

Effective Privatization of a  
Community Mental Health Agency:  
Assessing and Developing an Agency's Readiness to  
Change

*By*

Edythe S. Schwartz

A dissertation submitted to the Graduate Faculty in Social Welfare in  
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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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## Abstract

### Effective Privatization of a Community Mental Health Agency: Assessing and Developing an Agency's Readiness to Change

by

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On July 1, 1997, a county located outside of New York City, became the first in the state to privatize mental health services by creating County Family Services (CFS), a voluntary not-for-profit agency. CFS is additionally unique in that while the social welfare literature emphasizes the negative effects privatization has on staff, clients and services, this did not appear to be CFS' experience. Impressionistically, the agency appeared to flourish after privatization. However, no systematic evaluation had been done to document these positive outcomes.

The purpose of this study is to describe and demonstrate the effects of privatization on CFS and to see if this change did, in fact, result in more efficient and effective service provision. By systematically gathering and analyzing available agency data before, during and after privatization we could better evaluate the effects of privatization on CFS and document whether service provision improved without compromising quality of care. Measures of effectiveness and efficiency used, included diversification of revenues, percent of revenue to gross costs, gross and net unit of service costs, numbers of clients

seen and number of units of service delivered. To see whether improvements came at the expense of quality of care, diagnostic profiles, number and type of social work interventions received, client outcomes and client and clinician perceptions of treatment prior to and after privatization were measured.

One possible explanation for these positive outcomes involved the administrative use of an organizational analogue of Psychiatric Rehabilitation (PR), a clinical philosophy and practice developed by William Anthony to help individuals cope with change. In this context, the PR analogue was used to assess CFS' readiness to change and to develop activities that would help the agency increase its readiness in the areas that required strengthening.

By exploring the process and outcomes of CFS' privatization, this study might help other social work administrators develop organizational practice models that encourage innovation, maximize resources and expand service possibilities.

## Acknowledgements

It is here that I finally get to thank the many people who helped me to undertake and then complete this project. Thanks go first to my fellow students and professors in the Doctoral program who shared their incredible wealth of knowledge and experience and encouraged me with their excitement about my project and my practice experiences. A special thank you goes to the members of my committee, Andrea Savage and Roberta Graziano, for sharing their knowledge and expertise and helping me to reach further for excellence. I would not be here today writing this acknowledgement page if not for the chair of my committee, Irwin Epstein, who with his vast knowledge, his wit and his understanding, helped me across more hurdles than I can begin to list. He is a “gentleman and a scholar” and I consider myself lucky to have had the opportunity to work on this project with him. Irwin always calmly but firmly asked me to dig a little deeper and look a little further resulting in a final product that I am very proud of.

I could not have completed this study without the support of the Board of Directors and staff of the “real” CFS, and the County Commissioner of Mental Health, who offered their expertise and understanding at many bends in the road. Everyone involved in the privatization was always willing to answer my questions and regale me with stories that preceded my arrival on the scene. All of this was important not only for this paper but for my understanding of what people had been through so that I could help them to move on and provide the kind of services that were so needed here.

I would be remiss if I did not thank Bill Anthony for opening my eyes to a very special way of thinking when I first heard him speak about Psychiatric Rehabilitation in the early 1990's. How could such a simple idea... the idea that all people are unique and deserving of success and satisfaction in their lives, be so revolutionary? It was the start of my commitment to putting recovery first and foremost in my practice and that commitment has been unwavering since then.

I would like to acknowledge two important men in my life who although not with us anymore, are certainly sharing this special moment with me in spirit. The first was my administration mentor, Harold Weissman, who taught me almost everything I needed to know about managing an organization. He used to say that we have two kinds of authority. One is the kind that we inherit with our title but the more important one is the authority we earn as we prove to those who follow us that we are worthy of their belief and their loyalty. I have never forgotten that the burden always falls on me to prove that I might be someone worth following. The second is my father Bernie Schwartz, who drove a New York City Taxi cab to support his family and only wanted his children to be well educated so that they could be better than he was. Well, Dad, I got my Doctorate, just as you always wanted, but I'm not so sure that will ever make me better than you.

Lastly, I'd like to thank my family and friends who were always understanding of my inability to take part in various activities because I was "working on my paper", a mantra they heard many times over the last nine years. And especially, to my husband Eddie, who has taken care of me physically and emotionally for the last 32 years and seen me through both high times and low

times. He is a very special man, one who can celebrate my strengths and forgive my limitations. Many times, when I wanted to give up, he just wouldn't let me. He is always right next to me "pushing and shoving", and making me go on. *I could never have done this without you and I can never thank you enough for sticking by me.*

And finally, I dedicate this project to the thousands of people labeled with mental illness who have had to suffer indignities within our mental health system and have managed to recover either with or despite our interventions. I challenge all of us to refuse to believe in chronicity and defeat, and to work in partnership to develop systems of care that are driven by consumers and centered on recovery, rehabilitation and rights protection.

## Table of Contents

Chapter I: Introduction.....	1
Swaying with the Rhetoric.....	2
One County's Experience.....	4
Planning for Change.....	5
Chapter II: History of Privatization.....	7
From Colonial Times.....	7
From The New Deal to the Present.....	8
Rising Conservatism.....	11
Curbing the Power of the Unions.....	11
Managing the Costs of Care.....	13
Chapter III: A Review of the Literature.....	16
Towards a Definition of Privatization.....	16
Provision vs. Production.....	16
For-Profit vs. Not-for-Profit.....	20
Public vs. Private.....	25
Pitfalls of Privatization.....	28
Positive Possibilities of Privatization.....	37
Peril or Possibility?.....	38
Unanswered Questions.....	40
Helping an Agency to Change.....	41

## Table of Contents (con't.)

Leadership: Managing Change.....	47
Chapter IV: Project Goals and Conceptual Framework.....	50
Goals of the Project.....	50
Program Theory.....	51
Conceptual Framework: Similarities in Practice Areas.....	55
Understanding the Paradigm Shift: Psychiatric Rehabilitation	
Theory.....	57
Assessing Readiness for Change.....	61
Developing Readiness to Change.....	64
The Prochaska Model of Change.....	65
Organizational Application.....	67
Planned Change at County Family Services.....	68
Utilizing Psychiatric Rehabilitation to Inform Administrative	
Practice.....	69
Helping an Agency to Change.....	71
Chapter V: Evaluation Research Design.....	73
Designing the Study.....	73
Selecting the Design.....	74
Designing the Data Collection Instruments and	
Data Collection Methodology.....	75
Time Studies.....	76
The Consolidated Fiscal Report.....	76

## Table of Contents (con't.)

Issues of reliability, validity and accuracy.....	78
Client Case Records.....	79
Issues of reliability, validity and accuracy.....	81
Selecting the Sample.....	85
Limitations of the Data-Mining.....	90
Documents and Observations.....	92
Chapter VI: Data Analysis: Assessing and Developing Change.....	95
Documents and Observations.....	95
Assessing CFS' Readiness for Change.....	95
Using Psychiatric Rehabilitation to Assess CFS'	
Readiness for Change.....	100
Need for Change.....	100
Commitment to Change.....	102
Environmental Awareness.....	103
Self-Awareness.....	105
Personal Closeness.....	106
Developing Readiness for Change.....	107
Summary Analysis of the ORRD.....	111
Chapter VII: Data Analysis: Efficiency and Cost Effectiveness.....	112
Introduction to the Analysis of the Consolidated	
Fiscal Report (CFR).....	112
Diversifying Revenue Streams.....	113

## Table of Contents (con't.)

Decreasing the Cost of Service Delivery.....	120
Increasing Productivity.....	122
Summary Analysis of CFR Results.....	127
Chapter VIII: Data Analysis: Quality of Care.....	129
Introduction to the Clinical Data-Mining Analysis.....	130
Characteristics of the Population.....	131
Payor Source.....	131
Referral Source.....	133
Diagnosis.....	135
Functional Ability.....	138
Presenting Problems.....	141
Clinical Interventions.....	143
Staff Development.....	144
Client Outcomes.....	145
Perception of Treatment Effectiveness.....	150
Summary Clinical Data-Mining Results.....	154
Chapter IX: Next Steps.....	156
Next Steps for Privatization.....	156
Next Steps for CFS in Evaluating Privatization.....	157
Next Steps for Psychiatric Rehabilitation as Administrative Practice.....	158

## Table of Contents (con't.)

Appendices.....	161
Appendix A: Organizational Rehabilitation Readiness Determination.....	161
Appendix B: Data Extraction Form/Consolidated Fiscal Report....	163
Appendix C: Data Extraction Form/Clinical Data-Mining.....	164
Appendix D: Organizational Logic Model.....	166
Appendix E: Code Book for Clinical Data-Mining.....	167
References.....	169

## List of Tables

Table 1:	A Paradigm Shift in Clinical Practice.....	59
Table 2:	Primary Payor Source.....	132
Table 3:	Referral Source and Length of Stay.....	134
Table 4:	Client Mental Illness Diagnosis.....	137
Table 5:	Factors Affecting Functional Ability.....	139
Table 6:	Presenting Problems at Intake.....	142
Table 7:	Number of Treatment Recommendations and Clinical Interventions.....	144
Table 8:	Treatment Goal Attainment Prior to and After Privatization.....	146
Table 9:	Reasons for Termination.....	147
Table 10:	Use of Hospital, Emergency and Crisis Service Prior to and After Privatization.....	148
Table 11:	Initiator of Termination.....	149
Table 12:	Client's Perception of Treatment Prior to and After Privatization.....	150
Table 13:	Clinician's Perception of Treatment Prior to and After Privatization.....	152

## List of Figures

Figure 1:	Program Theory Model: Privatization of CFS.....	52
Figure 2:	Forces Affecting the Creation of CFS.....	96
Figure 3A:	Sources of Agency Revenue Prior to Privatization (1995).....	114
Figure 3B:	Sources of Agency Revenue After Privatization (1999).....	114
Figure 4:	Comparison of Medicaid Revenue Prior to, During and After Privatization.....	117
Figure 5:	Comparison of Revenue Sources Other Than Medicaid.....	118
Figure 6:	Percent of Revenue to Gross Costs Prior to, During and After Privatization.....	120
Figure 7:	Comparison of Gross and Net Unit of Service Costs Prior to, During and After Privatization.....	121
Figure 8:	Total Units of Service Delivered Prior to, During and After Privatization.....	123
Figure 9:	Total Number of People Served Prior to, During and After Privatization.....	124
Figure 10:	Comparison of Units of Service per FTE Prior, to During and After Privatization.....	126

## Chapter I

### *Introduction*

Whether we like it or not, change, whether personal or organizational, appears to be inevitable. Our practice as social workers is based on the understanding that some level of change is always occurring or needs to occur. Weinbach (1998) and Huber and Glick (1995) offer some compelling reasons for managers to concentrate on organizational change. They point out that all members of our society depend in some way on the goods and services that organizations provide. Therefore, our health and well-being and the quality of our lives, are directly related to the responsiveness and capacity to change of these organizations. They also state that changes in these organizations affect all of us and by understanding and influencing these changes, we have an opportunity to “create a world more to our liking” (Huber and Glick, 1995, p. 12).

Change can be innovative even though it is often disruptive, but change “is essential for growth and ever improving services to clients” (Weinbach, 1998, p. 295). However, as Martinez-Brawley (1995) points out, “innovations are frequently perceived, almost by definition, as potentially disruptive and as such are often ignored in organizations, and innovators are frequently regarded as discontents or deviants whose ideas and processes, though at times successful, do not deserve systematic study and attention” (p. 671).

Throughout the last two decades of increasing political and fiscal conservatism, the idea of privatization has developed momentum as a viable option for state and local governments to get out of the business of providing for

those members of society who are least able to provide for themselves.

Privatization of services creates organizational change and the outcome of that change, whether it is successful innovation or perceived disaster, is the topic of fierce debate.

The shift from public to private control of services and service provision, although often presented in this country as an economic issue concerned with creating a more effective and efficient mechanism for service provision, has also been used as a political tool. Some politicians favor privatization to downsize government, save local money, and weaken the power of labor unions. Others point to the government's inability to provide productive, efficient, state of the art services in our current highly competitive marketplace and suggest privatization as a way to improve service provision. In speaking of government, Gibelman (1998) suggests that, "the system itself has become the identified problem" (p. 1). In any case, when talk of privatization occurs, it is often accompanied by fierce rhetoric from all sides. However, supporting evidence for any claims of better or worse service provision appears to be scarce.

#### *Swaying With the Rhetoric:*

The very word *privatization* unfortunately summons forth images from a deep reservoir and causes misunderstanding, premature polarization, and shrill arguments that are beside the point more often than not. Some read into the word a plot to restore a completely free market, with overtones of dog eat dog, exploitation of the weakest, and survival of the fittest. Others interpret the word

as an attack on government and the things government has been doing; direct beneficiaries of government programs, including employees, may therefore defend their self-interest by attacking privatization. Still others are provoked by the term because they see it as an attack on the ideals they cherish. *Public* to them denotes brotherhood, sharing and community, and they mistakenly interpret *private* to mean the negation of these important values.

(Savas, 1987, p. 277)

Alternatively, some predominantly non-social work authors, (Bendick, 1989; Gurwitt, 2000; Karger and Stoesz, 1998; LaFaive, 2000; Melese, 2005; Osborne and Gaebler, 1992; Richardson and Gutch, 1998; Sanger, 2001; Savas, 2006; Stoez, 1994) see privatization as an opportunity for expansion of services through cost containment and effective and efficient service delivery. Waters (1987) states that “the real issue is between private (competitive) and public (noncompetitive) production. Who gets the output is a separate issue, an issue of public finance” (p. 60).

Radical critics (Abramovitz, 1986; AFSCME, 2006; Bell-Lowthar, 1988; Dumont, 1992; Dumont, 1996; Fabricant and Fisher, 2002; Sclar, 2000; Smith and Lipsky, 1993; Starr, 1989) see privatization as a political tool of a conservative government, consistently trying to decrease the size and scope of the welfare state. They feel that the private agency’s pressure for cost containment, accountability, efficiency and productivity can generate serious concerns for social workers and service recipients.

### *One County's Experience*

On July 1, 1997 a county located 1-½ hours from New York City became the first county in New York State to privatize its mental health services by creating a voluntary not-for-profit agency, which I will call County Family Services (CFS). At the point of privatization, I became this new agency's first Executive Director. What makes the experience of CFS unique and worthy of further exploration is that, while most of the social welfare literature reviewed centered on the negative effects that privatization has had on staff, clients and services, this has not appeared to be the experience at CFS since the privatization. In fact, from my position as Executive Director, my impression was that CFS has flourished, with increased productivity, cost-effectiveness and efficiency, good staff morale and innovative new programming. My perception was that the client population did not seem to have changed markedly, access appeared to have improved and both staff and clients seemed to be consistently satisfied with the services. However, no systematic evaluation has ever been done to document the achievement of these positive outcomes. More generally, privatization presented an opportunity for massive organizational change within CFS, and it's worthy of study to attempt to assess if that change process created results that differ from the dire images found in the literature. Findings from this study can be used to help other administrators to better prepare for and manage change.

The purpose of this study is to explore and describe both the positive and negative effects of the privatization on this community mental health agency and to see if this profound organizational change resulted in more efficient and

effective service provision for CFS and its clients. In studying the agency's experience, this research utilized data and observations gathered before, during and after the privatization to try to understand the multiple and complex effects of privatization on CFS and to begin to compare CFS' experience to the experiences of other agencies in the literature (Patton, 1990). "Vicarious experience is an important basis for refining action options and expectations" (Stake, 1994, p. 245). By exploring and describing the changes CFS experienced as a result of privatization, this study might help social work administrators to sort out the positive and negative aspects that this form of organizational change engenders and develop successful practice models that encourage innovation, maximize resources and expand service possibilities.

### *Planning for Change*

In the 1990's, I first learned about Psychiatric Rehabilitation theory while New York State was promulgating this philosophy and practice in order to facilitate a change in its service delivery system (Anthony, 2000; Anthony, Cohen and Farkas, 1990; Anthony, Cohen, Farkas and Gagne, 2002; Anthony and Lieberman, 1986; Cohen, 1989; Farkas, Gagne, Anthony and Chamberlin 2005). The New York State Office of Mental Health was trying to retrain staff, in an effort to shift from a medical model to a recovery-based model of care provision. Part of the practice of Psychiatric Rehabilitation is to assess an individual's readiness to change, intervene to increase that readiness if needed, and increase the skills and supports that the individual needs to function successfully in the community (Anthony, Cohen, Farkas and Gagne, 2002). Relying on Morgan's (1997) theory

that organizations are living organisms, I assumed that we should be able to use techniques analogous to those that are used to assess an individual's readiness to change to assess an organization's readiness to change.

