



**Social Work and Managed Behavioral Health Care: We Don't Want to Be your Darlings Anymore**

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<b>Author(s):</b>	<i>G. Brent Angell, and Glenn E. Rohrer</i>
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## **Social Work and Managed Behavioral Health Care: We Don't Want to Be Your Darlings Anymore**

*G. Brent Angell, PhD, and Glenn E. Rohrer, PhD*

Comparing how various professions are doing under managed care, Cooper (1997) indicates that clinically licensed and certified social workers have come to be considered the "darlings" of managed behavioral health care, and are likely to be in even greater demand in the future. The rationale behind Cooper's statement is founded on the fact that social workers are affordable, available, and permitted to provide reimbursable third party behavioral health care services in every state (Clinical Psychologist & Clinical Social Worker Services, 1997; Services & Supplies Incident to Clinical Psychologist & Clinical Social Worker, 1997; Cooper, 1997; Jackson, 1996a, 1996b; National Association of Social Workers, 1997). Not surprisingly, social work's privileged position vis-a-vis managed behavioral health care has attracted both the envy and ire of other not so fortunate helping professionals who covet social work's advantage. For example, anticipating being shut out from licensing and certification, a number of non-social work mental and behavioral health providers sought and achieved social work status by way of "grandfather" clauses, which were included in state legislation dealing with the establishment of clinical boards of social work. They effectively argued that their experience and education were commensurate with that of formally trained and educated Master's level social workers.

Subsequently, the desire of non-social work professionals to revisit the issue of who can and cannot be sanctioned to practice as social workers has led to lobbying and legal maneuvering in several states where allied helping professionals have bid to become licensed or certified as social workers by taking clinical board examinations ("Licenses' Integrity Challenged," 1998). However, the vast majority of approved social work providers are formally trained, hold Master of Social Work degrees, and have passed state board clinical examinations (Korczyk & Witte, 1998; Levenson, 1998).

Buckling under social work's advantage, doctoral level psychologists, the profession's main competition, have sustained their managed care market share by accepting Master's level pay, moving into supervision, and working with more difficult consumer groups (Belar, 1989, 1995; Broskowski, 1995). This is the face of the American Psychological Association's increasing anti-managed behavioral health care stance, a position which has been shared by the National Association of Social Workers (NASW) (Gumpert & MacNab, 1995; Mizrahi, 1993; National Association of Social Workers, 1993, 1994; Newman & Bricklin, 1991).

In a bid to understand further the workday world of practitioners, and better prepare beginning social workers for the profession, NASW and the Council on Social Work Education (CSWE) reviewed the competencies needed to survive under managed behavioral health care. They concluded that learning occurs on the job due to the fact that few social work programs address, let alone prepare students for, the reality of professional life in a managed care environment (Council on Social Work Education and the National Association of Social Workers, 1997). In response, NASW, CSWE, and others have recommended that educational preparation become more responsive to the demands of the marketplace through the injection of managed care practice, process, and outcome measure content into the curriculum (Corcoran & Vandiver, 1996; Newscome, 1996; Strom & Gingerich, 1993; Strom-Gottfried, 1997; Strom-Gottfried & Corcoran, 1998)).

Not surprisingly, there is dissension within the practice and academic rank and file. The more educated social workers become about the conflicts between their professional ethics and the incentives of managed behavioral health care, the more they question and balk at this insurance fee-for-service reform movement (Boyle & Callahan, 1995; Hudson & DeVito, 1994; Keigher, 1995; Mechanic

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*G. Brent Angell is Assistant Professor, and Glenn E. Rohrer is Associate Professor, School of Social Work, East Carolina University, Greenville, NC 27858.*

& Aiken, 1989; Paulson, 1996). This does not make managed care companies happy to work with them, and can lead to social workers receiving fewer referrals or being dropped from preferred mental and behavioral health provider insurance plan panels altogether (Corcoran & Winslade, 1994; Corcoran & Vandiver, 1996; Davidson & Davidson, 1996; Gottlieb, 1992; Korczyk & Witte, 1998; Paulson, 1996; Reamer, 1997; Sunley, 1997). How did the social work profession get to be the "darlings" of a system that raises so many practice and ethical issues?

