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THE EFFECTS OF MANAGED CARE
ON SOCIAL WORK MENTAL HEALTH PRACTICE

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An individual seeking psycho-therapy services for a mental health disorder has 60-70 percent chance of receiving services from a master's level clinical social worker. Despite their lower status, clinical social workers make up 60 to 70 percent of the mental health workforce (Ivey et al, 1998; Clinical Social Work Society of Delaware; Testimony of the National Association of Social Workers Washington, DC Submitted to the Senate Committee on Health, Education, Labor and Pensions, September 26, 2001). This analysis examines the effects of managed behavioral health care on social work mental health practice. It begins with a synopsis on the historical background of the social work profession, its domain and market position within the mental health field before the advent of managed care organizations. Analysis includes the effects of managed behavioral health care on clinical social workers' labor market in the mental health field, their scope of practice, reimbursement rates on services provided by clinical social workers. In analyzing the price of social work services, it becomes imperative to deliberate on the following question: Is the social work market-share gain merely determined by the price of their services? How is the quality of social work services in the treatment of mental health? Analysis also includes the effects of managed behavioral health care on the traditional values and philosophical practices of social work and the ethical dilemmas resulting from the advent of managed care. The discussion concludes with some recommendation on the future of social work.

INTRODUCTION

An individual seeking psycho-therapy services for a mental health disorder has 60-70 percent chance of receiving services from a master's level clinical social worker. Despite their lower status, social workers make up 60 to 70 percent of the mental health workforce (Ivey et al, 1998; Clinical Social Work Society of Delaware; Testimony of the National Association of Social Workers Washington, DC Submitted to the Senate Committee on Health, Education, Labor and Pensions, September 26, 2001). This research analysis examines the effects of managed behavioral health care on social work mental health practice in perspective of the profession's historical background.

Available literature on social work shows three major watershed eras in the profession's development and growth in mental health practice. The late 19th century through the early 20th century mark the first watershed era of the social work profession. This era was the inception stage of the profession during which it carved its turf through aftercare function with persons who had severe and chronic mental illness. Aftercare included linking clients who were discharged from psychiatric hospitals to agencies and programs that met their psychosocial needs. This function developed into what is now known as case management. Although social work remained a step child of psychiatry, it gained reputation in community based mental health practice.

The early 1960s marked second watershed era in social work mental health practice. President John F. Kennedy introduced the mental health initiative led to the Community Mental Health Centers Act of 1963. J.F. Kennedy's mental health initiative resulted in noticeable strengthening of role of social work in mental health practice because the initiative created extraordinary demand for community based mental health treatment (Hoppe, 1987).

The emergency of managed behavioral health care organizations in the early 1990s ushered the third watershed era in social work practice of mental health. In the process of analyzing the effects of managed care on social work mental health practice, the following questions are explore: How did managed care affect the labor distribution of social workers, their scope of practice and reimbursement rates for mental health services? What are the effects of managed care on the traditional values, practice philosophy and ethics of social workers who practice mental health?

HISTORICAL BACKGROUND OF THE SOCIAL WORK PROFESSION

Vourlekis, Edinburg and Knee (1998) recognize that in the early years of the 20th century, social work's practice boundaries expanded to include direct work with people with the most serious mental illnesses through the function of aftercare for mental health clients who were released from psychiatric hospitals. Proctor (2004) also recognizes that the profession was able to establish a history of concern for the population suffering with severe and chronic mental illnesses with a practice focus of helping this population achieve their maximum functional capacity. Aftercare functions became the vehicle for linking the emerging methods and tasks of social work with the existing structures of psychiatric care. Beyond its original focus working with indigent people, the social work profession established its presence in the emerging public mental health field and significantly broadened prevailing standards of acceptable care (Vourlekis, edinburg, and Knee, 1998).