In this study, I will describe how I utilized Psychiatric Rehabilitation practice as an organizational tool to help assess and develop CFS' readiness to engage in the process of privatization. I offer this application of a clinical intervention as administrative practice as one possible tool that may have informed my management practice as I led CFS through the difficult transition of privatization; and if the effects of privatization were positive, as one possible explanation. Within this study, I will describe the implementation of Psychiatric Rehabilitation as administrative practice to assess this Agency's readiness to engage in change during the planning for the privatization, and I will indicate some of the mechanisms employed to increase the Agency's readiness for change during the early years after the privatization. Privatization is a complex organizational change process and, as such, an understanding of Psychiatric Rehabilitation as a theory of change may provide one useful framework for understanding the changes that occurred at CFS during and after privatization.

As the first Executive Director of this newly privatized agency, I had a major stake in assuring the success of CFS' transition and as such, cannot know how much of the picture of this agency's experience might be biased by my own administrative involvement. Other than the hard facts of the time studies conducted, there is a degree of built in bias in the interpretation of research results that most likely cannot be totally eliminated.

## Chapter II

### *History of Privatization*

#### *From Colonial Times*

Privatization is not a new concept. From early in our nation's history, public funding of private sector giving was common (Abramovitz, 1986; Dukakis, 1998; Fabricant and Fisher, 2002; Gibelman, 1998; Kammerman and Kahn, 1998; Megginson and Netter, 2001; Naff, 1991; Trattner, 1974). Wedel (1976) points to purchase of service contracting practiced in Colonial times and continuing in various degrees throughout the history of social welfare. In the Colonial era, public relief, based on the English Poor Laws, provided a safety net for the most indigent citizens and those who were too infirm to care for themselves. However, the public domain was slow to accept all of the responsibility for the poor and shared the care of those in need with the church, private philanthropy, and mutual aid societies. In the 19<sup>th</sup> century, as a result of the work of reformers attempting to respond to abuses in the early system of public relief, humanitarian aid increased from government and non-government sources. Both religious and non-sectarian organizations, funded through private charity and through contracting by the states, provided alternatives to the publicly funded poor relief for the "worthy poor" who might improve their lives and therefore be deserving of rescue (Kammerman and Kahn, 1998). Even at that time, contracting with the private sector for services seemed more cost effective than building more public facilities (Gibelman, 1998).

Gibelman describes a study conducted by Amos Warner in the 1890's in which Warner summarized the pros and cons of government subsidies to the private sector for the provision of charitable services and found that it looked strikingly like the current arguments for and against privatization. On the pro side, he cited cost savings, better quality of care, more professional business operations and fewer stigmas for the poor and aged who accessed services. Arguments against subsidies included loss of public control and waste and duplication of services. Services were far from perfect in these times and arguments about quality of care at public as well as privately run institutions continued to rage throughout the years that followed. Despite the debate, however, government subsidies of private organizations continued until the 1930's, when funding arrangements began to shift and there was a substantial increase in the number and variety of purchase of service arrangements that began to be developed (Gibelman, 1998).

#### *From The New Deal to the Present*

Only during the Depression, when the needs of the public became so great and so overwhelming, did government, once again, begin to provide more services directly. During the Depression "voluntary charity simply could not cope with the situation; only public agencies could deal with the collapse of the economy and mass unemployment" (Trattner, 1974, p. 228). During the 1930's, for the first time, government expenditures for social welfare exceeded those of the voluntary sector (Wedel, 1976). In addition, after the Depression, increasing public spending was thought to be a way to stimulate the economy by creating a

productive workforce, increasing consumer spending and assuring social stability (Bell-Lowther, 1988).

From the New Deal through the 1960's, government production of services steadily increased, fueled by economic prosperity, growth of trade unions and the growing civil rights movement. The social welfare budget rose from \$3.9 billion in 1929 to \$52 billion in 1960. Membership in public employee unions grew from 1 million in 1956 to 4.5 million in 1970 (Abramovitz, 1986). Several amendments to the Social Security Act enlarged government's role in funding and monitoring services to a rapidly increasing needy population. During this time, privatization expanded as private, mostly not-for-profit, groups vied for a piece of the increased government spending, offering to provide local grass roots answers to community problems. Lourie (1979) contends that during this turbulent time in our history, decentralization and local community control were advocated to avoid the abuses of a large and distant government.

During the War on Poverty, The Economic Opportunity Act of 1964 created local Community Action Programs (CAPs), which were an attempt to address poverty through small innovative local initiatives. At the same time, the Community Mental Health Act encouraged the growth of local mental health centers to provide alternatives to state hospitalization. In 1962 and 1967, additional amendments to the Social Security Act opened the doors for expansion of privatization. The 1962 amendments authorized states to enter into agreements with other public entities for provision of services that they felt could be more effectively and efficiently purchased rather than provided. The 1967

amendments went further, allowing states the purchase of services (POS) from nonprofit and proprietary agencies as well as from other state or municipal entities (Smith and Stone, 1988; Gibelman, 1998). In addition, prevailing opinion was shifting to a belief that the provision of appropriate rehabilitation services, rather than monetary subsidies alone, might help some people off the welfare roles and back to being independent, productive members of society.

“Broadened statutory authority for POS resulted in the escalated use of these arrangements. Such authority is found in each successive amendment to the Social Security Act” (Gibelman, 1998, p. 9).

During this time of unprecedented expansion, privatization acted as a mechanism for creating new programs and new opportunities for not-for-profit and for-profit sector providers. Between 1965 and 1975, the welfare state budget increased from \$77 billion to \$290 billion (Abramovitz, 1986). Although the original intent of privatizing services was to provide alternative and innovative ways to deliver services that would better serve the public, in the late 1970's, as the prosperous times began to recede, privatization started to be perceived as a device to curb costs rather than to expand services. Ronald Reagan's election in 1980 once again stimulated talk of privatization as a means to curb runaway costs in welfare and health services (Abramovitz, 1986). Both the Reagan and Bush administrations promulgated the belief that the private sector could do it better and cheaper; President Clinton continued that trend, repeatedly saying that Government should be out of the business of “doing” (Gibelman, 1998). The 1996 welfare legislation furthered privatization by allowing for-profit agencies, as

well as not-for-profit agencies, to vie for government contracts to provide child and family services (Kammerman and Kahn, 1998).

### *Rising Conservatism*

Bendick (1989) offers a number of reasons why privatization became so popular during the rising conservative years of the 1980's. First, there had been a growing dissatisfaction and a loss of faith in government and its ability to function well. Second, always pervasive in our society is the belief that this country was built on rugged individualism and self-determination. With this comes faith in voluntarism and community self-help organizations, not government agencies. Although neither is proven in the research, these two factors help to perpetuate the economic view that the private sector functioning within the forces of the market can provide services more efficiently than the public sector.

The continued growth of the conservative movement fuels the belief that our social welfare system “creates dependency, undermines personal responsibility, distorts incentives, stifles entrepreneurship, hinders the operation of the labor markets and serves the interests of bureaucrats and professionals” (Bell-Lowther, 1988, p. 102).

### *Curbing the Power of Unions*

In the extreme, privatization can be used as a political tool of the conservative movement to lower wages, reduce job availability and weaken unions in the public sector (Abramovitz, 1986; Starr, 1989). Ullman (1998) states that privatizing services to the nonprofit sector can undermine the importance of

organized labor. Nonprofit employees are seldom unionized, so shifting service provision to the nonprofit sector shifts jobs away from union members. She also points out that, as the nonprofit sector becomes more involved with service provision, it becomes the stronger voice of the poor in advocating for services, which can undermine organized labor's role as "the voice of opposition to business interests" (Ullman, 1998, p.172).

In a study by Eggers and Ng (1993), agencies in 29 states and 15 counties responded to a survey about privatizing social services and health services. For counties, labor problems were stated as the biggest obstacle to privatization. In addition, they cited political opposition and public opinion as significant impediments to privatization. Nightingale and Pindus (1997) agree, stating that public employees and unions represent the strongest opposition to privatization based on the fear that public sector job opportunities will decline. Chandler and Feuille (1991) describe a study conducted in 1989 that surveyed public works directors in municipalities across the country questioning the connection between contracting out services and the presence of a strong public employee union. Results showed that, in the cities that had unions, contracting was considered a less viable option. In addition, the nature of the relationship between the municipality and the union seemed to have an effect on whether or not contracting out occurred. In areas where there was a confrontational union-management relationship, there appeared to be a greater incidence of contracting. Naff (1991) agrees that union strategies strongly opposing privatization attempts have been less than successful. It is possible that

increased cost savings from privatization can be directly related to decreased wages paid to non-union employees and de-professionalization in the private sector.

### *Managing the Costs of Care*

The rise of privatization in the 1980's and the continued attempts to restrain and manage the costs of public services have led to dramatic changes in the delivery of social services and mental health that have not all been bad (Anthony, 1996; Astrachan, 1993; Croze, 1996; Sharfstein, 1993). In mental health, contracting out has resulted in increased access to private services for some, and increased coordination and integration of the many services that had been developed during the time of expansion in the 1960's and 1970's. Growth at that time was not based on an overriding national policy but on economic opportunity, creating increased services that were neither coordinated nor integrated, and that were often difficult for the consumer to negotiate and access (Sharfstein, 1993).

During the Reagan years, the growth of the mental health system gave way to the era of cost containment and the growth of the managed care industry. Since then, our federal administrations continue to be committed to reducing the size of government, each assuming that the private sector will always be more effective and efficient. This extended period of fiscal cutback, although often painful to manage within, may be providing us with opportunities to prioritize and plan for service provision. "There is theoretically nothing alarming about care that is managed...with the elimination of fee-for-service reimbursement, there's

no incentive to 'over-prescribe' but rather, there is every incentive to deliver less costly care and treatment" (Croze, 1993, p. 69).

Although difficult for some anti-privatization ideologues to accept, managed care may force us to develop ways to better integrate and coordinate services, reconsider costly long in-patient stays as a treatment option and, in general, develop ways to deliver health care differently. For example, "Managed care planners in particular, with their flexibility and relative freedom from preexisting regulations, are in an especially advantageous position to design mental health systems consistent with our new knowledge about recovery" (Anthony, 1993, p. 22). In addition, if State mental health authorities do not abdicate their role in assuring that it is care that is being managed rather than costs alone, managed care systems could be developed and implemented that provide the full range of services that are needed for people with serious mental illness (Anthony, 1996). Although there is much fear about the fit between managing care and providing services for people with severe psychiatric illnesses, Jacobson and Curtis (2005) suggest that managed care principles of reducing the cost of long term and medicalized services may be quite congruent with the recovery oriented principles of letting people redevelop a real life with real life supports and minimal custodial care. "Quality and cost do not always have to be competing values-especially in the managed mental health care field where an argument can be made that the relatively lower cost services are preferred by the consumers, improve their quality of life and decrease the use of more costly services" (Anthony, 1996, p.7-8).

The continued turbulence in our economic, political and health care environment has allowed for privatization and managed care to remain on the public agenda as a way to downsize government, curb costs and increase effective service provision. In looking at managing change in general, Astrachan (1993) offers us this positive comment: "Managing is more interesting... as one travels the rutted, even dangerous road to improved care while constraining cost" (p. 77). Understanding and facing the challenges of privatization and managing care can assist managers to successfully navigate the "rutted, dangerous roads" that seem to always await us in the constantly changing health care system.

## Chapter III

### *A Review of the Literature*

#### *Towards a Definition of Privatization*

In order to understand the complexities of the privatization debate, we must first define it and then identify the different aspects of the public/private debate. Abramovitz (1986) describes privatization as “placing public tasks in private hands” (p. 257). While this appears to encompass the basic assumptions of privatization, there are many more facets involved that make the definition far more complex. Bell-Lowther (1988) defines privatization as “a shift from public to private responsibility for social welfare” (p. 101). This definition implies transfer of responsibility not only for funding but also for service delivery and regulation. Other authors (Bendick, 1989; Blank, 1999; Gibelman, 1998; Koldarie, 1987; Savas, 1987; Winston, et al., 2002), separate the two distinct functions that government performs, provision and production of services. Privatization of each of these functions has very different implications for service delivery.

#### *Provision vs. Production*

*Provision* encompasses setting policy for service delivery, buying services, monitoring and regulating services and subsidizing services. *Production* implies actually operating, delivering and administering the services. Through mechanisms such as contracting, franchising, vouchers and subsidies, government can turn over service *production* but retain responsibility for *provision*. Different forms of privatization result in differing levels of involvement of government in ownership, financing and accountability of services (Starr,

1989). Involvement can be as diverse as total government separation from *provision* and *production*, referred to as “load shedding” (Bendick, 1989; Brodtkin and Young, 1989; Kolderie, 1987; Sangar, 2001; Savas, 1987; Sclar, 2000), to partial privatization exemplified by contracting out (Bendick, 1989; Kolderie, 1987; Munson, 1993; Savas, 1987; Winston, et.al., 2002). If the government continues to finance and provide for services, but privatizes *production* of services, it need not necessarily result in a shrinking of services or reduction in access and availability. In fact, it could actually provide an opportunity to increase and expand services if the contractor is a creative provider, and can utilize the contracted funding in a more effective and efficient manner.

Savas (1987), an academic advocate of privatization, tells us that the origins of the word government are in its Greek root, meaning helmsman. “The role of government is to steer, not to man the oars” (Savas, 1987, p. 290). He believes that privatization of *production* allows government to resume that original purpose. By only providing services, government concentrates on manning the oars; conversely, if busy at the day-to-day operational level of producing, government can lose sight of its helmsman role. Osborne and Gaebler (1993) agree, stating that, although the *production* of services might be turned over to the private sector, the responsibility for governance cannot. In addition, they claim, producing its own services can become a conflict of interest for government, which, in times of increased local control, has the role of monitoring and evaluating service production. For example, Demone and Gibelman (1989) described a 1983 report on the status of mental health services

in New York State, in which it was suggested that the dual role of *production* and *provision* of services for the Office of Mental Health had created a conflict of interest, since the agency was administering its own direct care, and monitoring, licensing and evaluating itself, as well as community agencies that it funded.

A similar 1981 report funded by the National Institute of Mental Health, studying services in Massachusetts, recommended that “states should finance, monitor and regulate mental health care and relinquish their operational responsibilities” (Demone and Gibelman, 1989, p. 9). Although this suggestion was made more than twenty years ago, and many states have privatized their mental health services since, New York State has not moved in this direction and continues to operate a vast majority of the in-patient and out-patient mental health services itself, utilizing a large percentage of the State budget for the delivery of state run mental health services.

Bendick (1989) categorizes attempts at privatizing *production* but not *provision* of services as part of an “empowerment” category. Based on the political climate in the United States at the time (1989), Bendick proposed that “empowerment” category changes would continue to experience growth while direct government *production*, as well as total load shedding, would not. Continued feelings of distrust and dismay in the public sector seem to support his conclusion, even today. The loss of faith in government’s ability to be effective and efficient continues to be one of the driving forces that placed privatization on the public agenda throughout the 1980’s and 1990’s and is keeping it there for now and in the foreseeable future.

Smith and Lipsky (1993) see some irony in the results of government's shifts from *production* to *provision* of services. First, rather than reducing government's involvement with service provision, contracting has, instead, often resulted in increases in government spending on services and, in some circumstances, much more involvement in the business of community agencies, although the distance created by contracting can hide this. "Politicians are regularly criticized if the number of public employees has increased while they have been in office. They are virtually never criticized if the number of employees working for agencies under contract to the state has increased dramatically" (Smith and Lipsky, 1993, p. 204). Shifting *production* of services to the private sector can give the illusion of government's reduction of control and shrinking size, hiding the fact that services may have increased and the control of the government over the private sector's business has certainly increased. "Contracting hides growth in the public sector. This is especially ironic as a policy designed to reduce government evidently has the opposite effect" (Fabricant and Fisher, 2002, p. 79). Winston, et al (2002) suggest that politicians and government organizations can maintain their distance from difficult social policy issues through privatization, assuring the provision of adequate public services that their constituents support, and yet maintaining the image of working towards shrinking the size of government.

