Professional Development:
The International Journal of
Continuing Social Work Education

Perceptions of Responsibility for the Acquisition of Skills and Knowledge in Current Service Environments

Journal:	Professional Development: The International Journal of Continuing Social Work Education
Article Title:	*Perceptions of Responsibility for the Acquisition of Skills and Knowledge in Current Service Environments*
Author(s):	*Michael N. Kane, Elwood R. Hamlin II, and Diane Green*
Volume and Issue Number:	*Vol. 4 No. 1*
Manuscript ID:	*41014*
Page Number:	*14*
Year:	*2001*

Professional Development: The International Journal of Continuing Social Work Education is published three times a year (Spring, Summer, and Winter) by the Center for Social Work Research at 1 University Station, D3500 Austin, TX 78712. Journal subscriptions are $110. Our website at www.profdevjournal.org contains additional information regarding submission of publications and subscriptions.

ISSN: 1097-4911

URL: www.profdevjournal.org **Email: www.profdevjournal.org/contact**

Perceptions of Responsibility for the Acquisition of Skills and Knowledge in Current Service Environments

Michael N. Kane, PhD, MSW, M Div; Elwood R. Hamlin II, DSW, MSW; and Diane Green, PhD, MSW

Introduction

Social work educators seek to provide current and future practitioners with a sophisticated knowledge and skill base informed by the profession's code of ethics. Current practitioners and administrators have a unique contribution to make to curriculum development and continuing education programs, as practitioners and administrators are critically aware of contemporary service issues.

Various health and allied health researchers have documented important educational changes as a result of evolving service delivery environments (cf: Blumenthal, 1996; Comorrow, 1999; Sherer, 1993). Some literature suggests that social work educational methods must be reevaluated in light of current service delivery climates (Berger & Ai, 2000- A; Berger & Ai, 2000- B; Vandivort-Warren, 1996; Voland, Berkman, Stein, & Vaghy, 1999). There is little empirical data that documents social workers' perceptions of current and changing needs in the service delivery arena, particularly in relation to managed care and privatization. This study requested social work administrators and practitioners, who serve as field supervisors, to rate the importance of skill and knowledge items identified by Vandivort-Warren (1996). Additionally, respondents were asked about who has the primary responsibility to teach these 23 items. Teaching options included the university, the agency through the field experience or continuing education, or collaboration between the university and the agency.

Current Service Delivery in the "Real World"

Health, mental health, and social service delivery are no longer the result of a confidential dialogue between client and practitioner (Davis & Meier, 2000). Instead, the client-practitioner dialogue may include payer-utilization reviewers, agency overseers, case managers, multidisciplinary teams, administrators, and others (Peebles-Wilkins et al., 1996). Clearly, the delivery of services within the public and private sectors has changed dramatically (Berkman, 1996; Davis & Meier, 2000; Edinburg & Cottler, 1995; Frazee, 1997; Motenko et al., 1995; Oss, 1996; Perloff, 1998; Rosenberg, 1998; Scuk, 1994; Vernon, 1998; White, Simmon, & Bixby, 1993).

Most public, private-for-profit, and private-not-for-profit service environments incorporate an articulated goal to control cost and to provide effective and efficient service (Beinecke, Goodman, & Lockhart, 1998; Borenstein, 1990; Corcoran & Vandiver, 1996; Davidson, Davidson, & Keigher, 1999; Elias & Navon, 1998; Fletcher, 1999; McEntee, 1993). The goal of controlling costs while delivering effective services appears to some critics of managed care and privatization as an attempt to ensure maximal savings for shareholders, organizations, governments, and taxpayers (Davis & Meier, 2000). Nevertheless, most service providers currently participate in a system that has opted to solve the economic pressures of a market-driven system by rationing expensive and scarce services (Kapp, 1999; Rose, 1996).

Previous service delivery systems depended on indemnity insurance policies and unlimited government funding. Practitioners were allowed to autonomously initiate intervention, generally without intensive review of service effectiveness or necessity. In this fee-for-service system, some providers received immense financial rewards for excessive and unnecessary services. Not surprisingly, insurance companies, governments, and taxpayers desired a system that would contain cost and provide effective intervention. Managed care, privatization, and other models of service rationing have been the result. While some perceive these restrictive service delivery models as unique to the United States, these models appear to have been exported globally through the presence of U.S. business and industry (Frazee, 1997).

