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The Impact of Type of Ownership on Mental Health Organizations: The Privatization Alternative

Gary R. Mathews

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THE IMPACT OF TYPE OF OWNERSHIP ON MENTAL HEALTH ORGANIZATIONS: THE PRIVATIZATION ALTERNATIVE

by

Gary R. Mathews

A Dissertation Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Doctor of Philosophy Department of Sociology

Western Michigan University Kalamazoo, Michigan April 1989

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THE IMPACT OF TYPE OF OWNERSHIP ON MENTAL HEALTH ORGANIZATIONS: THE PRIVATIZATION ALTERNATIVE

Gary R. Mathews, Ph.D.
Western Michigan University, 1989

In recent history most citizens have traditionally considered care of the mentally ill a public service, a government responsibility, and a financial expense best acquitted through taxation. A current topic of debate is whether or not mental health care should continue to be provided primarily in the public realm or instead be provided as a business. A question which must be answered as a part of this debate is: Does type of ownership affect service provision, and if so how? In order to answer this question data from the 1983 Inventory of Mental Health Organizations, a national survey sponsored by the Survey and Reports Branch, National Institute of Mental Health, were analyzed. Data analysis was confined to outpatient clinics, psychiatric hospitals and multiservice organizations. Specifically, differences in type of organization, quantity of clients served, race of clients, expenditures, income, net income, and staffing were investigated. Type of ownership was found to affect organizational type, client quantity, net income and staffing. The qualitative debate between those who favor the pursuit of economic efficiency through privatization and those favoring social equity and equal access to services through governmental control is discussed.
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The impact of type of ownership on mental health organizations:
The privatization alternative

Mathews, Gary R., Ph.D.
Western Michigan University, 1989
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And last, but not least, my deep appreciation goes to my mother, who taught me to dream, and my father, who taught me to pursue those dreams with vigor.

Gary R. Mathews
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CHAPTER I

THE PROBLEM

As the title of this study suggests, a relationship may exist between type of ownership and service delivery patterns in mental health organizations. What kind of impact, the extent, and the implications this fact might hold for the future direction of the mental health system is the subject of this dissertation. This is an important subject, a complicated subject and one that defies easy explanation. Therefore, it is important to understand and analyze the way the mental health system is organized. Both the effectiveness and efficiency of the system is, in part, determined by the manner in which it is organized.

The organization of mental health services is certainly complex. If its purpose is to promote mental health, most experts (Brown, 1985; Grob, 1983; Laing, 1967; Magaro, Gripp, McDowell, & Miller 1978; Szasz, 1970) would argue that it is not being successful. If its purpose is to treat the seriously mentally ill, many would argue that they are not being well served (Torrey, 1988). And while the combined total effort is often referred to as a system, some would argue that there is very little that is systematic when it comes to mental health. For example, Hasenfeld (1986) describes the difficulty Community Mental Health Centers (CMHCs) have in establishing domain consensus and portrays them as loosely coupled. Grusky et al.
(1986) comment on the fragmentary organization of mental health care.

One reflection of the complexity of mental health is the fact that it is operationalized through the medium of complex organizations as explained in Goldman, Taube, and Jencks (1987) and McCar- rick, Rosenstein, Milazzo-Sayre, and Manderscheid (1988). There are many competing forms of treatment for mental illness and competing ideas concerning the nature, extent, definition of and ways to measure effectiveness of mental health programs. It seems best to begin by identifying how these ideas combine to express the purpose of this study.

Purpose of the Study

The purpose of this study is to determine whether or not type of ownership makes a difference in the delivery of mental health services. This is important because a relationship between the current crisis in mental health and the type of ownership of mental health organizations is suspected. The study would be incomplete if only empirical evidence were to be considered. There is also a difference in philosophy and in goals that is not easily measured quantitatively. This qualitative difference shall be addressed both in the review of literature (Chapter II) and in the conclusion (Chapter V). There are philosophical differences between serving the owners and serving the clients, between contributing to the public good and serving private interests, between income generating activity and the pursuit of social goals, between commercialism and professionalism, between maximizing profits by providing minimal
levels of care and maximizing quality service by emphasizing equity, fairness and social justice. By "type of ownership" is meant the declared economic status of the organizations responding to the survey: private for-profit, private non-profit and public or governmental.

These types of ownership distinctions may have an effect on discipline or training of staff, expenditures and sources of funds. Descriptive statistics shall be utilized to measure the salient characteristics of the population under study. It is expected that differences will be discovered. While the data reported in this study are not new, there are two reasons that they are potentially useful. One reason is that the data, while technically available, are not easily accessible to casual inquiry. The other reason is that type of ownership, while a matter of great topical discussion and debate, is not a variable that has previously been scrutinized as an independent variable in the data set used herein.

The theoretical frames of reference to be utilized in interpreting the data are provided by the organizational typology and organization effectiveness literature. The typology literature can be traced from Parsons (1960) to Blau and Scott (1962) to Woodward (1965) to Etzioni (1975). The organization of mental health services has received much recent attention (see, for example, The Organization of Mental Health Services: Societal and Community Systems, Scott & Black, 1986). The organizational effectiveness literature has a relatively longer tradition, perhaps beginning with Barnard (1938). The more recent effectiveness literature has produced a
variety of models including the goal model, the competing values model, the "who provides" model and the financial viability model (see Figure 2 on p. 43). These threads will be woven into a whole cloth in the next chapter.

Contribution of the Study and Significance of the Problem

How will this dissertation contribute to understanding the problem under study? It will make a case for the correlates of ownership as being an important focus for future study. It will do so by examining the data from a new angle, and relating the empirical evidence to theoretical propositions developed during the 1960s. The new angle is to divide organizations by type of ownership. The theoretical propositions have to do with the intent (Blau & Scott, 1962), congruencies (Etzioni, 1975), environments (J.D. Thompson, 1967) and contingencies (Lawrence & Lorsch, 1967) of mental health organizations. These ideas are expanded in the following chapter. Finally, it will examine staffing and finances with a question in mind. The question is, can organizations serve two masters simultaneously and survive? Are profits and public responsibility compatible? If this question can be answered, or clues provided, the dissertation will have accomplished its purpose.

The current status of the mental health system is of particular interest at this point in time because it is in transition. The scope of the changes is wide. The amount of change is extensive. The direction of change is opposite from the philosophical orientation and programmatic preferences of many of the professionals.
currently affiliated with the mental health system. For these reasons the mental health system is worthy of our attention.

The shift from government subsidized to private, for-profit mental health services is one which strikes at the heart of the idea that service should be provided to all who have need and replaces it with the notion of serving all with the ability to pay.

The real issue, and it is a sociological issue, is that there is a crisis of ideology and economics. This is not just a financial problem, because it deals with the social organization of services as well as how they get paid. Arnold Relman, a physician and editor of the New England Journal of Medicine, puts it this way, "We want more and better health care, but we don't have a system of paying for it that distributes the cost equitably or assures equal access for all citizens. That is what I would call a real crisis" (Gray, 1986, p. 209).

Uwe Reinhart, an economist, agrees, "the true dimension of the crisis before us: an apparent unwillingness of society's well-to-do to pay for the economic and medical maintenance of the poor. It is not an externally imposed economic or cost crisis; it is a moral crisis" (Gray, 1986, p. 210). Relman (cited in Gray, 1986, p. 217) concludes that:

[the ethical considerations] ... boil down to the question of whether there is something special about health care which makes distribution of health services in a commercial marketplace problematic and inappropriate. A second issue (or set of issues) ... is whether there is in fact an empirical evidence of differences between not-for-profit and investor owned health care in terms of process, product, or broader social consequences.
As the financial burden falls less on the government and more on individuals, corporations and insurance companies, the federal government is de-emphasizing its involvement in mental health.

A different contribution will be made in terms of highlighting the data set used here (The Inventory of Mental Health Organizations [IMHO], 1983). The important feature of the Inventory of 1983 is that it marks the first time that the variable "Type of Organization" was added (see Appendix A). Since this is the first time such information was collected, and since additional data will be forthcoming in future surveys, the attention paid to examining this aspect of the nature of mental health organizations is seminal for future investigations in a similar vein.

Is the drift away from a public mental health model a definite trend? The IMHO data will not show this. However, a case can be made based on a review of the literature (see Chapter II) that the trend is away from a public mental health model. Are there discernible differences between for-profit and public service systems? These are some of the issues that will be addressed in the next section of this chapter.

Assumptions

There are assumptions on which this study is based. The first is that organizations are influenced by their environments both in what resources are made available and what limits are placed on operations; effectiveness and efficiency are influenced by task environment. Next, organizational choices both reflect and
contribute to the substance of an organization's domain (Hasenfeld, 1986). Third, the decisions made which define organizational domain greatly influence task environment (external to the organization) and resources (internal organizational attributes), (Hasenfeld, 1983).

Whether or not there are differences between for-profit, non-profit and public mental health organizations is the major question this study hopes to answer.

Mental health is a specialty which has traditionally been segregated from the rest of the health field but which more recently has been moving toward integration. Mental health has experienced three important thrusts in direction. There have been severe shortages of funds, causing cutbacks in service. There has been a focus on the chronically mentally ill. There has been a strong interest in privatization as a way of increasing efficiency, maintaining solvency and achieving organizational vitality and growth.

This trend toward privatization has raised questions and sparked debate whether the focus is government services, hospitals or mental health. The debate over privatization is of sociological significance because it is a debate over a social ethic, the moral values which govern or are descriptive of a particular society. Is health care a right or a privilege? And if it is a right, is it one to which all Americans should have equal access? These are the key issues which confront the mental health field and the general health field as well.
Hypotheses

There are basically nine variables to be examined here. They are: (1) type of ownership, (2) type of organization, (3) whether or not part of a chain, (4) total number of clients per organization, (5) race, (6) total expenditures per organization, (7) total income per organization, (8) net income, and (9) staffing.

Type of ownership is treated as the independent variable. The following seven hypotheses are to be tested:

1. Type of ownership will affect type of organization.
2. Type of ownership will affect the quantity of clients served.
3. Type of ownership will affect the proportion of minority clients served.
4. Type of ownership will affect the total expenditures per organization.
5. Type of ownership will affect the total income of an organization.
6. Type of ownership will affect the net income (income minus expenditures) of an organization.
7. Type of ownership will affect the staffing patterns of an organization.

Themes

There are four broad themes that will be considered:

1. The organization of the mental health system is important.
2. A historical sketch of the mental health movement.
3. The only constant is change.
4. The current system is in crisis and flux.

The Organization of the Mental Health System is Important

Organizations are the dominant form of institutions in our society. It is therefore not surprising that much effort is expended in studying organizations. They are such an integral part of our lives. Our social institutions are organized in order to maximize efficient utilization of human and economic resources (Robbins, 1983). This is no less true for mental health organizations than for any other.

The application of social science knowledge to solving problems confronting mental health organizations holds promise. But of course in order to apply knowledge to a problem, one must first understand the nature of that problem. This is another important reason to study the nature of mental health organizations.

The sociological analysis of the mental health services system holds the potential for answering some important questions about the changing resource picture. This analysis focuses at the organizational level rather than zeroing in on individuals at the microscopic end or metaorganizational units of analysis at the macroscopic end of the continuum. This is an exploratory study. The major hypotheses which form the core of this study center on how type of ownership, the independent variable, affects staffing, income, expenditures, organizational type, and clientele.
Organizations are social sub-systems characterized by boundaries, memberships, rules, and goals. They serve the purpose of ordering the complex relationships between and among the members of society. There are a wide range of factors to consider in analyzing organizations, including exchange, conflict, power, bureaucracy, structure, and accountability. This dissertation focuses on a comparison of types of organizations which can be traced to the work of Parsons (1960), and on effectiveness, which in modern sociology was first considered by Yuchtman and Seashore (1967). These and other themes are expanded in the following chapter.

Organizations affect us in diverse ways, some of which are intentional, some not. The outcome is seldom neutral for the participants of organizations. Organizational processes, such as patterns of income and expenditure, goals and philosophy, staffing configuration, and types of clients seen all have a direct and significant impact on whether the organization is successful in serving the consumers of service and ultimately whether the organization survives and prospers or declines and fails.

The scope of the study is all mental health services in the United States delivered by mental health organizations (see Chapter III for definition of mental health organization).

It is useful to study the way in which type of ownership affects mental health organizations. It is also important to recognize that most mental health services are delivered through organizations (Scott & Black, 1986). The dominant mode of service delivery has shifted substantially over the last thirty years from predominantly
inpatient to largely outpatient in form. In addition, the ideological basis of the external milieu in which these organizations function has changed remarkably in the past twenty years from a governmentally-sponsored effort toward achieving equity of access to an emphasis on for-profit organizations providing services to those who can pay for them, or are covered by insurance.

In order to get a better understanding of the relationship between organizational type and service delivery patterns, a brief overview of the evolution of the mental health system in the United States is subsequently provided.

A Historical Sketch of the Mental Health Movement

Characteristic of each humanitarian movement are four distinct periods. The first is a period of innovation or new ideas. This peaks rapidly after the initial outburst of enthusiasm, as the community mental health movement did between 1965 and 1970. The peak is followed by a period of criticism and then a time of retrenchment. The four periods are thus innovation, peaking, criticism, and retrenchment. (Glenn, 1975, p. 175)


The major periods in the history of mental illness and health in the United States are: (a) asylums, (b) the mental health movement, psychopathic hospitals and psychotropic medication, and (c) the
community mental health movement and deinstitutionalization. The relevance these historical periods hold for the purposes of this study is the close association between the philosophical approach to treatment, the organizational form chosen to deliver the treatment, the audience to whom the treatment was addressed, and the relative effectiveness of each effort. The historical periods described below differ significantly along each of these dimensions.

The philosophy of each historical period reflects the socio-economic conditions, the level of technological development, the extent of medicalization (the claims-making activities of the medical profession over deviance, e.g., homosexuality, alcoholism, insanity, etc.), the influence of professional thinking, and the attitudes of the citizenry toward mental patients. The philosophical approach of each age can be translated into goals and goals shaped into programs. Each programmatic effort of each historical period has been delivered through organizations that took shape and were sized according to the goal to be accomplished. This is not to imply that each of these historical periods is homogeneous or uniform in particulars. On the contrary, each of the four periods encompasses enormous diversity of time, place, and event. There are expectable and substantial variations in the theoretical approaches available to explain these socio-historical trends as well.

The organizational form chosen to deliver treatment has changed with each period. As would be expected, an organization serving a custodial function would assume an identity much different from one serving a treatment function. An organization built to provide a
The audience addressed by each epoch will vary in that each difference in approach will to some extent be motivated by a difference of opinion as to who should be the primary recipients of the services. Another way to put it is to ask what problem is to be solved. If the problem is one of moral degeneracy then those receiving the benefits of the program offered or imposed by those making the rules will be sinners, those possessed by demons, and heretics of various persuasions. If the problem is chronic and severe mental illness as diagnosed and treated by physicians then the emphasis of treatment will be toward providing mainly medical services, to a somewhat different (i.e., "sick") constituency. Not only will the explanation of the behavior differ, but those persons identified as needing "help" (treatment, protection, rehabilitation, etc.) will in some cases be different persons, and the emphasis in terms of who receives the most resources and attention from those in charge also is likely to change. This then is another reason for focusing on the predominant type of organization at a given point in time and the effectiveness of that organizational type in providing help to those for whom it was formed: because the type of organization has an interactive effect with both the philosophy and goals of the decision-makers on the one hand, and the kind, quantity and context of the audience for whom the service is intended on the other.
The relative effectiveness of each historical period's attempt at dealing with mental illness is yet another intriguing problem for applied sociology that is illuminated by historical analysis. It is, however, outside the scope of this research. No matter the level of knowledge, technology or available resources, each new effort has held the promise of containment, cure or some positive change in the condition of the mentally ill. Each new organizational intervention has been accompanied by proponents of the new system proudly trumpeting its effectiveness with extensive facts and figures. However, each of the new approaches has largely failed to live up to expectations thus giving impetus to the succeeding model of intervention. On the other hand, each historical period has contributed to the next and certainly vestiges of each period continue to play a role in the overall pattern of services to the mentally ill available today. For a discussion of the early history of madness, see M. Levine (1981).

Asylums

Scholars disagree on the timing of the emergence of the asylum in history. There is general agreement that the early institutions, even when given the name "hospital" were not hospitals in the modern sense. Bloom (1975) identifies the oldest mental hospital functioning today as one started in Valencia, Spain in 1409. The institution most frequently mentioned as marking the beginning of large scale social control is the huge place of confinement in Paris called the Hôpital Général which opened its doors in 1656. This place was a catch-all for the poor, the sick, and the insane. Its purpose was
not treatment or care so much as punishment and forced labor. By the 18th century the insane were being separated out from other kinds of deviant persons so as not to contaminate them. "Overall, from a sociological viewpoint, the separation and segregation of the mad from other deviants was accomplished largely for social and economic reasons, not for medical ones" (Conrad & Schneider, 1980, p. 45). Dorothea Dix waged a successful battle to remove the insane to the asylums. She succeeded in placing budgetary and political responsibility for the asylums, and thus for the residents of the asylums with the state legislatures rather than with the local municipalities which had jurisdiction over the previous residences of the insane--the home, the almshouse and the jail.

According to Rothman (1971) the proliferation of asylums in 19th century America was due to a belief that insanity was caused by the excessive fluidity and lack of structure in American society so the concomitant program of treatment was to provide definite structure in the form of asylums which could insulate and protect the insane from the chaotic and unpredictable society at large. It was expected that confinement would eventually lead to cure and release. Many practitioners of the day were only too eager to claim as much. Sammuel Woodward, the superintendent of the Massachusetts asylum at Worcester in 1834 calculated an 82.25% recovery rate. "Dr. Luther Bell, from Boston's McLean Hospital, had no doubt that all recent cases could be remedied...[In 1843] Dr. William Awl of the Ohio asylum simply announced without qualification one hundred percent cures. The statistics were inaccurate and unreliable" (cited in

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Although confidence in asylums as a method of treatment waned at the close of the 19th century, they were by then a significant and eventful form of treatment and organization that forever changed the conditions under which the mentally ill were cared for. They were taken out of the filth and squalor of the almshouses and jails. They were removed from usually cruel, sometimes barbaric conditions in the private residences of family members (including unheated cellars, pens, barns and cages). The predominant explanation for insanity had shifted from moral turpitude to an environmental model. The insane were differentiated from other deviants. Medical superintendents of asylums established the claim of physicians as the legitimate providers of care without evidence of disease as an etiological agent. By the end of the 19th century there were more than 75 asylums for the insane in America. But discouragement was already evident and the time was right for a new approach to emerge.

The Mental Health Movement, Psychopathic Hospitals and Psychotropic Medication (1900 - 1961)

Beers, a former mental patient, author of the book A Mind That Found Itself (1908/1944) and organizer of The National Committee for Mental Hygiene is generally considered the father of the mental hygiene movement. This was both a movement to reform the conditions of mental patients, and to further the acceptance of psychiatry as the sine qua non of organized treatment. So during the first half of the twentieth century, psychiatrists were consolidating their control.
over the domain of mental illness. This inevitably led away from moral and environmental explanations of insanity and toward an intrapsychic and biologically based explanation (Meyer, 1957). Asylums, originally designed for the benefit of orphans, the insane, or the feebleminded, thus were transformed into hospitals for the treatment of mental illness. Hospitals gradually filled up during this time with chronic, untreated or untreatable patients and the hopes of the mental hygiene movement faded as psychiatry depended on notions of organic causes, hereditary predispositions, and incurability to explain the failure of their patients to improve or matriculate out of the state hospitals (Bloom, 1975, p.13).

New enthusiasm was infused into institutional psychiatric care in early 1950 with the advent of psychotropic drugs. It was in the 1950s that drug therapy became the centerpiece in the treatment of mental illness. Chlorpromazine, first developed in France and introduced into the United States under the trade name Thorazine was immediately accepted by the psychiatric community and state legislatures as well. In 1954 state legislatures were in charge of drug budgets for state mental hospitals. Smith, Kline and French, a large pharmaceutical firm, utilized a special sales force to successfully lobby state legislators and hospital administrators (Conrad & Schneider, 1980, p. 61). Chemotherapy quickly became the major form of treatment and was usually unaccompanied by anything else. Once again, hope for real change through effective treatment burst for a time on the scene. The staffs of mental hospitals were hopeful that the new medications would allow them to interact more frequently with
patients. Eventually, there was hope that actual cures would result.

Two other changes occurred in the late 1950s. The philosophy of the therapeutic community was introduced, including the idea that patients as well as staff have the potential to help each other. This is one of the origins whence sprang today's flourishing self-help movement. The other development was the geographic reorganization of large state mental hospitals. Patients were rearranged into wards based on their place of residence prior to hospitalization (Bloom, 1975). This provided for a more functional interaction between local communities and state hospitals, an arrangement which survives to this day. It also laid the foundation, when combined with the social control features of medication and the simultaneous blossoming of the community mental health movement, for deinstitutionalization.

The Community Mental Health Movement and Deinstitutionalization (1955 - Present)

During the first half of the 20th century, the population of mental hospitals had increased at a rate double that of the general population (Joint Commision on Mental Illness and Health [JCMIH], 1961, p. 7). However, beginning with 1956 this trend reversed itself and decreased by 69% between 1955 and 1977. While other factors clearly contributed to the decline, such as the high cost of inpatient care and social science research on the negative effects of institutionalization, it is certain that the primary factor was the availability of psychotropic drugs and changes in the Social Security
law which permitted placement in nursing homes (Conrad & Schneider, 1980).

The passage of the Community Mental Health Centers Act (CMHCA) in 1963 was another benchmark identifying a major new cycle in the history of the treatment of mental illness. Another episode of enthusiasm, activity, disillusionment, and decline was about to begin, repeating the experiences of moral treatment, asylums, psychiatric hospitals and drug therapy. Even though a period of retrenchment is in progress, this is not to suggest that community mental health as a social movement is likely to disappear completely (Wagenfeld & Jacobs, 1982, p. 85).

That the community mental health movement is not what it started out to be is beyond question. The seeds of change were planted with the planning of the enabling legislation when the "seed money" concept was included as an integral part of the package. But if one were to examine the intent of the CMHCA (1963), and then evaluate the current program operations in comparison to what was envisioned nearly 25 years ago, the discrepancy between the two is both deep and wide. The nature and social consequences of that dramatic change in philosophy, policy, funding and program forms the point of departure for this dissertation. The purpose of the research is to utilize existing data in a new and hopefully unique way to provide a new understanding of the current status of mental health to perhaps anticipate future changes and developments.
Summary

In this section the major epochs in the history of mental health in the United States were reviewed and discussed. There were three goals for doing so. One goal was to simply present a historical backdrop for the data analysis to follow. Another was to illustrate the intimate connection between ideology, program, clientele and results in the episodic search for alleviation of mental illness. A third goal was to present the repeated refrain of innovation, peaking, criticism and retrenchment (Glenn, 1975) which has characterized each succeeding effort to reduce the incidence of mental illness.