Smith and Lipsky (1993) also find it ironic that, in forcing nonprofits to compete in the open market place for contracts, government has forced community agencies to be much more businesslike, as they have had to learn to

deal with the rules and regulations of government contracts. Rather than remaining responsive to local community needs, not-for-profits are sometimes faced with the difficult decision of spending scarce time and resources concentrating on their own fiscal health and on meeting the demands of the government contract. These circumstances created by contracting out have further blurred the boundaries between the public and private sectors. Fabricant and Fisher (2002) point to the many pressures contracting with government has placed on nonprofits as they state:

Voluntary organizations that contract substantially with the public sector are not only required to be more formalized and corporate in their financing, accounting, and evaluation, but also in the structuring of their services, clientele and workplace. The staff of nonprofits must increasingly contend with heightened tensions between a corporatized funding process, the needs of the workplace and the circumstances of the people who come to them for services. These tensions influence client selection, the composition of the workforce (volunteers vs. paid staff, levels of education, etc.), the time available to meet with clients and perhaps, most fundamental, the nature of the service exchange. (p. 85)

#### *For-Profit vs. Not-For-Profit*

In addition to the distinction between *production* and *provision* of services, there is a distinction between *private for-profit* and *private not-for-profit* providers. Each of these providers experience different forces that drive the development and implementation of their service provision models. A number of authors

(Brodkin and Young, 1989; Bendick, 1989; Demone, 1998; Krashinsky, 1998; Sclar, 2000; Schlesinger, 1998; Weisbrod, 1998) describe major differences between the *for-profit* sector and the *not-for-profit* sector that they feel affect the way that these agencies are perceived as well as the way they deliver service. Krashinsky (1998) states that consumers see *not-for-profits* as trustworthy and therefore less likely to attempt to exploit them. He feels that in *for-profit* organizations there is an increased incentive to cut quality and therefore exploit consumers, especially if government monitoring is lacking. "By agreeing not to appropriate any profits for themselves, owners and managers of nonprofits are agreeing to eliminate at least in part, the incentive to cut quality and to exploit consumers. But all this presumes that someone enforces such an agreement. If enforcement is lax, then the advantages of the nonprofit firm disappear" (Schlesinger, 1998, p. 115).

Weisbrod (1998) suggests that *not-for-profits* and *for-profits* behave differently because their mission, goals and objectives differ. Nonprofit managers and direct care staff are often interested in areas broader than financial gain. They are willing to trade higher pay for other social benefits. In addition, in *not-for-profit* agencies, administrators are very often trained professionals. As a consequence, "professionalization changes their preferences and hence their willingness to trade off various forms of nonpecuniary rewards for monetary rewards" (Schlesinger, 1998, p. 90). *Not-for-profits* are perceived differently by consumers as well. They are most often perceived as existing to serve the public good and to use public subsidies to reach those ends. *Not-for-profit* agencies that

are accepted by their communities, and trusted to provide high quality services, may not need to spend time and resources marketing themselves and, consequently, can devote more time and energy to developing and improving their services (Schlesinger, 1998).

Despite all the foregoing theorizing, empirical research conducted on similarities and differences in organizational behavior between the *for-profit* and *not-for-profit* service sectors is very limited. Schlesinger (1998) points out that the boundaries between *for-profit* and *not-for-profit* agencies are often blurred. In areas where there is substantial *for-profit* agency activity, *not-for-profit* agency behavior becomes more like *for-profit* behavior, as the *not-for-profit* agency fights for a place in the market. In areas where *not-for-profit* agencies are the norm, the opposite occurs.

Additionally, both Rein (1989) and Kramer (1989) also see overlapping between the *for-profit* and *not-for-profit* sectors. Since the expansion of purchase of service contracting in mental health and social services, these two sectors have increased their competition for funding. *For-profit* agencies are often staffed by professionals whose missions and values match those of staff in *not-for-profit* agencies. As governmental funding structures have become more competitive, and both process and performance outcomes are being more clearly stated in government contracts, *not-for-profits* have had to become more effective and efficient, concentrating more on the bottom line than ever before.

Karger and Stoesz (1998) use the terms “*voluntarization*” and “*corporatization*” (p. 202) to highlight the distinction between the for-profit and

nonprofit sectors. *Corporatization* is defined as reliance on the corporate, for-profit sector for service production. Supporters say that this sector is more efficient and cost-effective, more responsive to consumer demand and also pays taxes. *Voluntarization*, or reliance on the voluntary nonprofit sector, is often thought to produce services that are more community based, more firmly rooted in a social welfare tradition and more altruistic, since there is no profit motive involved. Kolderie (1987) asserts that success for contracting out does not rely on whether *voluntarization* or *corporatization* is in play, but rather on whether the privatization “substitutes a monopoly private supplier for a monopoly public bureau or introduces competition among producers” (p. 48). In Kolderie’s view, cost savings and increased effectiveness are created only through competition.

Questions of “competition, creaming, corruption, costs, control and community” (Kolderie, 1987, p. 48), can be successfully dealt with if government is a “smart buyer”. Government must assure that it gets exactly what it wants to pay for by closely monitoring and evaluating the service and removing the contract when target outcomes are not achieved. Kettner and Martin (1993) describe accountability in purchase of service contracting as traditionally focusing on the “process of service provision without much regard being given to the results of service provision” (p. 62). With process accountability, contractors are held responsible for assuring client eligibility, for providing only contracted services and the promised method of service delivery, and for assuring that some level of quality is maintained. If government were to concentrate more on performance indicators as outcome measures, accountability would center on

end products or results of the service provision. For this level of monitoring, government might look at the volume of services provided, the costs of a unit of service, how many clients successfully met their goals and the condition of the clients at the time of discharge and at some pre-determined period after discharge. Measuring performance outcomes has not been an easy task for government because measurable outcomes for human services have not been readily available.

Peat and Costley (2000) point out that a lack of clarity in goals and objectives will impact outcome. For the government to be able to be a smart buyer it must be clear and in agreement with its contractors concerning goals and objectives and the ways that results will be monitored and evaluated. Although accountability in purchase of service contracting appears to be of great importance to state politicians and administrators, and although states have gotten much better at establishing clear contract expectations, few state data management systems have been developed that could really monitor outcomes appropriately (Kettner and Martin, 1998). As the recent trend towards developing and monitoring measurable outcomes for human service programs becomes stronger, these outcomes measures could help government to better perform its role in provision and help to assure that it gets its money's worth. Improved outcome measurement could not only help in ensuring accountability but also could improve services and insure that clients' desired outcomes are being achieved. Of course, without additional resources, these accountability measures can add additional cost and burden to the nonprofit agency.

Accountability requirements dramatically alter the organizational form and culture of nonprofits, forcing them to develop greater internal organizational formalization, which distances them further from the communities they serve. As a result of the demands of contracting, organizations have to devote more resources and personnel to meet both fiscal and programmatic accountability requirements. (Fabricant and Fisher, 2002, p. 83)

### *Public vs. Private*

The last issue to explore in the privatization debate is the distinction between the meanings of *public* and *private* themselves, very different to different people, and not so simply defined (Weintraub, 1997). We often think of *public* as open and dealing with the whole of society. *Private* is then perceived as closed and dealing with the individual or a part of society (Starr, 1989). Institutions that are *public* are thought to be unaffected by market forces and, therefore, open and accessible to all. Institutions that are *private* are considered market driven, individually oriented and often in pursuit of self-interest.

Privatization has blurred these distinctions considerably. Contracting out has changed the look of both *for-profits* and *not-for-profit* organizations. Government restrictions and standards often accompany contracts with *private* providers who are required to follow rules and regulations including increased access to clients who they previously may have deemed too difficult or problematic to accept (Smith and Lipsky, 1992). The *not-for-profit* sector has changed as well, becoming dependent on government contracts and the politics

that are entailed in keeping them. “Nonprofit agencies have now become assertive political actors with an emerging focus of political activity at the state level. These agencies have also adjusted their internal behavior to reflect a new relationship to the state” (Smith and Stone, 1988, p. 243). Missions can become unclear as smaller agencies put more time into chasing government funding, obeying government regulations, and following government priorities, and less time into local community organizing efforts (Fabricant and Fisher, 2002; Smith and Stone, 1988). “In essence, the programmatic priorities of *nonprofit* agencies are no longer *private* (or community) priorities but *public* priorities defined in the political arena” (Smith and Stone, 1988, p.247). Gibelman (1998) points out that goal displacement is one of the unintended consequences of privatization. Voluntary not-for-profit agencies, dependent on purchase of service contracts for funding, can find themselves following the many RFP’s that are issued and losing sight of the original agency mission set by their Boards of Directors. Fabricant and Fisher (2002) point out that much of the nonprofit’s expansion is driven by its opportunities to obtain contracts and not always by the agency’s mission and programmatic goals or the community’s needs. “Voluntary agencies increasingly become outer-directed, handling a myriad of programmatic opportunities and meeting service needs, but these programs and services do not necessarily evolve from the agency’s own initiative or goals” (Fabricant and Fisher, 2002, p.87).

In addition, new monies for new program areas can result in new constituencies that local agencies had not planned to serve. Often, when

purchase of service funding stops for these new initiatives, the new constituency pressures for continuation of the service, and agency Boards of Directors are faced with a dilemma. Where do the cutbacks occur, in traditional programs or in the newer outreach efforts?

Weintraub's (1998) two images, *public* as open to all versus *private* as hidden, and *public* for the group as opposed to *private* for the individual, lay the foundation for the belief that only public institutions can provide for members of society who are needy or at risk. However, it is too simplistic to look to this *public/private* distinction alone for easy answers to the complex social and political dilemmas with which we often grapple.

Public administrators seek to improve public sector performance. Public employees' unions are concerned with the potential loss of members that may accompany the purchase of services. Accountants and economists, legislators and administrators are concerned with economy and cost benefits, for example, efficiency and expenditure control. Political scientists inquire about structure and function. Client advocates are concerned about accountability. (Gibelman and Demone, 1998, preface xv).

Although concerns about privatization are many and varied, one thing is becoming increasingly clear. There are both advantages and disadvantages to privatizing human services. Variations in *provision* and *production*, *profit* and *not-for-profit* and *public* and *private* auspice can drastically affect organizational outcomes. Also, it is clear that planning, performance, service monitoring, and

evaluation and accountability are among the important issues that have surfaced in the privatization debate.

### *Pitfalls of Privatization*

Privatization may create some cost savings based on increased efficiency, but it has also had some unexpected negative effects for social workers and recipients of services who are not accustomed to private sector issues. In an attempt to meet the challenges presented by privatization, a number of authors (Bell-Lowther, 1988; Dorwart and Schlesinger, 1988; Fabricant and Fisher, 2002; Karger and Stoesz, 1998; Sanger, 2001; Sclar, 2000; Starr, 1987) have identified issues of concern. For example, Starr (1987) questions whether privatization actually improves efficiency or whether it simply creates an illusion of efficiency resulting from lower costs for services, as he states:

After all, if privatization enables governments to cut wages and break unions, it is a means of imposing losses on public employees. If it enables governments to cut back services and allows providers to skim off the best clients, it is a means of imposing losses on beneficiaries. Neither of these ways of reducing costs improves efficiency. (Starr, 1987, p. 7)

According to Starr, looking to privatization for increased efficiency in service delivery just provides us with an illusory answer to a very complex set of problems.

In her review of privatization trends in Canada, Bell-Lowthar (1988) shares numerous objections to privatization voiced by Canadian social workers, including:

- the lack of public participation in the definition of privatization policies;
- the lack of concrete evidence that privatization really creates more effective and efficient services;
- the lack of research on problems experienced by existing organizations that privatization might address, such as fragmentation, lack of prevention services, lack of coordination, and poor performance outcome measures;
- the lack of clear criteria for contract selection;
- the loss of control and power of the public employee unions;
- the changes in the structure and mission of voluntary organizations creating agencies that are more dependent on government and less flexible, innovative and independent.

Bell-Lowther brought these issues to the public agenda, asking Canadian social workers to engage in discussion on the principles and methods of delivering human services so that they might ensure that their voices be heard as the Canadian privatization debate unfolded.

Likewise, Dorwart and Schlesinger (1988) reveal some pitfalls of privatization as they focus on the growth of private psychiatric hospitals in the United States, the concurrent decrease in public sector mental health services since the 1970's, and the implications of both. They conclude that although there is little evidence to assess the effects of privatization on mental health care delivery, there has been much discussion about the effect privatization will have on public policy in psychiatry.

The first concern of Dorwart and Schlesinger (1988) is that privatization might result in a multi-tiered mental health system where access will be available more readily for those who can pay. They are concerned not only with access to private facilities but also with access to services contracted out to nonprofit facilities as these agencies struggle to meet their contract requirements with more limited funds. In addition, the authors express concern that increased market pressures could create fragmentation of services as providers struggle to change and adapt existing services to meet changing demand. Last, they express concern that service providers are likely to become more pressured to develop new forms of organization and funding, such as capitation and case rate mechanisms, and that this thrust will affect their ability to adequately meet local needs (Dorwart and Schlesinger, 1988). Although unclear about the future effects of privatization on the delivery of services, these authors are clear that privatization efforts will continue, creating a more complex health care environment in which agencies must learn to function and thrive in order for human services to remain effective.

Karger and Stoesz (1998) highlight five additional issues that are important for social workers and service recipients to be aware of as they struggle with the process of privatization. These issues are *commercialization, creaming, cost effectiveness, standardization and oligopolization*. With *commercialization*, privatization creates a situation in which human service workers must become marketers, and the product being marketed is the success of their own interventions. Health care advertising is not a subject taught in social

work schools or offered in clinical staff development. Workers are not accustomed to marketing services or dealing with human beings as products; they often have professional and ethical concerns about performing these functions.

The second issue, *creaming*, is the tendency to select clients on the basis of their ability to achieve better outcomes. Pushed by the pressures of competition, private nonprofit agencies are forced to look at how many non-paying clients or difficult to treat clients they can handle and still compete successfully for limited resources.

Another issue of importance to human service workers is *cost effectiveness*. Many human service agencies are adopting different mechanisms for purchasing, management of information and record keeping to enhance efficiency. Precious resources are being spent in the name of efficiency and effectiveness instead of on direct service provision. Again, these activities are often in conflict with the value base of social work and create internal tensions for human service workers and administrators.

With *standardization*, organizations are forced to adopt certain standards that may be based not on good clinical judgment but rather on accepted market indicators. For example, agencies are often forced to adopt clinical protocols promulgated by companies managing care rather than by the professionals who are providing the care. The number of services and kinds of interventions provided are often dictated by the care manager of the insurance company rather than by the clinician or medical director of the agency. Often, the quality of

services rendered becomes less important than the number of services offered and the number of people served. “Because the logic of the market dictates that the goal of production is to process the largest number of people at the lowest possible cost, the standardization of services is an important method for lowering organizational costs” (Karger and Stoesz, 1998, p. 206).

The last issue presented by Karger and Stoesz, *oligopolization*, is the control of the market by a few providers. Smaller organizations are banding together in order to reduce competition and compete with more aggressive for-profit corporations. These alliances can be large and powerful and can shape public policy. Inability to join in these alliances or networks can signal the death of a small community agency as larger contracts and more business go to the alliances.

In many states, capitated service delivery plans have been developed for the provision of Medicaid reimbursable services for people with special needs. These plans are put to bid and are often contracted out to managed care companies or powerful hospital-based alliances. Once these provider networks are awarded the government contract, if a smaller community agency is not a part of the provider network, it would be unable to be reimbursed for any Medicaid services provided. Many nonprofit agencies have used hard earned fund-raising dollars to purchase equity shares in these networks so that they will be able to vie for government dollars when contracts are awarded. Winston, et.al.( 2002) points to other collaborations that have emerged as well, to bid on these service delivery plans. The authors suggest that some local small

nonprofits have become sub-contractors for larger for-profit organizations. Also, some nonprofits have formed for-profit groups to compete while other nonprofits have joined together into collaboratives (Winston, et.al., 2002). Sanger (2001) suggests that for some smaller nonprofits without adequate resources to compete, joining a collaborative might be the only way to survive within the special needs plan environments.

When I first became Executive Director at CFS in 1997, I experienced what Winston (2002) and Sanger (2001) were suggesting first hand when I joined a regional consortium of not-for-profit mental health providers who, with the help of a consultant, were planning to bid on the soon to be released New York State Special Needs Plan for delivery of services to people with mental illness. In a neighboring county, a number of nonprofit agencies that were also part of this consortium had additionally invested in a local hospital based consortium to develop an alternate response to the plan. After the Special Needs Plan was awarded to the hospital-based network, the New York State Legislature, by their very inactivity, let the Special Needs Plans legislation lapse, thus destroying the possibility of implementation. These local agencies that had invested much time, effort and hard earned dollars into participating in this network garnered no results. Money that could have gone to service provision for some of the most needy of their citizens instead went to protecting the long-term viability of each of the consortium member agencies.

In a report for the Brookings Reform Watch, Sanger (2001) presents findings from case studies of for-profit and nonprofit agencies that have engaged

in contracting in New York City, Milwaukee, San Diego County and Houston in the area of welfare service delivery. She points out the possibilities and perils of introducing market competition in this previously government dominated service field. On the possibility side, Sanger found that competition was forcing increased innovation and improvements in management systems for many nonprofits. Unfortunately, among the perils were nonprofits as well as for-profit agencies making service delivery decisions based on minimizing costs that could potentially have a negative impact on service recipients. Sanger presents her concern that these lapses in quality could go undetected since “public organizations responsible for monitoring are often ill equipped or under invested in the means or measurement capacity to uncover lapses in quality” (Sanger, 2001, p. 11).