Michael N. Kane, PhD, MSW, M Div; Elwood R. Hamlin II, DSW, MSW; and Diane Green, PhD, MSW, teach at the School of Social Work, Florida Atlantic University.

Correspondence should be addressed to Michael Kane, 7311 Lyons Road, Coconut Creek, FL 33073
Telephone: (954) 236-1162; E-mail: MNKane@aol.com

Managed care and other rationing models of service delivery have affected most health and allied health disciplines. These professional groups have been challenged to adopt new skills and integrate knowledge of new service methods in their educational curricula and in continuing education programs. Medical schools and educators have been forced to respond to the demands of managed care. Fee-for-service reimbursement and indemnity insurance policies have essentially disappeared, budgets have become leaner, and service organizations have cut staff (Barzansky, 1996; Blumenthal, 1996; Coggan, 1997; Fletcher, 1999; Gottlieb, 1996; Hagland, 1996; Nordgren, 1996; Veloski, 1996). More importantly, medical schools have added content to their curricula to assist graduates for employment in increasingly restrictive environments. Comorrow (1999) reports that 117 of 127 U.S. medical schools have added coursework on managed care to their curricula.

Nursing educators have added managed care content to their program curricula and continuing education programs. Their training programs provide the opportunity to work in rotations that are impacted by managed care and other service rationing models. Working in systems that are becoming ever more profit oriented, nursing educators have understood the importance of equipping their graduates with the knowledge and skills that will ensure their continued presence in these organizations. Nursing education incorporates material on service delivery models, cost of care, performance improvement/continuous quality improvement, practice guidelines, and case management (Jacobson, 1998; Sherer, 1993).

Critical Knowledge & Skill

Increasingly, managed care and privatized service delivery are more common and pervasive (Poole, 1996). Although managed care has been identified with medical models of service delivery (Kane, Houston-Vega, & Neuhring, forthcoming), the heavy emphasis on bottom-line thinking has led some to suggest that services are delivered using business models (Davis & Meier, 2000). This bottom-line thinking has redefined the roles and functions of many health, mental health, and social service practitioners (Leahy, 1997).

Social workers are no less affected by changes in service delivery than other disciplines (Donner, 1998; Munson, 1998). As an example, traditional mental health service providers have included psychiatrists, psychologists, social workers, and counselors to provide psychotherapy. Since Master's-level clinicians are often reimbursed at lesser rates than psychologists and psychiatrists, the managed care company profits. This preference is supported by empirical findings that report equal effectiveness of all disciplines in providing psychotherapy (Consumer Reports, 1995; Crane, 1995). Clearly, social workers can find ample opportunities in the current service delivery system. Yet to compete effectively in the marketplace, current and future practitioners may need specialized knowledge and skills.

Some social work researchers, educators, and clinicians have begun this process of knowledge and skill identification for managed care and privatized service environments (Callahan, 1998; Kadushin, 1997; Kane, Hamlin, & Hawkins, 2000; McQuaide, 1999; Munson, 1998; Reamer, 1998; Sessions, 1998; Shera, 1996). With some empirical literature supporting the inclusion of specific material in the social work curriculum and in continuing education programs, most social workers writing about managed care and other restrictive forms of service delivery believe that social work educators need to specifically address these current environments.

Perhaps most powerfully, Berger and Ai (2000-A; 2000-B) recommend significant changes for social work education. They suggest that educators provide information on the realities and language of managed care, as well as the skills necessary to negotiate, contract, and document. They encourage the use of rapid clinical assessment strategies, competent usage of DSM-IV terminology (American Psychiatric Association, 1994), and short-term,

empirically-based practice interventions. Field instruction and various aspects of contemporary social work practice have sometimes appeared disconnected from the didactic classroom (Voland et al, 1999). Berger and Ai (2000-A) propose that field sites not providing significant exposure to managed care and privatization be discontinued, because they will not adequately prepare future practitioners. As a result of these changing venues, educators must be responsive. Voland et al (1999) suggest that strengthening the ties between the field experience and didactic coursework will alleviate the lack of synergy that has been documented in social work education since the 1970's. There is no doubt that that which is not learned in social work classrooms and through field experiences will surface as issues that must be addressed in continuing education programs.