The Only Constant is Change

Financial Changes

In the last ten years, there has been a major shift from federal control to state control, from categorical funds to block grant funds, from a putative preventive, public model to a treatment-oriented medical model. It may well be that deinstitutionalization, rather than being a complement to the community mental health concept, has actually contributed to the demise of the concept by placing untenable strain on a fledgling system.

Programmatic Changes

Perhaps, rather than deinstitutionalization, what has transpired is a transfer from large scale institutionalization in state
hospitals to small scale institutionalization in acute care hospitals or in adult foster care homes (Brown, 1985). Another trend seems to be the "revolving door." A person will be released from a state hospital, placed in a group home, decide it is too structured, move to a private living arrangement, soon stop all medication, require rehospitalization, and so on (see, for example, Torrey, 1988). One by-product of this routine is that it has brought community mental health staff and state mental hospital staff into a necessarily close and frequent working relationship with one another. In Michigan, at the least, it is the "community" workers who are stationed inside the state hospitals rather than vice versa. Another is that those patients revolving through the system experience the physical trauma which accompanies repeated large doses of drugs followed by abstinence and so on.

Comprehensiveness was a concept of providing for every kind of mental health needed right at the center. These included crisis services, short-term inpatient care, partial day care, outpatient and prevention services. Attempts were also made to ensure that the centers would be available 24 hours a day. So there was comprehensiveness both in terms of service alternatives, coverage around the clock, and coverage around the calendar.

**Philosophical Changes**

There were two new philosophical principles enunciated by the community mental health movement. One was that all persons would receive adequate care based on need rather than ability to pay. This
would be a dramatic departure from past practice which was to provide vastly inequitable services for the affluent and the poor. The other principle which was heralded as a major innovation was the idea of prevention as an equal partner with treatment. Prevention was to be provided by means of consultation and education, utilizing a public health model (Wagenfeld & Jacobs, 1982).

The community mental health movement developed in the reformist spirit of the 60s and in a social climate of ferment and change in many sectors of the society. The federal government headed by President Kennedy spearheaded this mental health initiative which originally called for "the establishment of a national network of 2,000 centers" (Wagenfeld & Jacobs, 1982, p. 52). Some of the key concepts around which community mental health centers were to organize their services were the concepts of geographic responsibility, comprehensiveness, continuity of care, accessibility, responsiveness, community involvement, and prevention.

Continuity of care is a phrase that has become part of our language but it was a brand new idea 25 years ago. It means that consumers of mental health services, rather than approaching separate community programs in a fragmented, unconnected series of independent efforts to solve their "problems in living," would enter an interdependent ecological system of related programs requiring only one intake interview. Ideally, a principal worker would be assigned to facilitate and "harmonize" the clients' movement through the mental health system. This continuity of care concept survives today in altered form in many states, often in the guise of hospital-community.
liaison workers who facilitate relations between community mental health programs and state psychiatric facilities that episodically release and admit chronic patients in what some critics of the present system have dubbed a "revolving door" as described above.

Community involvement was a concept aimed at spanning the potential gap between the center and the community. It was also hoped that community involvement would aid assessment of need. One of the important vehicles for involvement was the local advisory board that was formed for each center. Some of these were later restructured into governing boards (Wagenfeld & Jacobs, 1982).

Geographical Changes

The idea of geographic responsibility required each community mental health center to serve a catchment area which was the area immediately surrounding the center itself. In this way, everyone in the area was to be assured accessibility regardless of location. Therefore, rural areas, inner cities and other locations previously distant from mental health programs would for the first time be within convenient proximity to service.

Accessibility and responsiveness are closely related concepts. Accessibility relates to the ability of all persons within a given catchment area to have the services made available to them. It refers not only to geographic location and timeliness of the services, but also the doing away with social, economic, and psychological barriers. Responsiveness relates to the fit between the services provided and the special populations needing service within a
center's catchment area.

**Peak Becomes Pique**

The 2,000 community mental health centers (CMHCs) never materialized. "By 1981, with 763 operational centers, about one half of the country had geographic accessibility to a CMHC" (Wagenfeld & Jacobs, 1982, p. 59). After the original CMHCA (1963), several amendments were passed including, most importantly, for construction funds the 1965 amendment, the 1970 amendment, and the 1975 amendment. The Omnibus Reconciliation Budget Act of 1981 repealed the Mental Health Systems Act and implemented block grants to the states. This Omnibus Budget Act, pushed through Congress by the Reagan Administration, completely unraveled all that had been done in community mental health in the previous twenty years (Bloom, 1975; Wagenfeld & Jacobs, 1982).

Next a consideration of the present system of services shall be considered.

**The Current System is in Crisis and Flux**

The current state of the mental health system is one of uncertainty, instability and apprehension. A clear philosophy of service provision is not evident to show an overall direction to workers within the network of mental health organizations. An organizational structure has not emerged as clearly superior to other models. Evidence from the research arena suggests no consensus on the path toward stability, security and organizational effectiveness.
One reason for this dilemma is the conflicting choices facing administrators, with the outcome problematic regardless of the decision. For example, it makes fiscal sense to look toward the private sector for future program direction and market share. But this would mean abandoning those most in need of mental health services and those for whom the community mental health system was originally erected.

**Clientele**

The audience for whom mental health services are mounted is not clear. Should all persons within the mental health centers' program boundaries be serviced or should specific populations be targeted? If specific service populations are selected should the target be those persons who most need service or those most able to pay? Should mental health programs stay with their traditional orientation to emphasize services to those acutely in need or revise them to focus on the needs of the chronic population? How might existing data be brought to bear on the relationship between type of organization and organizational effectiveness?

Two ways of understanding this volatile and deteriorating mental health system are: (1) to focus on the internal organization of these services, using existing data; and (2) to focus on the ideological and programmatic effects of quality of care on type of ownership. While narrowing the perspective of the dissertation to a more manageable scale, it is important to not lose sight of the sociological process of social change which lends significance to the
endeavor.

**Ideology of Type of Ownership**

Social change has always been of interest because it impacts upon individuals, organizations and social systems (Garner, 1977). When change transcends the personal troubles of individuals and has to do more with institutions, then we are dealing with public issues in which a cherished social value is felt to be threatened. The particular cherished value that some observers of the mental health field consider threatened is the idea that the care of the mentally ill has historically been considered a public duty, and to some extent a government responsibility (Lemkau, 1982). An issue often involves crisis in institutional arrangements (Mills, 1959). The current shift is considered by some to be an institutional crisis while some welcome it as an organizational opportunity. It is the shift in traditionally public services to private entrepreneurs, developers and corporations. It is whether mental health care is a business or a public enterprise. While much of the dialogue seems to focus on the "bottom line" this is much more than a financial concept. It is only fully understood in a sociological context.

These then are some of the trends perceived in the mental health arena: changing organizational arrangements, crisis and flux, and ideological debate. These trends follow the historical cycle of innovation, peaking, criticism, and retrenchment. The current situation is one of fiscal scarcity, anti-government sentiment among a growing number of the citizenry, a fractionalization and diminution
of the once promising community mental health center program, and a gravitation toward entrepreneurship as a reaction to short term financial concern and long term structure hunger. **Structure hunger** is a term first introduced by Eric Berne (1964) which he applied to individuals and here is being adapted to organizations. It refers to the need to have boundaries, goals and a mechanism for obtaining and evaluating feedback both internally and environmentally.

**Summary**

This chapter has documented a need for studying the variations in resource choices, deployment and consumption according to the type of ownership of certain mental health organizations. The investigation is being limited to outpatient clinics, psychiatric hospitals, and multiservice organizations in order to keep its scope within reasonable limits, as well as to emphasize the policy choices of the last thirty years.

A justification has been presented for choosing organizations as a focus of the study. A socio-historical context for the current status of the mental health system has been offered. That history has been characterized by a cyclical pattern of hope, social reform, a restructuring of the delivery system, qualified success, disappointment and a search for alternatives leading back to hope. The mental health system currently seems to be in a "search for alternatives" mode. This is being experienced as a crisis of large magnitude by some, while others see it as the latest in an evolutionary pattern. A novel form of mental health organization (the community
mental health center) is attempting to become an institution while simultaneously avoiding extinction. In order to do the former one must avoid the latter.

Having demonstrated the need for this study, the purpose of the research is presented along with a brief overview of history, background, and assumptions. The hypotheses have been stated in broad form. A point to be repeated is that even though a quantitative description of data will form the basis for the findings, an important qualitative discussion will be included. This discussion will concern itself with the ideological dimension of ownership type, as well as consider the relationship between type of ownership and privatization.

The next chapter will review sociological and related literature on organizational theory, organizational typologies, organizational effectiveness, mental health organizations in a changing environment, and privatization. In so doing, the stage will be set for proceeding to the particulars of the findings.
CHAPTER II

TYPES, HYPES AND HUNTING FOR SNIPES:
FINDING SOME KEEPERS AND LOSING SOME WEEPERS

"Types" refers to types of organizations. "Hypes" are the flashy and often short-lived ideas that temporarily hold the limelight only to be replaced by the next fad. In reviewing literature it is crucial to develop the capacity to distinguish between works of long term value and those that fail to provide a lasting contribution. Sometimes seminal works offer important understanding even though they may extend beyond the purview of the work at hand. Just so is the pioneering work of J.D. Thompson (1967) and Woodward (1965). It is brilliant material but perhaps not directly relevant to this effort except in holding the promise of future work. When sociology of this caliber is discovered it is worthwhile keeping it near, thus "finding some keepers." "Losing some weepers" refers to the sadness of looking for literature that turns out to be nonexistent. Such dismay was experienced in looking for but not finding more literature on "creaming" or "cream-skimming." However, the path to success is often built on life's failures. Such failures are not usually mentioned in dissertations, but since it influenced the present chosen course it is included here. Finally, "hunting for snipes" refers to the occasional sense of being on a "wild goose chase" when doing a literature review. Is a given book or article in the main library or the business library? Is it available through
interlibrary loan? Sometimes it is hunting for something that is not there. Or, is it there but unattainable?

The literature to be reviewed is from two major domains. The first is organizations, the second is contemporary mental health literature. Organizations are important because the independent variable in this study, "type of ownership," is one aspect of "type of organization." Contemporary mental health literature is important in supporting the contention of this study that the mental health system is experiencing turbulence at this point in time, and more obviously, mental health organizations are the focus of this study. In each case the literature will be introduced in its broad context and then specifically related to the problem under study.

Themes

1. Organizational typologies.
2. Organizational effectiveness.

The classical tradition in the study of organizations can be traced to such luminaries as Marx (1956), Weber (1946), Michels (1949), Taylor (1911).

According to Scott (1981) the study of organizations did not emerge as a separate field of sociological inquiry until the late 1940s. He credits Merton, Gray, Hockey, and Selvin (1952), Selznick (1949), Blau (1955), Lipset, Trow and Coleman (1956), as engaging in
the sociological study of organizations qua organizations in a groundbreaking sense. Three other seminal works are March and Simon (1958), Likert (1961), Blau and Scott (1962).

Scott (1981) describes organizations as open systems. As such, they are capable of self-maintenance based on a throughput of resources from their environment (Boulding, 1953), have boundaries, and are capable of growth. Boundaries can either be characterized by attention to differences between the organization and the environment, or by focusing on the nature of the interaction between the organization and the environment.

Boundaries are a way of distinguishing or separating organizations from their environments. The social environment in modern society is necessarily composed of complex organizations. Therefore, the interaction between an organization and its environment is to some extent an interaction between one organization and others. But as Etzioni (1964) points out,

To the degree that the relationship between any two organizations in any society is not ordered by a superior organization or regulated by a legal framework (e.g., antitrust laws in the United States), the actual pattern of interaction is determined in the process of exchange, conflict, or cooperation, or bargaining, all of which are affected by ecological, cultural, and power factors. (p. 112)

The open systems approach emphasizes the changing, shifting, evolving character of boundaries. As described in Chapter I, this certainly characterizes the present status of the boundaries of the mental health system.
Organizational Typologies

Parsons

Parsons speaks to both issues of typologies and effectiveness. Various schemes for the classification of organizations have been proposed over the years. Most, if not all reviews of typologies begin with a description of Parsons' classification system which he conveys in a scant four pages (Parsons, 1960, pp. 44-48). Parsons uses goals to differentiate between types of organizations, which are formulated to solve specific societal problems or to fulfill social needs with an organizational response. The four functions to be addressed are: (1) adaptation, (2) goal attainment, (3) integration and (4) latency. Parsons formulates goals for each of these functions respectively: (1) adaptive goals, (2) implementive goals, (3) integrative goals, and (4) pattern maintenance goals. Corresponding to each of these societal needs, and in pursuit of the above societal goals, the four classes of organization proposed by Parsons are: (1) economic organizations, (2) political organizations, (3) stability maintaining and deviance reducing organizations, and (4) socializing organizations such as religious and educational agencies.

Using Parsons' (1960) distinction between levels of responsibility and control, it is evident that non-technical considerations are more important than technical in comparing mental health organizations. Parsons identifies the technical, managerial and institutional as three levels of organizational life. For Parsons, every formal organization has a technical core component that he
refers to as a suborganization. The problems experienced by the technical suborganization are problems of performance effectiveness. In other words, performance of the functions of the organization in the manner most conducive to fulfilling the goals of the organization is the main purpose of the technical suborganization. The problems that occur in the process of pursuing organizational goals emerge as a result of the nature of the technical task. It is generally accepted that at the technical level, mental health organizations perform a limited number of tasks which do not vary by type of ownership. For example, all mental health facilities do either drug therapy, "talk" therapy, case-management, etc. or a combination thereof.

At the next level, the managerial, the purpose is to operate at the service of the technical core. The two ways this is accomplished are mediation and administration. Mediation is between the technicians and the consumers of the products or services which are being offered by the organization. Administration is the control of the technical suborganization and obtaining the resources needed by the technical workers to complete the organizational goals.

The institutional level has to do with the cultural authority of the organization and its task environment—that is, the web of social interactions and affiliations in the larger community necessary to the continued existence and successful life of the organization.

Thompson and Tuden

This typology is one based on means and ends. Thompson and
Tuden (1959) utilize a classification based on consensus of objectives and knowledge of achieving the objectives. If there is agreement on both means and ends, then rational decision-making can occur. If there is consensus on goals but not on methods, a judgmental approach is suggested, utilizing a peer review such as a board of directors. If there is agreement on means but not on ends, a compromise is called for, such as decisions emerging from a legislative process. Finally, if disagreement on both means and ends is evident, a situation of relative disorganization or pre-organization prevails and requires charismatic leadership and the conditions for a "movement" are present. The latter of the four scenarios seems to describe the present state of mental health sans the charismatic leadership.

**Blau and Scott**

The typology developed by Blau and Scott (1962) is predicated on the idea of "cui bono" or "who benefits." Four categories of organizations are presented: (1) mutual benefit associations, (2) business concerns, (3) service organizations, and (4) commonweal organizations. Just as Parsons (1960) makes the point that the type is a matter of primacy, not of exclusivity, so too do Blau and Scott. They explain that when deciding between their four categories by asking "who benefits" they don't mean to imply that the (owners, clients, members, public-at-large) will be the only ones to profit from the outcomes or effects of an organization, but that each beneficiary will be the primary recipient of their respective
organizations. They go on to point out that there are particular problems associated with each type of organization (Blau & Scott, p. 42) (see Figure 1).

**Figure 1**

Typology, Cui Bono and Associated Problems

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Cui Bono</th>
<th>Type of Associated Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual benefit association</td>
<td>the membersh ip</td>
<td>maintaining internal democratic processes</td>
</tr>
<tr>
<td>business concerns</td>
<td>owners</td>
<td>maximizing operating efficiency in a competitive situation</td>
</tr>
<tr>
<td>service organizations</td>
<td>client group</td>
<td>conflict between professional service to clients and administrative procedures</td>
</tr>
<tr>
<td>commonweal organizations</td>
<td>public-at-large</td>
<td>development of democratic control mechanisms</td>
</tr>
</tbody>
</table>

The relevance of the Blau-Scott typology to the modern mental health scene is clear. Many mental health organizations that were traditionally thought to have been "service organizations," that is to say the welfare of the client is foremost, have been transformed into "business concerns" where the main goal is the welfare of the owner. Blau and Scott (1962) put the dilemma thus:

[In a service organization such as a mental health clinic,] the client does not know what will best serve his own interest...Hence, the client is vulnerable, subject to exploitation, and dependent on the integrity of the professional to whom he has come for help. The customer in a store, on the other hand, presumably can look after his

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own self-interest as epitomized in the phrase 'caveat emptor'--the professional's decisions are expected to be governed not by his own self-interest but by his judgement of what will serve the client's interest best. (p. 51)

Parsons (1960) refers to this idea in several places. For example, he says that type of organization is related to "variations in external relations" (p. 59). He also states that individuals perform roles within collectivities that pursue collective or public goals. These goals reflect certain value choices that are thought to be shared by members of a particular structural component of a social system. This is a major aspect of what this dissertation examines. It is generally to be expected that for the most part, members of the same collectivity, for example a university faculty, Knights of Columbus, used car salesmen, or members of the National Organization of Women, would generally share the same general value orientation. Members of the mental health profession are suspected to be presently holding quite divergent values which range from service-professional at one end to business-consumer orientation at the other. It is probable that Parsons (1960) would endorse such an investigation. To wit:

That a system of value-orientations held in common by the members of a social system can serve as the main point of reference for analyzing structure and process in the social system itself may be regarded as a major tenet of modern sociological theory. Values in this sense are the commitments of individual persons to pursue and support certain directions or types of action for the collectivity as a system and hence derivatively for their own roles in the collectivity. (p. 172)
Etzioni (1961/1975) developed a classification of organizations based on the concept of compliance. This typology differs from those of the others presented so far, in that Parsons (1960), Thompson and Tuden (1959), Blau and Scott (1962) were looking at organizational goals. Etzioni focuses instead on behavior as an aspect of social structure. Etzioni's compliance types were based on the relationship between the type of control over members available to those in power, and the effect the exercise of that control has on the members on the receiving end. Types of control are (a) coercive power, based on the potential to inflict pain or enforce confinement; (b) remunerative power, based on control over money, commodities, or services; and (c) normative power, based on allocation of symbolic rewards such as esteem and acceptance. Three kinds of member involvement with an organization are: (1) alienative, strong and negative; (2) calculative, positive or negative, low intensity; and (3) moral, positive and high intensity.

When the three kinds of control are combined with the three kinds of involvement, nine potential categories result. It is Etzioni's (1961/1975) position that there are only three congruent types of organizations and that "organizations tend to shift their compliance structures from incongruent to congruent types" (p. 32). The congruent types are alienative-coercive (including custodial mental hospitals), calculative-remunerative (e.g., businesses), and moral-normative (therapeutic mental hospitals included). Again, when
considering the application of the Etzioni typology to private, for-profit mental health organizations, the combination of moral-remuneration would appear on its face to be incongruent.

Hall, Haas and Johnson (1967) tested the predictive utility of both the Blau-Scott (1962) and Etzioni (1975) typologies. According to Tausky (1978), "Although each in different respects showed some merit, in predicting aspects of structure, neither classification impressively differentiated between organizational structures, and no conclusion could be drawn as to which was superior" (p. 15).

Joan Woodward

A classification based more on differences in structural features is one emphasizing technology developed by Woodward (1965). She compared for-profit organizations. Her findings may not generalize to non-profits and governmental organizations, nor to all fields of endeavor. Woodward, a British sociologist, studied 100 manufacturing firms in England. The primary finding of the work is that "the existence of the link between technology and social structure first postulated by Thorstein Veblen (1919) can be demonstrated empirically" (Woodward, 1965, p. 50). Looking at the various types of production (unit and small batch, large batch and mass production, and continuous process, e.g., gasoline) Woodward found a potential conflict between technical and social goals. People seem to be more satisfied by continuous process and unit and small batch production, but large batch and mass production is more efficient from a technical point of view. This does not seem to apply in the health field,
nor by inference to mental health.

Paul Starr

Starr (1982) describes the proliferation of for-profit multi-hospital systems in the last 20 years. Evidence is cited showing that in spite of theoretical economies of scale such as purchasing by volume and the feasibility of offering specialized services, the corporate chains are in fact neither cheaper to customers nor more efficient. They would seem to this writer to embrace the "large batch and mass production" mentality, with absentee owners, important decisions made at a distance from those directly involved, and an eye on profitability at all times. For-profit hospital chains are multiplying not because they are more efficient and not because they better serve the patients. They are growing in number because they benefit the organization by maximizing profits. As Blau and Scott (1962) postulate about business enterprises, the benefit of the organization is for the benefit of the owners.

Of course, not everyone agrees with Starr (1962) that American medicine is in serious trouble, just as not everyone believes the community mental health system to be in crisis. Ruderman (1986), a sociologist, attacks Starr's book ("such a bad book"), Starr himself ("given such impoverishment of both knowledge and thought, is it any wonder that Starr fails to understand American medicine or the American society of which it is a part"), and even all of medical sociology ("What is one to say of a field in which this kind of work is ... hailed as 'brilliant' and 'lucid'?") (p.45).
Herzlinger and Krasker

In "Who Profits From Non-Profits?" Herzlinger and Krasker (1987) maintain that the only advantage non-profits enjoy is that they benefit society because they give employees the best kind of environment in which to nurture their skills (as opposed to for-profits). This runs counter to the findings of this study, especially in regard to ratio of administrative and support staff to professional staff (see Chapter IV).

Arnold Relman

Relman (1982) reports that not only the owners are realizing profits. "There are virtually irresistible incentives for doctors to become entrepreneurial and profit seeking in their behavior" (p. 11). He goes on to discuss the new medical-industrial complex that consists of businesses that now control 15-20% of all personal health care in this country and accounting for $40 billion per year not including pharmaceuticals. This industry was virtually non-existent prior to 1960. It is now rapidly expanding into the mental health field which is relatively unregulated compared to the health field generally. Relman's key question which is also being applied to mental health is, "Will medicine now become essentially a business, or will it remain a profession?" (p. 16).

James D. Thompson

J.D. Thompson (1967) asserts that differences at the
institutional level "should make for significant variations among organizations" (p. 12). This is a basic test which can be conducted using available data with mental health organizations. Thompson believes that the major tension in organizations is the need to be in a state of certainty in order to make rational decisions and yet having to operate in an uncertain environment where many variables are beyond control. The organizational response to the dilemma is to create certain parts of the organization that operate under conditions of "near certainty" (the technical) while creating other parts whose major function is to cope with uncertainty (the institutional level). Following Parsons (1960) the managerial level then has as one of its primary goals to mediate between the uncertain task environment and the certain needs of the technical staff.

