to see MMHC in a more compatible light (Austad & Hoyt, 1992). Even though MMHC may force workers to alter their practice styles, it is not the case that MMHC necessarily imposes such things as discriminatory practices, creates exploitive practices, nor does it force workers to give up all of their cherished practices. Further, it may be the case that managed care offers the prospect of increasing the availability of services to under served groups. All of this would seem to be compatible with social work values and beliefs.

As it relates to complexity and social workers adoption of MMHC, it is likely that social workers will see it in similar terms as their colleagues in other mental health disciplines. Regardless of how it is presented, in comparison to the fee-for-service model, MMHC is more complex. First, it is felt that there is increased complexity for those clinicians unfamiliar with the distinctions between the major models of service delivery, as well as the differences in the theory and practice of brief psychotherapy, as compared to those already involved with MMHC. Those who are less familiar with the differences are likely to be subject to greater levels of bewilderment when required to coordinate treatment decisions within a MMHC context. Among other things, there is often confusion around who is entitled to patient information, and the nature and the extent of the information. Those who are less familiar with the differences in treatment philosophies and practices are more likely to be less clear on the reasons behind the significant demands for the coordination of reporting requirements, authorizations, and releases. Hence, this lack of familiarity is likely to increase the perception of complexity.
Second, in comparison to the fee-for-service system, the MMHC system is still plagued by vast differences in reporting requirements. This relates to both clinical reporting procedures and administrative reporting. As a result of the significant differences, many therapists view MMHC as being very idiosyncratic, complex, and difficult to learn. Hence, it is likely that those who are less involved with MMHC are more likely to see it as a very complex system because it really is more complex. It seems reasonable that clinicians would be less likely to get involved with something perceived to require them to give up known and predictable practices for more complex and unfamiliar practices.

In summary, it is felt that there are good reasons to believe that the diffusion of innovations model can be applied to the question of to what extent social workers have adopted MMHC technology. It is felt that the adoption relevant characteristics of relative advantage, compatibility, and complexity, can be operationalized in such a fashion as to yield information that will further the understanding of why the social workers who have gotten involved, did so, and likewise, why those who have not gotten involved, have not.
CHAPTER THREE

RESEARCH METHODOLOGY

Research Question

Beyond an actual descriptive account of clinical social workers' reported perceived involvement with managed mental health care technology, and associated questions pertinent to adoption of MMHC, the primary research question was the following: "Does perceived involvement with managed mental health care technology have a differential relationship with the diffusion of innovation adoption characteristics of, "perceived relative advantage", "perceived compatibility", and "perceived complexity"?" It was hypothesized that there would be a statistically significant positive relationship between level of perceived involvement in MMHC, and the perceived adoption characteristics relative advantage and compatibility. Similarly, it was hypothesized that there would be a statistically significant negative relationship between level of perceived involvement with MMHC, and the perceived adoption characteristic complexity.

Research Hypotheses

Using a sample of clinical social workers, this research tested the omnibus hypothesis:

The greater the level of perceived involvement with MMHC, the greater the perceived relative advantage and compatibility, and the lesser the perceived complexity.

Using the same sample of clinical social workers, this research tested the following sub-hypotheses:
Sub-hypothesis #1.

The greater the level of perceived involvement in MMHC, the greater the perceived relative advantage.

Sub-hypothesis #2.

The greater the level of perceived involvement in MMHC, the greater the perceived compatibility.

Sub-hypothesis #3.

The greater the level of perceived involvement in MMHC, the lesser the perceived complexity.

**Conceptual and Operational Definitions**

**Perceived Involvement with Managed Mental Health Care Technology**

Perceived involvement in managed mental health care technology is conceptualized as having the relative valence of adoption of MMHC, without having the same degree of definitional difficulty. As was noted in the first chapter, developing adoption criteria for a technology as new and as amorphous as MMHC technology would be very difficult and less productive than developing an indirect measure of adoption, such as perceived involvement. Whereas clinical social workers may perceive themselves as very involved with MMHC, either by employment, or by acceptance of MMHC sub-contracting, i.e., taking patients under specific MMHC terms, they could also avoid stating that they had "adopted" MMHC technology. The notion of adoption connotes acceptance, including the implicit assumption that there is a preference for something, in this case MMHC. For purposes of this research, preferring MMHC exceeded the requirements for adoption of the innovation. It is likely that the vast majority of psychotherapists would never choose MMHC on just its
own merits and in the form that it has presented itself. Most often, the reason for involvement/adoption of MMHC has included some amount of implicit coercion. For instance, it is becoming more evident that psychotherapists who resist doing brief psychotherapy, or resist complying with UR requests, will be shut-out of the growing referral stream created by MMHC companies. Therefore, to avoid the problem of defining adoption criteria, including the aesthetic consideration implicit in the term adoption, perceived involvement was selected.

Even though it is an indirect measure of adoption, perceived involvement of MMHC gets at whether or not the respondent is connected to the MMHC process. This is precisely what this research is about. Those clinical social workers who are connected to the MMHC process need to be further examined. Conversely, it is of great interest to examine those not connected to the process.

Questionnaire item #2 measures level of perceived involvement with MMHC. The following directions on the questionnaire instructed the respondent to consider the following definition of a "managed care clinician" before responding to the request to check the answer which best described the respondent's involvement in MMHC:

Check the statement that describes you best. Remember for purposes of this study, A MANAGED CARE CLINICIAN IS ANYONE WHO IS ACTUALLY EMPLOYED BY A MANAGED MENTAL HEALTH CARE COMPANY, AND/OR A PRACTITIONER WHO ACCEPTS CLIENTS UNDER SOME OR ALL MANAGED CARE CONDITIONS, SUCH AS CASE MANAGEMENT, UTILIZATION REVIEW, AND REDUCED FEES.

A four point scale was constructed to measure item #2, "perceived involvement in MMHC technology":

___ I am not involved with managed mental health care at any level.
___ I am minimally involved with managed mental health care.
I am fairly involved with managed mental health care.

I am very involved with managed mental health care.

Respondents who indicated that they were not involved with MMHC were instructed to skip questionnaire items three through five (questions dealing with actual MMHC experience) and continue with item #6. The remaining respondents' selections placed them in one of three groups ranging in level of perceived involvement with MMHC technology.

Perceived Relative Advantage of MMHC Technology

Perceived relative advantage is defined by Rogers & Shoemaker (1971) as the degree to which the new idea or invention is perceived to be better than the previous idea or technology. Similarly, Darley & Beniger (1981) report that the greater the degree to which a social group is disenchanted with the status quo, the more likely they would respond favorably to a new idea or technology. The innovation does not have to have an objective advantage over the idea or technology it supersedes. The critical condition is that the new technology is perceived to have an advantage over the technology it replaces. A number of indicators may serve to measure the relative advantage construct, including economic, prestige, convenience, and satisfaction factors (Williams, Rice & Rogers, 1988). According to diffusion of innovations theory, the greater the perceived relative advantage of an innovation, the greater the likelihood of its adoption.

In order to measure the diffusion of innovations construct, relative advantage, a fifteen item scale was developed specifically for this study. The items constituting the MMHC Relative Advantage Scale were in large part derived rationally, based on the researcher's seven years of direct practice in MMHC, which included the founding
and incorporation of a regional managed mental health care company, as well as a long standing subcontractor relationship with more than a half-dozen national MMHC organizations, including Assured Health Care/American Biodyne, Educational Training Programs, Human Affairs International, Metropolitan Clinics of Counseling, National Employee Assistance Services, The Travelers, and U.S. Behavioral Health Care. In addition to the researcher's experience with MMHC, the relative advantage scale was modeled after the scale developed by Guagnano, Hawkes & Acredolo (1986), and later modified by Pandey (1990). Guagnano, et al studied the adoption of solar technology in California. Pandey studied the adoption of new wood stoves in central Nepal. In each study separate scales were constructed to measure each diffusion of innovation's construct. The number of items measuring the respective concepts varied between the studies.

Four of the fifteen items on the "MMHC Relative Advantage Scale" were intended to tap a relative economic advantage to adopting MMHC. The items were:

#13. If I don't get involved with managed care eventually my practice will be unable to get sufficient 3rd party reimbursement.

#16. I don't expect managed care practice to increase my income.

#24. With managed care referrals I worry less about collecting my fee.

#46. Managed care practice has increased my income.

Two of the fifteen items on the "MMHC Relative Advantage Scale" were intended to tap relative advantage in terms of increased referrals. The items were:

#18. Managed care isn't going to build up my practice with referrals.

#48. Managed care has not increased the number of clients in my practice.
The remaining nine items on the "MMHC Relative Advantage Scale" seemed to be multidimensional in nature. The relative advantage was thought to be as follows:

#21. Because of managed care I have less of a need to be supervised by a psychiatrist or psychologist in order to be paid.

#27. Because of managed care I have more career options than before.

#28. Managed care practice has not afforded me greater status.

#31. Because of the steady flow of clients referred by managed care organizations, I can discharge clients sooner than before.

#36. Managed care has made it easier for me to get reimbursed for interventions such as marriage and family counseling.

#39. Managed care has made my work more satisfying.

#40. Managed care brings in clients who might not ordinarily seek mental health services.

#44. Managed care affords me an opportunity to develop more creative service options for my clients.

#49. Managed care affords me a greater opportunity to access alternative service delivery systems for my clients.