Some researchers have identified important skills and knowledge for current social work environments (Shueman & Shore, 1997; Vandivort-Warren, 1996; Kane, Hamlin, & Hawkins, 2000; Voland et al., 1999). Voland et al (1999) suggest that basic skills, such as interviewing, assessment, documentation, and data management be enhanced for managed care and privatized environments. They suggest that practitioners will need population-specific knowledge, including familiarity with treatment modalities and policy/regulation issues. Autonomy-building skills, such as networking, program planning, policy advocacy, team building, and financial management are also critically important.

Vandivort-Warren (1996) identified 23 skills based on her work with social work focus groups around the nation. Participants believed that ten of these skills must be taught to a practitioner before they provide services to clients. These ten items include: (1) treatment skills based on diagnostic protocols/clinical pathways; (2) research skills, which have practical aspects including client outcome measures; (3) conceptualizing treatment as the best outcome in a cost-conscious environment; (4) empowering social workers with better business skills; (5) knowledge of the direct service triad of therapist-client-payer; (6) understanding market forces; (7) routine use of client outcome measures; (8) treatment in non-traditional settings; (9) outreach; and (10) skills in determining diagnostic acuity. Participants suggested that an additional 13 skills might be strengthened in practice settings through agency training, experience, and continuing education (Vandivort-Warren, 1995).

If social work educators are to be responsive to current and future needs in the service delivery arena, input received from practitioners, administrators, field instructors, managed care organizations, and many other sources will need to be evaluated to inform curriculum. Using the 23-item knowledge and skill list developed by Vandivort-Warren (1996), social work administrators and practitioners were surveyed to determine their perceptions of which knowledge and skill items should be considered critically important, and whether the university, the agency, or a combination of both was the best venue to facilitate education for these knowledge and skill items.

Methodology

Respondents: The sampling frame for this descriptive, self-administered survey was a listing of social work practitioners and administrators affiliated with one Florida school of social work's graduate and undergraduate education program. Potential respondents were contacted by mail and were requested to complete an anonymous exploratory instrument. A total of 100 surveys with cover letters were mailed. No identifying codes or marks were placed on the instruments. Within three weeks of mailing, 47 instruments were returned. As suggested by Dillman (1978), a second mailing followed with 19 instruments returned. This resulted in a response rate of 66% (N = 66). Rubin and Babbie (2000) report that a response rate of 50% is acceptable, while a 60% response rate is considered good.

Instrument: The instrument consisted of two parts. The first part collected demographic informa-

tion. The second part listed 23 knowledge and skill items identified by Vandivort-Warren (1996). Respondents were asked to indicate which of these knowledge and skill items were critically important in their employment settings. Additionally, respondents were asked whether this item should be taught at the university, at the agency, or collaboratively.

The instrument was piloted using field supervisors and hospital-based utilization reviewers. On average, the instrument took less than 15 minutes to complete. An expert panel of social work educators, practitioners, and organizational utilization reviewers established face validity for all items.

Data Analysis: Survey items were at the nominal level and analyzed to determine variability within the sample and between the categories. To describe the knowledge and skills that respondents deemed important for social work educators, frequency distribution and Chi-square statistics were used. Further multivariate analyses were precluded because of the small sample size and the level of measurement used.

Findings

Demographics

Gibelman and Schervish (1997) report that the typical NASW member is white (87.9%), female (79.4%), and holds an MSW degree (85.5%). In this descriptive study (N= 66), the majority of respondents were female (77%), white (77%), and held MSW degrees (85%). These characteristics are similar to those reported for NASW membership (Gibelman & Schervish, 1997).

Respondents worked in a wide range of agency settings, including mental health inpatient settings (21%), mental health outpatient settings (18%), court/justice system settings (8%), residential treatment settings (14%), and social service agency settings (35%). Most respondents worked in private-not-for-profit settings (62%).