Organizational Effectiveness

A number of methods for judging organizational effectiveness have been reported in the literature over the years (Hansenfeld, 1983; Kotter, 1978; Price, 1968; Price and Mueller, 1986; Steers, 1977; Yuchtman and Seashore, 1967). Some methods focus on goals function, others on system effectiveness, still others on financial viability. Some authors use a contingency model, others a one-best-way model. Price (1968) uses goal-achievement as a criterion, but later in a collaborative effort with Mueller (1986) opts for financial viability. Yuchtman and Seashore (1967) dismiss the goal model on both methodological and theoretical grounds. They point out that it is not realistic to assume that goals can be accurately measured since

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they are actually ideals rather than statements of fact. Additionally, goals cannot be separated from efforts. Are goals the cause of actions or do actions generate goals? Finally, Yuchtman and Seashore observe that formal organizations are complex entities interacting with a complex environment. It is problematic to isolate goals generated by an organization as opposed to subunits or cultural influences. Yuchtman and Seashore propose a contingency model for effectiveness based on what they call an "open-ended multidimensional set of criteria" (p. 891) rather than the one-best-way orientation of the goal model. The problem with focusing on processes and activities rather than goals is that every activity is a potential criterion. Also, goals are intrinsically related to the ability of the organization to survive and prosper. As Kotter (1978) argues persuasively, there is some truth to each model but neither is sufficient by itself. There must be a fit between the various organizational subunits and their activities for an organization to be effective. There must also be a fit between an organization and its environment. On the other hand, each subunit must approximate progress toward goal attainment or "best states" and the organization as a whole must also. If any of these four dimensions is missing, the survival of the organization could be in doubt.

Hasenfeld (1983) offers a pragmatic and persuasive alternative in the context of the political economy perspective. This shares an emphasis on resources with the systems resource approach (Georgopoulos & Matejko, 1967; Steers, 1975; Yuchtman & Seashore, 1967) with an important difference in the level of analysis. Rather than
focus on the organization, this perspective focuses on those in the
task environment responsible for providing resources. Rather than
asking Blau and Scott's (1962) "who benefits?" this approach asks
"who provides?" Those that provide the resources decide which
criteria measure effectiveness. The organization, by demonstrating
the ability to meet the resource providers' criteria, is deemed to be
effective.

Applied to mental health organizations, this could mean that
public agencies must meet governmentally determined criteria, private
non-profits would be judged by contract or Boards of Directors, while
for-profits would answer to third-party payers and directly to fee-
for-service clients. Hasenfeld (1983) correctly points out the
possibility of multiple resource providers requiring numerous and
potentially conflicting sets of criteria which could change over
time. This is not an unfamiliar scenario to anyone with experience
in the health and human services.

Every alternative model of effectiveness has something to
recommend it and therefore to some extent the selection of a criter-
ion is arbitrary (see Figure 2).

A useful effectiveness measure for the purposes of this study
may be the one proposed by Price and Mueller (1986). Also, it is
adaptable to the limitations of the data. "Effectiveness is the
financial viability of an organization" (p. 128). Mental health
organizations that have more income than expenditures are therefore
more effective than those that are in debt. Price and Mueller offer
several reasons for selecting this measure of effectiveness. It is
Figure 2
Commonly Used Models of Organizational Effectiveness

<table>
<thead>
<tr>
<th>Model</th>
<th>Definition</th>
<th>When Useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal Model</td>
<td>It accomplishes its stated goals.</td>
<td>Goals are clear, consensual, time-bound, measurable.</td>
</tr>
<tr>
<td>System Resource Model</td>
<td>It acquires needed resources.</td>
<td>A clear connection exists between inputs and performance.</td>
</tr>
<tr>
<td>Internal Processes Model</td>
<td>It has an absence of internal strain with smooth internal functioning.</td>
<td>A clear connection exists between organizational processes and performance.</td>
</tr>
<tr>
<td>Strategic Constituencies Model</td>
<td>All strategic constituencies are at least minimally satisfied.</td>
<td>Constituencies have powerful influence on the organization, and it has to respond to demands.</td>
</tr>
<tr>
<td>Competing Values Model</td>
<td>The emphasis on criteria in the four different quadrants meets constituency preferences.</td>
<td>The organization is unclear about its own criteria, or change in criteria over time are of interest.</td>
</tr>
<tr>
<td>The &quot;Who Provides&quot; Model</td>
<td>Meets criteria set by resource providers.</td>
<td>Resources are scarce and there are multiple sources of income.</td>
</tr>
<tr>
<td>Financial Viability Model</td>
<td>Net profits exceed net reserves.</td>
<td>Comparison between models of ownership is desired and available data is budgetary.</td>
</tr>
</tbody>
</table>

(Adapted from Cameron, 1984)

easy to measure compared to goal or system resource approaches. It seems to fit well with traditional views of effectiveness. In other
words, organizations with a history of success at meeting goals that are hard to operationalize but nonetheless enjoy popular consensus (e.g., a goal of hospitals might be to provide "good patient care") are likely to also be financially viable, all other things being equal. It is also a criterion applicable to systems both smaller and larger than organizations. This makes the measure appealing from an ecological perspective.

In contrast to these and other advantages, Price and Mueller (1986) identify two obvious objections. One objection is based on reductionism, the second on the problem of standardized measurement. To reduce the effectiveness of extremely complex, multidimensional organizations to a single yardstick devoid of humanitarian capacity is risky. Who among us would measure Mussolini's tenure solely by the punctuality of Italy's trains? Also, commercial firms cannot be measured against non-commercial organizations operating in different sectors of the economy. However, since one goal of the dissertation is to compare mental health organizations differing economically this measure would seem to be potentially useful.

Price and Mueller (1986) report a frequently used measure of financial viability for businesses as being net profits. Net profits are defined as the amount of money left after expenses are subtracted from income. Since all of the organizations of concern here have clients, all are competing for mental health clients ("market share") and most have a combination of income sources from the marketplace (fees), non-profit sources (grants and contracts), and the government (e.g., medicaid reimbursement) the "net profits" concept will be

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applied comparatively. Since this figure can be reported as a ratio it will make possible comparisons between organizations of different sizes.

In stark contrast to the logical positivism of Price and Mueller (1986) is the focus on ideology and ethics by the physician Relman (1982) and his nemesis, the economist Reinhart (Gray, 1986). From another perspective, the problem used to be posed as how to share the cost of public mental health between the various levels of government (Foley & Sharfstein, 1983). The assumption was that government was the only locus of service for most citizens. Now the problem is posed as finding the minimum acceptable extent of government intervention while maximizing privatization. For example, one highly touted mental health consultant advises CMHC directors to "move sharply in the direction of the private pay market" by such commercial tactics as "capturing market share" and "providing the most treatment possible with the least trained staff" (emphasis supplied, Kipp, 1987, p. 27).

Another recent shift has been away from prevention and toward more traditional treatment. This indicates less emphasis on serving all of the residents within a given catchment area and instead shifting increasingly to the chronically mentally ill, those in need of residential services, and those clients who can benefit from a case management approach.

Another consequence of the termination of federal funds to support community mental health is that the administrators of those centers will likely become more preoccupied with issues of efficiency
and economy and less preoccupied with issues of program effectiveness (Jerrell & Larsen, 1985; Larsen, 1987; McLaughlin & Zelman, 1987; Roberts & Roberts, 1985). There is an organizational imperative to not only survive present circumstances but also to have some sense of future to anticipate. This long term security is absent for many mental health organizations given the present fiscal environment. (For a marvelous debate on this issue, see Gray, 1986).

Community Mental Health Organizations: Adaptation in a Changing Environment

Lessons From Recent History

What lessons might the history of the community mental health movement teach us? Two obvious lessons are that the current system is changing rapidly and that some organizations adapt to change better than others. The last lesson to be considered here is that therapy and other treatments of the mentally ill are social phenomena which shift in response to changes in the social environment.

There is much competition for and shifting of domain among community mental health agencies in the 1980s. This is reason for concern and not just from an economic perspective. Sociologically, it is understood that organizational strain occurs under the stress of rapid change and prolonged uncertainty. This change affects not only the clients receiving service and the individuals working as staff, but the organization itself. "From the point of view of a rational model of organizations, the compromises and maneuvering in defense of domains are disruptive and costly" (J.D. Thompson, 1967, reproduced with permission of the copyright owner. Further reproduction prohibited without permission.)
Much has been written about the turmoil, turbulence and instability in the community mental health field (Bass, Windle, Bethel, Henderson & Rosen, 1985; Buck, 1984; Leaf, Brown, Manderscheid & Bass, 1985; Woy, Wasserman, & Weiner-Pomerantz, 1981). Most trace the change to the Omnibus Budget Reconciliation Act of 1981 which halted direct federal funding of community mental health centers. Buck (1984) argues that community mental health services were originally funded in the form of a block grant program in the 50s and early 60s. He explains that the current block grant program really resembles revenue sharing, which is a distribution of funds to units of government who can decide to spend the money however they want. Because of this, Buck believes that the future of state-supported community-based mental health services is in jeopardy. This is a convincing argument to anyone familiar with the fiscal plight of state and local governments. The Reagan Administration has reduced federal revenues to state and local governments to pay for the federal government's vastly expanded defense program.

One of the first and certainly the most oft-cited looks at the change in direction of the CMHCs is that published by Woy et al. (1981). This study evaluates the "continued survival and prosperity" of CMHCs and finds that some centers have moved away from the mix of services as originally conceived while others remain ideologically faithful "at some expense to their financial growth" (p. 273). Woy et al. see a basic dichotomy in philosophy and mission existing prior to 1981 and believe that the more entrepreneurial centers are those
affiliated with the medical establishment. The authors express dismay that the movement away from the original philosophy of community-based care is occurring. Judging from this and other contemporary literature, it would seem that the "insider" professional, bureaucratic, service-oriented careerists sensed that they were in the process of becoming "outsiders" while the business-minded, profit-oriented accountants and cut-back managers were in the process of a hostile take-over.

Bass et al. (1985) recognized the structural diversity of CMHCs and compared centers directly providing inpatient care with those indirectly providing inpatient care through an affiliate. They found that those directly providing inpatient care almost always generated more revenue from all sources. They found major differences in funding, caseload, and service statistics. This is another example of how organizational structure makes a difference in the fiscal health of CMHCs.

There are those in the mental health industry that see the problems in the mental health system as so systemic, so permeating the social and cultural milieu that only radical change will suffice (Brown, 1985; Magaro et al., 1978). Interestingly enough, both Magaro et al. and Brown identify institutional inertia, obsolescence and professionalism as important obstacles to change but reach remarkably different conclusions as to how to address these obstacles. Brown champions a restructuring of society but is rather vague in describing that restructuring. He does state that he is against "profiteering, militarism, anti-environmentalism, and a basic
disregard for human survival" (p. 227). He is for "large scale economic redistribution, widespread application of consumer-oriented self-help services, and curbs on many traditional psychiatric services" (p. 210).

Magaro et al. (1978), with almost identical premises as Brown (1985) reach the conclusion that treatment would best serve the mad in our society by evolving into a free-enterprise system. Their point is that the mad sorely lack freedom of choice in the one area that most concerns them: their madness. Therefore mad (their term) people should receive funds with which to obtain a choice of treatments, and treaters would be paid according to results, not the amount of work done by professionals.

This is a plea for a return to competitive capitalism in the mental health industry. Lest we forget, this return to a competitive system has only been half realized to date. More and more mental health organizations are entering the competitive arena, but the mentally ill have not been provided the resources with which to obtain services, let alone choose them. What then are the managers of community mental health organizations doing to survive? (For a status report on current economic developments in the health care industry and how they are affecting the mental health field, see Appendix B).

Management Strategies

Another approach to the transition (Larsen, 1987), cuts (Gople-rud, Walfish & Broskowski, 1985) and survival strategies (Zelman,
McLaughlin, Gelb, & Miller, 1985) that are the main focus of much of the current mental health literature, is to provide some possible answers to the managers of mental health services. How might managers have an impact on the system or their own organization that would protect and prolong them? Suggestions range from seeking an environmental fit (Jerrell & Jerrell, 1987), to listening to executives of community mental health programs (Goplerud et al., 1985), to listening to State Mental Health Directors (Ahr & Holcomb, 1985). But the message getting the most enthusiastic response would seem to be the one with the theme of marketing, competition, and commercialism (Kipp, 1987).

Ahr & Holcomb (1985) report that, of the top 5 priorities of state mental health directors, 3 of them relate to the chronically mentally ill (1, 2 and 3). The fourth is to improve ability to influence state government (i.e., the governor and the legislature) and the fifth is to maintain programs despite falling revenues. The message is unambiguous. States have increased control over total dollars for public mental health, and there are fewer dollars available. Therefore, if you want public mental health dollars you (managers) had better be serving the long-term mentally ill. "Community residential programs, partial hospitalization, and case management are seen as ways of achieving this overall objective" (Ahr & Holcomb, p. 44). Magaro et al. (1978) complain that moving the long-term mentally ill from one place to another merely changes the location of non-treatment. While it may be cheaper to treat chronically mentally ill in mini-asylums, in the eyes of Magaro and his
colleagues the outcome is identical.

Goplerud et al. (1985) did a Delphi study which recommends (a) good planning--"well-run businesses typically have good planning systems" (p. 18); (b) services--"expanding services that can generate private and third party revenues" (p. 19); (c) personnel--"improved productivity" (p. 20); (d) business practices--improve fee collections and insurance billing (p. 20); (e) information systems--"develop and maintain a sound accounting and management information capacity" (p. 21); and (f) monitoring the environment--"developing services to meet the priorities of one funding source may preclude access to other potential funding avenues" (p. 21). Serving the chronically mentally ill, for example, "... may virtually exclude the development of inpatient or outpatient psychotherapy programs attractive to middle class adults and their families" (pp. 22-23).

Kipp (1987) echoes this last point when he states that managerial choices are mainly driven by forces outside the organizations. He defines them as market forces. Kipp talks like the business person he is--his speech is sprinkled with terms such as "runaway costs," "over-supply," "product orientation," and "market share." He criticizes private, not-for-profits as being not competitive enough and not responding quickly enough to competition when it occurs. Finally, Kipp dismisses the concept of comprehensiveness as being anti-marketing. Kipp is definitely pro-marketing. He could be giving this speech to the Chamber of Commerce. In actuality he was the keynote speaker at the National Council of Community Mental Health Centers' Annual Program Meeting in 1986. He was so well
received that he was asked back to give a similar address in 1987!

Some clinics and centers have fully embraced this compete or die attitude while others have resisted this "survival of the fittest" social Darwinism. To avoid the negative consequences of competition, in a word "losing," one must either win or develop strategies to avoid competition.

**Survival Strategies**

An important question should be asked about purpose. If strategy is the means what, then, is the end to be achieved by surviving? One answer is that the same three objectives apply regardless whether the strategy concerns politics, funding, program, structure or role change. The goals are always (a) to cut expenses and/or increase revenues, (b) to see that clients get the desired level of services, and (c) to strategically position the organization so that it can influence and take advantage of environmental changes affecting the delivery of mental health services (Zelman et al., 1985, p. 229).

The trends reported by Larsen (1987) are consistent with those she and her colleagues reported earlier as described above. The outcome in terms of service found that for the first few years following the Omnibus Budget Reconciliation Act of 1981, major changes did not occur in the external relations of community mental health centers in 1983. This, in spite of the fact that a major shift in funding and policy occurred, moving money and responsibility from the federal to the state level. These same authors in another
analysis of the same data did find that important internal changes were occurring in many center operations, once again confirming J.D. Thompson's (1967) propositions.

Curiously enough, Jerrell and Larsen (1985) seem to contradict themselves in two succeeding articles, both based on the same survey data. The data were collected in 1982 and 1983. In their 1984 article, focusing mainly on external mental health center relationships they conclude that radical changes were not produced by the funding and policy shifts mentioned above. Yet, in their next work (1985), they detail what to this writer constitutes radical (albeit, internal) changes in the operations of many centers. "To survive, local centers have been forced to compromise some of their values to operate more as private businesses" (Jerrell & Larsen, 1985, p. 1169). They report, for instance, that community-based inpatient services were on the increase because private pay patients can underwrite the costs of other operations. Outpatient services toward patients paying privately increased, as well as outpatient services toward chronic patients.

This, once again, highlights a notable case of the immovable object meeting the irresistible force. The immovable object being chronic patients who have been deinstitutionalized and are now in the community needing help. The state in the early 1980s was providing up to 40% of center funding (Jerrell & Larsen, 1984). States and local governing bodies were clamoring for someone to do something about the chronic mentally ill. The CMHCs were the logical answer. The irresistible force in this instance is the increased income
generated by private pay patients. The market realities of attracting the middle class "worried well" require different strategies from those required to serve the chronics. Middle class clients are reluctant to share a waiting room with chronically mentally ill. They have different standards and expectations of service, physical milieu and behavior. Yet the marketing consultants have been telling the center directors to privatize, the state directors of mental health to increase services to those with severe illness.

To get back to the internal changes occurring in community mental health centers in 1982 and 1983: significant decreases in service were reported for consultation, education, prevention and evaluation services. Generally speaking, staff size remained unchanged but there was an increase in social workers and a slight decrease in doctoral-level psychologists. Total center revenues remained stable, with revenues from both medicaid and medicare increasing significantly.

Jerrell and Larsen (1985) identify two major problems to be solved for the continued well-being of the CMHCs. One is the fact of organizational decline. With shrinking resources it is difficult to mobilize to meet the demands of new environmental conditions. The other is the loss of a distinctive market persona. CMHCs were unique and enjoyed high visibility and appeal because of offering comprehensive preventive, locally-available and broad-ranging services. Ironically, by responding to the demands of diminished funding, increased competition, focused marketing and streamlined services, CMHCs may be in the process of losing their place in the network,
their visibility and perhaps, their viability.

The trends reported by Larsen (1987) are consistent with those reported by she and her colleague Jerrell (1984, 1985). The outcome in terms of service to clients would seem to be "the emergence of a community based institution for long-term clients...(combined with) ...other services designed along a private practice model and aimed at paying clients" (Larsen, p. 24).

Jerrell and Larsen (1984) point out that there are a variety of ways to cope with an uncertain environment. Interorganizational moves are just as crucial as internal changes to maintain a fit with the environment and a relevant, effective mission. Jerrell and Larsen cite J.D. Thompson (1967) as identifying contracting, coopting and coalescing as specific interorganization strategies as well as competition. While interorganizational strategies are important in helping organizations deal with change, they first look to internal adjustments. J.D. Thompson (1967) explains that internal adjustments require the expenditure of fewer resources and are less disruptive than interorganizational strategies. It would seem logical to extend that notion to say that cooperative interorganizational strategies would be less costly and disruptive than competitive strategies. This was apparently confirmed by Jerrell and Larsen's (1984) research.

Financial Trends and Financial Strategies

It was predicted as early as 1979 (Weiner, Woy, Sharfstein & Bass) that CMHCs would suffer a winnowing effect without federal
support: some centers would not continue to survive financially. This prediction has proven to be true. Those centers that have remained have, in almost if not all cases, diversified financially, and specialized programmatically. This is in marked contrast to the centers of the late 60s and early 70s which were specialized financially and diversified programmatically. The decrease in funded activities has stimulated financially "mixed" programs which utilize some mix of membership, donations, funded, and entrepreneurial financial sources (McLaughlin & Zelman, 1987). The biggest problem with combining these various kinds of programs is that often the only source of venture capital for entrepreneurial programs is public funds from the state. Can state funds be used to allow CMHC to compete in the marketplace? If so, who gets to keep the profits? If state departments of mental health impede the competitive activities of CMHCs, they may be tolling a death knell. Yet, according to McLaughlin and Zelman states have less to gain for equal risk in the short run. One logical answer is fiscal restructuring to separate the donative, funded and entrepreneurial cash flows.

As a consequence of the changes in financing and programming of CMHCs, a question persists. That question has to do with outcome evaluation. As Dowell and Ciarlo (1983) point out, the CMHC program has been the "centerpiece of the National Institute of Mental Health and hence, federal mental health policy for most of two decades" (p. 95). Yet the survivors of the financial changes must generate their own revenue which requires abandoning the policy from which the centers were launched. In the preface to the special edition of the
Community Mental Health Journal (21 [4], 1985) Spenser speaks enthusiastically of competition, serving clients with "transient reactions, social maladjustment or no mental disorders" (emphasis supplied) and marketing, defined as "sensitively serving an. satisfying human needs" (Sorensen, 1985). Critics of aggressive marketing strategies would argue that marketing is actually designed to create needs and whet appetites not previously in existence.

This glorification of private financing and targeting those with the ability to pay is perfectly understandable as an invention born of necessity. Kipp (1987) tells center directors that choosing to become entrepreneurial is difficult because to decide is to kill the alternatives. But in this case the reverse is perhaps more fitting. To kill the alternatives is to decide. Withdraw large amounts of public money and what is left? Take Virginia for example. "In Virginia from 1980-1984, federal funds declined on an average of 17% a year while state funds have increased an average of 13% a year, fee collections 12% a year, and local funds 9% a year" (Nissim-Sabat, Farr, McCune & Stith, 1986, p. 161). The point is that when federal funds disappear, either new public sources of funds are cultivated, or private funds are developed, or some combination of the two. The alternative to adaptation is stagnation and eventual demise.

Perhaps no issue reflects the changing times better than that of fee collection. Roberts and Roberts (1985) take the position that in the future, the only chance to serve the poor, chronically mentally ill will be to overcharge the middle or upper classes and use the excess to underwrite service to the most needy. In other words,
"Robin Hood" medicine. They go on to explain that therapist involvement is one of the two most crucial factors in fee collection. This violates Parsons' (1960) principle of separation between the closed system of the technical suborganization (therapists) and the managerial level which mediates between the technicians and consumers, and obtains the needed resources. Marketing, it is recommended, should emphasize programs with "higher revenue potential" and creating a "quality center image," because "if marketing focuses on treating 'normal people with common problems,' it will make a center more attractive for the mainstream of the community" (Roberts & Roberts, 1985, p. 292).

Privatization: The Next Mental Health Movement

Mental health organizations are, especially in the community mental health movement, vulnerable in the area of funding sources. Being a very new model of human service organization, there is no established track record of financial support. The federal coffers overflowed for a while and then the flow was diverted to the states. Some "runoff" occurred and over the past five years or so, those funds have been reduced. Now insurance companies and corporations have been cultivated and an uneasy alliance formulated between some mental health centers and the private sector. This is different from the general health sector in several respects. Just as public health was sharply distinguished from private health care, so too was the mental health system split off and so developed a separate identity. While the general health care system developed a private practice
model with a close working relationship with insurance carriers and corporate health plans, the majority of mental health patients were seen in the public system. So the process of cooperating with the private sector is new in mental health and is just now being explored. It goes without saying that there have always been two systems of general health care and mental health care. It's just that the dominant health care model has been private and the dominant mode of mental health care in the United States has been public.