A five point Likert-type scale (1932), with a neutral midpoint was employed to assess the extent to which the respondent agreed or disagreed, namely:

STRONGLY DISAGREE  DISAGREE  UNCERTAIN  AGREE  STRONGLY AGREE

Further, approximately half of these statements were worded negatively, and the balance were worded positively to avoid a patterned response set. The positive and negative statements were evenly distributed throughout the questionnaire. Also on the MMHC Relative Advantage scale, the scoring of items #16, #18, #28, and #48, was reversed because the statements were negatively worded. The reversed scores
resulted in a higher score indicative of advantage. With respect to the MMHC Relative Advantage Scale, the scores on the fifteen item scale were summed. A high score on the scale was indicative of greater perceived relative advantage.

**Perceived Compatibility of MMHC Technology**

Perceived compatibility, another attribute of diffusion of innovation "...is the degree to which an innovation is perceived as being consistent with the existing values, past experiences, and needs of the receivers (Rogers and Shoemaker, 1971, p. 152)." If, for example, MMHC technology is consistent with clinical social workers' values, beliefs and practices, then they will tend to accept it. A number of studies have born out the linkage between perceived compatibility and adoption of an innovation (Ashby, 1982; Musmann & Kennedy, 1989; Rogers & Shoeman, 1971). Childers & Stea (1982) report on the rejection of high milk yielding goats to India because the foreign expert had failed to account for only the lowest caste members drank goat milk. It makes common sense that acceptance of a new idea or technology conforms to some significant degree with an individual's outlook and values. Therefore, the greater the perceived compatibility of an innovation, then the greater the likelihood of its adoption.

In order to measure the diffusion of innovations construct, compatibility, an eleven item scale was developed specifically for this study. The items constituting the MMHC Compatibility Scale were in large part derived rationally, based on the researcher's above mentioned extensive involvement with MMHC, as well as modeling the scale after the one developed by Guagnano, et al (1986), and latter modified by Pandey (1990).
Four of the eleven items on the "MMHC Compatibility Scale" were intended to tap the "status quo" of practice. The items were:

#12. I can't imagine giving up traditional practice for managed care practice.
#19. Managed care is good for my kind of practice.
#22. I like managed care practice better than traditional practice.
#25. Managed care forces me to give up cherished practices.

Three of the eleven items on the "MMHC Compatibility Scale" were intended to tap into professional social work values. The items were:

#29. Managed care practice reduces exploitation of professional relationships for personal gain.
#41. Managed care fits in with my social work values.
#45. Managed care does not promote discriminatory practices against persons or groups.

Two of the eleven items on the "MMHC Compatibility Scale" were intended to tap into the social worker's concern for the client. The items were:

#33. Managed care doesn't impinge on my primary responsibility to my client.
#37. I don't think I can adequately treat a client in a managed care environment.

The remaining two items on the eleven item "MMHC Compatibility Scale" were felt to be unidimensional. The items were:

#15. Managed care practice is O.K. with my clients.
#32. I can't do my work with clients within the time frame imposed by managed care.

A five point Likert-type scale (1932), with a neutral midpoint was employed to assess the extent to which the respondent agreed or disagreed, namely:
Further, approximately half of these statements were worded negatively, and the balance were worded positively to avoid a patterned response set. The positive and negative statements were evenly distributed throughout the questionnaire. Also on the MMHC Compatibility Scale, the scoring of items #12, #25, #32, and #37, was reversed because the statements were negatively worded. The reversed scores resulted in a higher score indicative of compatibility. With respect to the MMHC Compatibility Scale, the scores on the eleven item scale were summed. A high score on the scale was indicative of greater perceived compatibility.

**Perceived Complexity of MMHC Technology**

Perceived complexity is the remaining diffusion of innovations characteristic of interest. The more difficult an innovation is to understand or use, the less likely it will be adopted (Rogers & Shoemaker, 1971). It makes sense that something more complex than something else would be avoided. It is a common occurrence that a person opts to take the path of least resistance in an attempt to make life as comfortable as possible. Regarding MMHC, it can be fairly complicated. For instance, most MMHC companies have their own special forms and reporting procedures. It can be very difficult to coordinate one company's requests, let alone the coordination of numerous MMHC companies requirements. This is very different from the traditional reporting system, which is quite well standardized, e.g. the use of the standard HCVA 1500 insurance reimbursement claim form. Complexity has been shown to significantly correlate with adoption or rejection of an innovation in a number of studies. Allan & Wolf (1978) found a significant negative correlation between greater complexity and the adoption of new teaching methods. Likewise, the
same kind of correlation was observed with the adoption of solar technology in California (Guagnano et al, 1986). Those who perceived greater complexity were less likely to adopt. However, not every one finds complexity to be negatively correlated with adoption. Pandey (1990) found complexity to be significantly and positively correlated with adoption of new stoves in central Nepal. She concluded that complexity alone would not inhibit the adoption of a new technology. Nevertheless, in general complexity has been shown to be negatively correlated with the adoption of a new technology (Musmann & Kennedy, 1989; Rogers, 1971; 1983)). Therefore, the greater the degree of complexity inherent in an innovation, then the lower the likelihood of its adoption.

In order to measure the diffusion of innovations construct, "complexity", a twelve item scale was developed specifically for this study. The items constituting the MMHC Complexity Scale were in large part derived rationally, based on the above mentioned researcher's extensive experience with MMHC, and further modeled on the scale developed by Guagnano (1986), and later modified by Pandey (1990).

Four of the twelve items on the "MMHC Complexity Scale" were intended to tap complexity in terms of "number". The items were:

#30. In order for me to get more involved with managed care, I would have to change to many things.

#38. The hassles inherent in the managed care process aren't worth it.

Four of the twelve items on the "MMHC Complexity Scale" were intended to tap complexity in terms of "knowing", "capacity to teach it", "figuring it out". The items were:

#20. Managed care procedures are easy to learn.
#23. I could teach my peers the basics of managed care.

#47. I can't seem to figure out what case managers want.

#43. I haven't been able to figure out how to get more involved with managed care.

The remaining six items on the "MMHC Complexity Scale" were intended to tap complexity by name, as well as by degree of difficulty. The items were:

#14. Managed care reporting requirements are too complex.

#17. It seems that I have to bill every managed care company differently for services rendered.

#26. Managed care requirements are hard to coordinate.

#34. It seems that every managed care company wants something different.

#35. It's to hard to coordinate treatment decisions with managed care treatment authorizations.

#42. Managed care is far to complicated for me.

A five point Likert-type scale (1932), with a neutral midpoint was employed to assess the extent to which the respondent agreed or disagreed, namely:

STRONGLY DISAGREE  DISAGREE  UNCERTAIN  AGREE  STRONGLY AGREE

Further, to avoid a patterned response set, approximately half of these statements were worded negatively and the balance were worded positively. The positive and negative statements were distributed evenly throughout the questionnaire. On the MMHC Complexity Scale, the scoring of items #14, #17, #26, #30, #34, #35, #38, #42, #43, #47, was reversed because the statements were negatively worded. The reversed scores resulted in a higher score indicative of complexity. With respect to the MMHC Complexity Scale, the scores on the twelve item scale were summed. A high score on
the scale was indicative of greater perceived complexity.

**Methodology**

**The Research Design**

To assess the extent to which Qualified Clinical Social Workers (QCSWs) had adopted MMHC technology, this study asked subjects to respond to a mailed survey questionnaire. A standard nonexperimental, single cross-section survey design was employed.

**Subjects and Sampling**

This study surveyed 2139 Qualified Clinical Social Workers (QCSW) who were mental health and/or alcohol and drug abuse providers. A QCSW was defined by his or her listing in *The 1990 Register of Clinical Social Workers* (NASW, 1990). Subjects were randomly selected. The registered were targeted as subjects for two reasons. First, the Register provided a list of "clinicians" who were at the highest level of the social work profession by virtue of their education and experience, since listing in the Register required a minimum of a master's degree in social work from a graduate school of social work accredited by the Council of Social Work Education, and a minimum of 1500 hours of clinical practice under supervision by a social work supervisor. Second, those individuals in the Register were those social workers most likely to have been exposed to MMHC technology, i.e., clinicians. The Register provided primary and secondary designations which clearly identified them as clinicians. Only those subjects with a primary and/or secondary designation were selected to be surveyed. The subjects selected had the following designations: 1) mental health only (n = 1039); 2) alcohol/drug, substance abuse only (n = 545); 3)
mental health as the primary designation, and alcohol/drug, substance abuse as the secondary designation (n = 365); and, 4) alcohol/drug, substance abuse as the primary designation, and mental health as the secondary designation (n = 200).

Materials

The materials for this study consisted of a cover letter and a five page survey questionnaire. The cover letter and survey were mailed to each of the subjects along with a stamped/self-addressed return envelope.

The Cover Letter

A standard letter (See Appendix) introducing the researcher, his university affiliation, and the nature of the research project (a dissertation examining the extent to which experienced clinical social workers had adopted managed mental health care practice), accompanied the survey. To discourage self-selection, the letter stated that the subject's response was very important regardless of their involvement and knowledge of managed mental health care technology. Subjects were also informed that the questionnaire would take about ten minutes to complete. They were asked to return the questionnaire by May 6, 1992. Subjects were then assured that their responses would be kept absolutely confidential (subjects' names were not correlated with responses). Deep appreciation for their participation was expressed. Nothing was promised for participation in the survey.

