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Diane Weis Farone DSW, JD

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Mental Illness, Social Construction, and Managed Care: Implications for Social Work

Diane Weis Farone

ABSTRACT. Managed care is creating a social reality that affects the lives of millions. Mental health coverage under health care plans is a function of how mental illness and its proper treatment are defined. These definitions are shaped by social actors competitively seeking to satisfy their particular interests. This paper examines the influence of privatized managed behavioral health care on these evolving social definitions, as evidenced in published works, written reports, and legal actions. It is written from the perspective of social workers as providers of services and advocates for social justice. Options for social work responses to managed behavioral health care are explored. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2002 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Medical necessity, utilization review, social construction

Certain behaviors and experiences have been recognized as indicators of mental illness in modern industrialized cultures, and mental illness has been accepted as a social problem calling for social responses. Conceptions of both what constitutes mental illness and what are appro-

Diane Weis Farone, DSW, JD, is affiliated with Arizona State University West.

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priate treatments have changed over time. Currently in the United States the debates have intensified, with emerging entities joining the discourse since the advent of managed behavioral health care.

Managed care has been creating a social reality that affects the lives of millions of people. In 1999 managed behavioral health care organizations covered approximately 177 million Americans under private insurance plans (U.S. Department of Health and Human Services [DHHS], 1999, p. 422) and forty-two of the 50 states were operating some form of managed care plans for their Medicaid populations (Substance Abuse and Mental Health Services Administration [SAMHSA], 2000, p. 1). What kind of mental health care these people receive under their health care plans is a function of how mental illness and its proper treatment are defined. The phrase "medical necessity," as applied in a context of "utilization review" (UR), has been the key that unlocks access to payment for services. The meanings of these newly coined words are shaped by social actors competitively seeking to satisfy their particular interests through available social processes.

The purpose of this paper is to examine the influence of privatized managed behavioral health care on evolving descriptions of mental illness and medical treatment from the perspective of social workers as both providers of services and advocates for social justice for vulnerable populations. Options for social work responses are explored.

THE MEDICALIZATION OF DEVIANCE AND SOCIAL CONTROL

Social construction theorists would definitely disagree with the old saying, "Sticks and stones may break my bones, but words can never hurt me." All kinds of socially created categories and classifications, including those in the area of mental health and illness, have significant power to affect lives in ways that hurt, as well as in ways that help. Mental illness has been described as a myth (Szasz, 1974). The suffering that accompanies the symptoms associated with mental illness, however, is all too real to those who experience them. Whether the symptoms or behaviors are viewed as mad, or perhaps as eccentric or sacred depends upon the culture and often on the person's social status within that culture (Porter, 1987). In his formulation of the historical development of the concept of mental illness as a psychological phenomenon Foucault (1987) concluded "mental illness has its reality and value *qua* illness only within a culture that recognizes it as such" (p. 60).

To say that mental illness is socially constructed does not mean there are not physiological or psychological processes that affect a person's perceptions, motivations, feelings, behaviors, and cognitive abilities. As stated by Conrad (1980), "Illness and diseases are human judgments on conditions that exist in the natural world" (p. 105). The definition of certain behaviors as illnesses, rather than possession (a religious problem) or criminal (a moral problem) has been referred to as the medicalization of deviance and social control. When particular behaviors or perspectives are defined as illnesses, the implication is that something is wrong and that medical treatment should be able to modify the behaviors or perspectives in a positive direction.

Through a lens of social construction, illness is considered a departure from norms or possibilities that are acceptable to a particular culture within a specific historical time period. The departure from norms may be in forms that are disturbing to the community or distressing to the individual or both. Treatment may be involuntary, coercive, or actively sought. Thus, the state and the market economy have the power to force or to withhold treatment through laws, regulations and definitions of coverage and eligibility. Both coercion and reward have the power to influence the behaviors and self concepts, or identities, of individuals.

Since the advent of managed care as a strategy to try to control rapid inflation in the health care sector of the economy, what are considered to be mental illnesses, what treatments are medical, and what constitutes proof of the efficacy of medical treatments for mental illnesses are all being questioned. Many of the elements of the debate are contained within the legal construct, medical necessity.

DEFINING MEDICAL NECESSITY

The term medical necessity is a legal concept established in the legislation that created the Medicare program in 1965 (Ford, 1998). The language has also been adopted by private insurers to set boundaries for conditions and treatments that will be covered under their policies.