Although the profession successfully established its domain in the mental health field, Lacase and Gomory (2003) acknowledge that the social work profession remained subservient to psychiatry due to its lack of critically

distinct scientific content and ideology apart from psychiatry's medical model. Right from its inception social work has emerged as a profession subservient to psychiatry out of necessity: In order to survive the professional test in the "personal problems jurisdiction" of the 19th century new scientific age, social work had to appear scientific; yet the "only science in town was psychiatric" (Lacasse and Gomory, 2003). For this reason, some characterize the social work profession as psychiatry's "handmaiden" (Lacasse and Gomory 2003) although in due course the profession has been gradually defining its own domain and turf in an attempt separate from psychiatry. Mizrahi (1992) acknowledges the historical struggle for social work to gain recognition with other health care professions such as psychology and psychiatry. In the private mental health arena, competition for clients has been the main reason for other professionals' opposition to social work vendorship (Mizrahi, 1992). Professionals in medical and psychiatric settings have resisted social work autonomy, including social work's desire to define its role and relationship to clients and its perspective on patient assessment and intervention (Mizrahi & Abramson, 1985 cited in Mizrahi (1992). As a result, social work remained an agency-based profession largely confined to public social and health service organizations that served the poor and individuals with mental illnesses. Segal (1999) notes the role of social workers as independent private practice providers was a source of some disagreement and concern within professional circles. Disagreements and concerns originated from the belief that social workers who entered the private practice market had become unfaithful to the profession's commitment to serve the poor in public service (Segal, 1999). Hence, the commitment to serve the poor and those with severe and chronic mental illnesses became a characteristic distinction of social workers in contrast to other professionals in the mental health field including psychologists, and psychiatirists.

Cohen (2003) asserts that as recently as 1960, before the onset of managed mental health care, the roles of psychiatrists, psychologists, and clinical social workers tended to be distinct. The distribution of labor in the mental health field includes professionals from the fields of clinical social work, psychology, and psychiatry. Social work is the least prestigious of the mental health professions in contrast to the other professions. Psychiatry is at the top of the hierarchy with the prestige of its M.D. qualification. Cohen (2003) states that psychiatrists had the overall responsibility of patient care, conducted psychotherapy, prescribed medication, and supervised hospital care. Clinical psychologists conducted testing and provided group therapy and other therapeutic modalities in institutions and hospitals. However, in due course, psychologists were able to gain greater independence from psychiatric dominance at the same time lobbying for drug prescription privileges although without much success. In most localities, psychologists gained direct access to reimbursement for services without having to go through a psychiatrist or a clinic (Mechanic, 1999). Clinical social workers performed comprehensive

psycho-social assessments, counseled regarding family issues, and created discharge plans for patients in social services agencies (Cohen, 2003). As noted before, discharge planning was traditionally social work's "jurisdictional claim" since the late early twentieth century (Vourlekis, Edinburg, and Knee, 1998).

These functional distinctions began to blur after President John F. Kennedy's mental health initiative and particularly after the Community Mental Health Centers Act of 1963 (Hoppe, 1987) marking the second watershed period of the social work profession. John F. Kennedy's initiative resulted in noticeable strengthening of role of social work in mental health because it created extraordinary demand for community based mental health treatment (Hoppe, 1987). At that time community based mental health practice had become professional domain for social workers. Segal (1999) observes that the social work profession did not develop in response to public social service needs alone. The profession was also shaped significantly market forces. Initially, the advent of the community mental health centers during the 1960s created a demand for relatively inexpensive practitioners with counseling skills. The two-year Master of Social Work graduate education proved to be a cost-effective and expedient solution to market demand (Segal 1999). Increased demand for community based mental health services resulted in a phenomenon that Ivey and colleagues (1998) describe as "role fusion," characterized by the overlapping of roles and functions among mental health professionals. Since then, many have observed less distinction and more overlapping of roles among the professions that deliver mental health services, and an expansion of interdisciplinary methods and policy (Hoppe, 1987; Ivey, 1998).