### **Opposition to Managed Behavioral Health Care**

Social workers have been among the most vocal of the critics of managed care (Brown, 1994; Hudson & DeVito, 1994; Keigher, 1995; National Association of Social Workers, 1993c; Paulson, 1996; Popple & Leighninger, 1996). However, as managed care has come to dominate American health care through its active management of the delivery system of providers, services, and centers, the profession has begun to acquiesce. In keeping with this, social workers, as reflected in the professional literature, have increasingly accepted managed care as the new health care service mechanism status quo, and are busily "getting in tune with the times" (Brown, 1994; Corcoran & Vandiver, 1996; Mizrahi, 1993; Strom-Gottfried, 1997). In this "about face," the profession has gone, in a matter of a few short years, from endorsing comprehensive universal health coverage for all Americans to acceptance of a market-driven system of care concerned with cutting costs, controlling access, and capitating benefits (Mechanic & Aiken, 1989; Mizrahi, 1993; Paulson, 1996; Strom-Gottfried, 1997).

Forgotten is President Clinton's 1993 American Health Security Bill, designed to guarantee comprehensive health care coverage for all people in the United States (Office of the President of the United States, 1992, February 6). This bill, strongly supported by social workers and NASW, proposed that all Americans would enjoy comprehensive, uninter-

rupted health insurance coverage regardless of whether they lost or changed jobs, moved, became ill, or experienced a family crisis (National Association of Social Workers, 1993a, 1993b). It recognized and addressed the health care inequities in America, and was consistent with social work's values and concern for the plight of the poor and underprivileged (National Association of Social Workers, 1993c; Popple & Leighninger, 1996).

However, health care reform was strongly opposed by conservative free enterprise business and industry, and by the American Medical Association (AMA) which saw it as limiting choice, increasing taxes, and being destined to fail due to ineffective and inefficient government involvement (Popple & Leighninger, 1996). The combined political influence and highly publicized advertising campaign of these powerful groups led to the demise of this far-reaching reform, and social workers loudly lamented the bill's defeat as it seemed to fit so well with the profession's social welfare tradition (Popple & Leighninger, 1996).

In the wake of the bill's defeat, business interests, led by insurance companies, saw the opportunity to enter the health care field and reap enormous profits in the bargain (Anders, 1996; Church 1997a, 1997b; Korczyk & Witte, 1998; Popple & Leighninger, 1996). Their response was the creation of an hybrid market-driven, cost-conscious medical services insurance scheme which covers an array of fee-for-service health care options. Collectively known as managed care, the approach has proven to be highly profitable for insurance companies and cost-conscious employers. Furthermore, its support by influential lobbyists and politicians has helped ensconce it as the "preferred" way to do health care business in America (Anders, 1996; Church 1997a; Korczyk & Witte, 1998).

### **The Allure of Managed Behavioral Health Care**

Managed care has created a new world order in how mental and behavioral health services are provided. It is a system by which insurers and providers are brought together to contain costs

through supplying only "essential" market-driven care. Business, industry, and insurance companies have embraced this approach in an effort to rein in skyrocketing health care plan costs provided to employees and their dependents. As a result, managed behavioral health care has been able to regulate the amount, type, provider, and site of care available to consumers (Levenson, 1998; Korczyk & Witte, 1998).

In particular, the ability of managed care companies to control professional autonomy has been identified as a "top concern," and is indicative of the threat that this fee-for-service system poses to providers and, consequently, recipients of mental and behavioral health services (Anders, 1996; Korczyk & Witte, 1998; Pipal, 1995; Popple & Leighninger, 1996; Strom & Corcoran, 1998). Strom-Gottfried and Corcoran (1998) see the cost controlling combinations that comprise managed behavioral health care as having a direct effect on how social work is practiced, taught, and learned. In essence, they see the autonomy of the profession as ethically compromised by managed care's external administration of what, how, and by whom services will be provided. This raises important ethical issues for social workers that include conflicts of interest relating to obligation, confidentiality, informed consent, negligence and abandonment, and fiduciary duty.