In the field of mental health, delineating what is an illness and what treatments are reasonable and necessary is much less clear than in medical/surgical fields. The desire for something more tangible can be seen in the adoption of the term "behavioral" health care in the insurance field to replace mental health care. Behavior is something that has the potential to be observed and measured. Mental criteria are abstractions

about postulated inner workings of the “black box” that mediates human experience.

Generally the criteria for decision making with respect to payment require that services must be necessary for the treatment of a diagnosed disease or injury and be at a cost efficient and appropriate level of care. The American Psychiatric Association’s Diagnostic and Statistical Manual (DSM), in its various editions, has provided an anchor for defining what constitutes a diagnosed mental disease. The method used in developing the DSM-IV (American Psychiatric Association, 1994) emphasized consensus in order to gain both widespread acceptance by professionals from all theoretical persuasions and reliability in application of the diagnostic criteria. The DSM-IV defines a mental disorder as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or disability . . . or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom” (p. xxi). The extent to which these features and risks are alleviated creates logical medical measures of the effectiveness of interventions by healthcare service providers.

Medicine and the managed care industry are in agreement on some basic components of how to solve health care problems. Both apply rational means to understand and seek solutions and both value the scientific method of establishing credibility. The interests of psychiatrists and the interests of behavioral health care management companies, however, do not always coincide. Psychiatry may have professional and humanitarian reasons to be expansive in research and treatment of mental illnesses, while managed care companies are under pressures from the purchasers of their services to be more restrictive in scope and more specific concerning accountability.

For managed behavioral health care companies what is a mental disorder is a necessary, but not sufficient criterion for making decisions about paying for care. Insurers have excluded various conditions contained in the DSM from definitions of medically necessary because they are seen to be other than medical in origin or are seen to be untreatable (Donovan, 1998; Sabin & Daniels, 1994). Some conditions might be medical issues but not be severe enough to obtain a priority in the allocation of resources available to pay for care. People with these conditions have been redescribed by the managed care industry as the “worried well” or those merely experiencing “problems in living.” How exclusions from the definition of medical necessity have formed differs

between the private sector and the public sector due to differences in the contexts.

COVERAGE IN THE PRIVATE SECTOR

Most insured Americans rely upon plans made available through their employers or labor unions. A combination of competition for attracting and holding employees and tax incentives that give favorable treatment to qualifying employee benefits have contributed to this result. Tax incentives are one way the federal government has privatized for a large portion of the American public what has been a public responsibility in other western welfare states. It is a strategy that dilutes public control over social definitions that affect social provisions. Reliance on the employment system for health insurance benefits (as supplemented by Medicare and Medicaid for the elderly and medically indigent) has not served the social goal of universal coverage. Especially disadvantaged have been the working poor, for example seasonal and part time employees, employees of small companies, self employed, and many people in low skill and low paying industries. Further, reliance on the employment system for health care benefits also subjects people to discontinuities in coverage when contracts are not renewed and creates pressures to remain in unsatisfactory positions in an attempt to maintain continuity.

It is in the interest of employers to have a healthy, productive work force. Employers would be interested in care that would promote low absenteeism and high levels of employee functioning on the job at reasonable cost. Paying for treatment of all conditions listed in the DSM would not be necessary to address the interests of employers, resulting in some predictable gaps in service within private sector coverage. People experiencing the elements of the DSM's V codes, adjustment disorders, personality disorders, conduct disorders, substance abuse, and dissociative disorders have been excluded from coverage in some plans (Dana, 1996; Donovan, 1998). If the disorders are not explicitly excluded, an inability or unwillingness to comply with recommended procedures may be used to foreclose receipt of treatment services (American Society of Addiction Medicine, 1999).

Managed care has influenced the behavior of mental health service providers in various ways that affect the range of options available to consumers. Employers as purchasers have exerted pressure on the industry to demonstrate and document effectiveness of interventions.

Treatments are to be directed toward observable, measurable results, with particular attention paid to symptom relief and improvements in behavioral functioning. The use of psychotropic medication and cognitive behavioral therapy have been the methods best suited to show positive, observable, measurable effects. Although the emphasis on observable outcomes has led to effective alleviation of suffering, some conditions do not lend themselves to that kind of proof. Some causes of and contributors to apparent mental disorders may not be directly observable (such as psychodynamics), or able to be isolated in experimental design (for example such naturalistic influences as mass media, educational institutions, or the structure of workplace systems), or their impact requires a long period of repeated occurrences to manifest (for example oppression or genetic expression of a multi-determined condition). What may be seen as cognitive restructuring by some may be seen as contra-indicated by people of other theoretical persuasions. Actualization, improvements in quality of life or interpersonal relationships, insight or "working through" psychological conflicts or trauma would not be considered medical goals under many insurers' plans. Supportive therapy has been described as encouraging too much dependence on the therapist. The move to short term, focused treatment that produces measurable change hampers the development of relationships that foster consciousness raising through depth exploration of individual experience. In depth exploration can lead to questioning socially generated assumptions and to grass roots social change movements, both important functions in the social work tradition.