According to Cohen (2003) by the mid-1970s the number of clinical social workers providing mental health treatment in the United States had grown, almost equaling the number of psychiatrists. In the subsequent 15 years, clinical social workers and clinical psychologists tripled their numbers, while the number of psychiatrists grew by less than 40 percent. As the number of non-medical practitioners increased and psychopharmacology, biology, genetics, and hard science influenced psychiatry practice, psychiatrists began to withdraw from the practice of psychotherapy or non-medical practice. Psychiatric practice instead shifted its primary focus to patients in need of psychopharmacological therapy (Cohen, 2003). Currently Psychiatrists predominantly prescribe and monitor medication use and administer medical procedures such as electroconvulsive therapy (Committee on Therapy; Hartman, 1994 cited in Cohen, 2003). With psychiatrists' shift in practice emphasis, clinical social workers and clinical psychologists assumed more responsibility in mental health treatment and specifically the practice of psychotherapy. This shift in practice distribution among mental health professionals was going to be accelerated by the advent of managed behavioral health care organizations.

THE EMERGENCE OF MANAGED CARE

Essock and Goldman (1995) trace the rise of managed care in the mental health field during the 1980s, when managed mental health care firms were growing rapidly in size and number. In the 1980s, managed care organizations targeted employers paying for health care as primary market. Companies realized that mental health care costs rose even more rapidly than general health care costs. Essock and Goldman (1995) present a study on the IBM mental health care cost as a case in point. The mental health care costs for IBM's rose from $80.8 million in 1987 to $105.7 million in 1989 which turned out to be an increase of more than 30 percent in just two years. Benefit managers at most major U.S. corporations viewed the IBM case with concern. Major U.S. corporations, decided that they needed specialized health care management expertise to "carve out" mental health benefits, for management by a specialized vendors (Essock and Goldman, 1995). That was the start of managed behavioral health care organizations (MBHCO). For the purposes of this discussion, MBHCO will be referred to as "managed care organizations". As a result managed care vendors proliferated in response to this eager market. Employers realized the savings that came with vendorship of mental health care through managed care. Essock and Goldman (1995) point out that after IBM carve-out of mental health benefits to managed care vendorship in 1990; the company realized a drop in expenditures to $97.9 million in 1992 and to $59.2 million in 1993.

Realizing that states historically play a central role in providing mental health services, far more than their role in providing general health care services, managed care firms started to look to public-sector mental health services as their next market. The new public market frontier was ease to enter because at that same time, states looked to such companies to assist them with cost containment and service delivery issues (Essock and Goldman, 1995).

SHIFT IN LABOR MARKET SHARE OF MENTAL HEALTH PROFESSIONALS

Managed care organizations shifted the control of mental health service delivery from mental health providers to individuals working for the managed care organizations. Under managed care, providers must authorize treatment before it is rendered if reimbursement for services is to occur. Once treatment is authorized, individuals in the managed care organization determine which professionals the patient may see, what type of treatment he or she may receive, how frequently the patient may be seen, and for how long. Moniz and Gorin (2003), concede that a new development in the mix of mental health services providers that came with the emergence of managed care. While clinical social workers were previously excluded from fee-for-service reimbursement

mechanisms, managed care organizations began to include social workers as approved providers in their networks of independent providers (Moniz and Gorin, 2003) which ushered the third watershed period of the social work profession.

Managed care introduced some basic mechanisms that led to this seismic shift in the mental health labor market. Clinical social workers emerged as the single group of mental health professionals performing the largest portion of psychotherapeutic services in the United States. Some authorities suggest that social workers comprise 60-70 percent of the mental health workforce (Ivey et al, 1998; Clinical Social Work Society of Delaware; Testimony of the National Association of Social Workers Washington, DC Submitted to the Senate Committee on Health, Education, Labor and Pensions, September 26, 2001). Along with that social workers also provide more community based mental health services than any other profession (Ivey et al, 1998). First, managed care introduced the mechanism of gate-keeping and utilization management. The basic idea in gate-keeping is to reduce the use of more expensive specialty practitioners and medical procedures. In utilization management, the basic idea is to develop a flexible, and efficient treatment plan for high cost clients. In both mechanisms (gate-keeping and utilization management), managed care removed control over many treatment decisions from mental health practitioners and placed it in the hands of managed care decision makers, giving officials from managed health care organizations the authority to make many decisions that mental health practitioners and consumers used to make. This gave social workers equal opportunity to compete in the labor market since other professionals traditionally resisted social work vendorship in order to reduce client competition (Mizrahi, 1992). Previously, the market place referees for social workers were their own competitors (which were the psychiatrists and psychologists). Therefore when managed care controlled decision making on 'who provides what services', it was a development in favor of social workers. Proctor (2004) points out, that trends in managed care will continue to narrow access to specialty mental health care, leaving many individuals with a mental disorders dependent on social workers.