Most managed care companies operate as for-profit corporations, whose shares are traded on the major stock exchanges. Their purpose is to cut costs and to make a profit for their shareholders. To do this, managed care companies deny services, reduce payments to providers, decrease hospital stays, and introduce complex procedures that serve to discourage providers from appealing denied claims (Anders, 1996; Keigher, 1995; Korczyk & Witte, 1998). The bottom line, after calculating patient care payouts (referred to as medical-loss ratios), results in between 6% (non-profits) and 41% (for profits) of every insurance premium dollar being made available to cover administrative expenses and profits (Church, 1997a; Gleick, 1997). For

example, Columbia /HCA Health Care Corporation, the largest for-profit health care organization in the United States, reported third quarter profits of 4.88 billion in 1996 ("2 Health Care," 1996).

Within managed care, mental and behavioral health services are generally provided as part of the health benefits package offered by employers, Medicare, and Medicaid (Cuffel, Snowden, Masland, & Piccagli, 1996; Popple & Leighninger, 1996). As competition for lucrative insurance contracts has increased, managed care companies have packaged behavioral health and substance abuse treatment benefits into their plans as a way of marketing their product. By so doing, competing insurers hope to lure employers and subscribers to buy their benefit plans because of the desirable "add-on" benefits. It is important to note that most behavioral health service benefits are not provided directly by managed care companies, but rather are brokered as "carve-outs" to independent providers and companies who operate under the insurer's cost-containment guidelines (Anders, 1996; Korczyk & Witte, 1998).

However, these "add-on" benefits are often more marketing than matter. Managed care views psychotherapy as crisis management, quick-fix, "brief" care which augments pharmacotherapy interventions in restoring consumers to some minimal level of functioning. They encourage primary care physicians to refer patients, if necessary, to cost-saving providers, such as social workers, who accept lower fees, and see the consumer for five to 20 sessions, depending on the diagnosis. It is this expeditious, cost-effective service that has earned social workers the dubious title as the "darlings of managed care" (Cooper, 1997).

However, Anders (1996), and Korczyk and Witte (1998), indicate that managed care presents a frustrating and bewildering maze of rules and obstacles to consumers as they bid to understand and access mental and behavioral health services. Mental and behavioral health treatment is based on medical necessity, with more serious problems receiving the most number of sessions. However, as consumers

begin their quest for care, they are confronted with trying to determine how to get connected to a provider (often by calling a separate number); who the mental and behavioral health providers are (most often a clinical social worker); how many sessions are offered by the insurer (ranging up to 20 sessions on average, depending on the diagnosis); and at what cost (with co-pays often above that of non-behavioral health services).

Even with the Mental Health Parity Act (1998), consumers, although having annual and lifetime caps on intervention similar to physical care, may still experience limits on treatment, higher cost-sharing deductibles, and differing standards of care. In addition, substance abuse treatment is not even covered by the Act, and employers with fewer than 50 employees are exempt from the legislation altogether. As for consumers with chronic problems requiring lengthy treatment, they may find themselves referred-out or "dumped" when they exceed the capitated limits of their benefit plan.

In addition, Medicaid's adoption of a managed care philosophy is having a devastating impact on institutional and community mental and behavioral health services provided to the poor and chronically ill (Cypres, 1996; Perloff, 1996; Santiago, 1992; White, 1997). This "new" approach, states Perloff (1996), weakens access and further deprives already disadvantaged populations characterized by those who are unemployed, at high-risk, and in need of long-term care. Perloff sees Medicaid's move to managed care as posing a grave threat to the chronically mentally ill, who are most vulnerable of falling through this eroded social welfare "safety-net."