In addition, although Sanger saw improvements in the management practices of many nonprofits, she also noted that some of these community based organizations, especially the smaller ones, were in real danger of losing their community mission and experiencing the goal displacement discussed previously. Her last concern was that, with private and nonprofit agencies going after the talented professional staff to meet their increasing contractual responsibilities, the public sector could experience a “brain drain [which] may weaken the capacity of government to be smart buyers and sophisticated contract managers” (Sanger, 2001, p. 11). Sanger’s case studies of these organizational changes took place shortly after they were instituted and, as a

result, she did not feel that there was sufficient evidence to judge whether or not her stated concerns had been substantiated.

In another study that looked at worker and client impressions of service delivery in Massachusetts (Kopito-Motenko, et.al., 1995), some of the previous concerns were substantiated. The authors studied nine agencies to determine the effect that severe cutbacks and auspice changes had on social workers and clients. They found that, although the amount of services produced had decreased, the demand for those services had not, thus creating an unstable delivery system. Clients' needs often went unmet, exacerbating their conditions, and forcing them to require more intensive, thus more expensive services. Staff were required to see more clients and produce more paperwork, which resulted in their achieving poorer client outcomes. Clients were not improving and staff were becoming increasingly demoralized. These kinds of results led anti-privatization factions in Massachusetts to agree with Matthew P. Dumont (1992) as he stated, "privatization means the systematic exploitation of mental health workers and the equally systematic repudiation of care for the chronic and impoverished mentally ill. It will result in more chaos in the community" (p. 328).

Although there are only limited studies of either successful or unsuccessful privatization attempts, some authors (Bendick, 1989; Chi and Jasper, 1998; Goldsmith, 2006; Gurwitt, 2000; Hasenfeld, 1984; Kolderie 1987; O'Looney, 1993; Savas, 1987; Sossin, 2003) have tried to outline the problems that can be associated with privatization and to present some mechanisms that can lead to success. An article in the Detroit Press (Webster, 2000) on the

results of privatization of mental health services in Wayne County, Michigan, reminds us, once again, that experts in the mental health field familiar with other attempts at privatization across the country agree that results have been mixed. A policy advisor for the National Mental Health Association in Washington, D.C. summed it up as follows: "If the government agency contracting for the service provides enough money for the care, the results can be decent" (Webster, 2000, p. 1). The attention that has been paid to Massachusetts (Dumont, 1992; Dumont, 1996; Johnston, 1998; Kopito-Motenko, et.al, 1995; Wieman and Dorwart, 1998; Sclar, 2000) might help us learn to avoid some of the pitfalls of privatization that we have been discussing.

One positive result of the Massachusetts privatization experience was the formation of an interesting coalition model. Dumont (1996) describes the development of a disparate group of public service unions, patient advocacy groups, consumers of service themselves, and clinicians, who banded together, educated themselves and the public, and lobbied to slow down the process of privatization. Over the Governor's veto, they were successful in getting the Pachecho Bill passed. This bill forced the state to show the actual costs saved while maintaining comparable quality that would occur through contracting with private corporations. In addition, it allowed public employees, through their unions, the chance to bid competitively to provide the same service. The Pachecho law requires decision making officials to move beyond using privatization as a purely political tool by demonstrating a financial cost benefit before instituting a change in auspice. "In general, it forces privatization out of

the realm of the ideological into that of the practical” (Sclar, 2000, p. 167).

Although only a small step in slowing down privatization in Massachusetts, Pachecho did demonstrate to the state and to others that a strong and active public alliance can help to change policy.

### *Positive Possibilities of Privatization*

Clearly, privatization, in its many forms, does not automatically signal disaster for the provision of human services. Osborne and Gaebler (1992) present privatization as an opportunity to create incentives for more effective and efficient management of public services. Gibbon (1995) tells us that privatization gives employees an opportunity to work in an agency that has “clear objectives, the means to achieve them, and rewards for success” (p. 3). He feels that privatized agencies can be more responsive to client demands and more innovative in creating services to meet those demands without the constraints of government and politics. Kolderie (1987) tells us “a privatization program ought to be possible, but for the moment both private and political leaders are mired in the old ways of thinking” (p. 51). Hasenfeld (1984) suggests that in times of conservative policies, cutbacks and retrenchment, organizations are forced to take a good hard look at themselves and evaluate their performance. This self-reflection can motivate providers to get out of their organizational “ruts” and become more effective and efficient in providing services. How organizations and the professionals who staff them “respond to the challenge of privatization, whether by reaction or innovation, will be critical for the future of American social welfare” (Karger and Stoesz, 1998, p. 210).

Bendick (1989) offers a suggestion not only for accepting privatization but also for embracing it as a means of expanding public services. First, he reinforces the need to defeat “load shedding” proposals, by which government separates itself from both the financing and the delivery of services. He proposes that governments develop and implement “empowerment” proposals for privatization which privatize the delivery of services, but in which government retains the responsibility for funding and monitoring the service. This distinction is important because:

Trends in American society suggest a steady and rising demand for collectively financed goods, and yet a long term and rising opposition to public delivery. This means that approaches in the “empowerment” category are associated with potential growth, whereas approaches in the “load shedding” category as well as traditional government provided social welfare programs are not. (Bendick, 1989, p. 99)

Second, Bendick suggests we stop fighting and begin to build alliances between public and private providers, like the ones built in Massachusetts to create the Pachecho Bill. Through these alliances, we can defend and insure the continuation of public expenditures for human services. Finally, he suggests that all interested parties work together to strengthen the managerial skills of public and not-for-profit service providers so that they can be competitive in current markets.

### *Peril or Possibility?*

The privatization movement arose from a neo-conservative view that

government should not and cannot be in the business of service delivery because it is too big, too complicated and too inefficient. On the other hand, the review of the literature demonstrated that the privatization debate is more complicated than that. It is steeped in ideology and politics and confounded by economic and political biases. "Those who support privatization in all cases because they dislike government are as misguided as those who oppose it in all cases" (Osborne and Gaebler, 1992, p. 46). Osborne and Gaebler (1992) point out that often what determines success or failure in privatization efforts are the incentives that drive those providing the services. Issues of motivation to excel, accountability for results, limitations on restrictive contracting rules and regulations, encouragement of flexibility in service delivery and rewards for effective and efficient functioning are the factors that they see as determining quality performance.

In a review of state privatizations conducted by the Council of State Governments, Chi and Jasper (1998) conclude that privatization can be a tool for improving productivity and that the success of that tool is dependent upon how well it is used by government leaders. Based on lessons learned in the review of state privatizations, they offer a number of recommendations for privatizing successfully. According to the authors, success begins with strong political support through legislation so that privatization efforts continue regardless of changes in administration. Next, they cite the need for clear and measurable goals throughout the contracting process. Like so many other authors, they remind us that government cannot delegate all responsibility or authority to the

private sector, but must remain “overseers rather than doers” (Chi and Jasper, 1998, p. 19). Government must continue to be responsible for monitoring and evaluating services and collecting the data that supports the effort. They also suggest that government involve employees in the plan to privatize, and protect them from loss of jobs or status. Finally, they suggest conducting pilot projects before trying the full-scale privatization efforts. In this way, states can develop safeguards to assure that needed services are not interrupted. They offer this warning: “from planning to monitoring privatization activities, policy-makers should be aware of the dangers of corruption, service interruption and mismanagement or unfair labor practices by private firms” (Chi and Jasper, 1998, p.19). Government must continue to hold contracted agencies accountable for the services they provide as well as the manner in which they provide them.

#### *Unanswered Questions*

Privatization continues to be a mechanism that government might use to save money and improve services. Still, the very word privatization instills dread in some and exhilaration in others, and many questions have emerged in the debate, including:

- Should government give up its role and responsibility for caring for its neediest citizens?
- Should government keep the responsibility for monitoring and funding services but stop producing services?
- How does contracting out change the structure of not-for-profits?

- Will privatization reduce access, increase fragmentation, and create a multi-tiered system of service provision?
- Can the private sector really produce services more efficiently and effectively than the public sector?

Empirical research of various kinds is needed before these questions can be fully answered. Indeed, as demonstrated earlier, most of the literature on privatization is theoretical and based on conflicting ideologies. Very few of the arguments have been tested empirically. Many states have been privatizing human services over the last fifteen years. However, much of the literature discussing privatization was written in the 1980's and early 1990's. Since then the debate has continued, restating the same issues and presenting little empirical evidence that the private sector is actually providing more effective and efficient services (AFSCME, 2006; Eggers, 2006; Fabricant and Fisher, 2002; Gilroy, 2006; Goldsmith, 2006; Hughs, 2003; Melese, 2005; Savas, 2006; Sossin, 2003; Winston, Burwick, McConnell and Roper, 2002).

The description and evaluation of the experience of privatization at CFS presented in this study may serve as a guide to management of the privatization process and may help service providers in both the public and private sectors to meet the continuing challenges of cutback management while still developing and implementing innovative services and programs.

#### *Helping an Agency to Change*

Gareth Morgan (1997) tells us that an organization is a living and breathing organism, operating most effectively when its needs are satisfied.

Those needs may be internal or external, requiring us to look at the organization from a systems perspective. “ A systems approach builds on the principle that organizations, like organisms, are ‘open’ to their environment and must achieve an appropriate relation with that environment if they are to survive” (Morgan, 1997, p. 39). With an understanding of the importance of organizational change and its effects on the functioning of the organization, “managers can better prepare themselves, their employees, and their organizations for the consequences of change, to the benefit of all concerned” (Huber, Sutcliffe, Miller and Glick, 1995, p. 250).

A number of authors (Brager and Holloway, 1992; Frey, 1990; Kast and Rosenzweig, 1974; Lewin, 1951; Weinbach, 1998) discuss ways to influence organizational change through understanding the competing internal and external forces that are driving the organization towards or away from change. Kast and Rosenzweig (1974) talk about the concept of planned change, where the task of the manager is to identify gaps between the organization’s current and desired positions. “Whenever the organization can identify differences between where it is and where it would like to be on any dimension, it can engage in a process of planned change” (Kast and Rosenzweig, 1974, p. 578). The dimensions the authors highlight include effectiveness, efficiency and participant (staff and client) satisfaction.

Brager and Holloway (1992) describe Lewin’s force field analysis similarly, stating, “stability exists when the driving forces (those pressing for change) are offset by the restraining forces (those inhibiting the change). For a change to

occur, the field of forces must be modified so that the driving forces are increased, the restraining forces are reduced or some combination of both” (Brager and Holloway, 1992, p. 31). This will create the disequilibrium Lewin feels is essential if change is to occur. Lewin calls this the unfreezing step. By analyzing these forces, managers can tease out the factors that can be instrumental in implementing successful change. The actual change is the second of Lewin’s steps. With the third step, refreezing, the system is returned to a state of equilibrium and stability. By using the force field analysis, an organization can identify which forces must be increased or decreased to return the system to a stable state (Weinbach, 1998).

Meyer, Goes and Brooks (1995) share an important message with managers. They assert that change is occurring with greater frequency and requiring organizations to adopt new strategies in order to survive. They also believe that organizations can survive these changes and emerge stronger as long as top leaders are brave enough to implement new and innovative ways of doing business. They suggest several managerial implications. First, they urge managers to develop and “inculcate shared values” (Meyer, Goes and Brooks, 1995, p. 98). These values are important to staff and clients alike and can serve to hold the organization together in times of uncertainty. Second, they suggest that managers be clear in their strategies for change, develop structures to implement those strategies that are consistent with the organization’s values and that they use limited resources wisely. The authors caution us to stay focused on the changes ahead and never rest on past successes, so that those successes

will not promote behavior that becomes rigid and inflexible. They also warn managers that change is continuous and paradoxical, and that responses to change must be innovative, varied and flexible. Lastly, they remind us, “even in the throes of revolutionary change, astute managers can recognize and seize the opportunity to revitalize their organizations and reshape their environments” (Meyer, Goes and Brooks, 1995, p. 100).

Van de Ven (1995) distinguishes routine change from novel change that he calls innovation. “By definition, an innovation is a leap into the unknown. If an innovation is to have a chance to succeed, traditional notions of managerial control may need to be relaxed somewhat” (Van de Ven, 1995, p.291). Routine changes can be handled by standardized methods that have been previously developed and instituted, but novel changes that have not been previously introduced often require the development of new techniques to assure their successful implementation. Van de Ven (1995) shares six process elements that he feels are common among organizations involved in implementing novel changes. The first is that change is facilitated when the “stage” is set over a period of time and people are given a chance to understand and accept the change. Once the change begins, however, he states that “shocks”, rather than persuasion are more likely to facilitate and move the change along. “Shocks” move individuals to a level of dissatisfaction that allows them to more quickly accept the change and therefore move to a more satisfied place.

Third, once change begins, it does not continue in a linear fashion but presents the manager with multiple options often in conflicting arenas, and

requires the manager to keep focused on the innovation and on track with the change plan. Next, he points out that setbacks and errors will unexpectedly occur and the manager must be open to changing and adapting by seeing the setback as an “opportunity for learning through reinvention” (Van de Ven, 1995, p. 290).

The fifth element is that change will be facilitated if it is unique to the special needs of the organization and accepted by the top management. And lastly, the greater the change, the more complex the adoption process will be. Innovations that are particularly different, large and complex will demonstrate more of the above elements and will be more difficult to manage and achieve. As Van de Ven (1995) reminds us, “Managing these novel changes is far more complex and unpredictable than managing routine changes because the former require developing and implementing new change procedures, while the latter entail implementing tried-and-tested procedures” ( p. 270).

Spaniol, Zipple and Cohen (1994) talk about change as being constant within organizations and state that managing change is one of an administrator’s most important functions. They have identified a number of key principles for understanding the change process. The first is to realize that change is difficult, that it can challenge our values and force us to question many of our basic assumptions. Next, they liken organizational change to personal change and suggest that it requires a developmental process akin to personal adjustment. Change may be *planned*, which can be experienced as change that is wanted, or *unplanned*, which may be perceived as change that is forced upon an individual or an agency. In either case, the authors point out that change generates

resistance, which can be a normal reaction to the change process and therefore, resistance to change should not be viewed negatively and punished. “If the organization deals with the planned change process sensitively, then unplanned changes can be dealt with and people can be helped to live with the new system more easily” (Spaniol, Zipple and Cohen, 1994, p. 510). They also point out that change takes time and acceptance will not occur overnight. They continue by suggesting that change requires resources, as well as commitment and support of management and all levels of staff within the organization. Change must be functional and relevant and assured of making a positive difference in the work of the organization, and change requires readiness, which can be built if it is not present. The authors present these following guidelines to help managers engage in successful change:

- Make a clear commitment to the change effort;
- Assess readiness and available resources (know your strengths and limitations);
- Anticipate potential problems;
- Involve key staff and potential adopters;
- Provide for outside consultation and training;
- Create a positive vision for the change;
- Build organizational enthusiasm and support for the innovation;
- Assure substantial interpersonal contact between those leading the change and those adopting the change;
- Evaluate the change effort and share it with those involved in the change.

(Spaniol, Zipple and Cohen, 1994, p. 515).

If done right, the authors state that change can have substantial benefits for an organization, including: releasing creative energy to develop and build new programs and services; increasing hope in the face of future changes; and developing intra-organizational bonds around achieving common goals.

### *Leadership: Managing Change*

Attaining the benefits that might be derived from moving an agency from a *public* to a *private* auspice would have to require effective leadership. “Effective managers play a significant role in influencing the culture by the messages they communicate and, more important, through their own behavior” (Brody, 1993, p. 23). Kouzes and Posner (2002) believe that, through strong and appropriate leadership, challenges are turned into successful outcomes. Kay (1994) sees leadership as “sense making and sense shaping” (p. 207), influencing staff and the development of agency culture by helping staff to understand what is happening around them and developing a shared sense of values that motivates people to function more effectively and efficiently. Weick (1995) talks about the difficulties managers face when organizational redesign is involved.

Organizational redesign can change the way resources will be distributed, how information will be conveyed and how authority will be determined. Privatization requires major organizational redesign and therefore, according to Weick, frequently creates organizational turbulence. “The way out of turbulence may lie in continuous improvisation in response to continuous change in local details” (Weick, 1995, p. 376).

Leading an agency out of turbulence and through a time of organizational change requires not only skills, but also vision and creativity. Austin (1989) points out the distinction between administrators who focus on efficiency, rather than effectiveness. “The managers focus on efficiency by doing things right. The leaders focus on effectiveness by doing the right things” (Austin 1989, p. 70).

Perlmutter and Gummer (1994) state, “to meet the challenges created by both the changing environment and their particular organizational setting, executives in nonprofit organizations must have both the conceptual understanding and the organizational skills to be effective leaders” (Perlmutter and Gummer, 1994, p.243). They feel that managing organizational change requires flexibility and a readiness to look at situations in new ways. “The change-oriented manager needs to see the unexpected as something to be explored rather than hidden” (Perlmutter and Gummer, 1994, p. 242).

Young (1991) highlights some essential skills of what he calls the entrepreneurial leader, the type of leader that organizations might look for when they are seeking innovation in times of turbulence. These skills include developing a sense of mission, problem solving, remaining creative, having good timing, analyzing and taking risks, building consensus, mobilizing resources and being persistent. “The entrepreneurial leader takes an idea or an ‘invention’ off the drawing board and into practice, thereby achieving innovation” (Young, 1991, p. 62).