Changes in coverage have been reflected in the behavior of providers. Some have seen the turn to short term, focused, accountable treatments as something beneficial (Cypres, Landsberg, & Spellmann, 1997; Beinecke & Perlman, 1997). Others have learned to use language to obtain the services they believe their clients need from the managed care companies, without internalizing the model (Keefe & Hall, 1999). Others have opted out of the managed care system (Brown, 1994).

COVERAGE IN THE PUBLIC SECTOR

Promoting the general health and welfare of its people is a legal responsibility of government. In legislating and funding for mental health services, balancing the perceived reluctance of taxpayers to pay taxes against the welfare needs of people, governments often use a safety net model. Resources are directed to those who are most vulnerable and

least able to obtain social necessities for themselves in order to bring their share of the distribution of social goods up to a minimal acceptable level (Bazelon Center for Mental Health, 2000). Beginning in the 1960s, the stated emphasis of the community mental health movement has been on providing for those with serious mental illnesses the treatments, education, and supports that are needed to allow integration into the larger community whenever possible. Such an undertaking requires means beyond those that can be provided by the medical profession alone. For example, financial support through social welfare programs, new forms of sheltered and subsidized housing, special education and vocational rehabilitation services all serve the purpose of enabling those with mental illnesses to live and function in the community. The medical profession, however, retains the key to access services that are categorically provided only to those whose need is based upon having a diagnosis of mental disorder or disability.

When state hospitals began to be downsized or closed and more patients were being maintained in the community, many states did not have the staff, knowledge or technical capacity to develop and administer comprehensive, effective and efficient mental health programs. They needed to buy expertise on the market (Bachman, 1996). Privatization of public mental health services has also been stimulated by the financial structure of Medicare and Medicaid. Neither program would pay for services rendered in state hospitals but would pay for care in private community hospitals. Thus, states encouraged the use of private facilities for hospital care in order to bring in more federal dollars (Frank, 2000). This in turn opened new markets to for-profit health care companies, which grew rapidly following the creation of Medicare and Medicaid.

Another hoped for result from privatizing the management of mental health services was better integration of services through case management. In order to live in the community, people with serious and persistent mental illnesses need housing, incomes, and the ability to take care of their activities of daily living. To be able to function at optimum levels of independence they may need development in social and work related skills. States have experienced continuing fragmentation in addressing the needs of those with serious mental illnesses because of the separation of the various services into different agencies with different eligibility criteria, waiting lists, and organizational cultures. People who have difficulty integrating their own psyches and behaviors and sustaining motivation would have particularly difficult times negotiating the maze of services. It was hoped that, by combining different funding streams and

hiring companies experienced in managing networks of providers, services would become more seamless in a continuum of care flexible enough to meet the fluctuating needs of those with serious mental illnesses. This hoped for result has been perceived as taking place to some extent (Beinecke & Woliver, 2000). In other studies, significant problems in integration of services still exist under managed care programs (Rosenbaum, Silver, & Wehr, 1997; Protection & Advocacy, Inc., 2000; *State of Minnesota v. Blue Cross and Blue Shield of Minnesota*, 2001).

As the government privatizes both services and management, its remaining role is to design ways to assure that the vulnerable populations for which it is responsible are adequately served. Because patients in public mental health programs are not the worried well with problems in living ("Massachusetts Centers Analyze," 1998), the public debate has been about what constitutes appropriate medical treatment more than about what is a mental illness. For example, hospitalization has been denied as not being medically necessary, even though there were no available services to meet a lower level of care (Stout, 1998). In the abstract, hospitalization might not have been medically necessary but, in the context of the resources of a rural area, it was the only available option. Now that states have had experience with behavioral health care companies and definitions of medical necessity, some have been able to negotiate for a broader concept of psychosocial necessity that includes context in evaluating options (Sabin & Daniels, 2000). Maintaining the broader definition helps retain treatment for the deviant behaviors associated with mental illness in the medical arena.