Privatization Defined

In order to define "privatization," it makes sense to first define publicness. Although we have operationally defined "public" to be synonymous with "governmental," it is more complicated than that. Bozeman (1987) has posited three axioms which are worth repeating here:

Axiom 1: Publicness is not a discrete quality but a multidimensional property. An organization is public to the extent to which it is constrained by political authority.

Axiom 2: A given organization may be more influenced by political authority in some of its processes and behaviors than in others and thus can be said to be more public in some of its processes and behaviors and less so in others.

Axiom 3: For purposes of judging the impact of publicness on organization behavior, it can be assumed that political constraint is equivalent to political endowment. It is unnecessary to distinguish the motives underlying the influence of political authority. (pp. 84-86)

There are many definitions for privatization. It is basically the conduct of business by private organizations in what had heretofore been considered the public domain. Starr (1987) defines it as
"the shift from publicly to privately produced goods and services" (p.2). Bailey (1987) says that privatization is "a general effort to relieve the disincentives toward efficiency in public organizations by subjecting them to the incentives of the private market" (p. 138). As defined by the Heritage Foundation it is "a generic term for the use of the private sector in some capacity to carry out functions previously undertaken by government" (Seidman, 1988, p.1). Perhaps the clearest definition has been proposed by Kolderie (1986). He distinguishes between two distinct types of privatization which have entirely different public policy consequences. Kolderie explains that the policy decision to provide a service is one dimension of government. The administrative action to produce a service is another dimension entirely. Kolderie terms provision the primary decision and production the secondary decision of government. It is not surprising then that he is less concerned with the privatizing of production and more concerned with the privatizing of provision. He states that if provision is privatized, "the objective of social equity may be put seriously at risk" (p. 285).

Even in the area of service production, there are potential problems. Kolderie (1986) identifies six issues of note: (1) competition, (2) "creaming", (3) corruption, (4) cost, (5) control, and (6) community. Each of these issues will be considered in turn. They are important in clarifying the privatization debate because they focus attention on specifics.

Competition is a concept that is synonymous with private enterprise in many minds. Americans are educated to equate
capitalism with "free enterprise." In fact there is an inherent contradiction between competition and capitalism (B. Thompson, 1981). The utilization of private business in the production of public goods and services by no means ensures competition, just as the utilization of public sector organizations by no means prohibits competition. The armed forces are an example of public enterprise combined with unapologetic competition between the army, navy and marines. Therefore, one important issue to consider when evaluating privatization is competition. Is competition feasible? Is it fostered in the contractual relationship between public and private sectors, or is it prohibited?

"Creaming," sometimes referred to as "cream-skimming" or "skimming" is the tendency to maximize profits by servicing only those clients having the most profitable type of problem for reasons of prognosis, location, duration of treatment, or other factors. It also refers to reducing or shutting off those services, locations, or client groups that are not cost-effective or income producing. Examples often cited are chronic conditions not fully insured, student internship programs, services to indigent clients, and services to the inner-city and rural areas. Relman (1980) points out that only for-profits could cream-skim. Others could not,

even if they wished to do so, because they have community obligations and are often located in areas where there are many welfare patients. Another form of skimming by proprietary hospitals, whether intentional or not, is their virtual lack of residency and other educational programs. Teaching programs are expensive and often oblige hospitals to maintain services that are not economically viable, simply to provide an adequate range of training experience. (p. 969)
If the government specifies the work to be performed and monitors progress toward goal achievement, then creaming should be less of a problem than it is for private buyers. Private buyers lack the resources, the sovereignty and the community sanction possessed by the government. On the other hand, examples abound of government buying vague services with ambiguous, difficult to measure outcomes. Monitoring purchase of service contracts is also easier said than done.

Corruption is less likely to occur in the scrutiny of the public spotlight. Bribery, insider trading of information, and other illegal activities are a problem when private profit accrues from decisions made in public office. The efficiency of the market driven private sector is supposed to occur as a direct result of competition. But as was mentioned earlier, the maximization of profit results from eliminating competition. So there is a dynamic tension between the capitalistic ends of competition and the capitalistic ends of maximizing profits. This tension is sometimes resolved by cheating competitors in the form of corruption.

Cost is an issue that has no simple explanation. When it comes to purchasing services through contracting, for example, some argue that it saves money because of increased efficiency (Butler, 1985) while others (American Federation of State and Municipal Employees [AFSME], 1987) say that it often results in higher costs. While there is not unanimity about contracting costing more or less than government producing a service itself, most experts agree that the contracting process aids the expansion of services.
The issue of control is rather self-explanatory when it comes to privatization. The control of an operation is closer to the originator of that operation when both are part of the same organization. So if the government makes provision for a program and that government's employees produce the program, there is a closer span of control between policy and service. On the other hand, if a service is purchased from an outside agent, then periodic review of performance and renewal of the agreement provides more potential for leverage and less likelihood for having a permanently entrenched addition to the bureaucracy. In other words, in contracting the producer is always at risk, while public production means better span of control.

Community has to do with public purpose and its possible loss in turning over part or all of certain government functions to the private sector. Will a sense of community be diminished or lost if the private sector takes over some of public enterprise? Again Kolderie's (1986) belief is that if production is at stake, the threat to a sense of community is quite small. If, on the other hand, the provider role is at stake, the danger to community is quite real. This position seems to be the moderate one. Strong opponents of privatization, exemplified by AFSME, are against all forms of privatization. Butler (1985) and his politically conservative colleagues take the extreme opposite position. They take the position that privatization is best when government reduces its role or withdraws altogether.

For those who care about government maintaining a strong
policy role, health care is not privatized when the county board contracts the management of the public hospital to a private firm, when it sells the hospital to a private firm, or even when it closes the hospital and buys care from the other hospitals in the community. The responsibility to provide is truly privatized when the county board says it will no longer pay for the care of the medically indigent. (Kolderie, 1986, p. 288)

The important risks, then, are in terms of losing a sense of community and sacrificing the ethic of social equity in the provision and production of services traditionally placed in the public domain. On the other hand, public resources seem to be diminishing, especially for domestic social programs. Governments at all levels are searching for ways to improve efficiency, flexibility, and responsiveness to changing conditions. Privatization for better or worse is an option increasingly considered by government officials as an alternative.

How It Came To Be Popular

Privatization is currently enjoying wide popularity and public debate. A variety of reasons have been offered to explain these phenomena. Fitch (1988) believes that strains of governmental budgets combine with Reagan's fondness for the private sector. Seidman (1988) postulates that the citizenry is fed up with the failures of public sector performance. E.S. Savas (1987) identifies pragmatic, ideological, commercial, and populist pressures for privatization. Pragmatics include resistance to higher taxes by taxpayers which makes the putative cost-savings touted by proponents attractive. Money saving can be translated into better productivity.
Ideological pressure comes from the perceived threat to freedom, justice and efficiency by "big government." Commercial pressure comes from the fact that government is big business, so the private sector wants some of it. There are big profits to be made, so commercial interests are enthusiastically pursuing them. Populist pressure is based on a desire for greater choice and empowerment to address local problems without encumbrance from government. "They can rely instead, to a much greater degree, on family, neighborhood, church, and ethnic and voluntary associations" (Savas, 1987, p. 10).

Types of Privatization

The experts agree (Bailey, 1987; Fitch, 1988; Savas, 1987; Seidman, 1988; Starr, 1987) that there are four or five basic methods of privatizing. They sometimes call them by different names or combine them differently. All agree that decreasing government responsibilities and programs is one type of privatization. Proponents of privatization refer to this as "load-shedding." Opponents argue that this term is biased because it sounds like government programs are a burden rather than a boon. Contracting out is a second type of privatization that is vociferously opposed by the AFSME for obvious reasons. Vouchers are a third type of privatization sometimes placed in the same category as contracting and franchising. The fourth is deregulation of public monopolies. The fifth type is asset sales, the selling or giving of public enterprises such as Conrail or the Bonneville electrical company to private...
Load-Shedding. According to Bailey (1987) this is the oldest and most often used. "[It] is the transfer of a service or operation from a public agency to a private organization" (p. 139). However, Bailey provides no evidence for his claim that this is most often used. Moreover, contracting seems much more a subject of debate in the literature, and if load-shedding is so popular, how does this explain the growth in the size of government that is so apparent? Load-shedding is a radical form of privatization. It is what Kolderie (1986) refers to as primary privatization because it affects the provision of services at the policy level which he sees as a threat to social equity. To the extent that the government has reduced its financial commitment to support mental health through deinstitutionalization without putting comparable resources into community mental health, it would seem to be engaging in de facto load-shedding.

Contracting, Vouchers, and Franchises. Starr (1987) would have us believe that contracting and vouchers are the most frequently utilized types of privatization. Contracting out is government paying for-profit or non-profit private organizations to perform services that would in other circumstances be performed by government employees themselves. Seidman (1988) informs us that contracting out is most often performed by state and local governments.

Vouchers support the consumer directly. They allow free choice in the marketplace. Food stamps are an example of the voucher
system. Franchising is another example of what Savas (1987) terms "devolution". Franchising is the award of monopoly privileges by the government. Examples of franchising are with toll goods such as electric power, gas, water, and cable television.

**Deregulation.** This is a rather straightforward concept in which restrictions that had formerly been placed on the private sector by the government are lifted thus enabling private organizations to compete in areas previously prohibited. Examples are the airline industry and telephone service.

**Asset Sales.** This is the selling of tangible or financial assets.

**The Effect of Privatization on America as a Welfare State**

A growing number of writers are addressing the privatization of the welfare state (Abramowitz, 1986; Gilbert, 1986; Stoesz, 1986). A major reform is in the offing. The speculation is that America may be transformed from a public welfare mode to corporate welfare. Not everyone is happy about this trend. Abramowitz (1986) complains that, "Privatization channels public dollars into private hands, strengthens the two-class welfare state, and reproduces inequalities that the free market inevitably creates" (p. 257). She cites the corporatization of hospitals as an example, and cites dramatic statistics to document the decline of public and non-profit hospitals over the last thirty or so years, and the concomitant ascension of for-profit hospitals. She lists several major problems, among them.
excessive profits, higher prices, and less service for those most in need. "The National Institute of Mental Health data suggest that on average, only 0.3 percent of all patients in private psychiatric hospitals receive care without charge compared to 33 percent of patients in public hospitals" (p. 262).

Gilbert (1986) raises a series of cogent questions about shifting responsibility for the welfare state from the public to the private sector, something he believes both the Democratic and Republican parties favor though in different forms. Do workers benefit from increased dependence on the workplace for the meeting of both economic and social needs? If corporate America takes care of the cradle to grave social and health concerns of workers, who takes care of those outside the labor force? Finally, can corporate welfare balance competing social and economic goals while simultaneously providing for equality of opportunity and outcome?

Stoesz (1987) identifies two principles for welfare reform. A reduction of government involvement (load-shedding), and private sector substitutes as a way of producing services. Stoesz identifies nursing homes, hospital management, and health maintenance organizations (HMOs) as prime examples of new human services markets. Like Abramowitz (1986), Stoesz (1986) anticipates that privatization will "exacerbate the dualism in service provision already evident in social welfare" (p. 247). These authors all agree that changes of major proportions are in process. They seem to identify the health field as the leading edge of the trend.
Summary

This chapter has considered in some detail organizational typologies, organizational effectiveness, the mental health literature, and the privatization literature. There is a connection between these four strands in both time and context. Parsons (1960) discusses the utility of analysis which examines values, goals and types of organizations and then compares functions of each type. This idea is advanced by others including especially Blau and Scott (1962) and Etzioni (1964, 1975). They focus more specifically on who benefits and congruency between control and involvement, respectively. The work of J.D. Thompson (1967) and Woodward (1965) extend typology analysis in a way that theoretically complements the present "medical-industrial complexities" and the impact of this phenomena on mental health. Organizational effectiveness is also a theoretically important issue (Cameron, 1984; Price, 1968). The goals of this dissertation are to apply a test of economic effectiveness to organizational type by computing net income, and explore the qualitative and ideological aspects of effectiveness by examining the underlying values associated with public mental health vs. privatization.

The typology and effectiveness literature is cogent to the more specific and immediate case of the community mental health system. And all of the above are at the service of the consideration of privatization as the next mental health movement.
CHAPTER III

METHODS

This chapter will present the methodology utilized in gathering the data for the 1983-84 Inventory of Mental Health Organizations (IMHO) by the Survey and Reports Branch (SRB), Division of Biometry and Applied Sciences (DBAS), National Institute of Mental Health (NIMH) in cooperation with the State Mental Health Agencies and the National Association of State Mental Health Program Directors (NASMHPD). It also includes the analysis of these data for this particular study.

Description of the IMHO

The Inventory on which this analysis is based was conducted in June, 1984 and covers 1983 data. Information was gathered on state mental hospitals, private psychiatric hospitals, freestanding psychiatric outpatient clinics, and multiservice mental health organizations. Other types of organizations were also studied but not included in this analysis. For a more detailed discussion and comprehensive overview of the 1983 Inventory, see NIMH (1986).

Definitions

According to the Instructions for the 1983-84 Inventory of Mental Health Organizations, a mental health organization is:
Any administrative and functional structure of one or more service units and a grouping of persons within this structural entity, defined by law, charter, license, contract, or agreement to directly provide mental health services to persons for the purpose of preventing, identifying, reducing, or stabilizing mental disabilities. Specific requisite criteria are as follows:

1. A formal organization established by law, regulation, charter, license, or agreement

2. An established organizational structure including staff

3. A primary goal for all or part of the organization of improving or maintaining the mental health of its clientele

4. A clientele with psychiatric, psychological, or associated social adjustment impairments or who seek to prevent these impairments from developing

5. Direct provision of mental health services beyond room and board" (IMHO, 1983, p. 1 [see Appendix C]).

The basic research question to be considered is whether or not type of ownership affects the provision of mental health services. Type of ownership, the independent variable, is defined as private for-profit, private non-profit or public (governmental) according to how each organization reported ownership/control in the IMHO (1983).

Mental health services, for the purpose of this analysis includes inpatient psychiatric hospitals, psychiatric outpatient clinics, and multiservice organizations. All of the dependent variables that are actually investigated are defined according to those definitions used by the NIMH in the Instructions for the 1983-84 IMHO (Appendix C) as follows:

An outpatient mental health clinic is an organization which provides only ambulatory mental health services on either a regular or emergency basis. The medical responsibility for all patients/clients and/or direction of the mental health program is generally assumed by a psychiatrist.
A psychiatric hospital (public or private) is an entity either operated as a hospital by a State (e.g., State mental hospital) or licensed as a hospital by the State (e.g., private psychiatric hospital) which is primarily concerned with providing inpatient care to mentally ill persons.

A multiservice mental health organization is an organization that directly provides two or more of the following elements...Inpatient care...Residential treatment care...Residential supportive care...Partial care...[and/or] Outpatient care...

Racial/Ethnic Group -- This category [is] based on the patient's self-classification, where appropriate and feasible. It may also be based on observation. In practice, it will ordinarily reflect information available in records or statistical reports. Specific categories are as follows:

White (not Hispanic)
Black (not Hispanic)
Hispanic -- A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
Native American -- American Indian or Alaskan Native
Asian or Pacific Islander
Unknown -- Report as unknown only after a reasonable effort has been made to obtain a specific category (p. 2)

These definitions are applied here because the data analyzed have been collected based upon these definitions. It would be potentially misleading to insert contrary definitions. Who can say how respondents might have changed their responses having applied different definitions? These are adequate definitions at any rate. They represent the collective wisdom of the social scientists at NIMH. They are concise, clear and comprehensive. These definitions also benefit from using language that is familiar to those in the field. They are consonant with definitions generally used in the literature, and, in the case of the catch-all category "multiservice mental health organization," the term is sufficiently inclusive.
without overlapping the other categories.

Professional staff analyzed include physicians, psychologists, M.A. and above, social workers, M.S.W. and above, nurses, M.S.N. and above. "Administrative and support staff includes [in addition to executive staff]: Medical record administrators and technicians; accountants; business staff; and clerical and maintenance staff" (Instructions for the 1983-84 IMHO, p.3)

Income includes all income.

"Expenditures...Exclude: Estimates of the value of in-kind services, and expenditures for non-mental health programs if data from these programs have not been included elsewhere on the form" (Instructions for the 1983-84 IMHO, p. 4).

Data from the Inventory supplies information on:

A. Name and Mailing Address...

B. Ownership/Control...

C. Whether or Not Part of a Chain...

D. Relation to State Mental Health Agency...

E. Type of Organization...

F. University or College Connection of this Mental Health Organization...

G. Types of Program Elements...

H. Client/Patient Characteristics: End of Year Census by Program Element...

I. Caseload Data by Program Element: Inpatient and Residential Care Services...

J. Caseload Data by Program Element: Partial Care and Outpatient Services...
National data by type of organization include the fifty states and the District of Columbia, but exclude Puerto Rico, the Virgin Islands, and Guam (NIMH, 1986).

This dissertation is much less extensive in scope than the original inventory. The large size of the data set makes analysis quite challenging. Focusing on particular features of the overall data set may add clarity and focus to this endeavor. For these reasons, the analysis which follows was originally intended to be limited to ten variables. They are: (1) location of organization, (2) type of ownership, (3) type of organization, (4) whether part of a chain, (5) total patients, (6) race of patients, (7) staff, (8) total expenditures, (9) total income, (10) net income (total income minus total expenditures).

Data were collected for 3,120 organizations, a survey of the entire population of mental health organizations meeting the above definition.

The questionnaire (see Appendix A) is nine pages in length.
Procedures

There were two steps in obtaining the data from the 1983 IMHO data. First, the Chief of the SRB, DBAS was contacted. A preliminary meeting was held during the annual program meeting of the American Public Health Association in Las Vegas, Nevada, October, 1986. It was tentatively agreed that permission would be granted. Then in June, 1987 a trip was made to the Washington D.C. area. Several days were spent in and around the NIMH Offices in Rockville, Maryland, interviewing staff and visiting the library. The data were hand carried back to Kalamazoo. They were stored on magnetic tape. The tape was deposited with the Western Michigan University Computer Center. The data were then transferred onto a scratch disk and analysis followed. Permission to conduct the analysis was requested and an exemption from a full review granted by the Western Michigan University Human Subjects Review Board (see Appendix D).

Because the entire universe of mental health organizations is surveyed, tests of significance are not required. Instead, tables reporting data on pertinent variables by number and/or percent are presented. An important aspect of this dissertation is a qualitative discussion of type of ownership and privatization which occurs throughout the text. This discussion focuses on defining privatization, examining its philosophical implications, and on the positive and negative implications of applying privatization to the mental health field.
Analyses

For the variable "type of organization," analysis was limited to three of seven categories. Outpatient mental health clinic, psychiatric hospital, and multiservice mental health organizations were included. Residential treatment centers for emotionally disturbed children, other residential organizations, not elsewhere classified, partial care organizations and mental health organizations not elsewhere classified were eliminated from consideration.

There are several reasons for this. First, partial care organizations accounted for less than 1% of total patient care episodes in 1983. Second, of the total number of patient care episodes, "in the residential treatment, residential supportive, and partial care programs of mental health organizations, the majority of these episodes occurred in multiservice mental health organizations" (NIMH, 1986, p.4). Third, children's residential treatment facilities have been and continue to be treated separately from all other types of organizations by NIMH. There were only 322 residential treatment centers for emotionally disturbed children in 1983, a decrease of 5% from 1982 (NIMH, 1986, p. 15). And this type of organization has not been a target of privatization as have other types of facilities. The original intent was to focus on "community mental health" organizations. Later, as the research progressed, the analysis was broadened to include psychiatric hospitals.
Limitations of the Study

The decision to exclude consideration of psychiatric treatment in general hospitals was made to preserve the focus on the principal players in the twin dramas of deinstitutionalization and community mental health. For example, general hospital psychiatry as a system differs from specialty psychiatric hospitals as a system. The effects of deinstitutionalization on general hospital psychiatry differs and, some would argue, is the direct opposite from the effects upon psychiatric hospitals. As Brown (1985) observes, there is a new alliance of private mental hospitals and general hospital psychiatric units. While this is an important and fertile area for further investigation, it is beyond the scope of this study. Issues like these would distract from the main thrust of the dissertation, namely, type of ownership, privatization, and the mental health system.

Another limitation to this study is that there are large numbers of missing data in some of the analyses. The impact of missing data is softened because all mental health facilities were surveyed. Still, it is important to keep in mind when reading the tables.

The responses were coded in such a way (e.g., "no response" was coded a "-9") that the Western Michigan University computer rejected repeated attempts to obtain printouts. The final solution was to combine the "no response" category with the "0" category. This erases the potential for distinguishing between these categories. Necessity required a compromise in this regard. This may bias the
results by inflating the "0" category.

Some would criticize the use of data which are five years old at the time of this writing. It is, however, the only data set available. Further, these data provide a valuable baseline for future studies on type of ownership as a variable.

Another limitation is that this was a single method of data collection—a questionnaire with self report. As Webb, Campbell, Schwartz, Sechrist, and Grove (1981) point out,

Today, the dominant mass of social science reasearch is based upon interviews and questionnaires. We lament this overdependence upon a single, fallible method. (They) intrude as a foreign element into the social setting they would describe, they create as well as measure attitudes, they elicit atypical roles and responses, they are limited to those who are accessible and will cooperate, and the responses obtained are produced in part by dimensions of individual differences irrelevant to the topic at hand. (p.1)

Respondents reporting on their program characteristics may be tempted to exaggerate the good news and suppress the bad news when self-reporting. They are vulnerable to the influence of what they assume to be the socially desirable response. If the answers to this type of questionnaire are expected to either directly or indirectly impact on future funding levels from any number of sources, then this may influence the reaction of the respondent as well.

Leaf (cited in Scott & Black, 1986) expresses caution about the NIMH inventories as data sources:

It should be clear by now that the NIMH inventories represent an extremely complex database. Despite the extremely attractive nature of the data, they need to be analyzed with great care...On the other hand, we feel that these data contain a wealth of untapped information. Given the paucity of data concerning the existence and
organization of mental health organizations, the NIMH data represent a resource that is too rich to be ignored. (p. 115)

This is an important statement because it so aptly summarizes the limitations and strengths of the data set analyzed here. The 1983 Inventory is complex in the following ways: (a) in obtaining a copy of the data; (b) in unlocking the key to the data once obtained (in this instance, programming the necessary steps to upload the magnetic tape); and (c) in translating the data into tables which illuminate those ideas and relationships of interest. With this having been said, it is a wealth of information. Without the good offices of the SRB of the NIMH there is no way a study of this magnitude could have been accomplished in this dissertation. The time, cost, and logistics would have been prohibitive.
CHAPTER IV

FINDINGS

There were 7 major research questions to be addressed by data analysis. They all were part of a larger question: Does the type of ownership influence mental health services? The plan of this chapter is to address each hypothesis in turn.

Hypothesis 1: Type of Ownership Will be Related to Type of Organization

The data show that there is a relationship between type of ownership and type of facility.