The type of client served by the respondents was varied, with the majority (35%) working with various types and ages of clientele. Forty percent of

Table 1. Demographic Information

Variable	Frequency	Percentage*
Gender		
Female	52	77%
Male	14	23%
Culture		
African American	5	8%
Caribbean/Black American	2	3%
Asian/Pacific Islander	1	1%
Hispanic	6	9%
White	52	77%
Educational Degree		
MSW	59	89%
Other	7	11%
Employment Setting		
Private-for profit	10	15%
Private-not for profit	41	62%
Public	15	23%
Primary Practice Setting		
Health-Inpatient	14	21%
MH/Sub outpatient	12	18%
Courts/justice	5	8%
Residential	9	14%
Social service agency	23	35%
Other	3	4%
Clients		
Children/adolescents	12	18%
Families	10	15%
Adults	14	21%
Older persons	7	11%
Mixed	23	35%
Job Responsibilities		
Administrative	16	24%
Supervisor/no clients	11	16%
Supervisor with clients	21	32%
Front line	17	26%
Other	1	2%
Years of Social Work Experience		
Less than 2	5	8%
2-5	11	17%
6-10	23	35%
11-15	9	14%
16-20	8	12%
21 or more	9	14%

**Percentages may not total 100% due to missing data*

respondents were in administrative or supervisory positions with no client-contact, 32% were in a position with some client contact, and 26% were in front-line positions. Seventy-five percent of respondents had worked in the field for more than six years. (See Table 1, page 17.)

Critically Important Knowledge and Skills

Several items were identified as being critically important knowledge and skill items for current service environments, including: cultural competence (79%), using systems thinking (77%), clinical case management (65%), client participation in treatment planning (64%), and practical research skills (58%). Table 2 provides detailed information regarding the skill and knowledge items respondents identified as critically important for current service environments, as well as their perception of where these items should be mastered. (See Table 2.)

Chi-square statistics were computed for all skill and knowledge items and the various employment venues (private-for-profit, private-not-for-profit, and public). Since these entailed 23 separate analyses, and to control for family-wide error, the Bonferroni technique was used to adjust the significance level. This adjustment is obtained by dividing the generally agreed upon significance level of 0.05 by the number of separate analyses (23), resulting in a new significance level of 0.00217.

Table 2 - Ratings of Knowledge & Skills as Critically Important & Where They Should Be Taught

Field Instructor's Critically Important Skill/Knowledge List	University		Agency		Both	
	N	%	N	%	N	%
Cultural competencies	52	79	53	80	5	8	8	12
Use systems thinking	51	77	50	76	5	8	11	17
Clinical case management	43	65	35	53	14	21	17	26
Client participation in treatment	42	64	32	49	18	27	16	24
Practical research skills	38	58	44	67	4	6	18	27
Outcome measures	37	56	31	47	15	23	20	30
Economic realities of care	35	53	32	49	13	20	21	32
Nontraditional treatment settings	34	52	25	38	17	26	24	36
Outreach and accessing services	33	50	24	36	19	29	23	35
Knowledge of diagnostic acuity	32	49	30	46	13	20	23	35
Administrative roles in marketing	31	47	34	52	7	11	25	38
Diagnostic protocols	29	44	29	44	9	14	28	42
Computers/technology	29	44	20	30	19	29	27	41
Triad (client, payer, social worker)	26	39	23	35	15	23	28	42
Gate-keeping skills	26	39	24	36	14	21	28	42
Contract negotiation	24	36	26	39	9	14	31	47
Best outcomes treatment	22	33	25	38	8	12	33	50
Entrepreneurial alliance building	22	33	23	35	10	15	33	50
Bridge payer relationships	20	30	16	24	15	23	35	53
Document for payers/triage	20	30	18	27	14	21	34	52
Knowledge of market forces	18	27	23	35	8	12	35	53
Utilization review knowledge	14	21	15	23	13	20	38	58
Manage capitated rates	13	20	13	20	16	24	37	56

No statistically significant differences were found between employment type and venue of instruction. Chi-square statistics were employed to analyze each knowledge and skill item and the variables of practice setting, culture, years of social work experience, and gender. Again, the Bonferroni technique was used to adjust the significance level. No statistics approached significance.