Popple and Leighninger (1996) indicate that the corporate appeal of mental and behavioral health care lies in the high profits that can be realized due to low overhead and few operating restrictions. These carve-out specialty companies compete with one another for a piece of various managed care plans and are, as Korczyk and Witte (1998) state, "... sensitive to market demands, so they provide benefits that their purchasers, mainly employers, or

health plans, want. "Competition among these firms is among the fiercest in the health care industry" (p. 211). In addition, Popple and Leighninger relate that the allure of streamlined services that are purported to be more "innovative, efficient, and cost effective" have created a dichotomy between the comprehensive insurance "haves" and "have-nots." As Popple and Leighninger state:

Ideally, this system (managed care) brings about the most efficient use of resources and the highest possible quality of services to clients, at the same time holding down costs. However, it has the very real potential of putting cost containment before effective treatment, and of reducing the autonomy of both client and therapist (p. 391).

It is ironic that social workers, so strong in its support of President Clinton's health care reform proposal in 1993, have now become the "darlings" of a system that has as its chief aim, making profits at the expense of consumer rights and public well-being. For social work, continued involvement in managed behavioral health care poses several challenges and opportunities.

### **Challenges to Professional Service**

#### **Questions of Care**

Adjusting to managed care has not been easy for any of the helping professions, but it has been particularly troubling for social work. However, as Allen-Meares (1998) states, social work's concern over-compromised care has not curbed our willing participation in managed behavioral health care. Some basic and burdensome questions arise for social workers in regard to the shift in care that has swept the nation.

How can a profession that has traditionally been committed to public sector mental health care remain true to its values in a world driven by privatization and profit?

How can we justify a shift in our focus from valued mental and behavioral health programs and interventions to cost-effective, billable therapeutic units?

Where does it leave our basic values as a profession if we agree to move from a client-oriented egalitarian approach to an organizationally-directed capitated focus?

How do we care for the severely and chronically mentally ill in a system based on a short term, crisis oriented, quick fix mentality?

**The Move to Managed Behavioral Health Care: A Professional Debacle**

Managed care has moved payment and service delivery to a centralized and privatized model that is brief, concrete, and behaviorally objective. The organization, not the provider, determines who does or does not get served, what treatment they receive, and for what period of time. Medical necessity, as defined by "outsiders," has replaced the social worker's judgment. Time-limited capitated services, failure to obtain insurance approval, or therapists being dropped from an insurance panel, can lead to discontinuation of care and abandonment of mental and behavioral health consumers.

Under managed behavioral health care, social workers have had to safeguard themselves against compromising their ethical beliefs. In particular, social work's conviction in the primacy of clients' interests is frequently challenged by managed care utilization reviewers whose business orientation and focus on the bottom-line has taken precedence over clinical judgment (Korczyk & Witte, 1998; Lowenberg & Dolgoff, 1996; National Association of Social Workers, 1996; National Association of Social Workers, 1998). Those authorizing service do not see the patient and do not share in the liability, yet they control treatment. Some insurance panels have even been forbidden from providing pro bona services. Creative diagnosing is required to ensure that clients get services, and that therapists get paid. The pressures of winning approval, getting reimbursement, getting and staying on approval panels, and being audited by micro-managers has led to clients being viewed as symptoms, behaviors, and diagnostic categories rather than as unique human beings.

Chipman (1995) discusses the problem faced by service providers who, while working in a managed care environment, are having to reconcile their personal and professional values. This value dilemma relates to being "forced" to move from a caregiving to marketplace mentality. Examples include:

Pre-Treatment Authorization, which involves managed care organizations in the clinical decision-making process regarding the kind of behavioral health care, length of treatment, service provider's credentials, and place of provision.

Continued Stay Reviews, which permit managed care companies to review the type, duration, provider, and site of behavioral health service.

Case Management, which lets managed care corporations monitor and control the delivery of behavioral health care by requiring pre-authorization of treatment plans, recommending alternative care arrangements, and reviewing service utilization.

Chipman believes that the ethical bases of professions have undergone a radical surgical procedure which in effect has altered the appearance and conduct of professionals charged with providing mental and behavioral health services. Patients and clients have given way to consumers and customers. Solving problems and curing disease has given way to purchasing merchandise. The end result of this shift has been one of increasing the emotional distance between social workers and their clients.

The sophisticated descriptions of a patient's past, filled with complex, multilevel drives, defenses, ego functions, object relations issues, behaviors, biopsychosocial factors, and cognition are no longer relevant. In their place, we have "1-800" numbers and "Insurer's World." Problems under managed behavioral health care are required to fit DSM-IV diagnostic categories, characterized by shorthand, behaviorally observable, numerically scaleable, time-limited symptoms (Chipman, 1995).