The Questionnaire

The Clinical Social Worker Managed Care Questionnaire was developed specifically for this research. It contained 58 consecutively numbered items (See Appendix). The questionnaire may be divided into five parts. Part one includes items
one and two. Items one and two were originally intended to complement each and serve as measures of adoption. Upon further consideration, item number one, "perceived knowledge of MMHC" was dropped from the analysis after the questionnaire had been circulated. Upon further consideration, "perceived knowledge of MMHC" did not have the same valence as "perceived involvement in MMHC" (item two). Whereas involvement seemed to strongly connote adoption, on a conceptual level, knowledge did not seem to strongly discriminate between those who may or may not adopt MMHC, as was originally thought.

Part two of the questionnaire, items three through eleven dealt with the respondent's actual experience, if any, with MMHC. Each of these items was derived rationally, on the basis of the researcher's experience with MMHC and the review of the literature. These items were utilized to tap several perceptions of the respondents. Item three determined whether or not the subject was employed at any level by a MMHC company. Item four determined whether or not the subject had any specific MMHC preferred provider contracts. Item five determined the amount of time the subject had actually been involved with MMHC. Item six determined the respondent's treatment orientation. And, item seven determined whether or not the respondent could work effectively in a problem focused model. Items three, four and five should positively correlate with perceived involvement with MMHC. Additionally, by themselves these items should provide important descriptive information. Similarly, items six and seven should provide important descriptive information. Those that are more involved should reflect a cognitive/behavioral treatment orientation, as well as a greater perception of being able to work in a problem focused model. Item eight, "average number of sessions", was dropped from the analysis because it could not be
interpreted. Items nine through eleven were included in the survey to establish whether or not the respondents were in a clinical private practice, and to what extent.

The third part of the questionnaire included items twelve through forty-nine. These items constituted the three scales which measured the adoption characteristics, relative advantage, compatibility, and complexity.

The fourth part of the questionnaire included items fifty through fifty-three. These items were rationally derived from both the review of diffusion of innovations literature, as well as the MMHC literature. Item fifty is intended to tap whether or not the respondents' close peers were in favor of MMHC. Item fifty inquired whether the respondents felt MMHC practice was going to last. Item fifty-two attempts to determine whether or not the respondents feel MMHC was revolutionizing the delivery of mental health services. And, item fifty-three elicits the degree to which the respondents feel social workers had a professional obligation to learn more about MMHC. A five point Likert-type scale (1932) was employed to assess the extent to which the respondent agreed or disagreed.

Finally, the fifth part of the questionnaire, items fifty-four through fifty-eight, determined gender, age, income, years in practice, and race, respectively.

The Pretest

The study materials were administered to a mixed group of psychotherapists in order to refine the items and instructions. The pretest consisted of a convenience sample of psychotherapists (n = 16). Some of the pretest respondents worked for managed mental health care organizations (n = 8). Others worked for an alcohol and drug treatment hospital (n = 4).
The pretest respondents were interviewed following the completion of the questionnaire. Only minor changes were made in wording. None of the respondents had any major complaints, and none reported any difficulty in comprehending or following the directions.

Procedure

On April 10, 1992, the Clinical Social Worker Managed Care Questionnaire, along with the cover letter, was mailed to each of the randomly selected qualified clinical social workers. The researcher's voice-mail number was included on the survey cover letter. The subjects were told that they could call this number if they had any questions and/or if they wanted a summary of the results (Twenty-one respondents requested a summary; nobody requested clarification.). Questionnaires received through May 15, 1992, were included in the survey.
CHAPTER FOUR

RESEARCH FINDINGS

Description of the Sample

A total of 950 subjects (44% of the subjects surveyed) returned usable questionnaires. Compared to most surveys of this type, this response rate was sufficiently robust (Warwick & Lininger, 1975). Three hundred and seventy-three respondents were male (39%) and 562 were female (59%). Respondents ranged in age from 28 years old (n = 1) to 81 years old (n = 1). The mean age was 52 years of age (SD = 9.23). The youngest 25% (N = 235) of the sample ranged in age from 28 years old to 45 years old. The middle 50% (N = 437) of the sample ranged in age from 46 years old to 57 years old. The eldest 25% (N = 279) of the sample ranged in age from 58 years old to 81 years old. Respondents were mostly Caucasian (n = 881, 94%). The remaining 6% of the sample included the following: Black, Non-Hispanic (n = 24, 3%); Asian/Pacific Island (n = 12, 1%); Spanish Surname (n = 8, 1%); and, American Indian (n = 4, .1%). Respondents annual income ranged from under $10,000 (n = 10, 1.1%); to over $100,000 (n = 41, 5%). The median income was between $40,000 and $50,000 (n = 197, 23%). The reported mean number of years in practice was 22 years (SD = 9.16). Years in practice ranged from a minimum of 1 year (n = 2), to a maximum of 58 years (n = 2). The bottom 25% of the sample (N = 231), the fewest years in practice, ranged from 1 to 14 years in practice. The middle 50% of the sample (N = 472) ranged from 15 to 27 years in practice. The top 25% of the sample (N = 239), ranged from 28 to 58 years in practice. Table 1 provides a summary of some of the key sample characteristics.
Table 1

Description of the sample: Income, Gender, and Race

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<td>1.1%</td>
<td>Females</td>
<td>562</td>
<td>59%</td>
</tr>
<tr>
<td>10,001 to 20,000</td>
<td>26</td>
<td>2.7%</td>
<td>Males</td>
<td>373</td>
<td>39%</td>
</tr>
<tr>
<td>20,001 to 30,000</td>
<td>81</td>
<td>8.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30,001 to 40,000</td>
<td>168</td>
<td>17.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40,001 to 50,000</td>
<td>197</td>
<td>20.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50,001 to 60,000</td>
<td>128</td>
<td>13.5%</td>
<td>Black, Non-Hisp.</td>
<td>24</td>
<td>3%</td>
</tr>
<tr>
<td>60,001 to 70,000</td>
<td>88</td>
<td>9.3%</td>
<td>Asian/ Pac. Island</td>
<td>12</td>
<td>1%</td>
</tr>
<tr>
<td>70,001 to 80,000</td>
<td>61</td>
<td>6.4%</td>
<td>Spanish Surname</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>80,001 to 90,000</td>
<td>41</td>
<td>4.3%</td>
<td>Amer. Indian</td>
<td>4</td>
<td>.1%</td>
</tr>
<tr>
<td>90,001 to 100,000</td>
<td>30</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100,000+</td>
<td>41</td>
<td>4.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing data</td>
<td>79</td>
<td>8.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Sample Characteristics

As stated previously, that perceived involvement in MMHC was one of the primary variables of interest in this study. Approximately 18% (N = 175) of the sample indicated that they did not have any involvement with MMHC, 36% (N = 341)
of the sample indicated that they were minimally involved with MMHC; 27% (N = 253) of the sample indicated that they were fairly involved with MMHC; and 18% (N = 169) of the sample indicated that they were very involved with MMHC. Missing data accounted for 1.3% (N = 12) of the sample.

In addition to perceived involvement with MMHC, there were three variables of interest that had to do with the respondents explicit perceived involvement with MMHC. Of the total number of respondents (N = 950), slightly more than 80% (N = 763) of the sample had some degree of involvement in MMHC. These variables were "actual employment by a MMHC company", "number of actual preferred provider contracts with MMHC companies", and "actual time involved with MMHC". Approximately 6% (N = 51) of the sample were employed full time by a managed care company. Slightly more than 12% (N = 116) of the respondents indicated that they were employed by a MMHC company on a part time basis. The vast majority of respondents, 61% (N = 576), were not employed by a MMHC company. And, as the instructions on the questionnaire had directed the respondents not to answer the several MMHC specific items unless they had actual MMHC experience, 18% (N = 175) of them did not answer the question.