Discussion

Respondents identified several skills as critically important to current service delivery environments, including: cultural competency, systems thinking, clinical case management, client participation in treatment planning, and practical research skills. Most respondents indicated that the knowledge and skill items of cultural competency, using systems thinking, clinical case management, practical research skills, and administrative roles in marketing are the responsibility of university education. In general, knowledge and skill items that were not perceived by most respondents as critically important were believed to be a shared responsibility between the university and the agency.

In general, the knowledge and skill items identified as critically important in this descriptive research are consistent with the work of Vandivort-Warren (1996). As noted previously, Vandivort-Warren (1996) identified a list of critically important skills from work with social work focus groups. In this study, nine (39%) of the items were perceived as critically important by half or more of the respondents. Knowledge and skills identified as critically important from Vandivort-Warren's (1996) list are broad and encompassing in scope. Respondents agreed that social workers need broad-based knowledge and skills, such as cultural competency, systems thinking, clinical case management, practical research skills, outcome measures, and knowledge of the economic realities of care options.

Vandivort-Warren (1996) found that of the 23 items identified as critically important, ten of these items must be learned before practitioners can provide services to clients. These ten items have been listed above. In this study, only four of these ten items were perceived as critically important by more than half of the respondents. These four knowledge and skill items were practical research skills, outcome measures, treatment in non-traditional treatment settings, and outreach and accessing services. Respondents were less clear about the critical importance of diagnostic protocols, understanding the client-payer-social worker triad, and perceiving treatment as the best outcomes in a cost-conscious environment. This finding may be a result of the small number of respondents working in the private-for-profit sector.

Equally interesting are the skills that fell lower in respondents' rankings. Respondents did not seem to agree overwhelmingly with the research of Vandivort-Warren (1996) that knowledge of market forces, utilization review knowledge, and management of capitated rates were critically important. This may, to some extent, be a result of the respondents' employment setting. Additionally, the Bonferroni technique may have increased the probability of committing a Type II error.

Managed care organizations indicate that practitioners who plan to work in managed care environments or provide services to managed care subscribers should possess the knowledge and skills specific to these service delivery systems, and that this knowledge and skill be incorporated as a part of the educational curriculum or through continuing education (Shueman & Shore, 1997). However, these organizations wish to assume no responsibility for providing initial or ongoing education to their employees, providers, or those associated with providers. No doubt, the cost of education and training may be at the core of this stance. Respondents in this survey were not so clear that educational responsibility fell to the school alone. Interestingly, those items identified by respondents as critically important were also identified as items that the university had the primary responsibility to

teach. Items perceived as less important by respondents were more likely to be assigned to a collaborative relationship between the university and the agency. This collaborative relationship could conceivably take the form of continuing education sponsored by professional organizations or universities. This finding may also have important implications, in that it may provide a method to bridge what has been identified as a lack of synergy between the classroom portion of social work training and the field setting (Voland et al, 1999). While much is written in the literature regarding bridging this gap, little is written about methods to do so. Finding ways of maximizing collaboration in knowledge and skill acquisition may provide the opportunity to strengthen ties between educational programs and the professionals who operate in practice settings. This study indicates a willingness on the part of the agency representatives to assist in that process.

Suggestions for Future Research/Limitations

Further studies are needed with both larger and more representative samples. Undoubtedly, many studies of social work educational needs and practice environments employ small sizes due to fiscal constraints. Studies are needed that have larger and more representative samples in order to ensure generalizability and statistical power. As with all anonymous self-report research, the potential of selection bias is problematic. Researchers were unable to contact non-respondents to determine differences and reasons for non-responsiveness.

While this study is delimited to field instructors in south Florida, other sources and perceptions of critical skill and knowledge need to be studied, including employers, educators, managed care organizations, and new practitioners. Findings from such studies would allow for comparisons from multiple sources, as well as the establishment of inter-rater reliability between sources.

Given these limitations, some conclusions can be drawn from the data. First, critically important items in this study were also critically important items for the focus-group participants in Vandivort-Warren's (1996) work. Additionally, the majority of items were believed to require collaboration between agencies and professional educators. These findings lend empirical credibility, as well as a strategy to engage both professional educators and agencies in bridging the gap between the profession and necessary service skills and knowledge.