As seen in Table 1, the number of each kind of organization varies greatly in terms of both type of ownership and total numbers. There were very few for-profit multiservice organizations (17) in 1983. There were a relatively large number of for-profit psychiatric hospitals (133) which constituted 27% of the total.

Table 1 shows that there is a relationship between type of ownership and type of organization. Each of the three types of organizations is distributed differently among for-profit, non-profit and governmental types of ownership.

Regarding the influence of chains, only 2 out of 32 for-profit outpatient clinics reporting are part of a chain. Seventy-three percent of for-profit psychiatric hospitals are part of a chain. By comparison, only 10 of 80 non-profit psychiatric hospitals are chain
Table 1

1983 Inventory of Mental Health Organizations
Crosstabulation of Type of Organization by Type of Ownership

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>For-Profit</th>
<th>Non-Profit</th>
<th>Governmental</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Clinics</td>
<td>36</td>
<td>524</td>
<td>229</td>
<td>789</td>
</tr>
<tr>
<td></td>
<td>4.6</td>
<td>66.4</td>
<td>29.0</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>19.4</td>
<td>35.4</td>
<td>26.0</td>
<td>30.9</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>133</td>
<td>80</td>
<td>280</td>
<td>493</td>
</tr>
<tr>
<td></td>
<td>26.0</td>
<td>16.2</td>
<td>56.8</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>71.5</td>
<td>5.4</td>
<td>31.6</td>
<td>19.3</td>
</tr>
<tr>
<td>Multiservice Organizations</td>
<td>17</td>
<td>877</td>
<td>375</td>
<td>1269</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>69.1</td>
<td>29.6</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>9.1</td>
<td>59.2</td>
<td>42.4</td>
<td>49.8</td>
</tr>
<tr>
<td>Column Total</td>
<td>186</td>
<td>1481</td>
<td>884</td>
<td>2551</td>
</tr>
<tr>
<td></td>
<td>7.3</td>
<td>58.0</td>
<td>34.7</td>
<td>100</td>
</tr>
</tbody>
</table>

* Count
Row Percent
Column Percent

affiliated. In terms of multiservice organizations, 47.1% of for-profits and 4.8% of non-profits are part of chains. Expectedly, no governmental organization reported being part of a chain.

It is perhaps surprising that for-profit organizations were a scant 7% of the total number of all mental health organizations in 1983. The fact that 73% of for-profit psychiatric hospitals in 1983 were part of a chain foretells the probable future as for-profits increase their market share. It would be most interesting to compare these figures with 1989 data. This kind of comparison may be possible in the near future with the completion of a Harvard
University study of privatization in mental health facilities. This study is focusing on the influence of ownership on the delivery of mental health services. It is being conducted by Dr. Julius Richmond, Director of the Division of Health Policy Research and Education, and Dr. Robert Dowart and Dr. Mark Schlesinger of the Division's Mental Health Policy Working Group.

Hypothesis 2: Type of Ownership Will Affect The Quantity of Clients Served

It has been hypothesized that type of ownership will affect the numbers of clients served. Three categories of service delivery were scrutinized. Psychiatric hospitals are analyzed by both numbers of patients seen and type of ownership. The full analysis is presented in Table 2. As can be seen in the table, there is a clear difference in the numbers of clients seen in every category. Most for-profit hospitals are small in size, with about 92% of for-profit hospitals serving less than 200 patients in 1983. On the other end of the spectrum, about 72% of the governmentally owned psychiatric hospitals served more than 2,000 patients in 1983. Sixty-five percent of the 80 non-profit psychiatric hospitals reported serving 1,000 or more patients in 1983.

When outpatient clinics are considered, only 4.6% of the total number reporting declared themselves to be for-profit organizations. Of the 36 for-profit outpatient clinics reporting, 14 saw less than 200 patients in 1983. Of the 229 governmental outpatient clinics reporting, 101 saw 500 or more patients (see Table 3). Of the 524
Table 2
1983 Inventory of Mental Health Organizations
Crosstabulation of Total Numbers of Patients
By Type of Ownership for Psychiatric Hospitals

<table>
<thead>
<tr>
<th>Clients</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 99</td>
<td>99 *</td>
<td>38</td>
<td>23</td>
<td>160</td>
</tr>
<tr>
<td>99</td>
<td>61.9</td>
<td>23.8</td>
<td>14.4</td>
<td>32.4</td>
</tr>
<tr>
<td></td>
<td>74.4</td>
<td>13.6</td>
<td>28.8</td>
<td></td>
</tr>
<tr>
<td>100 through 499</td>
<td>32</td>
<td>120</td>
<td>17</td>
<td>169</td>
</tr>
<tr>
<td>499</td>
<td>18.9</td>
<td>71.0</td>
<td>10.1</td>
<td>34.3</td>
</tr>
<tr>
<td></td>
<td>24.1</td>
<td>42.8</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>500 through 2000</td>
<td>2</td>
<td>122</td>
<td>40</td>
<td>164</td>
</tr>
<tr>
<td>2000</td>
<td>1.22</td>
<td>74.4</td>
<td>24.4</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>43.6</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>133</td>
<td>280</td>
<td>80</td>
<td>493</td>
</tr>
<tr>
<td></td>
<td>27.0</td>
<td>56.8</td>
<td>16.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Count
Row Percent
Column Percent

non-profit organizations reporting, 85 saw 1,000 or more patients.

The figures for multiservice organizations are similar in pattern but questionable because there were 737 missing observations reported.

There are substantial differences in numbers of patients served by type of ownership in each category, both because of the different numbers of organizations in each ownership category and because of the varying sizes of the organizations by type of ownership category. In terms of numbers, there were more than twice as many governmental-ly owned psychiatric hospitals in 1983 as for-profit psychiatric hospitals. There were many more for-profit psychiatric hospitals...
Table 3
1983 Inventory of Mental Health Organizations
Crosstabulation of Total Numbers of Patients by Type of Ownership for Outpatient Clinics

<table>
<thead>
<tr>
<th>Clients</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 199</td>
<td>14 *</td>
<td>59</td>
<td>155</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>6.1</td>
<td>25.9</td>
<td>68</td>
<td>28.9</td>
</tr>
<tr>
<td></td>
<td>38.9</td>
<td>25.8</td>
<td>29.6</td>
<td></td>
</tr>
<tr>
<td>200 through 499</td>
<td>13</td>
<td>69</td>
<td>171</td>
<td>253</td>
</tr>
<tr>
<td></td>
<td>5.1</td>
<td>27.3</td>
<td>67.6</td>
<td>32.1</td>
</tr>
<tr>
<td></td>
<td>36.1</td>
<td>30.1</td>
<td>32.6</td>
<td></td>
</tr>
<tr>
<td>500 through More than 2,000</td>
<td>9</td>
<td>101</td>
<td>198</td>
<td>308</td>
</tr>
<tr>
<td></td>
<td>2.9</td>
<td>32.8</td>
<td>64.3</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>25.0</td>
<td>44.1</td>
<td>37.8</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>36</td>
<td>229</td>
<td>524</td>
<td>789</td>
</tr>
<tr>
<td></td>
<td>4.6</td>
<td>29.0</td>
<td>66.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Count
Row Percent
Column Percent

than non-profit psychiatric hospitals. However, the non-profits saw more patients than the for-profits. With both the multiservice organizations and the outpatient centers, the non-profits predominate both in terms of numbers of units and numbers of patients seen. Therefore type of ownership will affect the quantity of clients served for two reasons. One is that the absolute numbers of each type of organization varied by type of ownership. The other is that the number of clients served per organization varies by type of ownership.
Hypothesis 3: Type of Ownership Will Affect The Proportion of Minority (Non-White) Clients Served

The data do not support this hypothesis. On the contrary, there are relatively small differences between organizations with different types of ownership. As shown in Table 4, for-profits report serving

Table 4

1983 Inventory of Mental Health Organizations Cosstabulation of Type of Ownership by Race of Clients Served

<table>
<thead>
<tr>
<th>Type of Ownership</th>
<th>White</th>
<th>Non White</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-Profit</td>
<td>29,285*</td>
<td>10,028</td>
<td>39,313</td>
</tr>
<tr>
<td></td>
<td>74.5</td>
<td>25.5</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>717,326</td>
<td>279,820</td>
<td>997,146</td>
</tr>
<tr>
<td></td>
<td>71.9</td>
<td>28.1</td>
<td>39.7</td>
</tr>
<tr>
<td></td>
<td>37.8</td>
<td>45.7</td>
<td></td>
</tr>
<tr>
<td>Non-Profit</td>
<td>1,153,577</td>
<td>323,007</td>
<td>1,476,584</td>
</tr>
<tr>
<td></td>
<td>78.1</td>
<td>21.9</td>
<td>58.8</td>
</tr>
<tr>
<td></td>
<td>60.7</td>
<td>52.7</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>1,900,188</td>
<td>612,855</td>
<td>2,513,043</td>
</tr>
<tr>
<td></td>
<td>75.6</td>
<td>24.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Number of Missing Observations = 254,840 (10%)

* Count
  Row Percent
  Column Percent

25.5% minorities, public organizations report serving 28.1%, while non-profits report serving 21.9% minorities. This finding is counter-intuitive: One would expect to find differences by race. A recent study, using the same data set arrived at conclusions that

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were more consistent with expectations. By disaggregating the data they report that for all private psychiatric hospitals, 63.2% of which are for-profit, white patients are almost 87% of the total. Therefore our finding should be viewed with some caution (NIMH Series No. 11).

Hypothesis 4: Type of Ownership Will Affect Total Expenditures Per Organization

Table 5
1983 Inventory of Mental Health Organizations Crosstabulation of Total Expenses by Type of Ownership for Outpatient Clinics

<table>
<thead>
<tr>
<th>Expenses</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than</td>
<td>22 *</td>
<td>106</td>
<td>239</td>
<td>367</td>
</tr>
<tr>
<td>$300,000</td>
<td>6.0</td>
<td>28.9</td>
<td>65.1</td>
<td>46.5</td>
</tr>
<tr>
<td></td>
<td>61.1</td>
<td>46.3</td>
<td>45.6</td>
<td></td>
</tr>
<tr>
<td>$300,000 -</td>
<td>14</td>
<td>88</td>
<td>220</td>
<td>322</td>
</tr>
<tr>
<td>$999,999</td>
<td>4.3</td>
<td>27.3</td>
<td>68.3</td>
<td>40.8</td>
</tr>
<tr>
<td></td>
<td>38.9</td>
<td>38.4</td>
<td>42.0</td>
<td></td>
</tr>
<tr>
<td>$1 Million -</td>
<td>11</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1.25 Million</td>
<td>28.2</td>
<td>71.8</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.8</td>
<td>5.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over</td>
<td>24</td>
<td>37</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>$1.25 Million</td>
<td>39.3</td>
<td>60.7</td>
<td>7.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.5</td>
<td>7.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>36</td>
<td>229</td>
<td>524</td>
<td>789</td>
</tr>
<tr>
<td></td>
<td>4.6</td>
<td>29.0</td>
<td>66.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Count
Row Percent
Column Percent

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Table 6

1983 Inventory of Mental Health Organizations
Crosstabulation of Total Expenses by Type of Ownership for Multiservice Organizations

<table>
<thead>
<tr>
<th>Expenses</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $300,000</td>
<td>1 *</td>
<td>12</td>
<td>72</td>
<td>85</td>
</tr>
<tr>
<td>$300,000</td>
<td>1.2</td>
<td>14.1</td>
<td>84.7</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>5.9</td>
<td>3.2</td>
<td>8.2</td>
<td></td>
</tr>
<tr>
<td>$300,000 - $999,999</td>
<td>3</td>
<td>110</td>
<td>280</td>
<td>393</td>
</tr>
<tr>
<td></td>
<td>.8</td>
<td>28.0</td>
<td>71.2</td>
<td>31.0</td>
</tr>
<tr>
<td></td>
<td>17.6</td>
<td>29.3</td>
<td>31.9</td>
<td></td>
</tr>
<tr>
<td>$1 Million - $1.25 Million</td>
<td>2</td>
<td>36</td>
<td>75</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>1.8</td>
<td>31.9</td>
<td>66.4</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>11.8</td>
<td>9.6</td>
<td>8.6</td>
<td></td>
</tr>
<tr>
<td>Over $1.25 Million</td>
<td>11</td>
<td>217</td>
<td>450</td>
<td>678</td>
</tr>
<tr>
<td></td>
<td>1.6</td>
<td>32.0</td>
<td>66.4</td>
<td>53.4</td>
</tr>
<tr>
<td></td>
<td>64.7</td>
<td>57.9</td>
<td>51.3</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>17</td>
<td>375</td>
<td>877</td>
<td>1269</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>29.6</td>
<td>69.1</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Number of Missing Observations = 737

* Count
  Row Percent
  Column Percent

The data are inconclusive about whether or not type of ownership affects the total expenditures of an organization. As seen in Table 5, data on outpatient clinics show little variation in the percentage of governmental and non-profit organizations at each of the expenditure levels. For-profit outpatient clinics are few in number. Of the 36 for-profit outpatient clinics reporting, 22 of them (61%) report expenditures of less than $300,000. Almost all of the psychiatric hospitals have total expenditures of more than $1.25
million, with 2% or less reporting smaller budgets. Because of this, no table for this data is presented.

There is a large number of missing observations in Table 6 (36.7%). The other problem in interpreting Table 6 with confidence is the small n in the category of for-profit multiservice organizations (n=17).

Hypothesis 5: Type of Ownership Will Affect The Total Income of an Organization

Table 7

1983 Inventory of Mental Health Organizations
Crosstabulation of Total Income by Type of Ownership for Outpatient Clinics

<table>
<thead>
<tr>
<th>Total Income</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $300,000</td>
<td>22 *</td>
<td>109</td>
<td>243</td>
<td>374</td>
</tr>
<tr>
<td>$300,000 - $999,999</td>
<td>5.9</td>
<td>29.1</td>
<td>65.0</td>
<td>47.4</td>
</tr>
<tr>
<td>$1 Million - $1.25 Million</td>
<td>3.8</td>
<td>27.0</td>
<td>69.2</td>
<td>39.9</td>
</tr>
<tr>
<td>Over $1.25 Million</td>
<td>12</td>
<td>85</td>
<td>218</td>
<td>315</td>
</tr>
</tbody>
</table>

* Count
Row Percent
Column Percent

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Table 8
1983 Inventory of Mental Health Organizations
Cosstabulation of Total Income by Type of Ownership for Multiservice Organizations

<table>
<thead>
<tr>
<th>Total Income</th>
<th>For-Profit</th>
<th>Governmental</th>
<th>Non-Profit</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $300,000</td>
<td>1 *</td>
<td>14</td>
<td>73</td>
<td>88</td>
</tr>
<tr>
<td>$300,000 - $999,999</td>
<td>3</td>
<td>115</td>
<td>275</td>
<td>393</td>
</tr>
<tr>
<td>$1 Million - $1.25 Million</td>
<td>1</td>
<td>33</td>
<td>72</td>
<td>106</td>
</tr>
<tr>
<td>Over $1.25 Million</td>
<td>12</td>
<td>213</td>
<td>457</td>
<td>682</td>
</tr>
<tr>
<td>Column Total</td>
<td>17</td>
<td>375</td>
<td>877</td>
<td>1269</td>
</tr>
</tbody>
</table>

Number of Missing Observations = 737 (36.7%)

* Count
Row Percent
Column Percent

The data are inconclusive about whether or not type of ownership affects the total income of an organization. As seen in Table 7, data on outpatient clinics show very little variation between governmental and non-profit outpatient clinics regarding total income. For-profit outpatient clinics are few in number. Of the 36 for-profit outpatient clinics reporting in 1983, 61% had total incomes of less than $300,000, and all but 2 of the 36 had total incomes of less than $1,000,000. More than 97% of psychiatric...
hospitals of every type of ownership had budgets exceeding $1.25 million.

It is not advisable to draw conclusions from Table 8 for two reasons. One is that there is an unusually large number of missing observations (36.7%). The other is that the total n for for-profit multiservice organizations reporting total income is 17, an unusually small total from which to draw conclusions.

Hypothesis 6: Type of Ownership Will Affect
The Net Income of an Organization

The data show that type of ownership does affect net organizational income as shown in Table 9. For example, a slightly smaller percentage of for-profits report a net income of less than $66,000 than either governmental or non-profit organizations. On the other hand, 28.8% of for-profits report a net income of more than $10,000, compared to 13.6% of governmental and 8.3% of non-profit organizations.

Hypothesis 7: Type of Ownership Will Affect
The Staffing Patterns of an Organization

It was expected that there would be two possible ways in which differences would exist. One is in the relative percentage between administrative and support staff on the one hand, and professional staff on the other. The other difference is in the relative numbers of internships accepted by organizations with different types of ownership.
<table>
<thead>
<tr>
<th>Type of Ownership</th>
<th>Net Income Less than $66,000</th>
<th>Net Inc. $65,999 to $29,999</th>
<th>Net Inc. $29,999 to $30,000</th>
<th>Net Inc. $1 to $29,999</th>
<th>Net Inc. $30,000 to $65,999</th>
<th>Net Inc. $66,000 to $99,999</th>
<th>Net Inc. More Than $99,999</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-profit</td>
<td>19</td>
<td>1</td>
<td>120</td>
<td>16</td>
<td>7</td>
<td>3</td>
<td>67</td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>5.5</td>
<td>.4</td>
<td>51.5</td>
<td>6.9</td>
<td>3.0</td>
<td>1.3</td>
<td>28.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Government</td>
<td>101</td>
<td>17</td>
<td>534</td>
<td>98</td>
<td>32</td>
<td>21</td>
<td>126</td>
<td>929</td>
</tr>
<tr>
<td>Mental</td>
<td>10.9</td>
<td>1.8</td>
<td>57.5</td>
<td>10.5</td>
<td>3.4</td>
<td>2.3</td>
<td>13.6</td>
<td>29.7</td>
</tr>
<tr>
<td>Non-profit</td>
<td>228</td>
<td>117</td>
<td>941</td>
<td>328</td>
<td>124</td>
<td>68</td>
<td>164</td>
<td>1970</td>
</tr>
<tr>
<td></td>
<td>11.6</td>
<td>5.9</td>
<td>47.8</td>
<td>16.6</td>
<td>6.3</td>
<td>3.5</td>
<td>8.3</td>
<td>62.9</td>
</tr>
<tr>
<td></td>
<td>65.5</td>
<td>86.7</td>
<td>59.0</td>
<td>74.2</td>
<td>76.1</td>
<td>73.9</td>
<td>45.9</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>348</td>
<td>135</td>
<td>1595</td>
<td>442</td>
<td>163</td>
<td>92</td>
<td>357</td>
<td>3132</td>
</tr>
<tr>
<td>Row Total</td>
<td>11.1</td>
<td>4.3</td>
<td>50.9</td>
<td>14.1</td>
<td>5.2</td>
<td>2.9</td>
<td>11.4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Number of Missing Observations = 157

*Count
Row Percent
Column Percent
Table 10 was constructed to see what the relative staff mix was for organizations with various types of ownership. Very small organizations were eliminated from the analysis by limiting consideration to those organizations with 500 or more scheduled weekly staff hours. This means that the organizations included in this analysis have at least the equivalent of 12 or 13 full time staff (f.t.e.) depending on the work week being either 37 or 40 hours. Administrative and support staff would include executives, secretarial personnel, bookkeepers, maintenance staff, etc.

Table 10

1983 Inventory of Mental Health Organizations
Crosstabulation of Type of Staff With Type of Ownership for Organizations With 500 or More Scheduled Weekly Staff Hours

<table>
<thead>
<tr>
<th>Type Ownership</th>
<th>Administrative and Support Staff</th>
<th>Professional Staff</th>
<th>Row Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For-Profit</td>
<td>152 (61.5%)</td>
<td>95 (38.5%)</td>
<td>247 (100%)</td>
</tr>
<tr>
<td>Governmental</td>
<td>468 (50.6%)</td>
<td>456 (49.4%)</td>
<td>924 (100%)</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>718 (50.7%)</td>
<td>699 (49.3%)</td>
<td>1417 (100%)</td>
</tr>
<tr>
<td>Column Totals</td>
<td>1338</td>
<td>1250</td>
<td>2588</td>
</tr>
</tbody>
</table>

Professional staff was considered to include physicians, psychologists, social workers, and nurses, all possessing at least a masters degree.

The data in Table 10 reflect a substantial difference between for-profit administrative/support staff as compared to professional
staff and similar comparisons of staff mix with both of the other
types of ownership. The percentage of administrative and support
staff to professional staff is higher in for-profits than the others.
The percentages are identical in non-profits and governmental
organizations, almost exactly 50-50 in each. Since salaries are the
biggest cost in service organizations, for-profits can decrease costs
by decreasing the relative number of professionals employed.

Table 11
1983 Inventory of Mental Health Organizations
Crosstabulation of Type of Ownership by Total
Number of Students, Trainees, Interns

<table>
<thead>
<tr>
<th>Type of Ownership</th>
<th>0 Students</th>
<th>1 - 9 Students</th>
<th>10 - 19 Students</th>
<th>20 - 99 Students</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-Profit</td>
<td>156 *</td>
<td>62</td>
<td>10</td>
<td>5</td>
<td>233</td>
</tr>
<tr>
<td></td>
<td>67.0</td>
<td>26.6</td>
<td>4.3</td>
<td>2.1</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>9.0</td>
<td>5.6</td>
<td>6.4</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Governmental</td>
<td>531</td>
<td>271</td>
<td>59</td>
<td>68</td>
<td>929</td>
</tr>
<tr>
<td></td>
<td>57.2</td>
<td>29.2</td>
<td>6.4</td>
<td>7.3</td>
<td>29.7</td>
</tr>
<tr>
<td></td>
<td>30.6</td>
<td>24.3</td>
<td>37.6</td>
<td>55.7</td>
<td></td>
</tr>
<tr>
<td>Non-Profit</td>
<td>1051</td>
<td>781</td>
<td>88</td>
<td>49</td>
<td>1969</td>
</tr>
<tr>
<td></td>
<td>53.4</td>
<td>39.7</td>
<td>4.5</td>
<td>2.5</td>
<td>62.9</td>
</tr>
<tr>
<td></td>
<td>60.5</td>
<td>70.1</td>
<td>56.1</td>
<td>40.2</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>1738</td>
<td>1114</td>
<td>157</td>
<td>122</td>
<td>3131</td>
</tr>
<tr>
<td>Total</td>
<td>55.5</td>
<td>35.6</td>
<td>5.0</td>
<td>3.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Number of Missing Observations = 157

* Count
Row Percent
Column Percent

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Of the total respondents from for-profit organizations (N=233), 77 or 33% took 1 or more interns, trainees or students (see Table 11). For governmental organizations (N=929) 348 or 37% reported taking 1 or more students. Of governmental organizations, 42.8% (N=929) accepted interns, including 1 that trained more than 500 in 1983! Of non-profit organizations (N=1969), 918 or 46.6% reported taking 1 or more students, interns or trainees. To this information must be added the fact that 62 or 80% of the 77 for-profits taking students reported having between 1 and 9 student interns. Twenty percent of governmental organizations, 5% of non-profits and 6.5% of for-profits accepted 20 or more students, trainees or interns.