Table 2 provides a break-down of the respondents in terms of their perceived number of preferred provider contracts with MMHC companies. An examination of the table reveals that 17% (N = 157) of the respondents indicated that they had no formal contracts with MMHC entities. However, the balance of the respondents indicated that they had at least one preferred MMHC contract. Approximately 15% (N = 139) of the respondents indicated that they had one MMHC contract. Slightly more than 30% (N = 294) of the sample stated that they had from 2 to 4 MMHC contracts. Slightly more than 16% (N = 154) of the respondents stated they had from
5 to 10 or more MMHC contracts. And, as the instructions on the questionnaire had directed the respondents, i.e., not to answer the several MMHC specific items unless they had actual MMHC experience, 18% (N = 175) of them did not answer the question, as expected.
Table 2

Break-down of Perceived Number of Contracts with MMHC Companies

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal MMHC contracts</td>
<td>157</td>
<td>16.5</td>
<td>17.1</td>
</tr>
<tr>
<td>One MMHC contract</td>
<td>139</td>
<td>14.6</td>
<td>32.2</td>
</tr>
<tr>
<td>Two MMHC contracts</td>
<td>111</td>
<td>11.7</td>
<td>44.3</td>
</tr>
<tr>
<td>Three MMHC contracts</td>
<td>109</td>
<td>11.5</td>
<td>56.1</td>
</tr>
<tr>
<td>Four MMHC contracts</td>
<td>74</td>
<td>7.8</td>
<td>64.2</td>
</tr>
<tr>
<td>Five MMHC contracts</td>
<td>44</td>
<td>4.6</td>
<td>69.0</td>
</tr>
<tr>
<td>Six MMHC contracts</td>
<td>28</td>
<td>2.9</td>
<td>72.0</td>
</tr>
<tr>
<td>Seven MMHC contracts</td>
<td>12</td>
<td>1.3</td>
<td>73.3</td>
</tr>
<tr>
<td>Eight MMHC contracts</td>
<td>20</td>
<td>2.1</td>
<td>75.5</td>
</tr>
<tr>
<td>Nine MMHC contracts</td>
<td>14</td>
<td>1.5</td>
<td>77.0</td>
</tr>
<tr>
<td>Ten or more MMHC contracts</td>
<td>36</td>
<td>3.8</td>
<td>81.1</td>
</tr>
<tr>
<td>Not applicable</td>
<td>175</td>
<td>18.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>950</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding those respondents who had some degree of perceived involvement with MMHC, 8% (N = 71) of the respondents had less than 6 months of involvement.
providing MMHC services. Another 8% (N = 76) reported having more than 6 months of involvement with providing MMHC services, but less than a year. Approximately 13% (N = 122) reported having more than 1 year of involvement with providing MMHC services, but less than 2 years. Sixteen percent of the respondents (N = 150) reported having more than 2 years of involvement with providing MMHC services, but less than 3 years; and 34% (N = 321) of the sample reported having more than three years of involvement with providing MMHC services. Hence, a very substantial number of respondents had significant involvement with providing MMHC services. In other words, of the 950 respondents, 740 individuals (81%) indicated that they provided some degree of MMHC services for at least the previous 6 months. Fifty percent of the sample (N = 471) indicated that they had been providing MMHC services, to some degree, for two or better years.

In addition to eliciting information on MMHC specific involvement, all of the respondents were asked to identify their treatment orientation, as well as respond to the question of to what extent they could effectively work in a "problem focused" model. The majority of respondents identified that their treatment orientation was psychodynamic (47%, N = 442), a model not particularly in vogue with MMHC philosophy. The next largest group identified "other" (22%, N = 205). Nineteen percent (N = 180) of the respondents stated that they had a "cognitive behavioral" orientation. A "systems" orientation was identified by 11% (N = 107) of the sample. Thirteen individuals (1.4%) stated that they had a "behavioral" orientation. With respect to the respondent's perception of his or her ability to work in a "problem focused" model, 35% (N = 334) said that they could work "very effectively" in it. Another 51% (N = 484) of the respondents stated that they could work "effectively" in
a "problem focused" model. Ten percent (N = 92) respondents said they were uncertain, and 2% (N = 21) said they could not work effectively in the model.

Several items were included in the questionnaire that attempted to establish the extent to which the respondents had a private clinical practice, or some other type of working arrangement. It had been expected and hoped that a significant number of respondents would reflect a private clinical practice. These items were, "auspices of primary work setting", "self employment", and "primary work function".

Over 40 percent of the respondents stated that they were self-employed on a full time basis (N = 414, 43.6%). Another 296 (31%) stated that they were self-employed on a part time basis, and the balance of respondents said that they were not self-employed at all (N = 233, 25%). Therefore, a substantial number of respondents, nearly three-quarters (74.6%), were either fully self-employed or self-employed on a part time basis.

With respect to the respondents' "primary work function", over 71% (N = 678) of the sample indicated that they were primarily involved as psychotherapists. The next largest groups were as follows: administrators (N = 91, 9.6%); mix (N = 59, 6.2%); supervision (N = 42, 4.4%); other (N = 25, 2.6%); case management (N = 22, 2.3%); education and training (N = 15, 1.6%); consultation (N = 13, 1.4%); and research (N = 1, .1).

Table 3 contains a break-down of the remaining descriptive variable, "auspices of primary work setting". As is indicated, slightly more than 80% of the respondents were working in either private, for profit settings (N = 572, 60%), or private, not for profit settings (N = 193, 20%).
Table 3

Break-down of Auspices of Primary Work Setting

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>28</td>
<td>2.9</td>
<td>3</td>
</tr>
<tr>
<td>State</td>
<td>54</td>
<td>5.7</td>
<td>8.9</td>
</tr>
<tr>
<td>County</td>
<td>35</td>
<td>3.7</td>
<td>12.7</td>
</tr>
<tr>
<td>City</td>
<td>11</td>
<td>1.2</td>
<td>13.9</td>
</tr>
<tr>
<td>Other Government</td>
<td>2</td>
<td>.2</td>
<td>14.1</td>
</tr>
<tr>
<td>Private, Not For Profit</td>
<td>193</td>
<td>20.3</td>
<td>35</td>
</tr>
<tr>
<td>Private, For Profit</td>
<td>572</td>
<td>60.2</td>
<td>96.9</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>3.1</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>2.7</td>
<td>Missing</td>
</tr>
<tr>
<td>Total</td>
<td>950</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Scale Reliabilities

Cronbach's alphas were computed for each of the three adoption characteristics scales in order to ascertain their reliabilities. An alpha of .85 was found for the MMHC Relative Advantage Scale. An alpha of .86 was found for the MMHC Compatibility Scale. And, an alpha of .83 was found for the MMHC Complexity Scale. Therefore, sufficient reliabilities (Carmines & Zeller, 1985) were observed for each of the three scales, which demonstrates that each of the scales possessed a high degree of internal consistency.

Hypothesis Testing

The first of three hypotheses tested in this research is:

The greater the level of perceived involvement in MMHC, the greater the perceived relative advantage.

To assess differences in perceived relative advantage, mean scores on the MMHC Relative Advantage Scale for the four groups which varied by level of perceived involvement in MMHC, were analyzed. Table 4 presents the means and standard deviations for the MMHC Relative Advantage Scale for each of the four groups. A one-way ANOVA for the MMHC Relative Advantage Scale (presented in Table 5) yielded a significant main effect for the Level of Perceived Involvement in MMHC, $F(3,771) = 38.11$, $p<.0001$. Post-hoc comparisons (Scheffe test) revealed that the mean score for Group 4, "...very involved with MMHC", was significantly higher (at the .05 level) than the means for Group 1, "...not involved", Group 2, "...minimally involved", and Group 3,"...fairly involved". The mean score for Group 3,"...fairly involved", was significantly higher (at the .05 level) than the mean for
Group 2, "...minimally involved". However, it was not significantly different from the mean score of Group 1, "...not involved". Moreover, the absolute difference in the means of Group 1 and Group 3 showed that the higher mean was obtained by Group 1. Additionally, and contrary to expectations, the mean score for Group 1, "...not involved", was significantly higher (at the .05 level) than the mean for Group 2, "...minimally involved".

Table 4.

Means and standard deviations for the MMHC Relative Advantage Scale by level of Perceived Involvement with MMHC

<table>
<thead>
<tr>
<th>Level of Perceived Involvement in MMHC</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 ...not involved at any level</td>
<td>117</td>
<td>2.57</td>
<td>.46</td>
</tr>
<tr>
<td>Group 2...minimally involved</td>
<td>292</td>
<td>2.28</td>
<td>.54</td>
</tr>
<tr>
<td>Group 3 ...fairly involved</td>
<td>223</td>
<td>2.51</td>
<td>.54</td>
</tr>
<tr>
<td>Group 4 ...very involved</td>
<td>143</td>
<td>2.89</td>
<td>.71</td>
</tr>
<tr>
<td>Total Groups</td>
<td>775</td>
<td>2.50</td>
<td>.60</td>
</tr>
</tbody>
</table>
Table 5.

ANOVA table for MMHC Relative Advantage Scale by level of Perceived Involvement in MMHC

<table>
<thead>
<tr>
<th>Source</th>
<th>D.F.</th>
<th>Sum of Squares</th>
<th>Mean Squares</th>
<th>F</th>
<th>Ratio</th>
<th>Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of involvement</td>
<td>3</td>
<td>36.40</td>
<td>12.13</td>
<td>38.11</td>
<td></td>
<td>.0000</td>
</tr>
<tr>
<td>Error</td>
<td>771</td>
<td>245.49</td>
<td>.32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>774</td>
<td>281.89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The second of three hypotheses tested in this research is:

The greater the level of perceived involvement in MMHC, the greater the level of perceived compatibility.

To assess differences in perceived compatibility, mean scores on the MMHC Compatibility Scale for the four groups which varied by level of perceived involvement in MMHC, were analyzed. Table 6 presents the means and standard deviations for the MMHC Compatibility Scale for each of the four groups. A one-way ANOVA for the MMHC Compatibility Scale (presented in Table 7) Yielded a significant main effect for the Level of Perceived Involvement in MMHC, $F(3, 833) = 33.75, p<.001$. Post-hoc comparisons (Scheffe test) revealed that the mean score for Group 4, "...very involved with MMHC", was significantly higher (at the .05 level) than the means for Group 1, "...not involved", Group 2, "...minimally involved", and Group 3, "...fairly involved". The mean score for Group 3, "...fairly involved", was significantly higher (at
the .05 level) than the mean for Group 2, "...minimally involved". The mean scores for
Group 1, "...not involved", and Group 2, "...minimally involved", did not significantly
differ, although the mean score for Group 1 had an absolute value that was greater than
Group 2.