Second, managed care introduced the mechanism of capitations. Mechanic (1999: 152) describes capitation as a "form of payment involving a fixed, predetermined payment per person for a specified range of services for a fixed period of time." Many observers attribute the huge erosion of the market share by social workers to the fact that clinical social workers are less-expensive sources of mental health services as compared to clinical psychologists and psychiatrists (Cohen, 2003, Ivey, 1998). The NASW estimates that a clinical social worker, who has a terminal MSW degree, earns 75 percent of the payment scale for clinical psychologists. In an effort to drive down fees for services, managed behavioral health care organizations started to use clinical social workers in a much more active role as preferred providers of non-medical

treatment for individuals suffering from mental illness (Mechanic, 1999, Cohen, 2003) resulting in a significant shift in the distribution of labor among the mental health professions. Ivey, Scheffler and Zazzali (1998) confirms this unique development in the 1990s where demand for psychiatrists was stable while that of psychologists was moderating and the demand for clinical social workers continued to increase.

Third, managed care increased the importance of clinical case management for mental health patients (Cohen, 2003). Historically clinical social workers have concentrated on case management. The National Association of Social Workers (NASW) describes social work case management as a method of service provision that addresses both the individual client's bio-psycho-social status as well as the state of the social system in which case management operates with intervention occurring at both the client and system levels. Case management becomes even more critical for the situation of the chronically mentally ill whose breadth of needs encompass the areas traditionally addressed by social workers (Hoppe, 1987). Therefore many managed care organizations hire clinical social workers to fulfill the role of case manager (Jackson, 1996 cited in Cohen, 2003) and psycho-therapist simultaneously. In contrast, clinical psychologists have not embraced case management as part of their routine clinical practice which makes clinical social workers the primary resource for providing case management responsibilities, an important role and a great opportunity in the managed care era (Bedell et al., 1997 cited in Cohen 2003). Thus the preference for social worker services by managed care organizations is not just based on the price of their services but also because the quality of social work services is comprehensive. While the social work profession has been historically known for their strength in case management or community based psychosocial services, there has been increasing research evidence proves the quality of their non-medical psychotherapy services is as good as that of other mental health professional including clinical psychologists and psychiatrists (Mechanic, 1999: 8-9).

THE QUALITY OF SOCIAL WORK SERVICES

Quality assurance and improvement has been addressed by social work organizations for the over 25 years. Proctor (2002) identifies quality assurance and improvement mechanisms within the social work profession such as credentialing, education and certification, licensure and standards of care through the NASW and its code of ethics. There are other organizations such as the Society for Social Work Administration and the Joint Commission on Accreditation of Healthcare Organization which establish the quality standards that social work practitioners in the mental health field follow (Proctor, 2002). While remarkably little is known empirically about the quality of social work services (McMillen, J. Curtis et al. 2005), Austad (1996) (cited in Cohen, 2003)

acknowledges that an objective review of empirical studies shows that there is no absolute proof that one profession can perform psychotherapy better than another. Henrey, Sims and Spray (1971, quoted in Mechanics, 1999) assert that social workers practice the same type of psychotherapies as psychologists and psychiatrists. Mechanics (1999) also notes that there is much reason to believe that the therapist's personality and interactive styles account for the difference more than the therapist's theoretical inclination or type of training.