Zipple, Selden, Spaniol and Bycoff (1994) describe a good manager as one who has a clear vision of the role and the strengths of the organization,

understands and remains passionate about the agency's mission, is committed to providing quality services and is skilled in implementing his or her passion and commitment. The authors point out that these managers are not afraid to engage in continuous innovation and change, they opt for effectiveness over efficiency, they are constantly open to learning, they generate enthusiasm for the agency mission and they empower their staff to be good managers. "Managing well means being an effective leader over time" (Zipple, Selden, Spaniol and Bycoff, 1994, p. 392).

Oddly, in the privatization literature, the role of leadership has not been offered as a determinant of success or failure. Since leadership plays such a major role in the administration of human services, and in successfully steering an agency through a change process, it is surprising that it has not been more strongly identified or studied in the privatization literature. By contrast, this study underscores the importance of leadership in assessing and helping to develop CFS' readiness to withstand the turbulence associated with the privatization.

As managers and leaders, we all know the possibilities that change can present to us, and yet, "organizational change is sort of like going to heaven; everybody says it's a great thing to do, but nobody wants to do it, at least right now" (Gummer, 1995, p. 83). However, as Morgan (1997) reminds us, an organization that remains static in the face of environmental changes cannot survive. Privatization created those environmental changes for CFS and as such, the organization had to remain open to change and innovation if it were to have a chance not only to survive, but also to flourish.

## Chapter IV

### *Project Goals and Conceptual Framework*

#### *Goals of the Project*

Much of the literature reviewed suggests negative effects that privatization has on staff, clients and services. Impressionistically, the experience of CFS does not seem to support this view. In fact, to administration, staff and service recipients, the CFS privatization appears to offer a remarkably positive picture. The purpose of this study is to more objectively evaluate the effects of this change by gathering and analyzing agency data from before, during and after the privatization, in order to compare the characteristics of service recipients and the effectiveness of service provision to see if the informal positive impression of CFS can be substantiated empirically.

In light of the privatization literature, the experience of CFS suggests the need to look past simplistic assumptions about the negative impact of privatization in order to analyze under what conditions, if any, privatization may create positive outcomes for human service agencies. In doing so, I will also describe how I have integrated a Psychiatric Rehabilitation analog into my administrative practice to assist me in assessing CFS' readiness to change and in helping CFS to navigate through the privatization process more smoothly.

As the Executive Director who led CFS through this change process, of course I have had a major stake in preserving the agency's mission. Therefore, there is no way of knowing how much of what occurred after the privatization is a consequence of my commitment to that mission and to a successful change

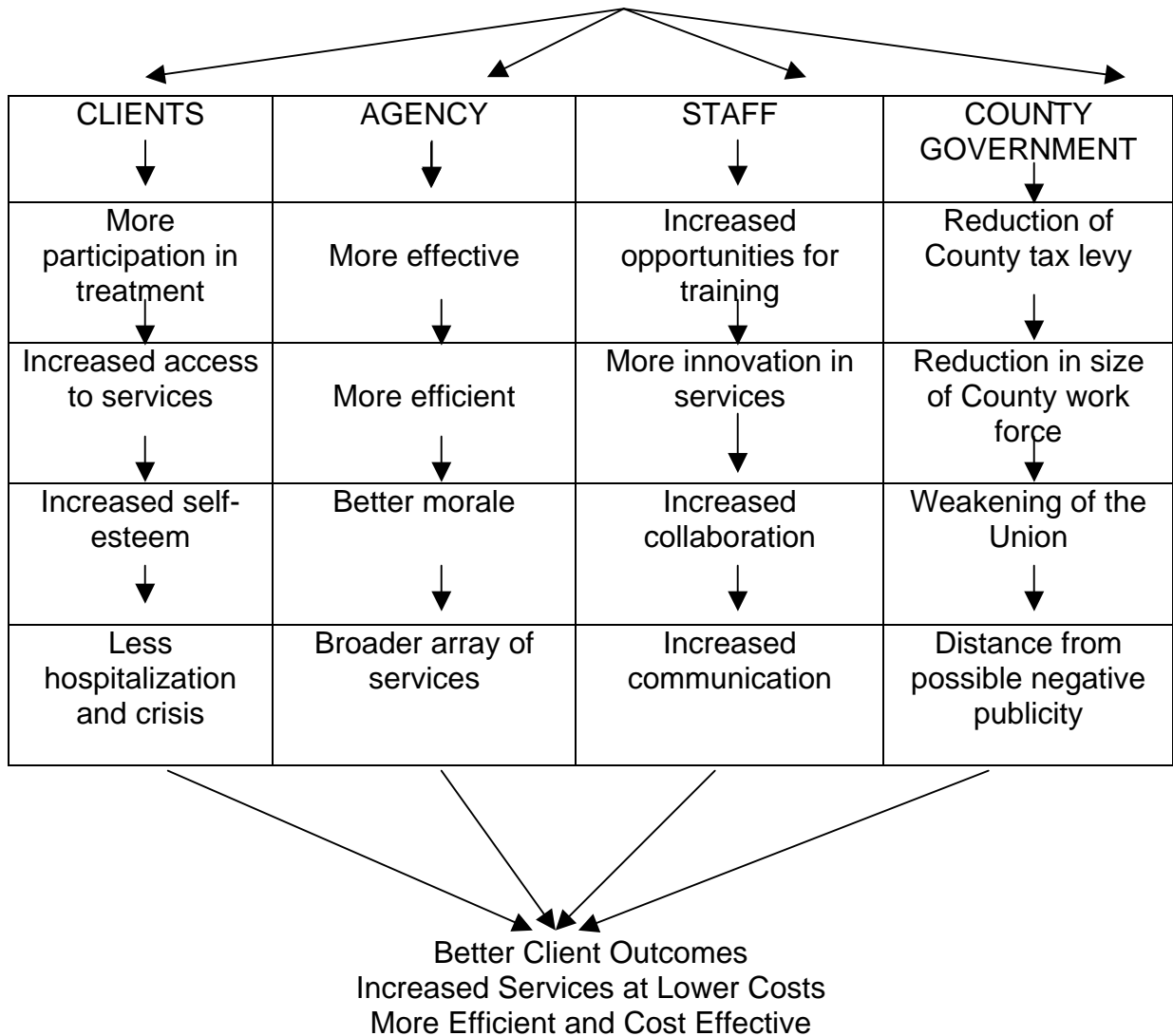
process. Other than the objective results of the studies, my role as leader creates a built in bias in interpretation of the study results that most likely cannot be eliminated.

### *Program Theory*

Each county in New York State is responsible for providing a system of mental health care for its residents. In defining a strategy for providing accessible, affordable, quality mental health care, the county we are investigating was faced with what Rittel and Webber (1977) call a “wicked problem” in which “the problems of social or policy planning are ill defined; and they rely upon elusive political judgment for resolution” (Rittel and Webber, 1977, p.135). Planning is a component of politics (Rittel and Webber, 1977) and the planning for auspice change for the mental health system in this county, like so many changes in our system, was fraught with politics and laden with value conflicts.

When the county privatized its services, it ceded all responsibility to the new agency for providing an administrative infrastructure. Further, all mental health and chemical dependency services were officially transferred to the not-for-profit agency, CFS, through a purchase of service contract. The County Executive and the County Commissioner of Mental Health promoted privatized mental health and chemical dependency services in order to reduce costs, increase staff productivity, expand opportunities for clients, reduce the size of government and remove the burdens and constraints imposed by government and civil service regulations. As Figure 1 illustrates, the underlying program theory of privatization (Weiss, 1998) is that the production of services would be

Figure 1: Program Theory Model: Privatization of CFS



(Adapted from Weiss, 1998, p.56)

far more efficiently and effectively run by a private organization, while still being monitored by County government.

The politically conservative County Executive had made a campaign promise to reduce the size of government and to limit the power of the civil service union. The equally conservative county voting population

overwhelmingly supported him in the transfer of service delivery. Also implicit in the privatization effort was the desire to divorce county government from the problems of the client population and the negative publicity that some of the people with psychiatric disabilities enrolled in county programs had occasionally generated in the past. The County Executive had a number of stated general objectives when he privatized the agency, including:

- 5% yearly reduction in tax levy contribution to mental health services;
- increased staff productivity as workers lost civil service union positions and became employees of the nonprofit agency;
- increased revenue collection by modernizing and computerizing billing systems;
- increased client self-pay and reliance on third party reimbursement.

If both the County Executive and this positive view of privatization theory were proven to be correct, the cost of implementing services should have decreased and the quality, efficiency and effectiveness of services should have improved as a result. Service efficiency and increased productivity might be seen through increased numbers of clients seen per year, increased numbers of units of service delivered per year and an increase in the number of units of service delivered per full time equivalent staff (FTE). Efficiency might be demonstrated by a decreased cost of delivering a unit of service and increased revenue collection as well as diversification of revenue sources. If quality and effectiveness were to be sustained or improved, it would be through the development of new and innovative services and demonstrated by increases in

the number and array of treatment interventions and referrals, increased numbers of clients achieving their goals and objectives and a positive perception of the treatment experience.

In conducting this study, I used financial and statistical data to evaluate efficiency and cost effectiveness by comparing relative expenses, revenues, full time equivalent staff, number of clients seen, and units of service delivered at various times before, during and after the privatization. However, efficiency and cost effectiveness were not sufficient indicators of success, especially if they were achieved at the cost of quality and effectiveness of care. Therefore, I gathered available agency information through clinical data-mining (Epstein, 2001) to explore the quality and effectiveness of service provision. The following indicators were used:

- length of stay, to see if the privatization caused staff to discharge clients prematurely;
- diagnosis and functionality to see if “creaming” occurred after the privatization;
- payor source, to see if clients who could not pay were denied services;
- number and diversity of staff interventions to see if the array of services available to clients changed;
- client and clinician perception of treatment, to see if outcomes changed.

In addition, I gathered and analyzed data from existing documents and closed client records to see if the privatization of CFS met the objectives laid out by the County Executive and the County Commissioner of Mental Health, and to see if

the data demonstrated that efficiency and effectiveness increased at CFS post-privatization. With multiple data sources and analyses, this study can provide a more complete description of possible changes in services, service provision and client responses to treatment at CFS. These findings can be helpful to other mental health administrators preparing for and managing the changes resulting from privatization.

*Conceptual Framework: Similarities in Practice Areas*

In social work, there is often a debate between practitioners and administrators about differences in perspectives and practices (Joelson, 1996; Payne, 1997; Penzer, 1989). To some degree, this is inevitable. The gap between the two is often enhanced by administrators' reliance on management and organizational theory to guide their actions while practitioners rely on a variety of personality and learning theories in designing new services and shaping therapeutic interventions. Trained as both a social work administrator and a clinician, I have always felt that the two fields of practice are not so far apart and that the theories that guide me in my management work are often the same ones that shape my clinical thinking (Joelson, 1996).

Penzer (1989) believes that much of what clinicians have acquired through their professional career is directly applicable to a career in administration. He emphasizes that it is important for a clinician to see the commonalities between clinical work and administration:

On one level, the analogues and parallels are obvious and require little elaboration. Given that administration demands high levels of communication

skills, understanding of human behavior and motivation, goal setting and different humanistic activities, clinicians are ideally suited to these skills. (p. 105-106)

Payne (1997) believes that social work occasionally develops its own theories, but more often selects from ideas developed in other disciplines and embellishes and adapts them to its own use. In doing so, both administrators and practitioners are borrowing and adapting theories every day to impact upon people's lives and help them and the world around them to change. Moreover, Payne (1997) sees social work clinicians as recognizing the individuality of each client and helping them to gain control and mastery over their environment and their own behavior. "Social work theory supports the notion that the needs and wishes of the individual served must count in any morally valid practice which intervenes in the social" (Payne, 1997, p. 298). In fact, he describes clinical theory in social work as more participatory than therapeutic and describes the need to utilize interventions that can advance these ends.

The same can be said for social work administrative practice. Facilitating systems change is a long and arduous process, especially in the current turbulent health care environment. Leading and guiding an agency through that change can be a struggle for any administrator, but it can be made far easier when staff are included in the process and understand the reasons behind the needed changes. When they gain some mastery over their own environment, they are empowered and can help foster positive change. With Agency change, the needs and wishes of the staff must be seriously considered in any change process if it is to be successful. (Weinbach, 1998)

### *Understanding the Paradigm Shift: Psychiatric Rehabilitation Theory*

“A theory’s construction and its career depend upon both the explicit and background assumptions forming the paradigm in which it is developed” (Roberts, 1990, p. 33). The paradigm shift from a maintenance to a recovery based vision of mental health (Anthony, 1993; Davidson, et.al., 2005; Mead and Copeland, 2005) has changed the assumptions of both practitioners and consumers about mental health services, creating a new set of theories to guide social work practice with people with psychiatric disabilities. In order to understand how Psychiatric Rehabilitation practice can be used to inform administrative practice, let me briefly describe the paradigm shift in mental health service delivery during the last two decades that has allowed for the rise of this innovative adjunctive service to prevention and treatment.

Kuhn (1970) suggests that most scientists work within one paradigm until that paradigm can no longer support situations that appear to be unexplainable or that appear to challenge formerly acceptable ways of thinking. Once this occurs, change is imminent and developing a new paradigm becomes essential (Roberts, 1990). Developed by William Anthony from the Center for Psychiatric Rehabilitation at Boston University in the early 1980’s, Psychiatric Rehabilitation sets out both a philosophy and a technology for helping people with psychiatric disabilities to choose, get and keep more valued roles in society. In other words, this process helps people to change for the better. Underlying this theory is a paradigm shift from a medical model to a rehabilitation and recovery model for the development of services required by people recovering from mental illness.

At the core of this model is the belief that “recovery from mental illness is the vision that will guide the mental health system in this decade” (Anthony, 1993, p.17). Three influences revealed a new picture of mentally ill people that challenged accepted ways of thinking and supported the paradigm shift in mental health service delivery: deinstitutionalization in the 1960’s and the 1970’s; the development of Community Mental Health Centers and the Community Support System; and a number of pivotal research studies (Harding, et.al., 1987) that challenged then existing theory and practice. No longer was it sufficient to maintain mentally ill people outside of the hospital, providing for their daily survival needs. People with mental illness and their families were asking for more and going out and getting it, despite the fears and biases of practitioners locked into the old paradigm. People with psychiatric disabilities were challenging existing ways of thinking and their positive results at achieving and maintaining normalized goals could not be explained within the traditional treatment model (Anthony, 1993).

The new recovery paradigm offered new ways of thinking about and working with people with mental illness, offered new roles for practitioners and consumers, and expanded ideas of service outcomes. Psychiatric Rehabilitation theory asserts that people with mental illness must “determine their goals, identify what they need to do and have in order to achieve these goals, plan what to work on first and how, and then develop the necessary skills and supports to achieve their goals” (Anthony, Cohen, Farkas and Gagne, 2002, p. 126).

The operationalized paradigm shift from the medical or maintenance

(pathology) model to a recovery or person driven model (competence) of mental health services is shown in Table 1. With this paradigm shift, people recovering from mental illness are seen as people first, emphasizing their strengths rather than their symptoms or illness, and proposing recovery, rehabilitation and normal functioning as their primary objective. This new paradigm is the basis of Psychiatric Rehabilitation theory and all Psychiatric Rehabilitation interventions

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Table 1

*A Paradigm Shift in Clinical Practice*

	Pathology Paradigm	Competence Paradigm
Nature of Paradigm	Disease based medical model	Health based developmental model
View of Person	Mentally ill	Person with a disability
Emphasis On	Pathology and limitations	Strengths and resources
Role of Professionals	Practitioners	Consultants
Role of Consumers	Patients	Collaborators
Assessment Based On	Clinical typologies	Competencies and deficits
Goal of Intervention	Treatment of mental illness	Recovery
Modus Operandi	Providing psychotherapy	Enhancing coping effectiveness
Systemic Perspective	Individual or family system	Ecological system
Service Model	Authoritarian model	Educational model

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(Marsh, Koeske, Schmidt, Martz & Redpath, 1997, p.358)

are based on helping clients to achieve a higher level of competence and functionality.

Psychiatric Rehabilitation theory is grounded in an integration of the physical rehabilitation model and elements of many psychotherapeutic and behavioral theories. From physical rehabilitation comes the basic premise that people with disabilities need skills and supports to function successfully. Psychotherapy lends an emphasis on recipient involvement, a need for the participant to have some degree of insight in the selection of his/her goals, and a trusting relationship between participants and providers of service (Anthony, Cohen, Farkas and Gagne, 2002).