Reference

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington, DC: Author.

Barzansky, B. (1996). Educational programs in US medical schools, 1995-1996. *Journal of the American Medical Association, 276(9)*, 714–719.

Beinecke, R. H., Goodman, M., & Lockhart, A. (1998). The impact of managed care on Massachusetts mental health and substance abuse providers. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 145–155. Washington, DC: NASW Press.

Berger, C. S., & Ai, A. (2000-A). Managed care and its implications for social work curricula reform: Clinical practice and field instruction. *Social Work in Health Care, 31(3)*, 83–106.

Berger, C. S., & Ai, A. (2000-B). Managed care and its implications for social work curricula reform: Policy and research initiative. *Social Work in Health Care, 31(3)*, 59–82.

Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work, 41(5)*, 541–551.

Blumenthal, D. (1996). Managed care and medical education: The new fundamentals. *Journal of the American Medical Association, 276(9)*, 725–727.

Borenstein, D. B. (1990). Managed care: Means of rationing psychiatric treatment. *Hospitals and Community Psychiatry, 41*, 1095–1098.

Callahan, J. (1998). Documentation of client dangerousness in managed care environment. In G. Schamess & A. Lightburn (Eds.) *Humane managed care?*, pp 299–307. Washington, DC: NASW Press.

Coggan, P. (1997). Medical education and marketplace competition. *Journal of the American Medical Association, 277(13)*, 1037.

Comarow, A. (1999). Teaching managed care the right way: Medical students participate in unique clinical program. *U.S. News & World Report, 126(12)*, 77.

Consumer Reports. (1995, November). *Mental health: Does therapy help?* 734–739.

Corcoran, K., & Vandiver, V. (1996). *Maneuvering the maze of managed care.* New York: The Free Press.

Crane, D. R. (1995). Health care reform in the United States: Implications for training and practice in marriage and family therapy. *Journal of Marital and Family Therapy, 21*, 115–125.

Davidson, T., Davidson, J.R., & Keigher, S. M. (1999). Managed care: Satisfaction guaranteed.....not! *Health and Social Work, 24(3)*, 163–168.

Davis, S. R., & Meier, S. T. (2000). *The elements of managed care: A guide for helping professionals.* Stamford, CT: Brooks/Cole.

Dillman, D. A. (1978). *Mail and telephone surveys: The total design method.* New York: John Wiley and Sons.

Donner, S. (1998). Fieldwork crisis: Dilemmas, dangers, and opportunities. In G. Schamess & A. Lightburn (Eds.) *Humane managed care?*, pp 442–454. Washington, DC: NASW Press.

Edinburg, G.M., & Cottler, J. M. (1995). Managed care. In *Encyclopedia of social work*, (Vol. 2, pp. 1635–1642). Washington, DC: NASW Press.

Elias, E., & Navon, M. (1998). Managing organizational change: The Massachusetts Department of Mental Health experience in preparing for managed care. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 111–122. Washington, DC: NASW Press.

Fletcher, R. H. (1999). Who is responsible for the common good in a competitive market? *Journal of the American Medical Association, 281(12), 1127 (1).*

Frazee, V. (1997). It's inevitable: Managed care is going global. *Workforce, 76(1)*, G24–29.

Gibelman, M., & Schervish, P. H. (1997). *Who we are: A second look.* Washington, DC: NASW Press.

Gottlieb, S. (1996). The role of managed care in financing medical education: A survey of views. *Journal of the American Medical Association, 276(9)*, 756–757.

Hagland, M. (1996). Anything but academic. *Hospitals & Health Network, 70(1), 20 (6).*

Jacobson, S. F. (1998). A faculty case management practice: Integrating teaching, service and research. *Nursing and Health Care Perspectives, 19(5)*, 220–223.

Kadushin, G. (1997). Educating students for a changing health care environment: An examination of health care practice course content. *Health and Social Work, 22(3)*, 211–222.

Kane, M. N., Hamlin, E. R., & Hawkins, W. (2000). Field instructors: What skills are critically important in managed care and privatized environments? *Advances in Social Work, 2*, 187–202.