Some published outcome studies, including one randomized, controlled trial comparing types of mental health specialists across disciplines, demonstrated similar outcomes or utilization of certain modalities (Scott et al. 1994; Meredith et al. 1996 quoted in Ivey, Scheffler, Zazzali, 1998). Lacasse and Gomory (2003) studied a random sample of 71 psychopathology course syllabi from 58 different graduate schools of social work to ascertain the quality of mental health education provided by these graduate programs. The findings conclude that, overall, social work programs did an excellent job teaching the psychiatric information regarding diagnosis and treatment of psychiatric disorders as presented the in the Diagnostic Statistical Manual (DSM) of the American Psychiatric Association. Such research studies have led managed care organizations to conclude that cheaper sources of labor, such as clinical social workers, are as effective in administering treatment to patients suffering from mental illness as other more-expensive practitioners (Austad, 1996 cited in Cohen, 2003).

DECLINING REIMBURSEMENT RATES

However, while the clinical social workers were gaining a bigger market share through approval of provider status by managed care organizations, Moniz and Gorin (2003) found that reimbursement rates were declining even as paperwork requirements were increasing. One would expect social workers to respond to these trends by seeking other jobs and entering the profession at a slower rate thus triggering a shortage. With other factors held constant, this shortage and demand for clinical social workers would make the price for their labor rise quite significantly. However, this does not seem to have occurred with social work labor. This development runs against simple economic assumptions. Barth (2003) explains that high moral commitment to being a social worker works against this type of demand and supply response and actually depresses social workers' wages. Apparently managed care organizations have been able to take advantage of this situation and perpetuated the depressed wages for social workers.

MOVEMENT INTO PRIVATE PRACTICE

Some observe that with the introduction of managed care, private practice became a viable and increasingly important role for clinical social workers resulting in a growing number carrying out services in a primary setting of solo or group private practice (Segal, 1999; Cohen, 2003). Traditionally, social work has been an agency-based profession largely confined to public social and health service organizations. There was a strong belief within some quarters of the social work profession that those who entered private practice market, have in some way, become unfaithful to the profession's commitment which was to serve the neediest population in public service organizations (Segal, 1999). However, with the advent of managed care, even this belief began to vanish in due course. Segal (1999) demarcates the period when distinction between private and public practice began to evaporate. Prior to 1990, managed care strategies were largely confined to health maintenance organizations which served a middle-class population through employee coverage plans (Segal, 1999; Essock and Goldman 1995). However, due to competition for new mental health patients, managed care organizations sought new markets and began provision of services to the poor who are covered by Medicaid. Some research show that managed care increased their Medicaid beneficiaries from less than 10 percent (2.7 million out of 28.3 million) in 1991 to 48 percent (15.4 million out of 32.1 million) in 1997 (Segal, 1999). Therefore, managed care strategies to provide services for Medicaid patients, helped ease the concern that came with the social workers movement into private practice, because it covered a target population (the poor) that was traditionally covered by social workers (Segal, 1999).

THREAT TO SOCIAL WORK TRADITIONAL VALUES AND PRACTICE PHILOSOPHY

As noted before, the profession's training programs are proven to do an excellent job teaching the psychiatric information regarding diagnosis and treatment of psychiatric disorders as presented by the American Psychiatric Association's (DSM) model (Lacasse and Gomory, 2003). With the emergency of managed care, social workers began to heavily rely on the DSM model for their definition of mental illness. The reliance on the DSM model was out of economic necessity. Managed care organizations use the DSM as reimbursement tool. Thus, it became imperative for social workers to rely on the DSM definition of mental illness if they expect reimbursement from managed care organizations. Hoppe (1987) admits that this situation poses a professional dilemma to social workers. The DSM is medical model while the practice of social work is rooted in the bio-psycho-social perspective which emphasizes the person-in-environment model. The person-in-environment model acknowledges

that the etiology of many problems resides beyond the individual. However, social work practitioners in the mental health arena find themselves measuring their practice modalities by other profession's standard or tools, such as those presented in the DSM model of diagnosis in order to get reimbursed by the third party payers. Further, managed care placed new demands on graduate schools of social work. Schools have had to change existing clinical courses, models, and theoretical content (Lacasse and Gomory, 2003; Moniz and Gorin, 2003) in order to reflect the need of managed care which include an extensive knowledge of DSM model of mental illness. Lacasse and Gomory (2003), point out serious concern that graduate schools of social work may simply be "reflecting the current academic deference to the intellectual framework of the funding source" which has the potential to drift the profession from the person-in-environment perspective: a traditional value and practice philosophy of the social work profession.