To discharge patients into the community without regard to community resources shifts the problem from the health care sector to the family, social welfare and/or criminal justice systems and contributes to fragmentation of services. In some instances the attempt to shift responsibility for dealing with those with mental illnesses away from the health care system has been more direct. The state of Minnesota filed a lawsuit against a behavioral health care company. Among other allegations was the assertion that the company was telling parents of troubled juveniles to seek help through the juvenile justice system or to place the children in foster care (*State of Minnesota v. Blue Cross and Blue Shield of Minnesota*, 2001). Minnesota is not the only state in which this has occurred (Bazelon Center for Mental Health Law, 2000, page 16). Another allegation in the Minnesota action was that the company was refusing or significantly delaying coverage for court-ordered treatment.

The arena of forensic mental health issues is another area where the tensions of differing interests are stimulating active negotiations over

the control of social definitions. Both psychiatry and the insurance industry have distinguished between medical concepts of mental disorder and legal concepts for the purposes of civil commitment or criminal responsibility. Neither wants to surrender control over its domain to the legal system. The ultimate concerns of psychiatry, the insurance industry and the legal system are different, but their concerns intersect in the issue of social responsibilities with respect to deviant behavior that is defined as an illness. From a legal standpoint, a determination of insanity asks the question whether an individual can be held responsible for his or her deviant behavior. If not, then the state has an obligation to provide treatment (*Youngberg v. Romeo*, 1982). In contracting for mental health services, the state would want the contracting agency to cover care. However, for insurance companies to automatically cover conditions for which the legal system defines duration of treatment would be to surrender the ability to predict and control significant costs. Psychiatry's questions would be whether the person's condition has some organic basis and has been accepted as being within the jurisdiction of the medical profession (Conrad, 1980).

UR AND THE POWER TO DEFINE

Most behavioral health care organizations do not directly deliver services, rather they rely upon contracting with independent providers to do so. The companies need some mechanisms to exercise control over the providers in order to contain the costs of obtaining care for beneficiaries. UR and gate keeping are flexible and powerful techniques for containing costs on a continuing basis. A primary care provider or a care manager decides, case by case, whether to authorize payment for a service. This organizational form broadly disperses the power to influence and make decisions and creates inconsistencies in application.

The executive adoption of standards to guide decision making is only the first step in the decision making process. How reviewers are trained and monitored affects the implementation of those standards. The restrictiveness with which standards are enforced by top levels of company management has been found to vary directly with the degree of financial risk the company has assumed (Ridgely & Giard, 1999). The structure of case by case UR allows significant decision making authority at the level of the front line. Reviewers retain some discretion in their authority to interpret the companies' guidelines, whether rigid and lit-

eral or contextual and flexible. To the extent that providers do not have access to the standards being applied, they will not know whether an individual reviewer has exceeded his or her authority or acted within the intent of the management company. Reviewers also can influence outcomes through the manner in which they interact with providers, whether intimidating or friendly. Further, providers will differ in their ability to obtain services for their clients. Although appeals procedures are available, providers and consumers tend not to avail themselves of the process (Fendell, 1998; Stout, 1998), sometimes feeling it is a futile hassle (Beinecke & Woliver, 2000, page 118), or that to do so would create a risk of removal from referrals or from provider panels (Donovan, 1998, page 112; Newman, 1998). Consumers are primarily dependent upon the advocacy skills of their providers in being able to access payment for care.

IMPLICATIONS FOR SOCIAL WORK

The widespread adoption of managed care strategies has had many impacts on social work. Particularly challenging have been intensified concerns about practicing within a medical model and ethical dilemmas with respect to clients' rights and principles of distributive social justice.

The appropriateness of the medical model for social work practice has frequently been questioned in the literature. Relying too much on professional expertise can distance providers from consumers and interfere with collaborative relationships. The system of diagnostic classification abstracts only certain elements of the person, fragmenting what should be a more holistic approach to understanding people in their environments. The application of diagnostic labels contributes to the internalization of stigmatizing self concepts (Goffman, 1963) and has pragmatic social costs. Having received a psychiatric diagnosis may preclude the ability to obtain life or health insurance, as well as certain types of employment.

Some progress has been made over the last forty years. Privatization of mental health services contributed to a reduction in stigma by dismantling the previous two tier public and private systems. Community education efforts associated with the community mental health movement and growth of consumer advocacy groups has made seeking care more accepted. Advocates for the civil rights of mental patients in-

creased public awareness of ways in which the coercive power of the state was being abused with respect to those with mental illnesses.