Table 6.

**Means and standard deviations for the MMHC Compatibility Scale by level of Perceived Involvement with MMHC**

<table>
<thead>
<tr>
<th>Level of Perceived Involvement in MMHC</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 ...not involved at any level</td>
<td>138</td>
<td>2.57</td>
<td>.65</td>
</tr>
<tr>
<td>Group 2 ...minimally involved</td>
<td>318</td>
<td>2.40</td>
<td>.62</td>
</tr>
<tr>
<td>Group 3 ...fairly involved</td>
<td>227</td>
<td>2.64</td>
<td>.68</td>
</tr>
<tr>
<td>Group 4 ...very involved</td>
<td>154</td>
<td>3.07</td>
<td>.80</td>
</tr>
<tr>
<td>Total Groups</td>
<td>837</td>
<td>2.62</td>
<td>.72</td>
</tr>
</tbody>
</table>
Table 7.

ANOVA table for MMHC Compatibility Scale by level of Perceived Involvement in MMHC

<table>
<thead>
<tr>
<th>Source</th>
<th>D.F.</th>
<th>Sum of Squares</th>
<th>Mean Squares</th>
<th>F</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of involvement</td>
<td>3</td>
<td>46.70</td>
<td>15.57</td>
<td>33.75</td>
<td>.0000</td>
</tr>
<tr>
<td>Error</td>
<td>833</td>
<td>384.25</td>
<td>.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>836</td>
<td>430.95</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The third of three hypotheses tested in this research is:

The greater the level of perceived involvement in MMHC, the lesser the perceived complexity.

To assess differences in perceived complexity, mean scores on the MMHC Complexity Scale for the four groups which varied by level of perceived involvement in MMHC, were analyzed. Table 8 presents the means and standard deviations for the MMHC Complexity Scale for each of the four groups. A one-way ANOVA for the MMHC Complexity Scale (presented in Table 9) yielded a significant main effect for the Level of Perceived Involvement in MMHC, F(3,793) = 34.74, p<.0001. Post-hoc comparisons (Scheffe test) revealed that the mean score for Group4, "...very involved with MMHC", was significantly higher (at the .05 level) than the mean score of Group1, "...not involved", Group2, "...minimally involved", and Group3, "...fairly involved". As expected, the mean score for Group3, "...fairly involved", was
significantly higher (at the .05 level) than the mean scores of Group2, "...minimally involved", and Group1, "...not involved". The remaining groups did not significantly differ.

Table 8.

Means and standard deviations for the MMHC Complexity Scale by level of Perceived Involvement with MMHC

<table>
<thead>
<tr>
<th>Level of Perceived Involvement in MMHC</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 ...not involved at any level</td>
<td>127</td>
<td>2.70</td>
<td>.51</td>
</tr>
<tr>
<td>Group 2...minimally involved</td>
<td>299</td>
<td>2.68</td>
<td>.52</td>
</tr>
<tr>
<td>Group 3 ...fairly involved</td>
<td>222</td>
<td>2.89</td>
<td>.59</td>
</tr>
<tr>
<td>Group 4 ...very involved</td>
<td>149</td>
<td>3.23</td>
<td>.67</td>
</tr>
<tr>
<td>Total Groups</td>
<td>797</td>
<td>2.84</td>
<td>.60</td>
</tr>
</tbody>
</table>
Table 9.

ANOVA table for MMHC Complexity Scale by level of Perceived Involvement with MMHC

<table>
<thead>
<tr>
<th>Source</th>
<th>D.F.</th>
<th>Sum of Squares</th>
<th>Mean Squares</th>
<th>F</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of involvement</td>
<td>3</td>
<td>33.51</td>
<td>11.17</td>
<td>34.74</td>
<td>.0000</td>
</tr>
<tr>
<td>Error</td>
<td>793</td>
<td>254.93</td>
<td>.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>796</td>
<td>288.43</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Findings

A number of correlations among the variables were considered. In particular, the correlation of the variables: perceived involvement in MMHC, age, income, and years in practice were examined. A negative correlation was observed between perceived involvement in MMHC and age (-.24, p<.0001). Likewise, a negative correlation (-.23, p<.001) between perceived involvement in MMHC and years in practice was obtained. A positive correlation (.11, p<.001) between perceived level of involvement in MMHC and income was also observed.

Finally, four questions were included in the survey which were of interest to the researcher, and rationally derived. A five point Likert-type scale (1932), with a neutral midpoint was employed to assess the extent to which the respondent agreed or disagreed with the statement. The first item, "My close peers are in favor of managed
care activity.". broke-down as follows. Approximately 64% (N = 950) of the respondents indicated that they disagreed (33%, N = 312) or strongly disagreed (31%, N = 290) with the statement. Twenty-six percent of the respondents (N = 249) indicated that they were uncertain. And, 9% (N = 85) of the respondents stated that they either agreed (7%, N = 64) or strongly agreed (2%, 21) with the statement.

The second item, "Managed care practice is not going to last.", broke-down as follows. Approximately 52% (N = 950) of the respondents indicated that they disagreed (33%, N = 309) or strongly disagreed (20%, N = 189) with the statement. Thirty-seven percent (N = 347) of the respondents indicated that they were uncertain. And, slightly more than 9% (N = 90) of the respondents stated that they either agreed (6%, N = 58) or strongly agreed (3%, N = 32) with the statement.

The third item, "Managed care practice is revolutionizing the delivery of mental health services. ", broke-down as follows. Approximately 23% (N = 950) of the respondents indicated that they disagreed (15%, N = 215) or strongly disagreed (8%, N = 72) with the statement. Twenty-five percent (N = 238) indicated that they were uncertain. And, 50% (N = 476) of the respondents stated that they either agreed (36%, N = 341) or strongly agreed (14%, N = 135) with the statement.

The fourth item, "Clinical social workers have a professional obligation to become more knowledgeable about managed care practice.", broke-down as follows. Approximately 9% (N = 950) of the respondents indicated that they either disagreed (5%, N = 51) or strongly disagreed (4%, N = 33) with the statement. Nine percent (N = 87) of the respondents indicated that they were uncertain. And, 80% (N = 764) of the respondents stated that they either agreed (57%, N = 537) or strongly agreed (24%, N = 227) with the statement.
CHAPTER FIVE

CONCLUSIONS AND IMPLICATIONS

Questions, Predictions and Summary of Findings

The present study investigated the degree to which clinical social workers have adopted MMHC technology, and attempted to identify reasons why that technology has been accepted or rejected by clinical social workers. To investigate these issues, adoption patterns were conceptualized in terms of Rogers' (1962; 1971; 1976; 1986) Diffusion of Innovations theory. Thus, the major question of this study was the following: Does perceived clinical social workers' involvement ("adoption") with managed mental health care technology have a differential relationship with the diffusion of innovations adoption characteristics "perceived relative advantage", "perceived compatibility", and "perceived complexity"? If there is an identifiable relationship, what is it and what does it suggest?

Rogers' (1962; 1971; 1976; 1983; 1986) Diffusion of Innovations theory posits that a new idea or technology is more likely to be adopted if the adoptee perceives the new technology to be better than the one it replaces. The theory does not require that the new technology has an objective advantage over the technology it supersedes. The critical point is that it is perceived to be better. A number of indicators may serve to measure the relative advantage construct, including economic, prestige, convenience, and satisfaction factors. Likewise, a new technology is more likely to be adopted if the adoptee perceives the new technology as more compatible with his or her values, past experiences, and needs. Finally, a new technology is more likely to be adopted if
the adoptee perceives the new technology as less complex. Complex technologies are less readily adopted because they are often perceived to be more difficult to understand, operate, and/or set-up (Williams, Rice & Rogers, 1988). Rogers (1962; 1971; 1976; 1983; 1986) also posited two additional adoption characteristics, trialability and observability. Because these two characteristics were felt to present measurement difficulties, they were excluded from empirical study in this paper.

Considering MMHC and diffusion theory, MMHC is a new technology spreading throughout the clinical social work community. This research tested several hypotheses regarding the extent to which clinical social workers were involved in, and have adopted MMHC technology. Perceived level of involvement with MMHC served as an indirect measure of adoption of MMHC technology. It was hypothesized that there would be a statistically significant positive relationship between level of perceived involvement in MMHC and the perceived adoption characteristics "relative advantage" and "perceived compatibility". Similarly, it was hypothesized that there would be a statistically significant negative relationship between level of perceived involvement with MMHC, and the adoption characteristic perceived "complexity".

To test these hypotheses, a survey was conducted of 2139 clinical social workers randomly selected from the 1990 Register of Clinical Social Workers (NASW, 1990). The study asked subjects to respond to a mailed, fifty-eight item questionnaire. Forty-four percent of those selected returned usable questionnaires. A nonexperimental, single cross-section survey design was employed. Subjects selected the degree to which they perceived themselves to be involved in MMHC technology, i.e., "not involved", "minimally involved", "fairly involved", and "very involved". The degree of perceived involvement was then examined along with each of the three characteristics of adoption, i.e., "perceived relative advantage", "perceived
compatibility", and "perceived complexity". Three scales, specifically constructed for this study, were utilized to measure the diffusion of innovation's adoption characteristics. A one-way analysis of variance (with four levels of the variable, "involvement") was performed for each of the three measures of the adoption characteristics. Besides the ANOVA's, demographic information, as well as information regarding the respondents' work context, practice experience, practice orientation, and managed mental health care experience to date, were elicited and reported.