Ideal managed behavioral health care clients are individuals categorized as consumers, prepared to work, and easily served within the time constraints imposed by managed care. Others, labeled shop-

pers/visitors, are told to come back when they are ready to work, and complainers are stealthily referred-out or "dumped." It is outcome, not process, that drives treatment. If mental and behavioral health consumers resist the service offered, or appear otherwise ill suited for treatment, they may find themselves "counseled out," "dumped," or tolerated until capitation of benefits occurs, each of which creates an ethical dilemma. Yet, any beginning level social worker knows that resistance is natural and necessary for the protection of self from pain and anxiety. In building a therapeutic relationship founded on trust the recipient of service should, over time, feel safer. But, third party payers authorize only quick cures dependent on short-term effort, not long-term trust.

#### **How Else To Save Money: An Alternative Perspective**

Managed behavioral health care is an American anomaly that coerces social workers into practicing in a manner which shows irreverence for their professional training and clinical judgment. In Germany, for example, those responsible for mental and behavioral health care policy are concerned with the potential long-term care costs of treating people inadequately or not at all. They fear that these individuals, if not treated sufficiently, may develop serious or chronic mental health problems, burgeon in number, and become dependent on welfare and long-term care. As such, the state, through its mandated but privately run insurance program, covers the mental health care needs of 90% of the public, and looks to insurers and providers to work together to safeguard the interests of all consumers (Karon, 1995).

If the therapist recommends a brief approach, a single review is conducted, and the consumer becomes eligible for up to 60 sessions. Most clients complete psychotherapy before the 60 sessions are up, but by being granted 60 sessions for brief psychotherapy neither the therapist nor the client is under pressure to "hurry up" the process of treatment which in itself adversely effects the quality and

long-term effect of care. If, however, the consumer is deemed in need of more treatment than provided initially, the therapist can recommend a longer course of psychotherapy. The therapist obtains a second provider's opinion that the client would benefit from additional treatment. In this scenario, the consumer is awarded up to 160 sessions with two further extensions being possible, for a maximum of 300 sessions. How can insurance companies manage this? Insurers do not have the option of dropping a patient from their plan and transferring costs to the state. Even if enrollees change insurance companies, they can at anytime choose to return to their original insurer without penalty or loss of coverage. Yet, of the total amount expended on health care in Germany, only 3% is used to provide mental health services, including both brief and long-term psychotherapy (Karon, 1995).

Several studies support the German model indicating that long-term treatment can be cost-effective when taking a life-span perspective. In particular, Herron, Eisenstadt, Javier, and Primavera (1994) question managed care's emphasis on service utilization rather than on outcome-effectiveness in determining the duration of service. Reviewing Howard, Kopta, Krause, and Orlinsky's (1986) earlier work, they discovered that "to feel good" consumers require 20 to 50 sessions of psychotherapy, and 100 or more sessions to make a significant change. Increasing the number of sessions, referred to as dose-effect, results in consumers being more productive, earning more money, and feeling better — even when compared with pharmacotherapy or hospitalization.

As Mone (1994) states, the provision of mental and behavioral health care should be quality-driven rather than cost-driven and, as such, the time needed to ensure adequate treatment should be flexible. It is misleading to assume that brief psychotherapy is as effective as long-term interventions. Treatment must depend on consumer needs, not the managed care company's time restrictions and medical-loss ratios. Mone contends that, many mental and behavioral health consumers experience a superfi-

cial "flight into health" after being in treatment for only a short period of time. This spurious improvement is seen as a reaction to the intrusive, "quick-fix" nature of many brief therapy models whose therapeutic impact rapidly dissipates. Furthermore, whether brief or not, as providers of care, "We are guardians of quality care and must employ our every resource to insure its continued existence" (Mone, 1994, p. 447).