Based on the data it is found to be true that type of ownership will affect the staffing patterns of an organization, both in terms of paid staff, and in terms of numbers of student interns accepted for training.

Summary

Seven hypotheses in all were proposed for testing. Of these, 4 showed evidence of association or relationship between variables (see Figure 3). Hypotheses 4 and 5 had inconclusive supporting data. A relationship was not in evidence between type of ownership and race. Chapter V will include a discussion of these findings, a discussion of the qualitative issues related to the broader issue of privatization, and implications for future research.
Figure 3

A Graphic Summary of the Findings of the Possible Relationship Between Type of Ownership and Mental Health Services

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Evidence of Support</th>
<th>Inconclusive Evidence</th>
<th>Evidence Contradicts the Hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ownership and Organizational Type</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ownership and Client Quantity</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ownership and Race of Client</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Ownership and Expenditures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ownership and Total Income</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Ownership and Net Income</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ownership and Staffing Patterns</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER V

CONCLUSIONS

Introduction

The relationship between "type of ownership" and the crisis in mental health is this: The crisis is partly ideological and partly financial. In response to dwindling financial support from the government, many mental health organizations are considering the adoption of private sector strategies, techniques, ethics and staffing which may dramatically alter the delivery of mental health services, especially to those in most need but with the least ability to pay. Ten years ago funding for community mental health was mainly from the federal government. Since the Omnibus Budget Reconciliation Act of 1981, public funding has diminished, and federal funding especially so. The greater the difficulty mental health organizations have had in procuring public funding, the more they have turned to the private sector for help. The chief executive officers of mental health organizations have begun importing the techniques, the strategies and, eventually, the ideology of the corporate world. This is a definite shift in values.

In this respect, mental health is experiencing a trend that is a part of the larger fiscal problems of general health. Health care is a field that sets itself apart as special and, in some ways, superior to the commercial marketplace. This has sparked much controversy
among health professionals. Some, such as Relman (cited in Gray, 1986), take the position that "too many physicians nowadays are succumbing to the lure of easy profits, and are becoming entrepreneurs" (p. 209). Others, such as Reinhardt (cited in Gray), see this occurrence as a positive one, in which "Americans have now decided to treat health care as essentially a private consumer good of which the poor might be guaranteed a basic package, but which is otherwise to be distributed more and more on the basis of ability to pay" (p. 220).

As a way of providing an empirical basis for policy discussions, this dissertation focused on determining whether or not a relationship exists between type of ownership and service delivery patterns in mental health organizations. Several factors contribute to the significance of this question, especially at this point in time. Privatization is blossoming to replace the wilted bouquet that was once the combined programs of the community mental health movement. Boundaries are blurring between once distinctly different private for-profit, private non-profit and public organizations. This in turn leads many observers to predict insignificant distinctions to exist between types of organizations. The trend in health care financing is dramatically impacting on the mental health field.

Typologies

As noted earlier, the examination of typologies is informed primarily by Parsons (1960), Blau and Scott (1962), and Etzioni (1975). Organizational goals and values, "who benefits" from the
organization, and congruencies between control and involvement, respectively contribute to the typology question. There is a well-established inverse relationship between social class and mental illness (Dohrenwend & Dohrenwend, 1969; Hollingshead & Redlich, 1958; Srole, Langner, Michael, Opler & Rennie, 1962). This clearly implies that to choose the principle of "ability to pay" necessitates sacrificing serving the most needy. Many studies, including Clausen & Kohn (1959), Turner & Wagenfeld (1967), and others established an association between indicators of stress and the need for mental health services with an implied need for a community (rather than solely intrapsychic) approach to mental health service. The epidemiological research efforts of the above authors and others significantly contributed to the intellectual underpinnings of the community mental health movement as it was initially formulated. The current shift is away from the values of social justice, equality and accessibility toward the values of mental health services as an economic good, subject to the whims of the marketplace. The community mental health movement suffered from inflated promises, underfunding, the opposition of the state hospital infrastructure, with the final blow coming from what Lekachman (1987) calls the "dubious social results of a Reaganite Dogma" (p. 302). There is a concomitant shift in the mission of agencies which adopt the modus operandi of the for-profit sector, from the altruistic notion of serving those most in need to the more pragmatic principle of serving those with the ability to pay. The fate of those most in need is homelessness, prison, degradation and despair (Torrey, 1988).
Before leaving the topic of the manner in which mental health services are structured and before arriving at the topic of effectiveness, it behooves us to spend a moment considering two recent authors who connect these two concerns: (1) Brown (1985), and (2) Torrey (1988). Together, they indict the mental health system as worse than a failure. They, each in their own way, provide evidence to support the contention that the system has done extensive, palpable harm to those it is supposed to serve.

Brown (1985) focuses on the development of a new public-private allied sector which has contributed to blurring the traditional two class system. He refers to a variety of transfers of care, for example, "from mental health to other social service systems and to non-system settings...a transfer of responsibility from public authority to private control" (p.8). He concludes that major changes such as "large scale economic redistribution, widespread application of consumer-oriented self-help services, and curbs on many traditional psychiatric practices" are required which must be preceded by a new appreciation of the inseparability of mental health to the overall social system (p. 210).

Brown (1985) hits the mental health system over the head with a club. Torrey (1988) dissects it with a scalpel. With relentless logic and dramatic case examples, Torrey builds his case. Some of his observations are that: a) at least twice as many seriously mentally ill are living on the streets as are in public mental hospitals, b) jails and prisons are increasingly being called home for seriously mentally ill individuals, c) laws designed to protect
the mentally ill don't, and d) most mentally ill discharged from hospitals have been officially lost (Torrey, pp. 6-7).

Where Brown (1985) lobbies for a new system, as described above, Torrey (1988) suggests incremental changes within the present system. Torrey's number one solution is that public psychiatric services should be targeted to emphasize treatment for the seriously mentally ill. While Torrey is more concrete in his analysis and more practical in pointing to possible solutions, Brown has the advantage of the broader perspective. He, therefore, more accurately identifies the major contribution of public versus private ownership in determining the limits to the problem. The task environment and economic structure of the service delivery system ultimately influences the effectiveness of public policy. This author would increase federal funding of mental health services and regulation of for-profit mental health organizations.

Organizational Effectiveness

There must be some concern over the issue of effectiveness. The data can only provide partial answers to whether or not a chosen path is most effective. As was seen in Chapter II, this is a complicated issue. The danger is that in our haste to find answers they are chosen out of convenience or ease of measurement. Economically, for-profits do better if the criterion of net income is applied. Ideologically, for-profits may be less attractive. Services usually cost more. The number of service professionals in comparison to administrative and support staff diminish. The values of justice,
equality and access to service are downplayed. "Consensus regarding the best, or sufficient set of indicators for effectiveness is impossible to obtain. Criteria are based on values and preferences of individuals...[and]...organizational effectiveness is mainly a problem-driven construct rather than a theory-driven construct" (Cameron, 1986, p. 541).

Regarding the implications of this suspected drift away from need and toward ability to pay, there are only two alternatives from a policy perspective: Either mental health organizations driven by a profit motive must abandon the most needy client population, or the government must regulate the market to favor serving the most needy (Long, 1970).

It may be too simplistic to assume that there is agreement over who is most needy. On the other hand, in a dual system of private and public health care such as exists in the United States, those not eligible for public care and without funds or insurance coverage to pay for private care might be good candidates for the "most needy" category, all other things being equal. Ineligibles include but are not limited to those not geographically or otherwise inaccessible to service, those not meeting eligibility criteria, and those public payees who are "dumped" as fast as the rules permit, after successfully gaining admission. Rigging the market is a possible response by planners to the seeming drift toward a market driven model of service provision by mental health organizations (Long, 1970). If the directors of mental health organizations do embrace the for-profit model of service delivery, and government planners identify
the chronically mentally ill population as being underserved, then by
creating quotas, paying premiums, or generating publicly supported
competitive programming, the planners can effect change even in a
market dominated by private business. "Rigging the market for public
goods turns out to be a device for transforming the public ecology of
activities into a rational, controlled instrumentality for the
achievement of consciously held and critically understood social
purposes" (Long, p. 204).

Another question is that of effectiveness. Are for-profits,
non-profits and governmental organizations different in terms of
effectiveness? Two ways of judging the answer were chosen. One is
quantitative: To compare net incomes, as suggested by Price and
Mueller (1986). The other is qualitative (e.g. Hasenfeld, 1983):
The crucial question is "who provides?" implying that those providing
the resources decide which criteria measures organizational effec-
tiveness.

The other important research question examined in this disserta-
tion has to do with a philosophical question: How might social
equity and economic feasibility be reconciled? This question is not
definitively resolvable. But it does directly relate to the trend
toward privatization.

The Impact of Privatization on Health and Mental Health

The literature is replete with past, present, and future
deprecated examples of the application of privatization to the health and mental
health fields. Rather than repeat in detail information from the
various writings on this subject, the reader shall be pointed in the right direction. To begin with, no source is more thorough, scholarly and complete on the subject of for-profit health care than the book edited by Gray (1986) *For-Profit Enterprise in Health Care*. One of the deciding factors in choosing "type of ownership" as an independent variable for this research was the statement in the preface to this book, written by Walter J. McNerney,

> In my view, this report makes clear that 'type of ownership' is an important variable affecting the entire health care system--delivery and financing institutions alike. And I believe that it will become even more important as competition among health institutions increases and services are paid for increasingly on a prospective or incentive basis. ...Special attention must be given systemwide to such key outcomes as cost, access, quality and equity, as well as to the viability of research and educational programs. (Gray, p. IX)

Fixler and Poole (1987) point out that "contracting out of hospital management and operation to for-profit firms increased some 53%" between 1973 and 1982 (p. 170). They go on to say that, "A recent trend is for some local governments and state universities to lease or otherwise contract out their teaching hospitals to the private sector" (p. 171). This is a concern to those who see the teaching function in other than economic terms. If professional education becomes dependent on for-profit organizations to provide internships and field practicums, and if for-profit organizations perceive internships as a drain on income, i.e., an inefficiency, then professional education may be in a predicament.

Figure 4 is a distillation of the arguments appearing in the literature. It was developed by this author to summarize and compare

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### Figure 4

**Privatization: Pro's and Con's**

<table>
<thead>
<tr>
<th>Pro</th>
<th>Con</th>
</tr>
</thead>
<tbody>
<tr>
<td>More efficient</td>
<td>Less equitable</td>
</tr>
<tr>
<td>Promotes competition</td>
<td>Results in hidden monopolies</td>
</tr>
<tr>
<td>Reduces red tape</td>
<td>Hinders continuing need to regulate</td>
</tr>
<tr>
<td>Opens doors to private enterprise</td>
<td>Unavailability of vendors for unprofitable, unwieldy services</td>
</tr>
<tr>
<td>Gain economies of competition</td>
<td>Lose economies of scale</td>
</tr>
<tr>
<td>Produces better management</td>
<td>Produces poorer quality of service</td>
</tr>
<tr>
<td>Busts government monopoly</td>
<td>Creates private monopolies</td>
</tr>
<tr>
<td>Lowered wages</td>
<td>Lowered wages</td>
</tr>
<tr>
<td>Better incentives for managers</td>
<td>Less professionalism</td>
</tr>
<tr>
<td>Contracting out brings new people and fresh ideas to old problems</td>
<td>Contract compliance increases cost and complexity</td>
</tr>
<tr>
<td>Costs less</td>
<td>Increases corruption</td>
</tr>
<tr>
<td>More flexibility</td>
<td>Less accountability</td>
</tr>
<tr>
<td>Spurs government to greater efficiency</td>
<td>Layoffs and lowered morale of public employees</td>
</tr>
<tr>
<td>Time limited activities helps to control size of government</td>
<td>Cost overruns and hidden costs create extra costs</td>
</tr>
<tr>
<td>Increases choice</td>
<td>Diminishes access</td>
</tr>
</tbody>
</table>

...the competing points of view. As expected, the policy stakeholders are choosing sides and attempting to educate their own constituencies...
and the general public to their point of view. What some see as positive, such as lowered wages, makes others see red. This figure may not be inclusive, but it does pretend to represent most of the major pro's and con's of privatization.

With all of the talk about efficiency, economy of scale and cost-effectiveness it is sometimes easy to mistake the core of the privatization debate to be economics. But there is ample evidence that for-profit health care is not cheaper! Of 8 studies summarized in Gray (1986) not-for-profit hospitals controlled their expenses better than for-profits, controlling for size. For-profit chains had higher expenses than not-for-profit hospitals in 4 out of 5 studies. Lekachman (1987) reports a 1984 study of 272 hospitals which found no significant efficiency differences between public and for-profit hospitals. If economics does not adequately explain the situation, why the stampede?

If our current festival of private enterprise continues, a thousand studies heaped high to the heavens will not slow privatization in the health sector, because the benefits are less financial than they are sociological. In the next bed may restlessly toss someone of the wrong color, occupation, life style or income. Privatization promises better company. (Lekachman, 1987, p. 303)

Another of the criticisms of for-profit hospitals has been their sometimes callous attitude toward the indigent. For example, when asked, "Why don't you put up a sign saying, 'This hospital will provide free care to people who are unable to pay'?" Charles Davis, administrator of a hospital owned by the Hospital Corporation of America replied, "Why don't department stores put up signs inviting shoplifters to shoplift more?" (AFSME, 1987, p.7).
Looking specifically at mental health, there seems to be the same trend only at an earlier stage. The proportion of all non-federal psychiatric inpatient beds in private facilities has increased from less than 10% in 1970 to 35% today. Furthermore, corporate for-profit auspices of psychiatric inpatient beds increased from about 1% to 15% (Dowart & Schlesinger, 1988, p. 543).

Marketing is also becoming more prominent in the mental health field. "Nearly half of 144 private psychiatric hospitals surveyed in 1987 reported advertising their clinical services on television, almost 14% more than in 1984" ("Private Psychiatric," 1987, p. 794.) One of the biggest reasons given for rapid incursion of for-profit organizations into the mental health field is the increasing regulation of the medical care industry. This chases for-profits into less regulated areas such as mental health (Gaylin, 1985).

Implications for Future Research

The case has been made for type of ownership to be an important focus for future research. There are many reasons for this to be true. Whether one prefers a competitive marketplace or a systematic, coordinated blend of services monitored by the government, there is reason to support or oppose the trend toward privatization. The problem of care for those unable to pay needs to be studied whether for-profit or not-for-profit mental health organizations predominate. More research is needed to ascertain the potential implications for professional education that spring from the apparent reluctance of for-profit mental health organizations to train students by providing
internships. The possible inaccessibility to private psychiatric hospitals by minorities needs to be studied. Perhaps the most important area for future research is the economic and social costs of choosing privatization. If for-profit organizations are more profitable for investors but actually cost more for consumers, is this the direction this country wishes to choose as a way of containing mental health costs? Is not the opposite effect likely?

Summary

1. A relationship exists between type of ownership and service delivery patterns. This is true in spite of blurred boundaries, tax loopholes for non-profits, and the increasing incidence of contracting by government.

2. Using net income as a measure, there is some difference in effectiveness between for-profit and both other types of ownership, but not between private non-profit and public ownership. Net income, or any other quantitative measure used without respect to values is not a good nor sufficient measure. It is reductionistic and ultimately misleading.

3. Looking back at the themes from the first chapter, the findings support the importance of how the mental health system is organized. Collateral data support the fact that the current system is in flux. Any and almost every professional mental health worker could (and would) tell you that.

4. The problems being experienced by mental health organizations are exacerbated by the dilemma of commercialism vs. profes-
sionalism. The data tell us that net income is better generated by for profits, while non-profits and governmental organizations represent the tradition of serving humanity as a social good.

5. The status of the mental health system in 1983 was that of private, non-profit organizations providing the most direct service, with governmental organizations next and private for-profit organizations providing the least amount of direct service. The most current information from collateral sources (see Appendix B) shows the for-profit mental health sector growing rapidly, whether or not it is desirable.

6. If students, interns and trainees are any example, then "creamining" or suppressing non-income-generating activities is a trend among for-profit mental health organizations. This may signify serious problems for professional education in the years to come. Professional education as it is known today is impossible without internships. If predictions are true that private for-profit organizations will come to be the dominant form of mental health organization, and they continue to decline the role of hosting students, this will dramatically alter the face of professional education.

Discussion

The impact that type of ownership has on the mental health system is to contribute to its not being a system at all. Since it is true that different types of ownership result in different organizational characteristics, this seems to interfere with the
development of common goals, values and points of linkage. According to Manderscheid (1985) local mental health services neither constitute systems of care, nor are they "responsive to unitary managerial control...[at the state level]...at least part of the public services available within each state have the potentiality [emphasis supplied] of constituting a system of care....Beyond this, state control is less evident" (p. 51). And finally he reports that a "mental health delivery system does not exist" at the national level either (Manderscheid, p. 52).

Now it has been established that type of ownership significantly affects the way in which mental health organizations are organized. The diversity in type of ownership has logically contributed to the fragmentation and economic crisis of the mental health system. Organizational effectiveness is partially decided by those contributing the resources. With mental health organizations dependent upon multiple sources of funds with multiple criteria of effectiveness, confusion and lack of domain consensus can be the result. For example, the public domain may emphasize services to the chronically and severely mentally ill because of problems generated by deinstitutionalization, and the cutbacks in funding of community mental health centers. Private insurers may emphasize substance abuse services and outpatient treatment for the "worried well" since these services may restore subscribers to productive employment and forestall further expensive health problems by other family members.

Current literature and data support the concerns identified here. The debate over privatization rages on. In 1960, health care
in this country was 5.3% of the Gross National Product (GNP). According to an editorial in *Medicine and Health* (Fackelman, 1987), that share rose to 10.6% in 1985 and 10.9% in 1986. All experts agree that health care will continue to consume an increasing share of the GNP as time goes by, unless dramatic changes occur. Perhaps this economic crunch is most responsible for fueling the transition in the organization of mental health services. A quality care task force commissioned by the Michigan Department of Mental Health (MDMH) in 1977 was admonished by the Director that "given the state's limited financial resources, it is imperative that the Task Force review administrative remedies as well as resource questions" (MDMH, 1988).

The Executive Summary of that report included the following advice: "The state is strongly encouraged to continue exploring alternatives offered by the private sector. We see increased contracting and the formation and growth of public-private mental health system networks to be a plausible and effective direction" (MDMH, 1988, p. viii).

It must be emphasized that utilization of for-profit (especially investor owned) organizations for the provision of mental health services may have many advantages over not-for-profit organizations. For example, in terms of hospital operations, for-profit hospitals are generally more profitable and restrict expenses more than not-for-profit institutions.

[They] respond more precisely to economic incentives than do not-for-profit institutions. These advantages come at a price. For-profits have slightly higher expenses. They
charge more per stay. Services that are profitable proliferate, but marginal or unprofitable services tend to be eliminated...there is a large group of services that are more commonly offered in not-for-profit hospitals (chain and independent) than in investor-owned chain hospitals and very few that are more common in investor owned chains than in not-for-profit hospitals. Not-for-profits are more likely to have an outpatient department, premature nursery, dental services, hospice care, home care hospital auxiliary, health promotion services, family planning services, various types of psychiatric services" (Gray, 1986, p. 108, [emphasis supplied])

Regardless of whether we like or dislike privatization, it is the next mental health social movement.

It has been demonstrated that there are clear differences between for-profit mental health organizations and other types in terms of net profit and ideology. There are both philosophical differences and concrete "bottom-line" differences. For-profit organizations are coming to mental health in ever increasing numbers. This is a new trend in mental health. For-profits may be more efficient. Better management and a greater incentive to control costs may result. But there are also reasons to be concerned about this latest answer to the problem of providing care for the mentally ill.

If mental health care is a basic right rather than a privilege, then the public good will be harmed by limiting care to only those with the means to pay. Since most consumers are really claimants who want mental health care without due regard to cost, caveat emptor no longer applies. For another thing, in the tradition of the medical model, the consumer has been socialized to depend heavily on the advice of the professional. If that professional is looking to make
a profit, or is being pressured by administrators to produce income, then the consumer is misplacing his or her trust.

The public has also come to associate private enterprise with high quality. Yet this analysis of the data shows proportionately fewer professionals employed in for-profit mental health organizations than others. In a labor-intensive enterprise like mental health, the most logical place to reduce costs is with the professional staff. It is doubtful that fewer professional staff in for-profit mental health organizations will result in higher quality service.

Private businesses are interested in marketing their product to increase sales, yet the major financial problem in the mental health field is to moderate use of resources while protecting equity, access and quality. These two goals seem to oppose one another.

Regulation or "rigging the market" is one way to moderate the effects of privatization. For example, for-profits tend to engage in cream-skimming. This is evidenced by their reluctance to accept training of students in mental health professions compared to non-profits and public organizations. Perhaps government regulation could require that for-profit mental health organizations provide some minimum level of unprofitable or low frequency services, serve some minimum number of poor people with chronic and complex mental illness, and provide some minimum amount of training opportunities to help educate mental health professionals.

A privately produced, publicly funded lobby may exert a dangerous kind or amount of political clout. Especially when that clout
comes from a large, financially well-endowed special interest group like for-profit mental health. Privatization may be the next epoch in mental health, but if it is the previously paramount values of social justice, equity and accessibility to care would seem to be imperiled.

In the Sixteenth Century the deranged were expelled, shipped off, or executed;
In the Seventeenth Century the insane were locked up in jails and houses of correction;
In the Eighteenth Century madmen were confined in madhouses;
In the Nineteenth Century lunatics were sent to asylums;
In the Twentieth Century, the mentally ill are committed to hospitals;
In the Twenty-first Century....
[....mentally disturbed customers may go shopping for services.]
(Adapted from Law and Lunacy, 1955, as quoted in the Quality Care Task Force Final Report, [Michigan Department of Mental Health, 1988]).

Caveat emptor.
INVENTORY OF MENTAL HEALTH ORGANIZATIONS

Please read computer cover sheet which is attached and complete or update any items on the cover sheet before answering the following questions.

A. NAME AND MAILING ADDRESS
   Make corrections, if necessary, in space at right.
   (Use only if computer sheet is not attached)

   Name of Organization

   Number Street

   P.O. Box, Route, etc.