Psychiatric Rehabilitation practice employs clinical assessment and intervention techniques based on orientations borrowed from many other theories including social learning theory, behavior theory, client centered therapy, human resource development and lifespan developmental psychology (Anthony and Liberman, 1986). Also apparent in the foundation of Psychiatric Rehabilitation theory are ideas and concepts from social psychology theory, communications theory, role theory and humanist and existential theory (Payne, 1997). From humanist and existential theorists comes the belief that “human beings are trying to make sense of the world that they experience ...[and workers are trying] to help people gain the skills to explore themselves and the personal meaning they attach to the world they perceive and which affects them” (Payne, 1997, p. 175).

One of the major influences on William Anthony’s work in the development of Psychiatric Rehabilitation was Robert Carkhuff, who held strongly to the

“person-centered” ideas of Carl Rogers. Payne (1997) describes Carkhuff’s theories as based on the belief that each individual counselor’s attitudes have the power to affect a client’s recovery. Carkhuff stressed each client’s individuality and the need for the worker to concentrate on each individual’s needs to successfully function in the real world. He recommended focus on each person’s current strengths rather than on their past history and deficits.

Anthony integrated Carkhuff’s beliefs as he developed Psychiatric Rehabilitation theory and these values and ideas are threaded throughout its basic principles and practices. Most importantly, Psychiatric Rehabilitation promotes the uniqueness of the individual, concentrates on skills and supports needed to perform real life roles and stresses the unwavering belief in the potential for human growth (Anthony, Cohen, Farkas and Gagne, 2002).

#### *Assessing Readiness for Change*

In order to engage in a rehabilitation change process, the client must be ready. The Psychiatric Rehabilitation process begins with assessing the individual’s readiness. Accordingly, the purpose of the readiness assessment is to determine the individual’s ability to successfully participate in a rehabilitation process in a meaningful way, and then to identify the areas of readiness that might need further development to insure successful change in the future (Cohen & Mynks, 1993).

Many people with psychiatric disabilities are unable to make decisions and engage in change because they have lost hope or have not been asked to decide on anything for so long. They may not be ready to engage in a

rehabilitation process until their readiness is developed. As a consumer advocate, Patricia Deegan (1997) offers an insider's look at the devastating effects of the stigma of mental illness and how it can deeply affect the will and the ability to recover as she shares from her personal experiences as follows:

The great danger is that you might undergo that radically devaluing and dehumanizing transformation from being a person to being an illness; from being Patricia to being a "schizophrenic" or a "bi-polar", or a "multiple". The reason this is so dangerous is because once a person comes to believe they are an illness, there is no one left inside to take a stand toward the illness. Once you and the illness become one, then there is no one left inside of you to take on the work of recovering, of healing, of rebuilding the life you want to live. Once you come to believe that you are a mental illness then you give away all your power and others take responsibility for you and your life. (p. 373)

Similarly, many people with mental illness have given in to their illness and given up hope. They have been expected to want little and have lost their dreams and sense of personal purpose (Deegan, 1996; Deegan, 1997; Unzicker, 1994).

Developing readiness for rehabilitation is designed to counter this loss of purpose and to help the individual to recapture the belief that he or she deserves to improve aspects of his or her life (Cohen & Mynks, 1993).

Practitioner training manuals prepared by the Center for Psychiatric Rehabilitation (Cohen, Farkas & Cohen, 1992) describe the *Psychiatric Rehabilitation Readiness Determination* process (PRRD) involved in assessing

an individual's readiness to engage in change. Practitioners conduct various exercises to assess the individual on the following five dimensions:

1. **Need for Change/ Dissatisfaction:** This dimension may be internally or externally motivated, coming from an internal desire to change or generating from someone else's external pressure on the individual to change. Without some level of dissatisfaction, it is doubtful that change will occur. A high rating for need would result from an individual's high level of dissatisfaction with their current situation or a high level of dissatisfaction from someone outside of the individual perceiving them as unsuccessful and in need of change.
2. **Commitment to Change/Motivation:** This is the belief that change is necessary, possible, that it will result in something positive and that it will continue because it will be supported. A high rating of commitment to change encompasses all four of these beliefs.
3. **Environmental Awareness:** This is the amount of knowledge a person has about the array of opportunities that the change will afford him or her. Engaging in change is hard enough when we know what the possibilities are but when we are unaware of what awaits us, change can be overwhelmingly frightening. A high rating for environmental awareness occurs when the individual can talk specifically about the people, places and activities that made up past opportunities and future opportunities.
4. **Self-Awareness:** This is the amount of knowledge a person has about why they like or dislike something they've experienced and how and why

they make the life choices they do. A high rating in self awareness will result from an ability to describe personal experiences and values in detail.

5. Personal Closeness: Without the ability to make a long-term relationship with someone and to stick with the process of change, positive outcomes would be doubtful. A high rating in personal closeness is obtained when there is the possibility of the development of a trusting relationship and when the leadership required to develop this relationship exists.

In the Psychiatric Rehabilitation model, the readiness assessment removes the blaming factor for people who have been unable to accept and engage in interventions that would lead them to change. Under the medical paradigm, these individuals were called “non-compliant” or “resistant” and often asked to leave programs. The readiness assessment implies that they are not unwilling but, rather, due to the debilitating consequences of their mental illness, they may be unprepared to engage in change.

#### *Developing Readiness for Change*

Once there is an understanding that the individual may not be resistant to change but may simply be unready to change, Psychiatric Rehabilitation practice can be used to develop readiness. The readiness activities should increase the ratings on the PRRD.

Cohen and Forbess (1992) describe five activities used to develop readiness to engage in change:

1. Processing Readiness: In this step, the individual reviews the PRRD,

develops an understanding of the results and begins to think about next steps.

2. Choosing a Direction: This involves deciding how to proceed with the change process. Alternative avenues of action are explored during this step.
3. Developing Awareness: A variety of activities are developed during this step to increase the individual's exposure to alternatives, hoping to increase the individual's information about alternatives and to help change attitudes.
4. Mobilizing Environmental Supports: In this step, significant others are enlisted to stimulate the individual's interest in engaging in change. The purpose of this step is to increase the belief that the change will be supported.
5. Personalizing Accomplishments: In this step self-confidence is increased by helping the individual to feel a sense of personal accomplishment by successfully completing actions that are personally meaningful and something that the individual did not think she or he could accomplish.

“Developing readiness for rehabilitation is designed to empower a person to believe that he or she can improve his or her life” (Cohen and Mynks, 1993, p. 7)

#### *The Prochaska Model of Change*

There are other similar models for assessing and developing individual change. One such model, developed by Prochaska, Norcross and DiClemente (1994), is widely accepted in the chemical dependency field and has recently

begun to be applied within the mental health field as well. The model defines six stages of change. The authors found that people used specific tools at different times within their change process to help them succeed and that these times were identical from one person to another. "Each of these experiences is a predictable, well defined stage; it takes place in a period of time and entails a series of tasks that need to be completed before progressing to the next stage" (Prochaska, et.al., 1984, p. 39). These stages are strikingly similar to the areas outlined in the Psychiatric Rehabilitation Readiness Determination.

The first stage is *precontemplation*, where people have no intention of changing their behavior and don't see the existence of any problem. In the Psychiatric Rehabilitation model, in the area of need/dissatisfaction they would rate low and have little or no need. The second stage is *contemplation*, where the individual is beginning to admit that he/she may have a problem but has not yet figured out how and when to solve it. In a Psychiatric Rehabilitation Readiness Determination these individuals would have a low commitment to change, and a slim view that change would be possible, positive and supported. The third stage in Prochaska's model is *preparation*, where the individual begins to plan to take action to change his/her behavior and begins to voice an intention to change. This stage is similar to the environmental awareness and self-awareness areas of the Psychiatric Rehabilitation Readiness Determination. In these, the individual would be exploring his/her own values and beliefs about making the change and learning as much as possible about what options for change are available. The fourth stage in Prochaska's change model is *action*,

where the individual changes his/her behavior and surroundings, followed by the fifth stage, *maintenance*, where the individual begins to accept and become comfortable with the changes. The last stage in this model is *termination*, where the change has been totally integrated and fear of relapse has disappeared.

These last three stages, action, maintenance and termination, are analogous to Psychiatric Rehabilitation interventions designed to follow readiness assessment activities where Psychiatric Rehabilitation practitioners assist clients to obtain and maintain their desired changes.

### *Organizational Application*

Analogous stages can be used to describe and assess an organization's journey through the change process. In *precontemplation*, an organization is not yet aware of the internal or external dissatisfaction that might be pressing it towards a change. The organization is functioning as it always has, unaware of or not interested in any factors that may be pushing it towards change. In the *contemplation* stage, the organization has realized that it is not functioning as it should and that some kind of change is necessary but the organization has not yet addressed what that change might be. In the third stage, *preparation*, the organization's personnel are beginning to talk about the needed changes and thinking about how to achieve them. During the next stage, *action*, the organization begins to implement the change process, followed by the fifth stage, *maintenance*, where the organization becomes comfortable functioning in its new way. During the last stage, *termination*, the organization has integrated the changes with no fears of reverting to old ways of doing business.

### *Planned Change at County Family Services*

There are a number of ways that administrators have to analyze an agency's readiness to change. Lewin's (1951) force field analysis provides another excellent tool to conceptualize readiness for change at CFS. Lewin felt that stability is a "dynamic rather than a static condition" (Brager and Holloway, 1992, p. 108). As a result of privatization, the forces within and outside of CFS were changing, especially in the turbulent health care climate of the 1990's. Like the Psychiatric Rehabilitation Readiness Determination, the force field analysis can help determine an individual's or an organization's readiness to change. "The analysis sharpens their focus on next steps. It allows the search for alternatives in regard to intervening to increase or decrease working force" (Brager and Holloway, 1992, p. 128).

Kast and Rosenzweig (1974), offer an additional but similar approach to exploring organizational change. They suggest the concept of "planned change...[which] assumes that the organization in general and the manager in particular can identify gaps between current conditions and desired conditions on a variety of dimensions" (Kast and Rosenzweig, 1974, p.578). The dimensions they found most relevant to planned change were effectiveness, which they describe as the achievement of organizational goals and outcomes; efficiency, or better use of agency resources; and participant satisfaction for staff, clients and other stakeholders. They describe the process of planned change as including a number of steps. The first, they call problem sensing or recognizing the need to change. The next step is defining the problem and

assessing the current condition the organization finds itself in and the desired condition it wished to move towards. The following step is problem solving, or generating alternative solutions and action plans and then evaluating their feasibility. The last step involves implementing the change, evaluating the outcomes, and choosing any necessary future course of action.

### *Using Psychiatric Rehabilitation to Inform Administrative Practice*

As was previously described, the practice of Psychiatric Rehabilitation requires, in part, that one assess an individual's readiness to change, intervene to increase that readiness if needed, and then increase the skills and supports that the individual would need to function successfully in order to meet his or her goals (Anthony, Cohen, Farkas and Gagne, 2002). As discussed earlier, relying on Gareth Morgan's (1997) metaphor of organizations as living organisms, we should be able to use analogues of the theories and techniques that have been developed to assess individual readiness to assess organizational readiness to change.

In using Psychiatric Rehabilitation theory to inform my administrative practice, I posited that in order to engage in change, an agency, like an individual, must be ready. Trained in the Psychiatric Rehabilitation model in the early 1990's, when I became Executive Director of CFS, I developed and applied an organizational version of the Psychiatric Rehabilitation Readiness Determination (PRRD) tool to help assess this agency's readiness to function as a successful nonprofit. I call this tool the Organizational Rehabilitation Readiness Determination (ORRD).

At CFS, using Psychiatric Rehabilitation practice to guide my administrative practice has helped me to assess this agency's readiness to engage in change during the planning for the privatization, and to explain some of the ways that readiness for change needed to be increased after the privatization occurred. By using Psychiatric Rehabilitation as a change theory, I found that it provided a useful framework for understanding and assessing the changes that resulted at CFS from the privatization.

One of the core values of Psychiatric Rehabilitation is seeing each person as a unique individual. Similarly, as leaders, we should promote the uniqueness of each agency and concentrate on the specialized skills and supports needed by the agency to be successful in its particular environment. Regardless of how turbulent that environment might become, the agency leadership, staff and clients must believe in the agency's unique ability not only to survive, but also to flourish.

Psychiatric Rehabilitation views the client from a strength-based perspective and does not see someone's unwillingness to change as necessarily "non-compliant". It is the practitioner's role to help the client understand the change process and explore the client's need for change. Similarly, from an organizational perspective there are always those who appear to be "non-compliant" with change. They can be viewed not as unwilling to change, but as unprepared to engage successfully in the change process at a particular time. Agency leaders can assist those staff and clients who appear to be "non-compliant", but are actually just not ready to change, to explore the need for

change and develop their readiness so that systems change might be successfully facilitated in the future.

Engaging in Psychiatric Rehabilitation readiness activities can empower people to believe that changing their life is possible. Similarly, staff empowerment is equally important in insuring successful organizational change. In many organizations leaders fail to communicate the pressures that an agency may face in the fast paced marketplace. Staff feel uninformed and incapable of having an impact on administrative decisions. Often, clinical staff engage in their day-to-day business, unaware of the problems that their agency may be facing. The rift and competition between clinicians and administrators fuels this poor communication as each side sees the other's practice as magic and beyond their comprehension. The clinician's lack of awareness of the agency's problems may not be detrimental in times of growth and prosperity, but when cutbacks and rapid change are the order of business, this lack of knowledge and lack of understanding of the need to change can create fear and chaos in an agency (Weinbach, 1998). By adapting Psychiatric Rehabilitation theory and practice, an administrator can help to facilitate both individual and systems change by helping participants to believe that they have a voice in the process and that the outcomes of the change will be positive. Conversely, change is impeded when participants do not understand the need for the change and feel powerless in the process (Brager and Holloway, 1978; Brody, 1993; Weinbach, 1998).

#### *Helping an Agency to Change*

If a leader is to assist an agency successfully through a process of

change, he/she must assess where an agency is in the process of change and help to: develop a more complete understanding of readiness to change (Cohen and Forbess, 1992); develop the tools needed to move to the next stage of change (Prochaska, Norcross and DiClemente, 1994); increase the driving forces and decrease the restraining forces for change (Lewin, 1951); and close the gap between the current and the desired organizational condition (Kast and Rosenzweig, 1974).

Privatization altered both CFS' culture and its process of service provision. Adapting the tools of the Psychiatric Rehabilitation approach to my administrative practice was a strategy that I used to lead CFS through the change process it was experiencing, and a possible explanation for its impact. Appendix A is an Organizational Rehabilitation Readiness Determination (ORRD), which I have adapted from the Psychiatric Rehabilitation Readiness Determination (PRRD). For this study, through the use of historical documents, discussion and observations, I will make use of the ORRD to demonstrate how CFS was ready for the changes necessitated by privatization and to highlight other areas where I needed to help CFS to develop its readiness to accept the changes it would be experiencing.

## Chapter V

### *Evaluation Research Design*

#### *Designing the Study*

The evaluation design of a study clarifies its structure, enabling clear and well-articulated research questions to be appropriately answered (Weiss, 1998). Smith (1990) describes four parts of a study design: selecting the design; choosing how to collect the data; designing a data collection instrument; and choosing the sample of who or what to observe and study. “The research design is the logic of how you answer the research questions” (Smith, 1990, p. 70). The overriding question in this study is how privatization impacted CFS. More specifically, did it become a more efficient and more effective organization? Did it become more efficient at the expense of effectiveness? Did CFS maintain prior levels of effectiveness and efficiency or was the impact of privatization wholly negative?

“Very little in human behavior and activity can be predicted exactly, so most studies are looking for evidence of trends or tendencies, rather than absolute cause and effect” (Black, 1993, p. 11). The privatization occurred over time and created massive organizational change at CFS. As Black implies, it would not be possible through this study design to prove direct cause and effect between the privatization and changes in service provision. However, as Weiss (1998) suggests, one can use the evaluation research methods described in this study as organizational learning to record program history so that others can learn from this privatization attempt. Administrators can begin to understand the

politics of this event “to study the stimuli that lead to change and the environmental conditions under which change is likely to occur” (Weiss, 1998, p. 28).

### *Selecting the Design*

Evaluation research can be defined as:

...the systematic assessment of the operation and/or the outcomes of a program or policy, compared to explicit or implicit standards, in order to help improve the program or policy. Evaluation is undertaken when the program is complex, hard to observe, composed of elements interacting in multiple ways; when the decisions to be made are important and expensive; when evidence is needed to convince others about the merit and/or failings of the program...[and] can also be a tool of accountability. (Weiss, 1998, p. 18).

The privatization of CFS and its subsequent development as a voluntary not-for-profit agency was administratively and politically complex and, as such, presented a necessary condition for evaluation research. Especially interesting is that, contrary to the negative predictions from many authors cited in the literature, after the privatization, CFS appeared to have better staff morale as well as more effective and efficient service provision than before. The quality of services seemed to have improved and become more client recovery focused. Further, the scope of services has expanded to include state-of-the-art clinical interventions not previously offered in this county. However, these were impressions only and were not yet supported by systematic evaluation.