ETHICAL DILEMMA

The influence of managed care organization does not only pose a threat to social work traditional values and practice philosophy but it also create an ethical dilemma. According to the social work code of ethics the social worker's first ethical responsibility is his or her commitment to the client:

> The Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others (www.socialworkers.org).

As managed care organizations began to determine which service-providers the patient may see, what type of treatment he or she may receive, how frequently the patient may be seen and for how long, social work practitioners often face a serious ethical dilemma on their primary responsibility to promote the well being of the clients. With the managed care personal often making clinical decisions about the services of the patient, the question that arises in such situations is "Who is the actual client for the clinical social worker…the managed care organization or the patient?" Moniz and Gorin (2003) characterizes the situation as posing "divided loyalty" on the part of the clinical social worker. The social work practitioner is made to choose between extremely difficult options on what they should do when they believe that clients require level of care greater than what managed care is willing to authorize.

DISCUSSION

Research findings are limited by the difficulty of estimating the number of social workers who work in the mental health field. One of the factors impacting the estimate is that social workers perform their practice in wide and varied settings, some of which are not obviously associated with mental health care such as jails and prisons. Another factor that limits the formulation of accurate statistics on the work force is the limitations of the data bases used. Most of the official information used to depict social work labor force is derived from the NASW. According to Barth (2003) NASW's membership criteria exclude many people listed as social workers in U.S. Census data. Barth (2003) recognizes this as reasonable, because the NASW adheres to specified professional standards, whereas individuals wishing to describe themselves to the U.S. census as social workers can do so. Because NASW membership is voluntary, social workers who become members are almost certain to be different from those who are eligible but choose not to join (Barth, 2003). Further, there are many professionals who identify themselves as social workers even when they have had no social work education.

This does not only present a significant limitation for labor market analysis but it also perpetuates the depressed wages of social workers: a situation that plays to the advantage of managed care organization. For a long time the social work profession has grandfathered persons trained in other disciplines such as psychology, education or religion without having to go through a social work educational program. The depressed wages among social workers have also been attributed to the profession's practice of grandfathering other disciplines into its ranks. This makes the social work professional too easily dispensable. Barth (2003) observes that the social worker's compensation is the lowest among the human service profession; only above that of the religious worker. When important factors such as age, education, and race are controlled, social workers are found to earn about 11 percent less than people working in all other occupations taken together (Barth, 2003). However there are increasing returns to education in the social work labor market (as in most labor markets). Other factors held constant, social workers with a master's degree earn 18.5 percent more than social workers with a bachelor's degree (Barth, 2003). Besides managed care efforts to decrease and suppress reimbursement rates, clinical social workers working in the mental health field have a lot to work against in order to begin moving their depressed wages up.

Some prevailing thinking in the field of mental health has been that preference for clinical social workers by managed care organizations was solely determined by market conditions and the need to cut costs. It's tempting to make such conclusion especially in a system with multiple providers who provide similar services. Ivey, Scheffler, and Zazzali, (1998) notices that in such a system, lower cost providers may erode the market share of higher cost

providers when purchasers perceive that similar services are offered at different prices. However, the preference for social work clinicians does not occur only because of lower prices and without effort on the part of the profession. During the major shift of service modality for persons with mental illness in the late nineteenth hundreds, the social work profession took advantage of the socio-economic environment of the time. Beyond its original focus working with indigent people, the social work profession established its presence in the emerging public mental health field and significantly broadened prevailing standards of acceptable care (Vourlekis, Edinburg and Knee, 1998).