### **Discussion**

Managed care companies have been criticized for lacking a social conscience, due to their primary focus on cutting costs, making profits, and limiting services and access. In effect, this fee-for-service approach to mental and behavioral health care violates many of the basic tenants of social work. As Church (1997a) indicates, the reality of managed care has caused a "backlash" by consumers, providers, unions, and elected representatives all of whom are concerned with the impact that cost-cutting has had on the caliber of care.

In fact, this public outcry against managed care led President Clinton to appoint a 34-member advisory committee in Spring 1997, charged with constructing an enforceable consumers' bill of rights. In response the American Association of Health Plans (AAHP) states that detractors of managed care have bought into a mass hysteria that is not founded on fact. However, AAHP has asked its members not to enforce gag rules and "drive-by" surgeries and is on the surface is supportive of Clinton's consumers' bill of rights initiative (Church, 1997a). Yet, parallels in the provision of mental and behavioral health services are inconsistent, at best, as managed care companies continue to authorize formula-based short-term, brief therapy according to diagnosis rather than care founded the provider's assessment of consumer needs.

Health insurance companies in America have gone from offering monetary rewards to providers for doing as much as needed to compensating them for doing as little as possible for consumers. Yet, social workers have become managed care's "dar-

lings." In understanding how this "honor" has been bestowed upon, and found acceptable to social workers, we need to appreciate that the profession's greatest achievement--independence and recognition as providers of billable services--in recent years has contributed to its acquiring this questionable notoriety.

The profession's clinical licensure or certification initiative has succeeded. Social workers are legally recognized in every state, and this has afforded social workers the opportunity to be competitive with psychiatrists and psychologists in the private practice arena. This, coupled with the fact that social workers need only hold a Master's degree, while psychiatrists and psychologists are required to hold doctorates, provides social workers with a "leg up" on the competition.

In the past, Master's level practitioners would have been at a disadvantage in a marketplace dominated by higher levels of professional education and training. In the present managed care environment, the objective is to cut costs. Therefore, professionals with terminal practice degrees at the Master's level, who can be fully licensed, and are willing to live with the dictates of the managed care companies, are going to be in high demand. It is in just such a situation that social workers find themselves at this critical time in the profession's development.

However, social work is under siege. Its favored position under managed behavioral health care is being challenged by other professional groups who see their Master's level education as comparable to social work's ("Licenses' Integrity Challenged," 1998). This wake-up call has "rallied the troops" who have so far effectively fended off the insurgents. But, for how long? It appears to be only a matter of time before some new "darlings" take social work's place as affordable, available, and reimbursable providers of managed behavioral health care services.

Managed care is not bound to doing business with social workers. Its only interest is in cutting costs. Insurance companies do not contribute to



professional teaching, continuing education, research, or care of the poor and the chronically mentally ill, social work's traditional charge. Yet, under managed care they can direct how social workers provide mental and behavioral health services. As such, social workers are placed in an unenviable, and conceivably unethical, position that either lures them to side with insurers in containing costs, or draws them to advocate for consumers in order to obtain authorization and extend benefits (Reamer, 1997). In particular, Reamer (1997), supporting Davidson and Davidson (1995, 1996) and Schreter's (1993) observations, sees clinical judgment being potentially sacrificed in the name of fiscal management as authority is transferred from the social work provider to the managed care payer.

Using an alternative analogy, Strom-Gottfried and Corcoran (1998), borrowing on McFarland, Bentson, and George (1995), label social workers under managed care arrangements as "double agents," whose allegiance is pledged at the same time to consumers, employers, insurance payers, and other parties with a vested financial interest in the provision of care. Regardless of how it is framed, social workers are caught in the crosshairs of the managed care backfire. How we respond will have a great deal to say about how we will be perceived by consumers. Kassirer (1997) points out that, "...managed care companies will have to show that they have become better citizens, that they care about more than profits, that they do not skimp on care, that they support their just share of teaching, research and the care of the poor" (p. 1013). Social workers, too, will have to reaffirm who they are professionally if they are to stay at the vanguard of helping the underprivileged. With this in mind, social workers can ill afford to remain the "darlings" of a movement so far removed from their basic values without regaining some measure of ethically-based professional autonomy.