The results of the study provide support for each of the three hypotheses advanced, namely: 1) The greater the level of perceived involvement with MMHC, the greater the perceived relative advantage; 2) The greater the level of perceived involvement with MMHC, the greater the perceived compatibility; 3) The greater the perceived level of involvement with MMHC, the lesser the perceived complexity.

Clinical social workers who identified themselves as "very involved with MMHC" were significantly more inclined to see MMHC as providing them a relative advantage, e.g., greater income, status, career options, etc.. However, there was not a fully hierarchical arrangement of groups according to level of perceived involvement with MMHC. Accordingly, even though those clinical social workers who perceived themselves to be "fairly involved with MMHC" (the second most involved group) were significantly more inclined to see a relative advantage to MMHC, as compared to those who perceived themselves to be "minimally involved with MMHC" (the third most involved group); the group of respondents who perceived themselves as "not involved at any level with MMHC" (the least involved group), showed a nonsignificant, yet greater tendency to see a relative advantage as compared with the "fairly involved" group. Furthermore, the "not involved at any level" group was
significantly more likely to perceive a relative advantage to MMHC technology, as compared to the "minimally involved" group.

Clinical social workers who identified themselves as "very involved with MMHC" were significantly more inclined to see MMHC as more compatible, e.g., in line with their social work values, acceptable to their clients, etc. Similar to the relationship between perceived involvement and relative advantage, for compatibility there was not a fully hierarchical arrangement of groups according to level of perceived involvement with MMHC. As expected the "fairly involved with MMHC" group perceived MMHC to be significantly more compatible than the "minimally involved with MMHC" group. However, even though the "fairly involved with MMHC" group had an absolute greater tendency to view MMHC as more compatible than the two lesser involved groups, this group did not significantly differ from them. Finally, the "not involved with MMHC at any level" group, demonstrated an absolute, yet nonsignificant inclination towards greater compatibility than the "minimally involved" group of respondents.

Clinical social workers who identified themselves as "very involved with MMHC" were significantly more likely to view MMHC technology as less complex. Likewise, those respondents who perceived themselves to be "fairly involved with MMHC" were significantly more likely to view MMHC technology as less complex than the "minimally involved" and the "not involved at any level" groups. Again, there was not a fully hierarchical arrangement of groups according to level of perceived involvement with MMHC. The "not involved at any level" group viewed MMHC as less complex than the "minimally involved" group. The difference was absolute, yet nonsignificant.
The study revealed that as of the Spring of 1992, the vast majority of the clinical social worker respondents had had some involvement with MMHC. Less than one out of five respondents reported "no involvement at any level". Further, approximately one out of five respondents reported that they were "very involved in MMHC". Most of the social workers reported that they had at least one formal preferred provider contract, specifically with a MMHC company. Approximately half of the respondents reported that they had at least two preferred contracts. More than twenty percent of the respondents indicated four or more PPO contracts with MMHC companies. Over forty percent of the sample identified two or more years of actual MMHC experience.

In addition, over two-thirds of the sample expressed that their close peers were not in favor of MMHC, whereas less than ten percent indicated that they were in favor of it. A number of respondents were uncertain about how their close peers felt. Approximately one-half of the social workers felt that MMHC was revolutionizing the mental health service delivery system. Another quarter felt it was not, and the remaining quarter expressed uncertainty. The vast majority of respondents stated that social workers had a professional obligation to become more knowledgeable about MMHC. Most of the respondents indicated that MMHC was going to persist over time. Less than ten percent of the respondents felt MMHC was not going to last.

A Consideration of the Findings

The assumption that perceived involvement with MMHC served as an indirect measure of adoption of MMHC was supported insofar as it significantly correlated with the adoption characteristics: relative advantage, compatibility and complexity, as predicted by diffusion of innovations theory (Rogers, 1962; 1971; 1976; 1983; 1986).
In addition, it appears that clinical social workers in private practice are involved in MMHC to a much greater extent than the social work literature to date might suggest.

The fundamental finding of this research is that a significant number of clinical social workers have indeed adopted MMHC. The most involved group, those who had adopted MMHC, in contrast to the less involved groups, found MMHC as offering some kinds of advantages. As compared to the nonadopters, as a group the adopters saw MMHC as offering such things as more income, increased status, more creative service options, and enhanced career choices. Likewise, the adopters related that MMHC was not in conflict with their social work values and beliefs, nor did it force them to give-up valued clinical practices. Further, the adopters did not find MMHC requirements and procedures as overly taxing, or difficult to learn.

It is puzzling why the "not involved at any level" group perceived MMHC more favorably than the minimally "involved" group did. The observed perceptions of the two groups is inconsistent with diffusion of innovations theory. Several things may explain this. One reason that may account for the group who were "not at all involved" favoring MMHC more than the "minimally involved" group, is that involvement in MMHC is restricted. In other words, it may be the case that the membership of the "not involved" group was comprised of a significant number of members who were not able to become involved in MMHC. Hence, getting involved in MMHC was not a matter of choice. For some individuals MMHC was unavailable. For instance, even though the majority of respondents indicated that they were psychotherapists in full or part-time private practice, a significant number of respondents were administrators and/or in public agencies. They may not have had the same opportunity to opt into MMHC. Likewise, it may be the case that a significant
number of responding psychotherapists who fit in the "not involved group" were practicing in rural areas, where perhaps MMHC is less available to them.

A second reason for the "not involved" group favoring adoption of MMHC more than the "minimally involved" group may be that the former group was really comprised of two groups. It may be the case that some of those not involved now will never be involved with MMHC. It may also be the case that some of those not involved now will be involved at a latter date. The fact of the matter is that diffusion of innovations is a dynamic and interactive theory. As such this study's research design was unable to control enough for this. To do so would have required a time series.

**Limitations of the Study**

There are several limitations to the degree to which the results of this study can be generalized. Perhaps the most obvious limitation is the use of the respondent's perception of his or her involvement in MMHC as an analogue to actual adoption of MMHC technology. On the other hand, any empirical indicator of adoption of a highly complex and abstract technology, such as MMHC, would have to deal with the problem of defining it. It seemed that for the purpose of this research, the adoption analogue bore a significant relationship to the adoption characteristics, and appeared to tap into the underlying construct, adoption.

A second limitation of this study derives from the extraneous and uncontrolled variable of history. Because this survey collected data at one point in time, it is impossible to determine how the respondents may respond upon a second administration. It is likely that the respondent's involvement and rate of adoption or rejection is subject to significant change due to many things that happen over time, not
the least being the MMHC model's rapid growth. For example, a clinical social worker reporting a noninvolvement in MMHC today, could be offered a managed care opportunity tomorrow, which would be of sufficient magnitude to change his or her perception of his or her involvement/adooption of MMHC. In addition to history and the fact that this study surveyed respondents at only one point in time, it may have been that at that point MMHC was unavailable to some of the respondents. It may have been the case that those individuals would have chosen MMHC if they had had an opportunity to be involved.

A third limitation of this study has to do with the population from which the sample of respondents was drawn, i.e., listing in the 1990 Register of Clinical Social Workers (NASW, 1990). The Register does not include all of the clinical social workers practicing. It only includes those who desired to be listed, and those who went through a fairly extensive process to be listed. It is noted that in the capacity of a very involved MMHC practitioner, the researcher is aware of numerous clinical social worker colleagues, possibly the majority, who are not registered. Many of these unregistered clinical social workers have advanced degrees, independent licenses, and are involved with MMHC in varying degrees.

A fourth limitation of this study is its inability to account for very much of the variance in perceived involvement in MMHC. In a weak sense this was an exploratory study. Hence, diffusion of innovations did not explain much of the variance between levels of involvement even though statistical significance was observed. If in fact the main thrust of the study had been different and more in terms of standard diffusion of innovations research, i.e., to develop an adoption equation, then it would have been necessary to proceed differently. One way of proceeding would have been to incorporate a greater number of variables into the model and
utilize them as predictive of adoption rather than as correlates of adoption. By doing so it may have had the effect of boosting the explained variance to a more substantive level.

Finally, even though subjects were selected randomly, there remains the bias of self-selection. Borg & Gall (1983) have identified a number of factors which cast some doubt on generalizing from a sample of volunteers to a population from which the sample was drawn. Accordingly, they report that volunteers tend to be female, higher social class, more intelligent, more unconventional, less authoritarian, more Jewish than Protestant, and more Protestant than Catholic, to name a few.

Implications of the Study

Even though there are a number of limitations to this study, the study raises a number of important issues which have significant implications for practice, policy, and future research.

Practice Implications

MMHC is a reality. The results of this study indicate that a significant number of clinical social workers find MMHC practice as quite acceptable. Very few respondents have managed to avoid some level of MMHC. Most of the respondents in this survey indicated some involvement. Hence, and assuming that MMHC continues to grow or to maintain its current level of penetration of the existent service delivery system, clinical social workers are likely to continue to adopt MMHC. Because there are already a number of clinical social workers who have adopted MMHC technology, and because it is reasonable to expect more clinical social workers to adopt MMHC with the passage of time and exposure to MMHC, social
work scholars, educators and practice leaders might devote more attention to MMHC's nature and practice. Special consideration should be given to better understanding the role of the clinical social worker in the MMHC environment. In particular, social work schools should take stock of their clinical courses and make sure to include courses on brief psychotherapy. If the rapid movement towards more MMHC continues, and there appears to be no indication that MMHC will wane, then clinical social workers will need to be trained in the theory and practice of MMHC, especially brief psychotherapy. The present review of the literature suggests that social workers may be lagging behind in this area.