“Program evaluation is the use of social science research methods by evaluators, administrators, or practitioners to assess the planning, implementation, or outcome of social programs in a political environment” (Smith, 1990, p.15). Evaluation research at CFS, conducted through a longitudinal study, a pre-post study, observations and analysis of historical documents, has enabled the exploration of the privatization experience at CFS and will be used to assess if, in fact, the effectiveness and efficiency of the Agency did improve, or at the very least did not deteriorate.

#### *Designing the Data Collection Instrument and Data Collection Methodology*

Common sources of data for evaluations include formal and informal interviews, observations, written questionnaires and surveys and existing records (Epstein and Tripodi, 1977; Weiss, 1998; Smith, 1990). Primary research methods based on original data collection such as observation, interviews and questionnaires are always considered part of the “gold standard” in research. The other necessary element is the randomized experimental design. Neither was chosen to use in this study because of my position as Executive Director and my unique role in leading CFS through the change process. Therefore, in order to limit the bias and ethical issues possibly created by my role as Executive Director, more secondary methods, such as exploring existing clinical and financial records, were chosen. These documents contained a wealth and range of information that was used to compare a number of relevant variables before and after the privatization without the ethical, methodological and inferential difficulties that might arise with the direct interviewing of staff or clients who might

feel compelled to report positive outcomes. The data collection methods used in this study are described below.

### *Time Studies*

Two time study approaches were employed. The first, a longitudinal study, used the Consolidated Fiscal Report that provides data that reveals cost effectiveness and efficiency. The second was the creation of a “retrospective quantitative data base” (Epstein, 2001, p.16) collected through a review of closed client records prior to and after privatization. The latter methodology added immeasurably to an understanding of possible changes to CFS’ client base and quality of care. Exploring any changes in organizational performance prior to and after privatization revealed how closely the assumptions of the previously stated program theory were met and which, if any, negative consequences predicted in the anti-privatization literature CFS may have experienced.

### *The Consolidated Fiscal Report*

An abundance of data was readily available in a document entitled the Consolidated Fiscal Report (CFR) that is a comprehensive record of expenditures, revenues, clients treated and units of service delivered. The CFR is a state budget and statistical reporting document that is required to be filed yearly by every agency in New York State that receives state funding. This document is reviewed by the County fiscal authority and the New York State Office of Mental Health and used by these authorities in monitoring productivity and cost effectiveness.

The data from CFS’ Consolidated Fiscal Report (Appendix B) helped to

operationalize the previously stated program theory and the County Executive's assumption that privatization would result in improved productivity and therefore increased cost effectiveness. For this analysis, increased productivity was defined as increased numbers of clients seen per year, increased numbers of units of service delivered per year and an increase in the number of units of service delivered per full time equivalent staff (FTE). Greater efficiency, or superior cost/outcome ratios, was defined as decreased cost of delivering a unit of service, increased percent of revenue collected in relation to gross costs and maximization of revenue sources other than Medicaid. Increasing the amounts and types of revenue other than Medicaid that CFS accessed would in turn, decrease the cost of delivering a unit of service. Data concerning these variables was readily available from the CFR and was extracted and compared for defined periods before, during and after the privatization to explore whether the administrative objectives of improved effectiveness and efficiency were met.

A data extraction form (Appendix B) was designed to clearly present the variables and to allow the use of the CFR to gather sufficient data to implement this longitudinal study for the period 1995, 1996, 1997, 1998 and 1999. These time frames were selected for a number of reasons. As previously stated, the privatization occurred in July 1997 and the six-month period directly before and after was a time of considerable turmoil and staff turnover. When I joined CFS as Executive Director in July 1997, there were staff vacancies created by staff transferring to other County services to protect their civil service status. Since the County Commissioner had been planning the privatization for more than a

year, any vacancy that arose was not filled to avoid the need to transfer staff from County to private auspice when the privatization actually happened. Essential staff that had to be hired during this period were hired on a contract basis that ended June 30, 1997 and then promised transfer to CFS auspice on July 1. From July to December 1997, a number of staff continued to transfer to County vacancies to retain their civil service status while others chose to retire from County service and continue with the agency on CFS' payroll.

Therefore, an after only study or a before/after study alone would not give a full developmental picture of the agency's functioning because the privatization itself was an intervening variable. In the year directly preceding the privatization, the staff of CFS were asked to be an active part of discussion and negotiation about how to privatize. Much of the time that would have been scheduled for service provision was used, instead, for planning and implementing the auspice change. The last full year of operation was most likely two years prior to privatization. By analyzing the data from that more typical, pre-change period, it was possible to obtain a more accurate impression of how the agency functioned over time.

*Issues of reliability, validity and accuracy.* The CFR is completed yearly by the CFS Director of Finance and is audited by an outside accounting firm. The yearly outside audit of the CFR helps to insure its reliability, validity and accuracy. Revenues and expenditures must match quarterly reporting and reimbursement submitted to the County. The statistical data in the CFR must match the monthly statistics sent to the State Office of Mental Health and the

Office of Alcohol and Substance Abuse Services. Content validity is assured through a comprehensive statewide CFR manual that clearly outlines each variable and describes the way that each is expected to be measured. The same person, the County Fiscal Manager, completed the CFR during the two and a half years prior to the privatization. For the two and a half years after the privatization, the CFS Director of Finance completed the CFR. The Director of Finance was trained by the County Fiscal Manager who monitors and checks the document before it is audited and submitted to the appropriate State government office. Although there have been small formatting changes, the CFR document has not changed during the years of the study allowing for consistency in response and therefore intended to ensure reliability. In my various management positions in the mental health field, I have completed and reviewed CFRs for many years and am very familiar with the document. However, I have never before used it to measure organizational change. The fact that I was the sole individual doing the data extraction helped to promote the reliability of the findings but this was never measured empirically. To promote external validity, triangulation, or checking multiple data sources for agreement on key variables, was also conducted in an attempt to look for corroborating measures of the same phenomenon. This was accomplished by checking other statistical reports and year-end audit reports that were readily available (Epstein, 2001).

#### *Client Case Records*

A second rich source of archival material was the client record. A practice-based retrospective research study based on available client information was

conducted to compare variables described below using what Epstein (2001) refers to as “clinical data-mining”. A quantitative SPSS database was created that contained the extracted information for the purposes of data analysis. This approach was very appealing since it was neither programmatically or clinically intrusive and, since it was not an experimental study, did not require the “random assignment and denial of service...” (Epstein, 2001, p. 22) that practicing social workers often find ethically objectionable. By mining and analyzing these available data, this methodological choice not only raised fewer ethical questions, but was also faster and more economically efficient and much less disruptive to the work of the agency than would be a prospective study based on original data. At the same time, it allowed for less than “gold standard” causal inferences (Epstein, Zilberfegin and Snyder, 1997).

Still, for a study such as this one in which direct access to the client may not be available for the study period, data-mining allows the creation of a valuable database that could not otherwise be assembled. Through data-mining, it is possible to test program theory concerning increased quality and effectiveness of services after the privatization by analyzing client characteristics that are clinically and programmatically relevant as well as treatment outcomes. Although measuring outcomes in mental health services can be difficult and somewhat ambiguous, given the breadth of issues for which people seek mental health services, through this chart review it was possible to look at service provision before and after privatization to see if any of the unwanted changes in client population, length of stay, achievement of goals and frequency and variety

of clinical interventions described in the anti-privatization literature occurred at CFS.

Most importantly, the mining of these data sources could conceivably lead to a more reflective social work administrative and clinical practice for CFS. As Epstein suggests, this practice-based research study is intended to “effectively link(s) research and practice through collaboratively addressing questions that emanate from practice. In return, the collaboration provides information, concepts, and theories that enhance practice” (Epstein, 1995, p 85). The results of this study can be discussed with clinicians and administrators and “through reflective processing with practitioners, the unanticipated findings... [can be] positively incorporated into a more refined understanding of their practice” (Epstein, 1995, p.94).

*Issues of reliability, validity and accuracy.* A data extraction form (Appendix C) was designed to retrieve and record information from the client record. The form includes:

- Client relevant variables such as client characteristics (e.g. demographics, payor source, existing co-morbidity issues and degree of functional disability and impairment);
- intervention variables such as therapeutic interventions and referrals at intake and during treatment;
- outcome variables such as use of emergency services, meeting discharge criteria at termination and clinician and client perception of treatment outcome.

Data were extracted by reviewing each client record and recording the identified data onto the data extraction form. Client names were not used and client records were numerically coded to insure confidentiality. Since individual clients were not identifiable and all results were aggregated, CFS' HIPAA rules and regulations were met and, therefore, did not pose any difficulty or limitation. As Executive Director, I assured access to records by obtaining the approval of the County Commissioner of Mental Health and the Agency Board of Directors to gather the data necessary to inform this study. In February 2005, this study was submitted to the Hunter College Institutional Review Board and on February 28, 2005 the Committee for the Protection of Human Subjects from Research Risk declared the study exempt under 45 CFR 46.101(b) (4). As requested by the Committee, an update on progress to date was resubmitted to the Board in February 2006.

Content validity was enhanced by drawing on the issues of concern outlined in the literature review and by "practice wisdom" gained from the many years of experience I have had developing and implementing mental health services (Mirabito, 2001). In order to maximize validity and reliability, I extracted the data from all of the client records myself. With many years of mental health experience in developing, completing and monitoring these records, I am most familiar with them (Epstein, 2001). In addition, the data extraction form was reviewed and revised based on discussions with CFS' Medical Director and clinical staff who had extensive experience, both in providing services to adults and in utilizing New York State Office of Mental Health's charting forms. The

process of designing the data extraction form included numerous revisions after discussions with clinical staff as I strove to include information that would be evidence of behavioral and organizational change in service provision and also clearly outlined and obtainable from the client record.

When the final variables were determined, before the data were extracted, a codebook (Appendix E) was developed defining the variables and outlining where within the client record the information for each variable would be taken. The codebook was developed in consultation with clinical staff and CFS' Medical Director to help ensure against my own biases in coding as I extracted the data. Client service outcomes and staff and client perceptions of treatment were quantified and recorded in the codebook to further minimize bias. In this way, the potential that each variable was accurately and consistently coded was maximized.

Guided by the negative consequences of privatization outlined in the literature review, and assisted by the clinical staff that helped in the review of the data extraction form, I developed the following clinical indicators of a successful, positive or clinically neutral privatization:

- no “creaming” or admitting clients who are less ill as evidenced by admission of clients with less serious or less complex diagnostic criteria;
- Global Assessment Functioning (GAF) scale ratings remaining similar or lower, indicating continuing to admit clients who are very ill;
- at least the same amount and array of interventions are afforded to each client (expensive “state-of-the-art” interventions are not withheld after

privatization to save money);

- clients are continuing to meet their goals and are not being discharged and denied further treatment;
- both clients and staff continue to perceive the program as producing treatment successes;
- the use of hospital and emergency services remains the same or decreases, indicating that more difficult to treat clients are not being shifted to alternate levels of care to save time and money.

In May 2005, the data extraction form was piloted on 15 randomly selected case records from the 1995/1996 Mental Health Clinic data list. From this pilot and discussions with staff, the form was revised to better quantify the qualitative information. For example, the original data mining form contained a question on the frequency of clinical interventions that were suggested at intake. I wanted to capture data to measure whether the frequency of clinical interventions declined after privatization possibly indicating less service provision for cost saving. This question was removed since, during the pilot, it became clear that the frequency of interventions suggested at intake was not always followed throughout the course of treatment. Throughout the course of treatment, the clinicians documented multiple changes to both the types of interventions and the frequency of those interventions on the progress notes and treatment plan updates and therefore, the frequency of the interventions was difficult to accurately capture.

I concluded that the number of treatment recommendations at intake

and the number of referrals during treatment would be a more reliable and valid indicator of the level of service provision than the frequency of those interventions. Information on treatment recommendations and referrals is readily accessible in the client record, and indicates a level of clinical understanding of the presenting problem and the needs of the client, as well as the client's access and referral to state-of-the-art techniques during ongoing treatment. In addition, changes made after the pilot also included further clarifying diagnostic categories, expanding the array of presenting problems and clinical interventions and including the presence of co-occurring chemical dependency issues.

### *Selecting the Sample*

The sample was selected from CFS' two largest mental health treatment programs, the Mental Health Clinic and Continuing Day Treatment. For the clinical data-mining study, purposive and systematic sampling was used, and analysis focused on comparisons before and after the privatization. In the CFR portion of the study, in addition to before and after measures, I was able to capture during measures since the data collected was reliable to capture, readily available, accurate and objective, and not client specific. On the other hand, for the clinical data-mining portion of the study, in order to capture reliable during measures, the sample would have had to include people who were admitted, seen and discharged within the one year period, January to December 1997. Since the mean length of stay for clients both prior to and after the privatization was longer than 12 months, sampling clients who were in treatment for only one year would create an atypical cohort different from the other two groups, and

could corrupt the findings. At CFS, clients who are in treatment for short periods of time are often obtaining evaluations for social services, the jail or the courts. Their reasons for coming to CFS might be different from the other clients who engage in treatment for more than one year. In addition, since average length of stay was usually longer than 12 months, I did not think that I could find a large enough sample of this group to make the comparison meaningful. Further study of this cohort of clients seen in the year 1997, 6 months prior to and 6 months after the privatization, might show interesting results.

Since the Continuing Day Treatment Program does not treat children, and in 1995-96 the Mental Health Clinic did not have an active children's component, treating less than 20 children and families, anyone under the age of 18 was excluded from the study sample. The study included all the clients who were admitted to the program and treated for at least 6 months during 1995-1996 and discharged within 30 days of the study years, as well as all the clients who were admitted to the program and treated for at least six months during 1998-1999 and discharged within 30 days of the study years.

People seen for less than six months were excluded for a variety of reasons that created situations where there would not be sufficient data available to mine. For example, CFS will often provide only an initial psychiatric assessment or evaluation for people who are in the County Jail, applying for services at the Department of Social Services or in need of a competency hearing for the local courts. These assessments and evaluations were much more common in 1995/1996 when CFS was a County facility. Since these

assessments and evaluations were more common prior to privatization, eliminating them would help to ensure that the data being compared prior to and after privatization were being mined from similar treatment cases.

According to New York State Mental Health licensure rules, treatment plan reviews are done in both program models after 30 days and then reviewed three months later. Only after the three month review would there be a written record that goals had been met, revised or canceled. The New York State Office of Mental Health procedures require that client charts be left open for 90 days past the last visit to allow for extensive outreach to return the client to treatment. Anyone seen less than 6 months might include clients who came for only a few visits, or sporadic treatment, and then were left open for outreach. These clients would not have sufficient documentation in their records for review. Also, in 1995/1996, records were not always terminated and closed in a timely fashion, so clients may have remained open without visits and without further contact from the clinic. Including only those clients who were in treatment for at least 6 months increased the possibility of finding client records that included: a full core history and psychosocial evaluation; the development of an initial treatment plan; a diagnosis; mental status; and a Global Assessment Functioning scale. In addition, sampling only those clients who had been in treatment for at least six months allowed for engagement of the client with the clinician and development of a personally meaningful treatment plan.

The Continuing Day Treatment program treats approximately 50-60 clients per year. During the study period, the Continuing Day Treatment admissions

were kept by hand on index cards in a file box with dates of admission and discharge clearly noted. For the purposes of this study, the cards in the file were separated to identify all clients who fell into the sampling criteria. There were 56 eligible Continuing Day Treatment clients, 28 in 1995/1996 and 28 in 1998/1999. Since the sample size was small, it was decided to enumerate all of them for this research.

During the selection of the 1995/1996 sample, three cases were excluded because the records were missing. In eight other cases, there were several missing chart notes. Although these eight cases were included in the study, I was not able to gather all the information on the data extraction form. In addition, during the selection of the 1998/1999 sample, three records were excluded. In one case the client stopped coming before the study year but the record had not been closed. The other two records were missing. For each study year 3 cases were not eligible for inclusion, leaving 25 case records for each study year for a total of 50 cases reviewed.

The Mental Health Clinic treated approximately 400-500 people per year in 1995/96 and 600-800 per year in 1998/1999. Creating an accurate database for this program proved a more difficult task. To begin, a client listing from an access database that had been developed in 1998 was run. After reviewing the results, it was discovered that they were not inclusive; there were a number of cases that had never been entered into the data base. In addition, cases that had been entered had not been closed when treatment terminated. Consequently, for the 1995/1996 cases, an examination was conducted of a series of composition

books that presumably held all clinic cases with accurate dates of admission and discharge. After compiling that list, it was discovered that names in these composition books were not accurate either and that the program attended was often incorrect. Consequently, both of these data sources were discarded. Instead, CFS' main Cardex file was used. This file contained all the clients seen since the inception of services in the 1950s until 2002 when it was eliminated.