In response, NASW has supported adoption of the proposed Patient Access to Responsible Care Act (PARCA) ("Managed Care Curbs Backed," 1998). The Republican sponsored PARCA would

regulate managed care companies, and protect consumers by establishing internal and external review processes to scrutinize the decisions of utilization reviewers regarding denial of benefits and limiting treatment. Furthermore, the proposed legislation protects consumer confidentiality, while enhancing access to information on matters of coverage, treatment, and capitation. Perhaps most importantly, PARCA would hold managed care companies liable for decisions made by utilization reviewers regarding treatment and payment issues.

In a parallel move, the Democrats have proposed the Patient Bill of Rights Act ("Health Rights Bills," 1998). This Act, also supported by NASW, includes a number of points in addition to those set forth in PARCA. They include the recommendations of the President's commission on health care, and strengthen consumer rights regarding the liability of managed care companies in matters of personal injury, wrongful death, discrimination, and cessation of coverage. Of particular interest to social workers, the Bill provides protection to providers who are terminated without cause, serve high-risk consumers, lose clients due to coverage changes, or lodge grievances.

In a bid to strengthen further social work's position with respect to managed behavioral health care, NASW, along with other non-physician providers, has gained access to the Health Care Practitioner Advisory Council (HCPAC). HCPAC contributes to the accrediting of over three-fourths of the managed care companies by providing a non-physician perspective on mental and behavioral health care operations, programs, and benefits through its advisory relationship with the National Committee for Quality Assurance (NCQA) ("Voice on Managed Care Gained," 1988; "Voice Sought on Care's Quality," 1998). This, in turn, has broader ramifications as NCQA, in addition to accrediting managed care companies, provides information to employers and consumers through its Health Plan Employer Data and Information Set (HEDIS) on coverage and treatment costs. In addition, NASW, by participating in HCPAC, has been able to raise its concern

over the issue of certain managed behavioral health care companies refusing to reimburse contractors and agencies who train and use student interns, supervised by clinically licensed and certified social workers, to provide billable services.

Despite these NASW initiatives, social workers continue to lack any real clout over the managed behavioral health care decision-making process as it relates to professional autonomy. So, how do social workers become proactive in devising strategies as independent contractors and agency-based employees that incorporate cost effective, time-limited services while not compromising their professional values and ethics?

### **Survival Strategies for Becoming Managed Behavioral Health Care Smart**

Licensed and certified providers who hold Master's level social work degrees need to be vigilant of the demands and limitations place on them by managed behavioral health care. As such, social workers need to assume a proactive stance by devising strategies which advance their and the consumers' position with respect to managed care companies.

### **Education & Professional Development**

Professional social work training and education must deliberately encompass knowledge of managed behavioral health care concepts, fiscal arrangements, and service delivery mechanisms. As such, social work educators need to devise and implement required courses on managed behavioral health care. The design and delivery of this service specific curriculum should be a collaborative effort involving clinical social workers, managed care companies, and consumers. The resulting course of study would be directed at social work practice in managed care environments and be founded on an understanding of, and competency in, pertinent legislation, corporate operations, care provider networks, brief therapy approaches, the DSM-IV, documentation, evaluative outcome research, and ethics.

For those social workers already in the field, a concerted effort must be made to extend to them a

similar foundation program of study on managed behavioral health care. In so doing, a degree of standardization in the application of social work practice methods and skills appropriate to practice in managed behavioral health care settings can be assured. In addition, an ongoing continuing education program must be offered on advances and changes in managed behavioral health care, which would be required for re-licensing and re-certification. To achieve this professional development goal, a partnering between schools of social work and others concerned with mental and behavioral health education needs to occur. This approach would garner community support and recognition for clinical social workers, and advance professional identity and autonomy.

For their part, CSWE and NASW need to establish consulting and accrediting site-visit teams to assist educators and trainers with curriculum and program development specific to managed behavioral health care. By taking this step, CSWE and NASW could set education and training standards, conduct quality assurance reviews, and provide accreditation for participating university and community-based training and education programs.