This study's literature review, as well as the results of the survey, suggest that it would be productive for clinical social workers to develop more than a rudimentary understanding of MMHC. First, social workers need to recognize the impact MMHC is having on the delivery of psychotherapeutic services. If MMHC’s impact is missed, social workers may not see the importance of learning about MMHC. Second, social workers should familiarize themselves with the assumptions, practices and values of the major models of psychotherapeutic service delivery. Clinical social workers should be able to articulate the similarities and differences between the major models of service delivery, i.e., fee-for-service, HMO, PPO, IPA, and the MMHC models. Third, critical to an understanding of MMHC, is an understanding of the evolution of MMHC. It is important to know that MMHC is not necessarily a better system for providing mental health services. MMHC emerged because it was thought to be a better way of controlling rising mental health care costs and because business demanded MMHC. Fourth, a basic understanding of MMHC requires some degree of knowledge of the cost-offset literature. In view of these issues, it is important that the Council on Social Work Education, as well as clinical social work schools and training
programs devote more attention to curriculum development and training in the MMHC model of service delivery.

With respect to the last point and in light of the results of this study, several things may be concluded. The observation that clinical social workers perceived that there was a significant degree of relative advantage and compatibility associated with adopting MMHC, and likewise that MMHC was not perceived to be particularly complex, has ramifications for helping social workers adapt better and perform more effectively in a managed care environment. First, teaching MMHC principles and practices may help lessen the barrier perceived complexity may currently present to some. For some clinical social workers "perceived complexity" is a deterrent to adoption. Teaching MMHC should enable a clearer picture of how MMHC functions. Similarly, if clinical social workers are taught that MMHC presents some significant advantages, e.g., increased income, greater status, more career options, etc., for some, and is compatible with the values and beliefs of many of their peers, then they are more likely to adopt MMHC. In any event, even if MMHC is not adopted as a function of increased efforts at informing clinical social workers about MMHC, the recipients of the training will be better informed and knowledgeable about a very important movement in mental health service delivery.

Overall clinical social work practice is being significantly altered by the changes attributable to the growth and proliferation of MMHC practice. Presumably clinical social workers will want to be in a MMHC leadership position so as to have a substantive influence on the developing mental health practice patterns. Clinical social workers need to understand the ramifications of MMHC practice if they are to help their clients with respect to quality of care, consumer choice and access to care. It is important that clinical social workers take an inventory of the problems associated
with MMHC and apply their social work training and experience to derive solutions. It is worth emphasizing that most of the respondents found MMHC to be something that fit with their social work values and beliefs. Their perception was that MMHC was compatible with practice. Likewise the majority of social workers saw advantage in MMHC. Hence, it is likely that most clinical social workers would make the effort to become better informed and trained in the ways of MMHC if given the opportunity. Therefore, it is important that curriculum and other kinds of training programs be developed and supported.

Policy Implications

In the Spring of 1992 over 80% of the respondents to this study reported that they had some degree of involvement with MMHC, with almost half of the respondents reporting being either "fairly involved" (27%) or "very involved" (18%). Since that time, it is highly likely that clinical social worker involvement with MMHC has increased. If one extrapolates from Moldawsky's (1990; 1993) surveys of psychologists in New Jersey, which documented a significant increase in MMHC's impact on psychologists over a three year span, then there is reason to believe that social workers may have had a similar experience. Because of Clinical social workers significant involvement in MMHC (which now has been empirically confirmed by this study), a policy on MMHC was needed. Like any official policy, it should facilitate a greater understanding of the clinical social worker's role and responsibility in MMHC as it relates to administration, program development, and direct service to individual consumers of professional social work services. Such an MMHC policy was formulated and approved by the NASW Delegate Assembly in August 1993. The findings of this study support the clear and well articulated MMHC policy statement adopted by NASW. Without a clear policy like NASW''s, clinical social workers
would run a greater risk of adapting to MMHC in a potentially haphazard or idiosyncratic fashion.

**Implications for MMHC Organizations**

In addition to the implications for clinical social workers this study has a few implications for MMHC organizations. First, the findings that clinical social workers frequently find MMHC compatible with their professional values and beliefs, suggests that clinical social workers could have expanding roles and responsibilities in a MMHC environment. Second, those clinical social workers that are not currently involved with MMHC may be a ready source of professional providers of MMHC services. It would make sense that MMHC organizations pay particular attention to a process of determining who may be favorable to MMHC if given an opportunity to get involved. Finally, given the paucity of studies of MMHC providers, MMHC organizations would do well to conduct studies of their current and potential professional providers. Results of such studies would be expected to allow MMHC organizations to better choose, recruit and train their professional providers.

**Suggestions for Future Research**

The results of the present study represent a beginning in the investigation of clinical social workers' adoption of MMHC. The data demonstrate that clinical social workers have indeed been involved with MMHC, some more than others, and that a significant number find various aspects of MMHC as advantageous to themselves, in agreement with their social work beliefs and values, as well as fairly simple to grasp and practice. In addition, the results of this study suggest that clinical social workers adoption of MMHC is for the most part congruent with the diffusion of innovations conceptualization. Nevertheless, there is a great deal of research to be done in order
to gain a clearer understanding of why some clinical social workers have adopted MMHC and others have not. To start with, constraints on the generalizability of this study's results bring about a need for research that amplifies this study's results. In particular, future research should concentrate on dealing with some of the methodological limitations of the present study, e.g., the limited scope of the sample, the problem of history, the problem of a one-shot survey, and the problem of self-selection. In addition, future adoption research efforts might consider incorporating parallel MMHC concerns. Such concerns would include, but not be limited to clinical social workers' understanding of cost-offset literature; the theory and practice of brief psychotherapy, as well as the nature of and differences between the major models of mental health service delivery.

Future study might attempt to sample more than just those clinical social workers who are listed in the Clinical Register. Perhaps a representative sample of clinical social workers who subscribe to the NASW NEWS or some other social work publication might be designed. Such a study may be able to capture some of the adoption behavior of those clinical workers who are not part of the Register, but who are to some degree adopters or rejectors of MMHC. It would be important to understand this more encompassing group, especially because it is a far larger group than the clinicians that make-up the Register.

To respond to the problems arising from a study that takes a sample at a single point in time, future researchers could refine and replicate this study with the present population, as well as extend it to a sample of clinical social workers who are not in the Register. Moreover, subsequent research efforts would do well to incorporate a longitudinal approach to account for changes in the respondents which do occur over time. Diffusion of innovations theory is dynamic. It implies that a person's perception
may change over time. Hence, some individuals who have not adopted MMHC will adopt in the future, and some who have adopted MMHC will give it up. Additionally, perceptions will change which will result in adoption changes and which may in fact be a result of adoption. Consequently measures need to be taken over time to determine where the changes are taking place. This will enable a determination as to whether or not clinical social workers are adopting or giving up MMHC.

Finally, the results of this study provide some evidence for understanding the factors which influence some clinical social workers to adopt MMHC and others to reject it. An important question to consider is whether or not one or more of the adoption characteristics, or some other variables not considered by this study, explains adoption of MMHC better. A promising study could be one where a more complicated model of adoption was formulated and tested. Besides the adoption characteristics, a model could be built to include such factors as demographics and other variables germane to MMHC.

**Conclusion**

The present study represents a beginning step in the inquiry into the MMHC adoption patterns of clinical social workers. It provides support for the conclusion that a significant number of clinical social workers have adopted MMHC, whereas others have not. Moreover, it provides support for the conclusion that many clinical social workers can find MMHC to be advantageous to them, compatible with their social work values and beliefs, as well as not particularly difficult to adapt to, in accord with Rogers' Diffusion of Innovations Theory (1962; 1971; 1976; 1983; 1985). Finally, the results of this study, as well as the review of current literature suggest the need and potential for future research.


Eggum, P. R., Keller, P. J., & Burton, W. N. (1980). Nurse health counseling model for a successful alcoholism program. *Journal of Occupational Medicine, 22*(8), 545-548.


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has one and all must have prizes"? *Archives of General Psychiatry, 32*, 995-1008.


Appendix A.

The Cover Letter
April 10, 1992

Dear Fellow Clinical Social Worker,

I am a full-time mental health clinician in private practice and a doctoral student at the Mandel School of Applied Social Science, Case Western Reserve University, Cleveland, Ohio. Currently, I am completing my doctoral dissertation and with respect to this I need your help. Enclosed you will find a questionnaire and a self-addressed, stamped envelope. I would appreciate it if you would take a few minutes to provide me with some information.

In this research effort, I am attempting to derive an empirical understanding of the extent to which experienced clinical social workers have adopted "managed mental health care" practice. You have been selected randomly from the 1990 N.A.S.W. Register of Clinical Social Workers. With your help, I hope to better understand clinical social workers' perceptions of "managed care" in terms of their perceived level of involvement with it to date. Your views as an experienced clinical social worker are very important to me. Please take a few minutes to complete the questionnaire and return it in the stamped, self-addressed envelope by May 6, 1992.