The current battlegrounds have been over the limits of public responsibility to assure access to services and who decides how to allocate scarce resources for mental health care. Allocation of scarce resources is a difficult task with many ethical dilemmas. Assume policy makers believe restrictive managed care policies are necessary in order to increase coverage, or that resources are better allocated to the people who comply with system procedures because they are the ones who will experience observable benefit from services. From a social work perspective, are those good policy decisions? Does the fact that the essence of the “disease” in many instances is an inability to conform to social expectations suggest that a different allocation principle should be used? In many respects where you sit may be where you stand on these questions. Of course, where you stand may also affect where you choose to sit.

Consider the following illustration of ethical dilemmas. Requiring a hospitalized consumer to attend a group therapy session whose agenda was designed by the unit staff to help him or her to develop skills in forming social relationships could simultaneously be viewed as violating client self determination and fostering human relationship. Both involve ethical values for social workers. The dilemma is that to attend to one may mean to neglect the other. Assume that managed care favors group treatment and it does not allow time for a consumer to come to an informed decision about whether he or she wants to participate. Assume further that refusal to attend would be against medical advice and would be grounds for denial of payment for the hospitalization. What is the essence of the ethical breach, if there is one? Is it the favoring of a particular protocol to be standardized for all? Is it the failure to allow the consumer to decide? Is it the severity of the sanction?

A market economy model would say the competitive market place is the best mechanism for allocating services. This has the advantage of not being paternalistic and not implying superior power through expertise. Theoretically, producers should produce what consumers want to buy. However, several factors distort a pure market model in behavioral health care. One is the separation of those who are making the decision to buy and those who are consumers of services. Another is that some consumers of behavioral health care services may not be using those services as a matter of free choice. Further, and most important for social work’s values, the market place works in the aggregate and does not assure the needs of marginalized consumers will be met.

CONCLUSIONS

Social construction is a helpful model for understanding current working environments in the field of mental health. It provides analytic focus for understanding the varying interests of the parties concerned with definitions of mental illness and medical necessities. It also offers opportunities to consider how social work can exercise power by contributing to the continuing development of social definitions in ways that will benefit those whose needs and voices are being marginalized.

Social work may not have the direct power to define mental illness that the medical profession and the insurance industry do. However, social work can pursue potential opportunities to influence the evolving conceptualizations of mental illness and necessary mental health services. Through its national associations social work exercises its influence with governmental legislative and administrative bodies to encourage the adoption of more consumer friendly policies. Individual social workers may also serve on boards of private behavioral health care management companies and, thus, give voice to concerns for consumers. Further, individual social workers can try to influence claims reviewers' interpretations of decision criteria within a negotiation process. Serving as mediator or interpreter between clients and social systems has been a role for social workers from the beginnings of the profession.

Part of the mediation between vulnerable populations and social institutions involves making social service systems more responsive, humane, and just. Both helping clients who are experiencing current pain and suffering to access services and trying to change social conditions that contribute to the development and maintenance of individual distress have been a part of social work's heritage.

Several elements are required in order to bring about change in the evolving managed care environment. One would be to understand the dynamics of the context within which the managed care companies are operating in order to see where collaboration is possible and where leverage can be found. Another would be awareness of other groups with whom to form coalitions in order to use the government's legislative or administrative power through advocacy. To have a sophisticated understanding of the complexity of social forces requires two kinds of knowledge. One is a breadth awareness of the numbers of people affected and population groups that are systematically marginalized. The other is an in depth understanding of the human experience of social structures and processes. It is no longer possible to explore in depth and raise the con-

sciousness of individuals in a managed care environment of brief, focused therapy and observable results. Other avenues need to be expanded to keep the profession in touch with the human experiences generated by our health and welfare service systems and to help clients critically sort out what are their shortcomings. Also, many worried well with problems in living or personality characteristics that cause suffering and dysfunction have been defined out of coverage in the mental health sector. They continue to have needs that can no longer be addressed in a mental health setting. Social work may need to look at how it can construct its own working environment to increase avenues for services outside of the health care system. In so doing, it may be able to create a better “goodness of fit” between its values and aspirations and the environment in which it functions.

Opportunities for in depth discussions with consumers could be purposefully designed to explore experiences with agencies or could be incidental to more general group or individual services. Finding solutions to problems in living could be structured in ways that would not require a diagnosis and could be based on alternative models, such as educational or consciousness raising. Such programming needs to occur in settings that are not primarily dependent on health insurance benefits for funding and are not secondary to organizations that are tied only to the medical model. Mental health agencies structured on a clubhouse model, family and children’s agencies, neighborhood community centers, women’s centers, or senior centers are examples of places that could potentially expand space for these important aspects of social work practice.

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