   City, Town

   County

   State Zip Code

   Telephone:
   Number __________________________
   Area code Number

   ☐ Check this box and return form if no direct patient services are provided

B. OWNERSHIP/CONTROL
   Check one box to indicate the legal responsibility for the operation of this organization.

   FOR PROFIT
   □ 1 Individual
   □ 2 Partnership
   □ 3 Corporation

   STATE-LOCAL GOVERNMENT
   □ 4 State government
   □ 5 County government
   □ 6 City government
   □ 7 City-county government
   □ 8 District/regional authority

   NONPROFIT
   □ 9 Religious organization
   □ 10 Other nonprofit

   FEDERAL GOVERNMENT
   □ 11 Veterans Administration

   OTHER
   □ 12 Ownership other than given in categories 1-11 (Specify):

   __________________________________________________________

C. WHETHER OR NOT PART OF A CHAIN
   If you checked box 2 (partnership), box 3 (corporation), box 9 (religious organization), or box 10 (other nonprofit), under Question B, are you part of a chain which includes other mental health organizations?

   0 ☐ No, go to Question D
   1 ☐ Yes, enter name of chain and address of headquarters below:

   Name __________________________

   Address __________________________

   City, State Zip Code_________________

   Telephone Number __________________________
   Area code Number

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D. RELATION TO STATE MENTAL HEALTH AGENCY
For definitions, please see instruction sheet.
1. In terms of administration:
   Check only one box.
   □ a. Operated by State Mental Health Agency. Specify: _____________
   □ b. Operated by State agency other than State Mental Health Agency. Specify: _____________
   □ c. Operated by other than a State agency.
2. In terms of funding:
   Check yes or no for each item.
   YES NO
   □ □ a. Directly receives State Mental Health Agency funds, exclusive of Medicaid.
   □ □ b. Indirectly receives funds from the State Mental Health Agency through an intermediary, such as a county or community mental health board.
   □ □ c. Directly receives funds from State agency other than State Mental Health Agency, exclusive of Medicaid.
   □ □ d. Directly receives no funds from any State agency, exclusive of Medicaid.

E. TYPE OF ORGANIZATION
For definitions, please see instruction page. Check one box only.
   □ 1 Outpatient mental health clinic.
   □ 2 Psychiatric hospital.
   □ 3 Residential treatment center for emotionally disturbed children.
   □ 4 Other residential organization, not elsewhere classified (e.g., halfway house, community residence, group home).
   □ 5 Mental health partial care organization.
   □ 6 Multiservice mental health organization.
   □ 7 Mental health organization, not elsewhere classified.
      (Specify): ____________________________________________________________________________

F. UNIVERSITY OR COLLEGE CONNECTION OF THIS MENTAL HEALTH ORGANIZATION
Check all boxes that apply.
   □ 1 This mental health organization is operated by a college or university.
   □ 2 Professional services are provided by a college or university for this mental health organization.
   □ 3 This mental health organization has the following type of affiliation with a college or university. Specify: _____________
   □ 4 This mental health organization has no affiliation or connection with a college or university.
H. CLIENT/PATIENT CHARACTERISTICS: END OF YEAR CENSUS BY PROGRAM ELEMENT

For each program element checked in Question G, report the numbers of clients/patients at the end of the reporting year for the following demographic and clinical characteristics. If end of year totals are not available, please use average daily census and indicate with a note at the bottom of the page. For definitions, please see the instruction sheet. Complete all entries, if possible. Be sure to provide totals for organization on top line even if breakouts for one or all characteristics are not available.

Indicate date at which end of year counts were obtained:
1  □  6/30/83  2 □  9/30/83  3 □  12/31/83  4 □ Other (Specify): ____________________________

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>NUMBER OF RESIDENTS/PATIENTS END OF YEAR</th>
<th>NO. OF CLIENTS ON ACTIVE ROLLS END OF YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INPATIENT CARE (IN A HOSPITAL)</td>
<td>RESIDENTIAL TREATMENT CARE</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
</tr>
<tr>
<td></td>
<td>OUTPATIENT CARE</td>
<td>PARTIAL CARE</td>
</tr>
<tr>
<td></td>
<td>(4)</td>
<td>(5)</td>
</tr>
</tbody>
</table>

1. Total for Organization
2. Age Groups:
   a. Less than 18 years
   b. 18-64 Years
   c. 65 Years and older
   d. Unknown
3. Sex:
   a. Male
   b. Female
   c. Unknown
4. Racial/Ethnic Groups:
   a. White (not Hispanic)
   b. Black (not Hispanic)
   c. Hispanic (any race)
   d. American Indian or Alaskan Native
   e. Asian/Pacific Islander
   f. Unknown
5. Major Disability Group with combined DSM-III/ICD-9-CM codes:
   a. Mental illness (290-328, except 291-292, 303-305), 317-319 and 327-328; all V codes except V71.09)
   b. Mental retardation/developmental disability (317-319)
   c. Alcohol/drug abuse (291-292; 303-306, 327-328)
   d. All other codes not shown above (0-289.9, 320-326, 330-999.9, except 799.90)
   e. Unknown and undiagnosed (V71.09, 799.90)
6. Prior Inpatient Care:
   a. Yes
   b. No
   c. Unknown
K. NUMBER OF STAFF, SCHEDULED WEEKLY STAFF HOURS, AND STAFF HOURS BY PROGRAM ACTIVITIES

In columns 1-6, enter the number of staff and scheduled weekly staff hours for all paid staff including clinical staff paid by contract working in your mental health organization during the week of June 3-9, 1984. Round hours to whole numbers. For further information on employees to be included or excluded and which employees to include under staff categories 9-12, see instruction sheet.

For each of the staff categories 1-13, add the hours in columns (2), (4), and (6) and enter the total in column (7). Distribute the total hours in column (7) into columns (8), (9), and (10) according to whether the hours are spent in clinically-oriented activities, administrative activities or other activities. The sum of columns (8), (9), and (10) should equal column (7). The types of activities included in columns 8-10 are defined on the instruction sheet.

<table>
<thead>
<tr>
<th>DISCIPLINE OR TRAINING OF STAFF</th>
<th>REGULAR STAFF</th>
<th>STUDENTS, TRAINEES, AND/OR INTERNS</th>
<th>HOURS BY TYPE OF ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time (35 hrs. or more)</td>
<td>Part-time (less than 35 hrs.)</td>
<td>Total staff hours</td>
</tr>
<tr>
<td></td>
<td>Persons (1)</td>
<td>Staff hours (2)</td>
<td>Persons (3)</td>
</tr>
<tr>
<td>1. Psychiatrists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Other physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Psychologists-Ph.D. or Ed.D.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Psychologists-Masters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Social workers-MSW and above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other social workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Registered nurses-Masters and above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Registered nurses-less than Masters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Other mental health workers-B.A. and above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Other mental health workers-less than B.A.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Other physical health professionals and assistants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Administrative and support staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. TOTAL ALL STAFF (1-12)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NUMBER OF VOLUNTEERS AND VOLUNTEER HOURS.
Enter below the number of volunteers and the hours they worked for your organization during the week of June 3-9 1984.

<table>
<thead>
<tr>
<th>Persons</th>
<th>____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours worked within a week</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

### 1. EXPENDITURES FOR THIS MENTAL HEALTH ORGANIZATION

**Year ending:**

1. □ 6/30/83  
2. □ 9/30/83  
3. □ 12/31/83  
4. □ Other (Specify): ____________

<table>
<thead>
<tr>
<th>EXPENDITURE CATEGORIES</th>
<th>ROUND AMOUNT TO THE NEAREST 100 DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff expenses:</td>
<td></td>
</tr>
<tr>
<td>a. Salaries (Include salaries of all personnel plus fringe benefits and payroll taxes).</td>
<td></td>
</tr>
<tr>
<td>b. Contract personnel expenses for this agency.</td>
<td></td>
</tr>
<tr>
<td>Expenses for contracts entered into with other mental health organizations for the provision of mental health services by that organization.</td>
<td></td>
</tr>
<tr>
<td>Other operating expenses, exclusive of depreciation (Include all maintenance, supplies, ordinary repair costs, and contract expenses other than those listed under 2 and 3).</td>
<td></td>
</tr>
<tr>
<td>Depreciation expense.</td>
<td></td>
</tr>
<tr>
<td>Capital expenditures (Include cost for construction of buildings, additions, and purchases of durable equipment). If none, enter &quot;0&quot;</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL EXPENDITURES (1a + 1b + 2 + 3 + 4 + 5 = 6) |**
N. SOURCES OF FUNDS FOR THIS MENTAL HEALTH ORGANIZATION

Year ending:
1 = 6/30/83  2 = 9/30/83  3 = 12/31/83  4 = Other (Specify): ________________________

Enter below the sources of funds for all directly operated programs of this mental health organization.

Please categorize funds according to the direct source from which they came to your organization, even if this is one or two steps removed from original source. For example, if a local government wrote a check to a mental health organization drawn on funds it received from the State mental health agency, the funds would be classified as local government funds. Please adhere to this method of reporting even if the original source of the funds is known.

<table>
<thead>
<tr>
<th>SOURCES OF FUNDS</th>
<th>ROUND AMOUNT TO THE NEAREST 100 DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. State mental health agency (exclusive of Medicaid)</td>
<td>2435</td>
</tr>
<tr>
<td>2. Other State government not elsewhere classified (exclusive of Medicaid)</td>
<td></td>
</tr>
<tr>
<td>3. Client fees received which do not revert to State or other governmental agencies and are available for expenditure by this organization. Include: direct client payments, commercial insurance, Blue Cross and Blue Shield payments, and any other payments from nongovernmental sources. Exclude: Medicaid and Medicare payments, vocational rehabilitation payments, Veterans Administration payments, CHAMPUS and any other governmental payments, as well as all client fees that revert to State or other governmental agencies, whether or not they are subsequently reallocated to your organization.</td>
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<tr>
<td>4. Client fees that revert to State or other governmental agencies and are not available for expenditure by this organization.</td>
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<tr>
<td>5. Medicaid</td>
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<tr>
<td>Include Federal, State and local share.</td>
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<tr>
<td>6. Medicare</td>
<td></td>
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<td>7. Other Federal</td>
<td></td>
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<tr>
<td>8. Local government</td>
<td></td>
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<tr>
<td>Include payments from county, city and city-county governments and district/regional authorities</td>
<td></td>
</tr>
<tr>
<td>9. Contract funds from other nongovernmental organizations for the provision of mental health services by your organization.</td>
<td></td>
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<tr>
<td>10. All other sources, not elsewhere classified</td>
<td></td>
</tr>
<tr>
<td>Include: foundation bequests, individual trusts, gifts, and contributions of cash or liquid assets, United Fund, Mental Health Association and other charitable campaigns. Exclude value of in-kind services.</td>
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</tr>
<tr>
<td>11. TOTAL FUNDS (1+2+3+4+5+6+7+8+9+10=11)</td>
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COUNCIL ON ECONOMIC AFFAIRS

Status Report

On

Developments In the Health Care Industry

(As of April 1988)

Office of Economic Affairs
American Psychiatric Association
STATUS REPORT OUTLINE

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VII. PSYCHIATRIC PROVIDER ORGANIZATIONS

An emerging area of alternative delivery schemes are organizations establishing to provide only psychiatric and substance abuse care or consultation/management services to developing organizations. There is not an extensive amount known about these firms at this time other than they are aggressively marketing their programs.

- **Admar Corp.** (Orange, California) has established a PPO of psychiatric and chemical dependency treatment providers in Southern California. The health benefits company has contracted with 25 psychiatric care and chemical dependency treatment providers in California. Operation should begin by 1987 including 150 providers. The PPO providers will offer inpatient and outpatient programs, intensive day care and community-based programs.

- **Alliance Alternative Delivery System Corp.** a subsidiary of Norfolk, Virginia-based Alliance Health System, has been awarded a 17.5 million demonstration contract from the Defense Department, to provide mental health services to military dependents and retirees in Virginia’s Tidewater region. Alliance will be available to the enrollees October 1, 1986. Alliance, a civilian company, contracted under a capitation basis, will service beneficiaries of the military’s Civilian Health and Medical Program of the Uniformed Services, CHAMPUS. Physicians under contract must agree to utilization and quality controls contained in their contracts.

- **Ambulatory BIODYNE Centers** (San Francisco, California) offers a program of outpatient psychotherapy and lifestyle management programs. It is currently known to be marketed through Blue Cross and Blue Shield of Arizona, with centers in Phoenix and Tucson.

- **American Psych Management** (Washington, D.C.) designs and manages programs for psychiatric care and substance abuse. The programs are provided through a review system, a PPO of therapists, psychiatric inpatient facilities and specialized outpatient programs. Clients include HMOs, insurance companies and self-insured groups. There are more than 650,000 people from coast to coast enrolled in these programs.

- **Bethesda Provider Organization** (Englewood, Colorado) has been formed to offer mental health and chemical dependency services to employers in the Denver area. The PPO is a hospital/psychiatrist/Ph.D. joint venture. BPO has been operating for approximately 9 months. Currently, 15,000 persons have the PPO option available to them. The BPO program features include preadmission certification, concurrent,
retrospective and ambulatory utilization review. BPO provides mental health services on an inpatient or outpatient basis. Outpatient care is available for patients who need treatment for acute and recurrent behavior problems, drug and alcohol abuse, eating disorders, mental and family issues and other similar problems. Inpatient care is ordered when a patient’s behavior becomes suicidal, homicidal or out of control. Other services include 24-hour emergency service and vocational rehabilitation. BPO provides employers with utilization review services, monthly management reports and claims processing services. Benefit levels can be custom designed.

- **California Preferred Providers, Inc.** is a not-for-profit PPO in Santa Barbara, California, and started operating in December, 1983. There are two psychiatrists and 13 psychologists on contract—they all have their own private practices. Contract rates are negotiated individually. The PPO provides a wide range of services besides mental health. It is sponsored by 250 M.D.s and six hospitals. All providers pay a fee to join and M.D.s pay a monthly administration fee of $50. Subscribers have a wide range of deductibles and copayment provisions.

- **California Wellness Plan** (Santa Monica, California) is an exclusive mental health provider plan. CWP, a licensed HMO, is a prepaid mental health care program available to employers which utilize the services of psychiatrists, psychologists, social workers and qualified social service agencies. Recognizing that mental health was a costly component in the delivery of the indemnity programs, CWP developed a program marketing the facts that a majority of health care sought by patients was more a need for psychological rather than physiological care. Focusing on outpatient benefit programs as a preventive health care and cost-containment mechanism, the program provides an information referral arm that serves as a built-in employee assistance program. An estimated 250-400,000 lives are under the plan.

- **California Psychological Health Plan**, established in 1975 and based in Los Angeles, California, is a prepaid mental health care program designed to allow employers to offer mental health services to employees as a component of their existing health insurance package at little or no additional cost to the employer. Panel providers are psychiatrists and licensed psychologists who have contracted with CPHP to provide outpatient care services to subscribers, subject to review by a Professional Standards Management Committee comprised of peers.

- **Capitations Payment System** New York now offers a mental health HMO which will be a revision and edified version of the existing state and county employees mental health care system. Integrated Mental Health, a non-profit corporation will administer CPS. Capitation payment will be calculated to
provide care at three levels, — $40,000 to 47,000 a head per year for patients who need hospitalization, $17,000 a head/year for patients in communities in need of inpatient services and $6,000 a head/year for outpatients. 50% of the funding will come from the state, 25% from the counties and 25% from the United Way.

- Community Psychiatric Centers (Santa Ana, California) is the nation’s second-largest independent operator of acute psychiatric hospitals. Analysts report that freestanding psychiatric hospitals have lower costs, ergo, are gaining market share over acute-care hospitals. CPC plans to restructure its corporation into a "limited partnership". Tax reform induced the company to reorganize to receive the greater tax cuts as a limited partnership versus the lower tax reduction allotted to corporations.

- Comprecare (Exploratory) (Newport, California) operates 19 freestanding chemical dependency and psychiatric facilities.

- Health Care Services of America (Birmingham, Alabama) has increased its revolving bank line of credit to $160 million from $120 million. The additional money will be used to finance the development, renovation and expansion of its psychiatric facilities. HSA has 21 psychiatric hospitals under development or in operation. It also operates three free-standing chemical dependency facilities. HSA agreed to acquire Greenleaf Health Systems, Chattanooga, Tennessee. Greenleaf operates four psychiatric hospitals, has one under construction, manages three substance abuse units; and is building five free-standing facilities. HSA anticipates a decline in its third quarter net income.

- Health Industries of America (Nashville, Tennessee) - While not technically an HMO/PPO, they are currently in the process of attempting to establish partial hospitalization alternative service programs.

- HealthWest Foundation (Chatsworth, California) has hired a consultant to help determine whether the not-for-profit hospital system should market a package of mental health services to health maintenance organizations and insurers. HealthWest would assume the financial risk of offering a prepaid, capitated benefit for these services. HealthWest’s system would include the low-cost, 24-hour psychiatric health facilities allowed only in California.

- HelpNet, (Long Beach California) is an HMO management company servicing psychiatric care. Utilization review is conducted in-house.

- Horizon Health Management (Oak Brook, Illinois) specializes in the design, development and implementation of mental health

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programs. The company offers intensive clinical treatment programs, and promotes its innovative management techniques and marketing programs.

- Integrated Mental Health is a private nonprofit corporation that will administer a new HMO program for the chronically mentally ill in upstate New York under a capitation payments system. Provisions for three levels of needed care will be given: for hospitalized patients, patients who only need partial hospitalization, and outpatient services.

- Mediplex (Boston, Massachusetts) is a mental health management company based in Boston. Mediplex is a subsidiary of Avon and was incorporated in April, 1986.

- Mental Health Management, Inc. (McLean, Virginia) is the nation's leading provider of professional services for planning, developing, and managing hospital mental health programs. In 1984 the company began operation of its first freestanding facility, Oakview Treatment Center, a 35-bed drug and alcoholism treatment center in Ellicott City, Maryland. MHM Inc. currently manages 85 psychiatric units, and owns three psychiatric hospitals. MHM entered a joint venture with Parkside Health Plan of Chicago and will act as a PPO for psychiatric care for approximately 750,000 enrollees.

- Mental Health Provider of Northern California, Inc. (Walnut Creek, California) is a physician-sponsored PPO operated by psychiatric benefits in developing health plans by:
  1. Emphasizing that many of the needs, issues, and problems regarding the field of psychiatry are unique and best considered separately from other medical specialties.
  2. Developing a variety of psychiatric benefit packages or both inpatient and outpatient care.
  3. Advocating that utilization review, peer review, and standards of psychiatric care can be formulated by practicing psychiatrists.
  4. Providing psychiatrists ready access not only to current information but to planning process regarding those matters affecting psychiatric practice.

- Metropolitan Clinics of Counseling (Minneapolis, Minnesota) MCC Companies offer MCC a full risk capitated mental health and substance abuse service. In operation for twelve years, the plan serves more than 600,000 lives. A full range of mental health and substance abuse benefits can be made available to any covered group for about 4%-5% of total premium.
Metropolitan Milwaukee Psychiatric IPA (Milwaukee, Wisconsin)Eigen & Associates, a marketing firm specializing in health care, assisted in the merging of two IPAs, the Milwaukee Psychiatric Hospital IPA and the Waukesha Elmbrook Mental Health (AODA) IPA to form Metropolitan Milwaukee Psychiatric IPA. Currently there are 60 physician members and contracts to serve about 100,000 people through six HMOs.

Preferred Health Care, Ltd. (New York, New York). The company’s Psychiatric Case Management (PCM) is a preadmission and concurrent review service for psychiatric-related cases and is touted as the largest psychiatric case management company in the country. Currently, PCM estimates that over 5 million beneficiaries are covered under this program. Clients of the PCM program include major insurance companies such as Equitable Life Insurance, Provident Life and New York State’s Empire Blue Cross and Blue Shield, corporations such as Merrill Lynch, Miller Brewing Company, GTE and Ciba-Geigy, as well as state and local governments. C&S Banks of Atlanta reported a 243% decrease in psychiatric expenditures resulting from PCM’s services.

Preferred introduced Preferred PsychCare, Preferred Health Care Ltd. and VHA Enterprises will jointly market and offer PsychCare, which offers a comprehensive psychiatric care program. The company recently agreed with Blue Cross Blue Shield of Michigan to provide PsychCare to BC/BS clients. The program will offer negotiated rates for mental health and chemical abuse services at VHA’s managed-care program, PARTNERS National Health plan. PsychCare estimates over 600,000 beneficiaries are covered under their program. PsychCare System acts as a provider network, providing EAP referrals, triage, and aftercare evaluation at risk or partial risk. Their first contract started in January 1987 with GTE Corporation. Based on a prospective payment system the plan will be comprised of the following: a capitation rate, concurrent and retrospective review, peer review, a provider criteria based on performance evaluations of quality care, a full range of psychiatric services and a detailed reporting system monitoring utilization trends. The company has joined with Equitable Life Assurance Society.

Psychological Networks (New York, New York) A nationwide network of psychologists have incorporated their services to offer employers psychological services for their employees as a preventive health care measure. The company is targeting companies that offer employee assistance programs. The program screens each individual in order to assess the problem and make an appropriate referral to a provider specializing in a particular area. In addition, the wellness program aims to
inform employees of measures useful in solving problems before they reach a crises level. Lecture series by representatives in the field of behavioral management of drug abuse, and stress reduction seminars are available to help reduce both medical and benefit costs associated with employee stress, low productivity, high absenteeism and workforce turnover.

Psychiatric Providers of Georgia, Inc. (Atlanta, Georgia) is a for-profit PPO. It became operational in July, 1983, and utilizes an IPA model. Charles Hendry, M.D., is the medical director, and there are six psychiatrists, six psychologists, six social workers and six masters-level general counselors on the staff. All the mental health professionals get referrals from the PPO and maintain their own private practices.

According to Hendry, the six psychiatrists put up the money to form the PPO. All the marketing, mainly to small and medium-sized businesses and organizations, is through an HMO-the Georgia Medical Plan. In general, the HMO pays a fee to have groups of patients covered for mental health services and each patient pays a 50% copayment directly to the PPO. Psychiatrists are paid part of the capitation fees and receive a share of copayments. Other providers are paid on a fee-for-service basis—at a rate that is $10 an hour less than the usual and customary fee. Most contracts of 20 outpatient visits a year from the HMO use the federal standard. The PPO also has arrangements with hospitals for providing services at a discount.

The Psychology Management Systems Health Plan, Inc. (Milpitas, California) is an HMO which offers psychological services treatments and inpatient psychiatric reviews. Employers can offer PMS's specialized psychological services by carving out the mental and nervous provision of their existing benefits package. There are about 500 participating physicians in the plan and PMS is marketed in California and 13 other states including Arizona, Colorado, Indiana, Georgia, Massachusetts, Texas, and Virginia. PMS limits the number of questionable inpatient treatment days and makes recommendations for less costly outpatient treatment through its Professional Review Organization. The reviews are conducted by a statewide panel of review doctors.