Please keep several things in mind as you complete the questionnaire. First, I am interested in your responses regardless of your involvement in and knowledge of "managed care". Second, for purposes of this study I am defining a MANAGED CARE CLINICIAN as anyone who is actually employed by a managed mental health care company, and/or a practitioner who accepts clients under some or all managed care conditions, such as case management, utilization review, and reduced fees. Finally, all of your responses will be kept absolutely confidential and data will be reported only in aggregate form.

I know your time is valuable and I cannot possibly reimburse you for it. The questionnaire should take only about ten minutes to complete and your participation will contribute significantly to the better understanding of managed care among social workers. I thank you in advance for your invaluable help.

Sincerely,

Jack Angelotta

If you have any questions, or would like a summary of the results, call (216) 292 9165. Please leave your name, number, and question or request. I will call back as soon as I possibly can.
Appendix B.

The Clinical Social Worker Managed Care Questionnaire
CLINICAL SOCIAL WORKER
MANAGED CARE QUESTIONNAIRE

Each of the following questions and statements has something to do with "managed mental health care," including alcohol and drug treatment. We are interested in your experience with "managed care" to date. Please read each of the questions and statements carefully and then respond as instructed. There are no correct or incorrect answers. There are no trick questions.

1. Check the statement that describes you best.
   ____ I know nothing about managed mental health care.
   ____ I know a little about managed mental health care.
   ____ I know more than a little, but not a lot about managed mental health care.
   ____ I know a lot about managed mental health care.

2. Check the statement that describes you best. Remember for purposes of this study, A MANAGED CARE CLINICIAN IS ANYONE WHO IS ACTUALLY EMPLOYED BY A MANAGED MENTAL HEALTH CARE COMPANY, AND/OR A PRACTITIONER WHO ACCEPTS CLIENTS UNDER SOME OR ALL MANAGED CARE CONDITIONS, SUCH AS CASE MANAGEMENT, UTILIZATION REVIEW, AND REDUCED FEES.
   ____ I am not involved with managed mental health care at any level.
   ____ I am minimally involved with managed mental health care.
   ____ I am fairly involved with managed mental health care.
   ____ I am very involved with managed mental health care.

   IF YOU INDICATED THAT YOU ARE NOT INVOLVED WITH MANAGED MENTAL HEALTH CARE, THEN SKIP TO QUESTION 6, ON THE NEXT PAGE.

3. Check the statement that describes you best.
   ____ I am employed full time by a managed care company.
   ____ I am employed part time by a managed care company.
   ____ I am not employed by a managed care company.

4. Check the statement that describes you best.
   ____ I have no formal preferred provider contracts with managed care companies.
   ____ I have one preferred provider contract with a managed care company.
   ____ I have ___ (fill in the number) preferred provider contracts with managed care companies.
5. Approximately how long have you been involved in providing managed mental health care services? Check the best answer.
   __ less than 6 months
   __ between 6 months and 1 year
   __ more than 1 year but less than 2 years
   __ more than 2 years but less than 3 years
   __ more than 3 years

6. Check the statement that describes you best.
   __ My treatment orientation is cognitive/behavioral.
   __ My treatment orientation is psychodynamic.
   __ My treatment orientation is systems.
   __ My treatment orientation is behavioral.
   __ Other (Specify: ____________________________).

7. Check the statement that describes your practice best.
   __ I can work very effectively in a "problem focused" model.
   __ I can work effectively in a "problem focused" model.
   __ I am uncertain about my effectiveness in a "problem focused" model.
   __ I am ineffective working in a "problem focused" model.

8. Regarding outpatient, individual, 50 minutes to 50 minutes psychotherapy, indicate your average number of sessions. ______

9. Place a check next to the answer that best describes the auspices of your primary employment setting.
   __ federal
   __ state
   __ county
   __ city
   __ other government
   __ private not-for-profit
   __ private for-profit, including private practice
   __ other (specify) ____________________________.

10. Place a check next to the most appropriate answer.
    __ I am self-employed on a full time basis.
    __ I am self-employed on a part time basis.
    __ I am not self employed.

11. Place a check next to the function in which you spend most of your time:
    __ psychotherapy
    __ supervision
    __ case management
    __ policy development
    __ research
    __ administration
    __ education/training
    __ consultation
    __ other (specify): ____________________________.
PLEASE REVIEW EACH OF THE ITEMS LISTED BELOW AND MAKE A JUDGEMENT
ABOUT THE EXTENT TO WHICH YOU DISAGREE OR AGREE. USE THE FOLLOWING
FIVE POINT SCALE TO EXPRESS YOUR JUDGEMENT. INDICATE YOUR CHOICE
BY PLACING THE SCALE VALUE IMMEDIATELY FOLLOWING THE STATEMENT.

1  2  3  4  5
STRONGLY DISAGREE  DISAGREE  UNCERTAIN  AGREE  STRONGLY AGREE

11. I can't imagine giving up traditional practice for managed
care practice._____

12. If I don't get involved with managed care eventually my
practice will be unable to get sufficient 3rd party
reimbursement._____

13. Managed care reporting requirements are too complex._____

14. Managed care practice is O.K. with my clients._____

15. I don't expect managed care practice to increase my
income._____

16. It seems that I have to bill every managed care company
differently for services rendered._____

17. Managed care isn't going to build up my practice with
referrals._____

18. Managed care is good for my kind of practice._____

19. Managed care procedures are easy to learn._____

20. Because of managed care I have less of a need to be supervised
by a psychiatrist or psychologist in order to be paid._____

21. I like managed care practice better than traditional
practice._____

22. I could teach my peers the basics of managed care._____

23. With managed care referrals I worry less about collecting my
fee._____

24. Managed care forces me to give up cherished practices._____

25. Managed care requirements are hard to coordinate._____

26. Because of managed care I have more career options than
before._____
PLEASE REVIEW EACH OF THE ITEMS LISTED BELOW AND MAKE A JUDGEMENT ABOUT THE EXTENT TO WHICH YOU DISAGREE OR AGREE. USE THE FOLLOWING FIVE-POINT SCALE TO EXPRESS YOUR JUDGEMENT. INDICATE YOUR CHOICE BY PLACING THE SCALE VALUE IMMEDIATELY FOLLOWING THE STATEMENT.

1  STRONGLY DISAGREE  2  DISAGREE  3  UNCERTAIN  4  AGREE  5  STRONGLY AGREE

28. Managed care practice has not afforded me greater status.

29. Managed care practice reduces exploitation of professional relationships for personal gain.

30. In order for me to get more involved with managed care, I would have to change too many things.

31. Because of the steady flow of clients referred by managed care organizations, I can discharge clients sooner than before.

32. I can’t do my work with clients within the time frame imposed by managed care.

33. Managed care doesn’t impinge on my primary responsibility to my client.

34. It seems that every managed care company wants something different.

35. It’s too hard to coordinate treatment decisions with managed care treatment authorizations.

36. Managed care has made it easier for me to get reimbursed for interventions such as marriage and family counseling.

37. I don’t think I can adequately treat a client in a managed care environment.

38. The hassles inherent in the managed care process aren’t worth it.

39. Managed care has made my work more satisfying.

40. Managed care brings in clients who might not ordinarily seek mental health services.

41. Managed care fits in with my social work values.

42. Managed care is far too complicated for me.

43. I haven’t been able to figure out how to get more involved with managed care.

44. Managed care affords me an opportunity to develop more creative service options for my clients.

45. Managed care does not promote discriminatory practices against persons or groups.

46. Managed care practice has increased my income.
PLEASE REVIEW EACH OF THE ITEMS LISTED BELOW AND MAKE A JUDGMENT ABOUT THE EXTENT TO WHICH YOU DISAGREE OR AGREE. USE THE FOLLOWING FIVE POINT SCALE TO EXPRESS YOUR JUDGMENT. INDICATE YOUR CHOICE BY PLACING THE SCALE VALUE IMMEDIATELY FOLLOWING THE STATEMENT.

1 | 2 | 3 | 4 | 5
---|---|---|---|---
STRONGLY DISAGREE | DISAGREE | UNCERTAIN | AGREE | STRONGLY AGREE

47. I can't seem to figure out what case managers want.____

48. Managed care has not increased the number of clients in my practice.____

49. Managed care affords me a greater opportunity to access alternative service delivery systems for my clients.____

50. My close peers are in favor of managed care activity.____

51. Managed care practice is not going to last.____

52. Managed care practice is revolutionizing the delivery of mental health services.____

53. Clinical social workers have a professional obligation to become more knowledgeable about managed care practice.____

The following information will assist me greatly in categorizing and analyzing the data. Please remember that all information will be kept confidential and data will be reported only in aggregate form.

54. Circle your gender:  male   female

55. Fill in your age. _____

56. Fill in your annual income. _____

57. Fill in the number of years you have been in practice. _____

58. Circle your race:
   - Pacific Islander
   - Asian/Pacific Islander
   - Caucasian
   - American Indian/Alaska Native
   - Spanish Surname
   - Black Non-Hispanic
   - Other

THANKS SO MUCH FOR YOUR HELP!!!

ANY ADDITIONAL COMMENTS YOU MAY HAVE WOULD BE MOST WELCOME:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________