Beyond the price of services, demand for social work services has been supply driven. Advocacy has been a major practice role in the social work profession. Social workers have advocated not only for the clients they serve, but also the work they do since the inception of the profession. When social workers sensitized the public about the social needs around them and how the social work profession can meet those needs, they created a supply driven demand which resulted in greater demand for social workers. Vourlekis, Edinburg and Knee (1998), observe that "the rise of social work in public mental health through aftercare of people with serious mental illnesses (during the early 20th century) illustrates the important reality that strengthening a profession takes place *by creating turf, not just defending it*".

The need to create demand for the social workers becomes even more imperative during a period when there is a blurring of distinctiveness among the professions that deliver mental health services and an expansion of interdisciplinary methods and policy. At the beginning, social workers were able to carve their niche market where it did not have any competition: the poor; persons with chronic and severe mental illness in setting where research indicated that these patients are not receiving adequate care (Proctor, 2004). Social workers now compete to provide services to the same client pool as psychologists and psychiatrists after managed care organization erased most of the major distinctions between the professions. This obviously creates an unstable and divisive atmosphere for the professions which might result in the profession losing its competitive advantage.

As noted before, in order to survive the professional test in the "personal problems jurisdiction" of the 19th century new scientific age, social work had to appear scientific and adopted psychiatry due to its lack of critically distinct scientific content and ideology apart from psychiatry's medical model. Throughout the years social work has made effort to demonstrate its distinctiveness through the person-in-environment theory. However, today the area of mental health continues to manifest the gap between research and practice. Proctor (2004) reports that social work has not produced mental health service research on levels commensurate with its services provision capacity. Given the breath and range of the profession's mission and practice areas, only a limited number of social work research focus on mental health issues (Proctor,

2004).   Greater mental health services research could produce enough distinct scientific content to strengthen the profession's standing on mental health issues without having to rely on the psychiatric model of mental illness.

CONCLUSION AND RECOMMENDATIONS

Managed care comes with great advantages and challenges for the social work profession. Managed care allowed the profession to expand its frontiers of professional domain; turf and market share. It expanded turf from advocating and providing aftercare for the indigent, severe and chronic mentally ill persons to providing private practice in non-medical psychotherapy. Managed care resulted in the expansion of social work market share in the mental health arena. Social workers became the predominant profession, providing 60-70 percent of the mental health services in United States. The profession happened to provide the right services (*comprehensive*), at the right time (during the period of managed care), and at the right prices (*less expensive*). Yet these opportunities pose the greatest challenge for the social work profession. One challenge is how to maintain these gains within a field that is characterized by an overlapping of roles and functions among the competing professionals. The second challenge is to balance meeting the demands of managed care organizations and the preservation of the values; philosophies and ethical practices which make the profession unique. With the role fusion that developed with the emergence of managed care, the social work profession has the pressure to show its distinctiveness besides being less expensive providers.   The following are the recommendation for the social work profession as they look ahead in this age of managed care.

1.   The profession should come up with mechanisms to maintain a reasonable balance between the needs of the client and the demands of the managed care organizations. Such a move helps to maintain the integrity of the profession and avoid the image of a cheap profession that succumbs to the pressure of managed care organizations.
2.   Social workers should adequately advocate for the full recognition of the person-in-environment perspective to the practice of mental health such that multifaceted nature of mental illness, which includes occupational and other environmentally based stress, long-term family and child bearing difficulties, troubled marriages, could become billable to payers of mental health services.
3.   Graduate schools of social work should conduct more research on social work. This might take care of the profession's subservience to psychiatry which stifles the profession from assertively pushing for development and acceptance of the perspectives that accurately reflect the profession's domain. More research will enable social workers to build critically

distinct scientific content and ideology apart from psychiatry's medical model.

4. In the meantime, while social workers continue to use the DSM as a tool of practice in the mental health arena, the profession should make rigorous efforts for the inclusion of its perspectives in the next DSM. Currently, there are only two social work trained contributors to the current DSM (Diagnostic and Statistical Manual of Mental Disorders, 2000)

5. Social workers need to maintain stricter licensing standards and procedures, one of which would be requiring training from an accredited social work program in order for one to receive a practice license. This takes off the pressure on depressed social work wages by making social workers less dispensable.

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