Westfall Psychiatric Associates (WPA) (Rochester, New York) is a partnership of psychiatrists who have "grouped" to serve two segments of the population: the growing number of patients in HMOs who will be treated for mental illness through a prepaid contract, and alcohol/drug dependent patients. In 1983, Joseph Messina, M.D., management partner and co-founder of WPA, joined with a group of his colleagues who recognized that cost-containment activities taking place in their community were changing the nature of psychiatric services. The main
difference between the WPA-developed treatment program and existing ones in the community is that services traditionally available in hospital mental health centers — to a limited degree — are offered in a private setting. WPA saw the need for a program to intensively manage acute psychotic cases outside the hospital setting. Also, WPA plans to develop an advisory board of experts in alcoholism and chemical dependency, and will hire social workers to provide counseling in a psychiatrist-supervised program of treatment.

- Rochester Managed Mental Health Care System, (no details available at this time.)

- The Psychological Health Plan, Inc. (TPHP), is a health care management firm which coordinates the outpatient and inpatient services of a network of preferred mental health providers. The network includes clinical social workers, psychologists and psychiatrists as participating providers. Although it may assume financial risk in the provision of mental health services it is not an insurance company. TPHP assures rapid reimbursement through intense utilization review which includes preadmission certification of hospital admissions and a second opinion program. TPHP has developed a multi-disciplinary PPO with a network of 200 mental health professionals in independent practice and several general and psychiatric hospitals. The program currently covers (90,000) employees and their dependents.

- National Psych Reviews A corporation conceived, owned, and operated by mental health professionals, for multidisciplinary peer review and case management of the full spectrum of mental health service: pre-admission certification and concurrent review, retrospective review, concurrent review of out-patient treatment, review of alcohol and chemical dependency services, claims analysis, quality assurance reviews, comprehensive consulting capability focused on mental health benefits and services, preferred provider contracting arrangements.

- Southeastern Wisconsin Medical and Social Services (Milwaukee, Wisconsin) is a for-profit PPO offering psychiatric services, conducting utilization review in-house and through contracting services.

- Southwest Health Plan (Austin, Texas) a psychiatric PPO providing services at a discounted rate, conducting utilization review, and planning to incorporate retrospective and outpatient review programs.

- Universal Health Services, Inc. a multihospital company in King of Prussia, and Philadelphia American Life Insurance Company, (PALICO), in Houston, entered a joint venture. The companies offer Universal Health Share, a group health indemnity plan with a PPO option.
Introduction

The Inventory of Mental Health Organizations is the questionnaire used by the National Institute of Mental Health (NIMH), in cooperation with the State Mental Health Agencies and the National Association of State Mental Health Program Directors (NASMHPD), to survey mental health organizations. The inventory is designed for all organizational providers of inpatient, residential or ambulatory mental health services, with the exception of general hospital psychiatric services. Public and private psychiatric hospitals, V.A. hospitals and clinics, outpatient mental health clinics, residential treatment centers for emotionally disturbed children, mental health day/night organizations, and multiservice mental health organizations are included.

Only organizations which directly provide services primarily to persons with mental disorders should be included. Organizations which may provide services to some persons with mental disorders, but which primarily serve other disability groups such as mental retarded/developmental disabilities, alcohol or drug abuse should be excluded.

Definition of a Mental Health Organization

Please read the definition of a mental health organization below. If your organization meets this definition, please complete the form. If your organization does not meet this definition, please check the box in Question A and return the form without completing the remaining items. The definition of a mental health organization is as follows:

Any administrative and functional structure of one or more service units and a grouping of persons within this structural entity, defined by law, charter, license, contract, or agreement to directly provide mental health services to persons for the purpose of preventing, identifying, reducing, or stabilizing mental disabilities. Specific requisite criteria are as follows:

1. A formal organization established by law, regulation, charter, license, or agreement
2. An established organizational structure including staff
3. A primary goal for all or part of the organization of improving or maintaining the mental health of its clientele
4. A clientele with psychiatric, psychological, or associated social adjustment impairments or who seek to prevent these impairments from developing
5. Direct provision of mental health services beyond room and board.

Instructions and Definitions

Before completing the form itself, read the directions on the computer-generated cover sheet and make corrections, additions, and updates to that sheet.

QUESTION C. WHETHER OR NOT PART OF A CHAIN

An organization should be listed as part of a chain if the organization which owns or controls it (parent organization) operated at least one other mental health organization. The parent organization may also operate other types of organizations, such as medical facilities.

QUESTION D. RELATION TO STATE MENTAL HEALTH AGENCY

In terms of funding, each box should be checked either yes or no. Box a should be checked “yes” if the organization directly receives State Mental Health Agency funds exclusive of Medicaid (e.g., grants in aid, contracts, purchase-of-service agreements). Box b should be checked “yes” if the organization indirectly receives funds from the State Mental Health Agency through an intermediary, such as a county or community mental health board, exclusive of Medicaid (e.g., grants in aid contracts, purchase-of-service agreements). Box c should be checked “yes” if the organization receives State Mental Health Agency exclusive of Medicaid. Box d should be checked “yes” if the organization does not receive State funds of any kind exclusive of Medicaid.

QUESTION E. TYPE OF ORGANIZATION

1. An outpatient mental health clinic is an organization which provides only ambulatory mental health service on either a regular or emergency basis. The medical responsibility for all patients/clients and/or directions of the mental health program is generally presumed as psychiatrist.
2. A psychiatric hospital (public or private) is an entity either operated as a hospital by a State (e.g., State mental hospital) or licensed as a hospital by the State (e.g., private psychiatric hospital) which is primarily concerned with providing inpatient care to mentally ill persons.
3. A residential treatment center for emotionally disturbed children must meet all of the following criteria:
   a. It is an organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for its patients/clients.
   b. It has a clinical program within the organization which is directed by either a psychiatrist, psychologist, social worker or psychiatric nurse who has a master’s and/or a doctorate degree.
   c. It serves children and youth primarily under the age of 18.
   d. The primary reason for the admission of 50 percent or more of the children and youth is mental illness which can be classified by DSM-II/ICDA-8 or DSM-III/ICD-9-CM codes, other than those codes for mental retardation, substance (drug) related disorders, and alcoholism.
4. Other residential organization (not elsewhere classified) is a freestanding organization that provides only residential treatment or only residential supportive services and meets the criteria of a mental health organization (see definition on page 1 of instructions).
5. A mental health partial care organization is a freestanding organization offering only day or evening partial care.
6. A multiservice mental health organization is an organization that directly provides two or more of the program...
elements defined under Question G below and is not classifiable as a psychiatric or general hospital or as a residential treatment center for emotionally disturbed children.

To be considered part of a multiservice mental health organization a program element must be under the direct administrative control of the organization. (See instructions for Question G below.) Administrative control includes financial and staffing and clinical and programmatic responsibility.

Community mental health centers (CMHCs) should be classified according to the additional criteria specified below:

a. A CMHC, whether federally funded or not, that is not part of a general or a psychiatric hospital should be classified as a multiservice mental health organization.

b. A CMHC, that is part of a general hospital should be classified as a general hospital with a separate psychiatric service. If your organization is classified as a general hospital do not complete a form, but instead send the form back with a note indicating that the organization is a general hospital. Such organizations will be included in an NIMH Inventory of General Hospital Mental Health Services.

c. A CMHC, whether federally funded or not, that meets the above criteria for a multiservice mental health organization and is part of a psychiatric hospital should be classified as a psychiatric hospital.

QUESTION G. TYPES OF PROGRAM ELEMENTS

Check all program elements that are under the direct administrative control of your organization. Administrative control includes financial and staffing and clinical and programmatic responsibility. Any program element that provides services through contract or agreement to your organization but is not under the direct administrative control of your organization should be excluded.

Definitions of Program Elements within mental health organizations.

Inpatient care — 24-hour care in a hospital setting.

Residential treatment care — Overnight care in conjunction with an intensive treatment program in a setting other than a hospital. Examples of residential treatment programs would be residential treatment centers for emotionally disturbed children; residential treatment centers for the mentally retarded; residential treatment centers for mentally ill adults.

Residential supportive care — Overnight care in conjunction with supervised living and other supportive services (e.g., halfway house, community residence, group home). Excludes programs which provide only room and board.

Partial care — A planned program of mental health treatment services generally provided in sessions of 3 or more hours to groups of patients/clients.

INCLUDE: (1) day/evening treatment programs, that is, treatment programs which place heavy emphasis on intensive short-term therapy and rehabilitation; (2) day/evening care programs which focus on sustained, maximization, or socialization through recreation, and/or occupational activities, etc., including sheltered workshops, and (3) education and training programs in which the focus is on change through an integration of education, habilitation, and training including special education classes, therapeutic nursery schools, habilitation and vocational training.

Outpatient care — Mental health services to ambulatory clients/patients generally provided for less than 3 hours at a single visit, on an individual, group, or family basis, usually in a clinic or similar organization. Includes ambulatory emergency care in a planned program to provide psychiatric care in emergency situations by staff specifically designated for this purpose.

QUESTION H. CLIENT/PATIENT CHARACTERISTICS: END OF YEAR CENSUS BY PROGRAM ELEMENT

For the inpatient, residential treatment and residential supportive program elements indicated in Question G, enter the number or patients actually in residence in the programs on the last day of the reporting period. If the census was taken on another date or was the average daily census during the reporting period, indicate that date and use those data. For outpatient and partial care program elements indicated in Question G, enter the number of clients on the active rolls of the program on the last day of the reporting period. If the roll count was made on another date during the reporting period, indicate that date and use those data. The active rolls include all patients who have not been removed through discharge or death and who have received a service within the last 90 days.

a. Age Group — Categorize clients/patients according to the age they reached during the reporting period.

b. Racial/Ethnic Group — This category should be based on the patient's self-classification, where appropriate and feasible. It may also be based on observation. In practice, it will ordinarily reflect information available in records or statistical reports. Specific categories are as follows:

- White (not Hispanic)
- Black (not Hispanic)
- Hispanic—A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
- Native American—American Indian or Alaskan Native Asian or Pacific Islander
- Unknown—Report as unknown only after a reasonable effort has been made to obtain a specific category

c. Major Disability Group — This item should be based on the principal psychiatric diagnosis as defined by aggregate diagnostic group shown on the form. The most recent available information on diagnosis should be used.

Mental or Emotional Illness—Include patients with any DSM-II/ICDA-8 or DSM-II/ICD-9-CM psychiatric diagnoses or their equivalents, except for patients with principal diagnoses included in other categories in this section. Also include here clients/patients who are being treated or evaluated in programs primarily for persons with mental or emotional problems whose diagnosis is undetermined or who are undiagnosed.

Mental Retardation/Developmental Disability—Include patients with a principal diagnosis of mental retardation or developmental disability. This includes autism.
cerebral palsy, neurological impairments and other developmental disabilities. Also include here clients/patients who are being treated or evaluated in programs primarily for persons with mental retardation or developmental disabilities whose diagnosis is undetermined or who are undiagnosed.

Alcohol/drug abuse—include clients/patients with a principal diagnosis of alcohol or drug abuse or addiction. Include those with mental disorders due to alcohol or drug use. Also include here clients/patients who are being treated or evaluated in programs primarily for persons with substance abuse problems whose diagnosis is undetermined or who are undiagnosed.

Other—include those who do not have mental health diagnoses and who are not included in one of the above categories.

Unknown and undiagnosed—Include those for which the major disability group is unknown or undiagnosed.

d. Prior Mental Health Inpatient Care—Include in the yes' category any patient who had inpatient mental health care at any time prior to his/her most recent admission to the program. Include prior inpatient care in a mental hospital or psychiatric service of a general hospital, regardless of auspices (State, county, voluntary, proprietary, VA, etc.). Prior care in a residential organization should not be included.

QUESTION I. CASELOAD DATA BY PROGRAM ELEMENT: INPATIENT AND RESIDENTIAL CARE SERVICES

Twenty-four hour care in a psychiatric hospital setting should be classified as inpatient care. Overnight care in a setting other than a psychiatric hospital setting should be classified as residential treatment or residential supportive care rather than as inpatient care (see definitions under instructions for Question G).

QUESTION K. NUMBER OF STAFF, SCHEDULED WEEKLY STAFF HOURS, AND STAFF HOURS BY PROGRAM ACTIVITIES

Inclusions for staff categories 9-12 of Question K.

9. Other mental health workers, B.A. and above:
   Includes: Psychologists, B.A. level; vocational rehabilitation counselors; schoolteachers; activity therapists (e.g., art, dance, psychodrama, vocational, and recreational therapists); other mental health workers, B.A. and above.

10. Other mental health workers, less than B.A.:
    Includes: Licensed practical and vocational nurses; aides; orderlies and attendants; all other mental health workers with less than a B.A.

11. Other physical health professionals and assistants:
    Dentists and dental assistants; dietitians, pharmacists and assistants; and other physical health professionals.

12. Administrative and support staff:
   Includes: Medical record administrators and technicians; accountants; business staff; and clerical and maintenance staff.

Columns 1-6

Report all staff working for this mental health organization all of its treatment and administrative locations, including its direct patient care, administration, and support activities such as pharmacy and research. Include staff who work directly for this mental health organization on a contractual ba. Exclude staff who work directly for another mental health organization regardless of who pays them.

In columns 1 through 6, report staff paid by this mental health organization, as well as staff working in this mental health organization but paid by an outside source, for example Vocational Rehabilitation or the school system. EXCLUDE volunteers, who should be reported in Question L.

Staff should be counted by discipline and level of training. For example, a psychiatrist who serves as the administrator of the organization should be counted on line 1.

Cols. 1 and 3:
Report the number of full and part-time staff for the reporting week including those who were sick or on vacation. Include consultants only if they work on a regular basis. Include persons working directly for the organization on a contract fee-for-service basis.

Cols. 2 and 4:
Report the total number of scheduled staff hours during the reporting week for staff listed in Cols. 1 and 3. If a staff member usually works during the week, but was sick or on vacation, include in the total the number of hours he or she would have worked if he or she had been present. If a staff member works part-time, but not every week, include in the total an average weekly figure. For example, if a psychiatrist provides 16 hours per month by working one day every other week, include 4 hours in the total as his or her average weekly hours.

Cols. 5 and 6:
Include as trainees those persons in the organization who are receiving a supervised work-learning experience as an integral part of a training program.

Col. 7:
Equals the sum of columns 2, 4, and 6.

Cols. 8-10:
This question asks for a distribution of the number of hours of work scheduled for each staff person during a one-week period. These hours are to be distributed into the 3 major activity categories defined below.

The data to answer this question may be available in your organization's management information system. If not, it may be necessary to gather the data on the basis of the staff activities for a sample 7-day week. The sample period should be the same for all staff. If it is not feasible to conduct such a survey, the percentage distribution among the three categories of staff activities may be estimated for each staff discipline. The percentage distribution of the three staff activities for the sample week may then be applied to the total scheduled hours reported in Col. 7 to derive the hours reported in Cols. 8-10. The preferred procedure is to conduct a 1-week survey.

The data should cover all full-time, part-time and trainee staff of your organization involved in the programs covered in Question G. Include those staff paid on a contract or session
basis, as well as those on salary. Staff working in your organization and under your programmatic and administrative control who are paid by other organizations should also be included.

Definitions of Activities/Services

a. Clinically-oriented services: Services provided to or on behalf of a specific person (client/patient, family, or group) to diagnose and prognosticate (describe, predict and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain or increase adaptive functioning. This includes patient recordkeeping other than those performed by medical record administrators which are included under administrative activities. Travel associated with clinical services is also included.

b. Administrative activities (intra-organizational support-oriented services): Activities, functions, and tasks which are undertaken to support the effective and efficient achievement of the organization's mission, goals, and objectives. The direct recipient of these activities is the organization itself, i.e., the services support the operation of the organization.

c. Other activities —included are:
   - Prevention-oriented services
   - Consultation-oriented services
   - Training-oriented services
   - Research-oriented functions.
   Default all other staff time except leave to this category.

QUESTION L. NUMBER OF VOLUNTEERS AND VOLUNTEER HOURS

Exclude any employees who were reported in Question K. Include only those volunteers working on a regular schedule.

QUESTION M. EXPENDITURES FOR THIS MENTAL HEALTH ORGANIZATION

Exclude: Estimates of the value of in-kind services, a: expenditures for nonmental health programs if data from the programs have not been included elsewhere on the form.

Salaries of Personnel

Include: All costs of fringe benefits including social security taxes, health insurance, life insurance, retirement plan, unemployment insurance, workmen's compensation etc.:

Exclude: Value of in-kind services rendered by volunteer and salaries and benefits of employees of nonmental health programs if data from these programs have not been included elsewhere on the form.

Contract Personnel Expenses

Include: Contract expenses paid for personnel who directly provide services to your organization.

Expenses For Contracts Entered Into With Other Mental Health Organizations For The Provision of Mental Health Services By That Organization

Include: Expenses paid to another mental health organization that provides clinically-oriented services to your clients.
RESEARCH SHOULD NOT BEGIN UNTIL THE PROTOCOL HAS BEEN REVIEWED AND APPROVED BY THE HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD, WHICH MEETS ON A REGULAR MONTHLY BASIS. PROTOCOLS MUST BE RECEIVED BY THE HSIRB CHAIR AT LEAST SEVEN DAYS PRIOR TO A REGULARLY SCHEDULED MEETING IN ORDER TO BE ACTED ON AT THAT MEETING. PLEASE TYPE EACH RESPONSE — EXCEPT SIGNATURES. REFER TO THE WESTERN MICHIGAN UNIVERSITY POLICY FOR THE PROTECTION OF HUMAN SUBJECTS TO DETERMINE THE APPROPRIATE LEVEL OF REVIEW.

PRINCIPAL INVESTIGATOR: Gary Mathews
DEPARTMENT: Sociology
Home Phone: 372-3624
Office Phone: 383-0233/367-3186
Home Address: 3726 Barrington Drive
Office Address: 405 Moore Hall
Kalamazoo, MI 49007

PROJECT TITLE: The Impact of Type of Ownership on Outpatient, Partial Care, and Multiservice Mental Health Organizations in the United States

SUBMISSION DATE: Feb. 24, 1983
PROPOSED PROJECT DATES: April 1 TO Sept. 1, 1983
APPLICATION IS: New Renewal Continuation Supplement

SOURCE OF FUNDING:

Signature of Investigator

STUDENT RESEARCH (Fill out if applicable)
Name of Student: Gary Mathews
Phone: 3-0233
Address: 3726 Barrington Drive
Kalamazoo, MI 49007
The Research is: Undergraduate Level Graduate Level
Faculty Advisor: Morton O. Wagenfeld
Department: Sociology
Phone: 3-1742
Signature of Faculty Advisor

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ABSTRACT: Briefly describe the purpose, research design, and site of the proposed research activity.

Most citizens consider care of the mentally ill a public duty and a government responsibility. A current topic of debate is whether or not mental health care should continue to be provided primarily in the public realm or instead be provided as a business. A question which must be answered as a part of this debate is: Does type of ownership effect service provision, and if so how? In order to answer this question data from the Inventory of Mental Health Organizations, a national survey sponsored by the Survey and Reports Branch, National Institute of Mental Health, Department of Health and Human Services will be analyzed to look for differences in five domains—clientele, size of organization, staffing, expenditures, and sources of funds. This secondary analysis of data will examine three types of mental health organization ownership; private for-profit, private nonprofit, and governmental.

The analysis will be performed here at UMK.
CONFIDENTIALITY OF DATA: Briefly describe the precautions that will be taken to ensure the privacy of subjects and confidentiality of information. Be explicit if data is sensitive.

Only grouped data is to be analyzed. Identifying information will not be included.

BENEFITS OF RESEARCH: Briefly describe the expected benefits of the research.

It is expected that this research will contribute to the ongoing debate about the trend toward for-profit care.

RISKS TO SUBJECTS: Briefly describe the nature and likelihood of possible risks (e.g., physical, psychological, social) as a result of participation in the research.

None

PROTECTION FOR SUBJECTS: Briefly describe measures taken to protect subjects from possible risks, if any.

Only grouped data analyzed.

INFORMED CONSENT: Please attach a copy of the informed consent form. If oral consent will be obtained, describe procedures for obtaining and documenting such consent. (Subject should be given a copy of the consent form).

None needed. Public data.

QUESTIONNAIRES OR INTERVIEW SCHEDULES: If questionnaires, interview schedules, or data collection instruments are used, please identify them and attach a copy of what will be used in the project.

Does not apply.
VULNERABLE SUBJECT INVOLVEMENT (Fill out if applicable)

Research involves subjects who are: (check as many as apply)

1. children
   approximate age __

2. mentally retarded persons
   check if institutionalized

3. mental health patients
   check if institutionalized

4. prisoners

5. pregnant women

6. Other subjects whose life circumstances may interfere with their ability to make free choices in consenting to take part in research

   (Describe please)

LEVEL OF REVIEW: Please indicate here if you think that the research project is exempt from review, subject to expedited review, or subject to full review.

x Exempt (Forward 1 application to IRB Chair)
Which category of exemption applies? # 5

Expedited (Forward 4 applications to IRB Chair)

Subject to Full IRB review (Forward 9 applications to IRB Chair)

Comments:

HSIRB ACTION

1. Exempt

   Signature HSIRB Chair
   Date

2. Expedited  Full

Your application was reviewed and the Human Subject Institutional Review Board (HSIRB) has determined that:

1. The proposed activities, subject to any conditions and/or restrictions indicated in Remarks below, have (a) provided adequate safeguards to protect the rights and welfare of human subjects involved, (b) established appropriate procedure and/or documents to obtain informed consent, and (c) demonstrated that the potential benefits of the research substantially out-weigh the risks.

2. The proposed activities, for reasons indicated in Remarks below do not provide adequate protection for the rights and welfare of the human subjects.

At its meeting on __________, the HSIRB (approved) (provisionally approved - see remarks) this application with regard to the treatment of human subjects. The HSIRB categorized this application as:

1. Involving subjects at no more than minimal risk.

2. Involving subjects at more than minimal risk.

REMARKS.

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TO: Gary Matthews  
FROM: Ellen Page-Robin, Chair  
RE: Research Protocols  
DATE: March 2, 1988

This letter will serve as confirmation that both of your research protocols, "Privatization in the Health and Human Services," and "The Impact of Type of Ownership on Outpatient, Partial Care, and Multiservice Mental Health Organizations in the United States," have been approved as exempt by the HSIRB.
BIBLIOGRAPHY

American Federation of State and Municipal Employees, American Federation of Labor - Congress of Industrial Organizations (AFSME, AFL-CIO), (undated). Government for sale: An examination of the contracting out of state and local services. Washington, DC.


American Federation of State and Municipal Employees, American Federation of Labor - Congress of Industrial Organizations, (1987). When public services go private: Not always better, not always honest, there may be a better way. Washington, DC.


Community Mental Health Centers Act Amendment of 1965, PL 89-105.

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Private psychiatric hospitals step up marketing activities. (1987). *Hospital and Community Psychiatry.* (38) 7, July, 794 and 797.