Kane, M. N., Houston-Vega, M. K., & Nuehring, E. M. (In Press). Documentation in managed care: Challenges for social work education. *Journal of Teaching in Social Work.*

Kapp, M. B. (1999). *Geriatrics and the law: Understanding patient rights and professional responsibilities.* New York: Springer Publishing Company.

Leahy, M. (1997). Preparation of rehabilitation counselors for case management practice in health care settings. *Journal of Rehabilitation, 63(3)*, 53–59.

McEntee, C. (1993). Clinton's next moves: Scoping out the White House on health care reform. *Hospitals, 67(2)*, 23–26.

McQuaide, S. (1999). A social worker's use of the "Diagnostic and Statistical Manual." *Families in Society: The Journal of Contemporary Human Services, 80(4)*, 410–416.

Motenko, K., Allen, E., Angelos, P., Block, L., DeVito, J., Duffy, A., Holton, L., Lambert, K., Parker, C., Ryan, J., Schraft, D., & Swindell, J. (1995). Privatization and cutbacks: Social work and client impressions of service delivery in Massachusetts. *Social Work, 40(4)*, 456–463.

Munson, C.E. (1998). Evolution and trends in the relationship between clinical social work practice and managed care organizations. In G. Schamess & A. Lightburn (Eds.) *Humane managed care?*, pp 308-324. Washington, DC: NASW Press.

Nordgren, R. (1996). The effect of managed care on undergraduate medical education. *Journal of the American Medical Association, 275(13)*, 1053–1054.

Oss, M. E. (1996). Managed behavioral health care: A look at the numbers. *Behavioral Health Management, 16(3)*, 16–17.

Peebles-Wilkins, W., Veeder, N.W., with Clay, C., Cohen, I., Coplon, J., Dillon, C., Geron, S., & Steketee, G. (1996, December). *Research needs in managed behavioral health care in Massachusetts.* Paper presented for the National Institute of Health, Boston, MA.

Perloff, J. D. (1998). Medicaid managed care and urban poor people: Implications for social work. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 65–74. Washington, DC: NASW Press.

Poole, D. L. (1996). Keeping managed care in balance. *Health and Social Work, 21(3)*, 163–166.

Reamer, F. G. (1998). Managed care: Ethical considerations. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 293–298. Washington, DC: NASW Press.

Rose, S.J. (1996). Managing mental health: Whose responsibility? *Health & Social Work, 21(1)*, 76–80.

Rosenberg, G. (1998). Social work in health and mental health managed care environment. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 3–22. Washington, DC: NASW Press.

Rubin, A., & Babbie, E. (2000). Research methods for social work (4th Ed.). Belmont, CA: Wadsworth/Thomson Learning.

Scuka, R. F. (1994). Health care reform in the 1990's: An analysis of the problems and three proposals. *Social Work, 39(5)*, 580–587.

Sessions, P. (1998). Managed care and the oppression of psychiatrically disturbed adolescents: A disturbing example. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 171–179. Washington, DC: NASW Press.

Shera, W. (1996). Managed care and people with severe mental illness: Challenges and opportunities for social work. *Health and Social Work, 21(3)*, 196–201.

Sherer, J. L. (1993). Will college nursing education include managed care? *Hospitals & Health Networks, 67(13)*, 47.

Shueman, S. A., & Shore, M. (1997). A survey of what clinicians should know. *Administration and Policy in Mental Health, 25(1)*, 71–81.

Vandivort-Warren, R. (1996). *CSWE/NASW report on preparing social workers for a managed care environment.* Washington, DC: National Association of Social Workers.

Veloski, J. (1996). Medical student education in managed care settings: Beyond HMO's. *Journal of the American Medical Association, 276(9)*, 667–671.

Vernon, D. M. (1998). New opportunities for social work with state Medicaid managed care providers. In G. Shamess & A. Lightburn (Eds.) *Humane managed care?*, pp. 401–406. Washington, DC: NASW Press.

Voland, P. J., Berkman, B., Stein, G., Vaghy, A. (1999). *Social Work Education for Practice in Health Care: Final Report - A Project of the New York Academy of Medicine.* New York: Authors.

White, M., Simmons, W. J., & Bixby, N. (1993). Managed care and case management: An overview. *Discharge Planning Update, 13(1)*, 17–19.