It is realistic to expect that managed behavioral health care companies should underwrite a portion of the cost of these educational, research, consulting, and accrediting initiatives through the establishment of an independent education and research foundation. They have a vested interest in and are beneficiaries of cost-effective clinical social work services, and have set prior precedence in this regard by sponsoring other professional groups' educational programs. In addition, accredited educational preparation could be an effective marketing strategy as it is in keeping with managed behavioral health care's own NCQA initiative.

### **Marketing**

With the ever increasing pressures of cost-containment and competition, social workers need to engage in effective marketing to maintain their favored position with respect to managed behavioral

health care. To improve their position and become more autonomous, social workers need to demonstrate their indispensability to consumers, managed care companies, and other members of the provider network.

A means of achieving professional indispensability to managed behavioral health care lies in the development of practice sub-specialties. For example social workers who develop expertise in working with people suffering from highly publicized conditions such as attention-deficit/hyperactivity disorder (ADHD) and posttraumatic stress disorder (PTSD) enhance marketability. Other social work providers who acquire knowledge and skills in treating socially and professionally "undesirable" and hard to serve consumers suffering from schizophrenia, developmental disability, personality disorders, and other chronic conditions, are also readily sought after by consumers, allied providers, and payers. In addition, specialized training in approaches and techniques like Brief Solution-Focused Therapy and Eye Movement Desensitization and Reprocessing (EMDR) can contribute to professional salability.

It is an imperative marketing strategy that social workers convey their expertise as clinicians by incorporating their unique understanding of human development and interaction. By way of illustration, using Eco-Maps, Genograms, and the Person-In-Environment classification system, social workers can provide tangible evidence of the importance of understanding and treating consumers from a systems perspective, which is unique to the profession (Cournoyer, 1996; Karls & Wandrei, 1994). In addition, the knowledge and ability of social workers to re-frame treatment as a larger system or community problem sets the profession apart from other more individually psychopathology-centered providers.

Finally, in a move similar for physicians, clinical social workers might well consider establishing preferred or independent provider networks. By so doing, social workers could advance quality assurance, safeguard their market-share, and gain greater autonomy.

### **Social Action: Staying Ethical**

Social workers increasingly will be called upon to provide help to consumers of mental and behavioral health services who are covered by some type of managed care arrangement. Understanding that managed care's focus on cost-containment and social work's concern with social justice will periodically conflict, providers and their professional organizations must be prepared to lobby and advocate for their professional autonomy rights of consumers. It is with this in mind that social workers need to use their position to work on behalf of those denied services due to their condition, insurance plan limitations, and socioeconomic status ("Voice on Managed Care Gained," 1998).

As an example, consumers seeking treatment are routinely offered limited outpatient sessions and inpatient lengths-of-stay, which may be contrary to the therapeutic assessment made by the provider. Faced with this fact, clinical social workers must decide what impact these treatment authorization decisions will have on consumers, and whether they will participate in providing inadequate care or take action on behalf of the client. Ethically, social workers must act in a manner which is in the best interest of the client, even though such action may place them in conflict with payers and employers. To avoid this seeming inevitability, NASW needs to negotiate an understanding with managed behavioral health care companies, possibly through NCQA, regarding the primacy of the NASW Code of Ethics. Furthermore, when conflicts are not resolved a bipartisan mediation a subsequent binding arbitration mechanism needs to be established to resolve impasses.

Through social action, the profession can renew its commitment to consumer rights and public sector mental health care in a work-a-day world driven by privatization and profit. Perhaps, as Manning (1997) states, social workers can employ moral citizenship, founded on their ethics, to determine what is the proper course of action in safeguarding consumer rights and preserving professional integrity. In so doing, social workers can avoid being seen as

collaborators with managed care corporations, and thus become professionally autonomous.

### Conclusion

Practice in the wake of managed behavioral health care has proved to be a difficult task for clinical social workers as they attempt to maintain their professional autonomy. In contending with the pressures to adopt a managed care mind-set, founded on cost-containment rather than patient care, it is vital that social workers position themselves as indispensable providers of service, while retaining their traditional stance as champions of the oppressed. The challenge to stay ethical while selling oneself professionally will be an important priority for future social work practice and education.

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