In May 2005, I reviewed the thousands of cards in this main Cardex file and extracted all of the names of clients who were: at least 18 years of age; admitted to the Mental Health Clinic; treated for at least 6 months during 1995-1996; and discharged within 30 days of the study years. In addition, I included all the clients who were at least 18 years of age and admitted to the program and treated for at least six months during 1998-1999 and discharged within 30 days of the study years. Then, an Excel spreadsheet was created which alphabetized the names and removed duplicates. The total number of eligible cases for 1995/96 was 159, and for 1998/1999, eligible cases numbered 133. I then chose to include 1/3 of the eligible cases in the study. A systematic sampling of every third case in each group was then selected for a total sample of 53 in 1995/1996 and 44 in 1998/1999.

During the selection of the 1995/96 clinic cases, 6 cases were discovered to be ineligible for inclusion. One was a continuing day treatment client, 1 client was under 18 years old, 1 client came only once, 1 client never came and declined treatment and 1 client's record was missing. Six additional cases were selected using the same sampling methodology of every 3<sup>rd</sup> case, starting from

the last case selected and skipping over any previously selected cases. During the selection of the 1998/1999 cases, 7 cases were discovered to be ineligible for inclusion in the study. One chart was incomplete, 2 clients were seen only twice but never closed, 1 was a continuing day treatment record, 1 client came only for a psychiatric evaluation, 1 was enrolled in the chemical dependency treatment program and 1 client's record was missing. Seven additional cases were selected using the same sampling methodology for a total of 44 eligible cases. The total sample for both years for the Mental Health Clinic was 97 cases. The total sample for the entire study including both programs and both study years was 147.

#### *Limitations of the Data-Mining*

Predictably, there are certain limitations to research using available clinical information. Some of these limitations were encountered in this study. First, the reliability of the data could be open to question since the client records are prepared by a variety of practitioners and not intended for research purposes. There could be variability in how similar characteristics and interventions are described and named (Nilsson, 2001). For example, one of the outcome variables used in this study is based on client's perceptions of the effectiveness of treatment. The response for this question is gleaned from the clinician's notes since the client does not write directly in the record. Some clinicians routinely record the clients' feelings about treatment while others rarely elicit and/or record the client's point of view, especially if it is different from theirs. Moreover, each clinician completes the client record within his or her own frame of reference.

The Global Assessment Functioning scale, assignment of the category seriously mentally ill, assessment of the degree of functional disability and even diagnosis are often a matter of clinical judgment. Although completing client records in a comprehensive and timely manner is a constant source of discussion in licensed mental health programs, clinicians are not equally rigorous about their charting. If records are incomplete, valuable information can be lost, thus making the accuracy of comparative analysis questionable. Finally, since this study does not use a control group and the numbers are small, we cannot infer causality or generalize beyond the population studied (Epstein, 2001; Mirabito, 2001; Nilsson, 2001).

Despite these limitations, information from the clinical records still contributed to our understanding of how the privatization affected clients and services at CFS. And, it was likely to be more objective and less biased than my administrative impressions. Epstein (2001) describes how this kind of study is ideal for “practice-based research” which is defined as “the use of research-inspired principles, designs and information gathering techniques within existing forms of practice to answer questions that emerge from practice in ways that inform practice” (p. 17). This study can provide an array of descriptive, practice-based information that will reflect on the complex story of this privatization and the change it created.

Statistics on cost effectiveness alone are not sufficient to answer the research questions posed here. The addition of the results of this data-mining attempt can provide a more complete picture of how the privatization affected the

clients and the services they received. Through the full description that can be provided by this study, CFS and other organizations can begin to understand the complexities of privatization. They can develop practice guidelines to assess and develop readiness to engage in change that can lead to more positive outcomes for agency, staff and clients. As practice based research, the value of this study “is perhaps best judged by the questions it has raised rather than by those it has definitively answered” (Nilsson, 2001, p. 66).

### *Documents and Observations*

Much rich information about an agency can be obtained from direct observation and discussion, as well as from program records and documents (Patton, 1980). “Program documents provide valuable information because of what the evaluator can learn directly from them; but they also provide stimulus for generating questions that can only be pursued through direct observation and interviewing” (Patton, 1980, p.233). Because of my role as Executive Director, I could not triangulate this information with formal interviews, since my position could bias the results. Instead, I gathered and summarized documents to “get a behind the scenes look at program processes and how those came into being” (Patton, 1980, p.235). In this way, I could “learn about things program participants or staff may be unwilling to talk about in an interview” (Patton, 1980, p.204), especially with the Executive Director.

As Executive Director of CFS, I have access to all of the records and documents from the time prior to privatization as well as the records that were kept during the privatization by staff, Board and the County Commissioner.

These include agendas and minutes of committee meetings planning for the privatization. Committees were formed to choose and develop the Board of Directors, apply for the Certificate of Incorporation and 501(C) 3, write the by-laws and mission statement, select employee benefit plans and hire the Executive Director. In addition, there are letters, memos and other administrative documents, newspaper clippings and client and staff testimony to special meetings of the County Legislature. When I became Executive Director I kept a log and journal notes, recorded minutes of board and staff meetings, developed and conducted consumer satisfaction surveys, and distributed informational memos to staff that were written to update them on agency changes. All of these documents have served to “corroborate and augment evidence from other sources” (Yin, 2003, p. 87).

With information gleaned from these documents, observations and notes taken in the first years after the privatization, I used various methods including Psychiatric Rehabilitation readiness techniques to assess CFS’ readiness to engage in the changes created by the privatization. “Observations can also generate ratings...this rating can be one of the measures of program process” (Weiss, 1998, p. 153). The ORRD (Appendix A) derived from the Psychiatric Rehabilitation Readiness Determination, (Anthony, Cohen, Farkas and Gagne, 2002) utilizes a complex set of scales that generates a rating that can serve as a measure of program process to offer insight into CFS’ ability to successfully navigate through the privatization. Of course, an alternative explanation could be that the staff, clients, funders and government officials were so unhappy with the

condition and functioning of the existing mental health services that they were ready for a change. That change, the privatization, may have been facilitated by assessing the organization's readiness to engage in that change and then systematically developing the areas where readiness for change was weak, guided by Psychiatric Rehabilitation theory and practice.

The narrative that follows was informed by observation, discussions with staff and the data gleaned from the documents, providing a wealth of information and revealing rich details of the story of CFS' privatization. Again, as CFS' Executive Director, with a large stake in positively leading this agency through the change process, this narrative interpretation may have a built in bias that most likely cannot be totally eliminated.

## Chapter VI

### *Data Analysis: Assessing Readiness for Change*

#### *Documents and Observation*

As was discussed in Chapter V, much rich information about an agency can be obtained from direct observation and discussion, as well as from program records and documents (Patton, 1980). As the first Executive Director of CFS, who led this agency through the challenges that the privatization presented, I had access to all records and documents and opportunity for observation as well as both formal and informal discussion with clients, staff, Board and stakeholders. This opportunity provided me with background information about CFS that was essential for assuring that the agency was ready and capable of engaging in the hard work of change necessary to become a successful not-for-profit.

#### *Assessing CFS' Readiness for Change*

Information gleaned from these documents, records, observations and discussions provided information that allowed me to apply Lewin's force field analysis (Figure 2), described in Chapter IV, to CFS. Through this application, we see an agency where the forces driving towards change, or privatization, appear to be far stronger than the restraining forces inhibiting change.

For the County Executive, the forces driving towards change included a number of issues that shaped his political platform, including reducing the local tax burden that residents paid for mental health services, reducing the size of government, and diminishing the power of the local employees' union. He was

Figure 2. Forces Affecting the Creation of CFS

CURRENT CONDITION		DESIRED CONDITION	
Public Agency		Private Not-For-Profit Agency	
<b>DRIVING FORCES</b>			<b>RESTRAINING FORCES</b>
<i>For the County Executive</i>			<i>For the County Executive</i>
Reduce local tax burden	→	←	Time spent exploring options
Reduce negative publicity	→	E ←	Political opposition
Low productivity of County workers	→	Q ←	Union opposition
Reduce the power of the Union	→	U	
Reduce the size of government	→	I	
<i>For the MH Commissioner</i>			<i>For the MH Commissioner</i>
Reduce political control over mental health services	→	L ←	Long history providing mental health services
Improve reputation of services	→	←	Loss of direct power and control
Reduce civil service restrictions on staffing	→	I ←	Need better understanding of purchase of service contract process
Increase innovation	→		
Create new opportunities for programs/contracts	→	B	
<i>For the Staff</i>			<i>For the Staff</i>
Find some leadership/support	→	R ←	Loss of civil service status and jobs
Increase innovation	→		
Improve the physical plant	→	I ←	Fear of new leadership
Improve community relations	→	U ←	Fear of change
Create staff development and training	→	←	Fear that clients without insurance would not be served
Reduce their hatred and distrust for government	→	M ←	Fear that the quality of clinical services would decline

also very concerned about the low productivity of the county mental health staff, some of whom had been at the department for many years.

The Mental Health Commissioner had other forces driving towards privatization. As a mental health professional himself, the Commissioner had begun his career as a counselor in one of the programs and now, as Commissioner, he was unhappy about the way that services were being delivered. He wanted to reduce the political control over mental health and improve the reputation of the agency by increasing innovation, creating new opportunities for state-of-the-art programs and hiring competent staff without the restrictions and time constraints of civil service.

The staff were experiencing yet another array of forces driving them towards change. Like the Commissioner, they sought to improve their opportunities for staff development so that they could provide innovative programming. They wanted to improve the condition of the physical plant so that it would be more respectful and inviting to clients and they wanted to improve community relations and their reputation as a quality service provider in the County. A very strong force driving towards change for the staff was their desire to find a leader that they could trust. They wanted to get back to the work of providing services and stop all the political fighting that they had been involved with. Forces driving towards change were strong for the County Executive, the Commissioner and the staff.

Restraining forces, although present, were not as numerous. For the County Executive, there was the fear of political opposition from the Legislature

and the Union and the time it was taking him to explore privatization alternatives. For the Commissioner, there was a fear about how the services would fare under private auspice after being county run for so long. Although he would retain the oversight role for mental health through a purchase of service contract, there would be a loss of control when the services were no longer County run. And lastly, this contract would be the largest the County would have to administer, creating some additional work for the Commissioner and his staff as they learned how to manage purchase of service contracts.

It was the staff that had the strongest restraining forces. They would be losing their civil service status and their pensions. They were facing a new leader and an unknown future. As unhappy as they were with the existing conditions at the agency, change was frightening. They were afraid that the clients without money would not be served and that the quality of services provided would decrease. Applying the force field analysis provides a clearer picture of the various driving and restraining forces that were generating stress on this system and encouraging change. For CFS, there were more driving forces than restraining forces, thus affecting the dynamic equilibrium and moving the organization towards its desired condition, privatization.

Kast and Rosenzweig's (1974), concept of planned change, described in Chapter IV, can also be applied to CFS. Prior to privatization and the creation of CFS, staff, clients and stakeholders involved with the county agency were voicing their concerns that there were real gaps between the then current condition of the agency and the desired condition. There were large gaps

between what existed and what the leadership, the staff and the clients wanted to have in the areas that Kast and Rosenzweig described as effectiveness, efficiency and participant satisfaction.

Although CFS is located in a small county, it is surrounded by larger, more sophisticated counties and also located near enough to New York City so that staff and government officials knew that the quality of services at this agency was not comparable to the quality of services at other agencies in the surrounding areas. Revenues had been consistently decreasing and frustration was mounting over the agency's inability to modernize and computerize due to the political constraints of this County's bureaucracy. There was a long waiting list for services, the physical plant was crumbling and, as a result of all of these factors as well as the constraints of civil service hiring procedures, it was difficult to attract and retain competent staff.

As the county agency struggled with its problems and began to look more seriously at privatization as a way of solving them, many staff realized that in order to survive they must move to a new condition. With twenty-five years of history behind it as a public mental health agency, the staff of the county agency knew that they were not performing as well as they once had and they certainly were not offering the quality and array of services that other successful community agencies that they interacted with were offering. As the privatization talks with the Commissioner and County Executive were going on, many staff shared that they knew that without some kind of change, their county run mental health service would cease to exist, and would eventually close. In many ways,

prior to privatization, staff at the county agency already knew that change was imminent.

### *Using Psychiatric Rehabilitation to Assess CFS' Readiness for Change*

Relying on the previously presented assumption that an organization is a living organism and that techniques and interventions that we use to help people to change can be utilized to lead organizations through change, I was most comfortable using another tool to assess CFS' readiness to change, the ORRD. Since being trained in the philosophy and practice of Psychiatric Rehabilitation in the early 1990's, I have integrated this approach into my management practice and often speak at state and national conferences about using this person centered, recovery based approach to explore organizational or systems change. Having become comfortable with the integration of Psychiatric Rehabilitation practice into my administrative practice, I began to apply the readiness assessment to CFS on my first day as Executive Director. Using documents, observation and conversations with staff, clients, board members and government officials over time, I assessed the readiness of CFS to change and identified the areas where there was a need to develop CFS' readiness. The information obtained from these sources is described below:

### *Need for Change*

Organizational Readiness Determination begins with the assessment of the agency's felt need to change and the level of dissatisfaction with their existing situation. This need can be internally motivated or the dissatisfaction can be external, coming from a force outside the agency.

For CFS, the degree of dissatisfaction/need for change both internally and externally appeared high. The dissatisfaction had been growing during the 1990's when, in a continuing effort to downsize government, the County Executive merged the Departments of Social Services and Mental Health and appointed one Commissioner. Continuing the theme of downsizing government, staffing within the newly created joint department was decreased and the time and expertise to access many innovations and opportunities that were being offered statewide in mental health and chemical dependency disappeared. The external forces for change included the conservative political atmosphere in New York State supporting privatization of service provision and the reduction in public funding for social services. It also included the County Executive's strong desire to distance himself from the provision of mental health services and the problems and publicity that some of the clients of the County's mental health programs had generated in the past. In addition, it gave the County Executive an opportunity to shrink the size of county government and reduce the power of the local union, two of the platform planks that helped to get him elected.

Internally, neither staff nor clients were happy with the existing services. Prior to privatization, clinical and physical resources were scarce and client waiting lists were long, due to inadequate staffing and poor staff productivity. Leadership for the organization was weak and staff morale was poor. Although fearful of losing civil service job security, staff disliked existing management and government leadership and wanted a change. With minimal leadership, few staff training opportunities, decreasing productivity and limited program development,

this agency was remaining static and slowly becoming less and less able to function. As Gareth Morgan (1997) tells us, organizations that remain static cannot survive. On some level, staff, clients and government officials knew this and began the planning for change, with privatization being the waiting vehicle to operationalize that change.

### *Commitment to Change*

The second dimension of the readiness assessment is commitment and motivation to change, which is based on the belief that the change will be possible, positive and supported. On this dimension, CFS rated somewhat lower. Prior to privatization, the Commissioner of Mental Health had explored alternatives and felt that privatizing the agency was the best vehicle to create the change to better service provision. The Conference of Local Mental Hygiene Directors, a State group of County Directors of Mental Health, had formed a sub-committee on managed care that the Commissioner had been a part of, and through this group, there was much sharing of fears for government run services in the upcoming managed care environment. The fears included concern that counties would not be willing to assume financial “risk” in a managed care environment and that the bureaucracy of government was too cumbersome and inflexible to change to meet the needs of the changing health care system. In discussion with other counties, it appeared that contracting out to not-for-profits was a way to maintain services to the county’s indigent population but to not assume the financial “risk” of the managed care environment. Through his discussions with other County Commissioners, our Commissioner knew that

contracting out was a widely used option for mental health service provision in New York State and that it could be a viable alternative for his county.

The Commissioner also felt that the change would be positive and it would be possible. He committed himself to the ongoing financial and professional support that the agency would need to survive the turbulent road ahead. He was not sure at the time, however, that the existing mental health staff would be able to offer and sustain the level of service that would be required of a voluntary not-for-profit, since many of them had been government workers for many years and were unaccustomed to the pace and pressure under which non-government agencies functioned.

Staff and clients had fears that once privatized, the agency would be forced to see only those people who could pay for services, so that people who could not afford to pay for mental health treatment would not be able to receive it. As the only not-for-profit mental health service in this county, if CFS abandoned the county run mental health service's mission of seeing all people regardless of their ability to pay, there would be no other agency to serve that population. On the other hand, staff had been a part of many of these pre-privatization discussions, they knew that the County was serious about changing the auspice of the agency, and they were highly motivated to show that they could make an independent agency run better than past management had.

#### *Environmental Awareness*

On the third dimension of environmental awareness, or understanding the array of options that the change will afford the organization, CFS rated fairly high

again. Staff and government officials worked side by side to research all possibilities for change in the community. Those possibilities included merging the mental health services with the local community hospital, merging the services with another not-for-profit, developing a public benefit corporation or creating an independent organization. The Commissioner invited proposals from existing agencies for mergers, and interviewed a number of agencies from the County and surrounding counties. He had lengthy discussions with the local community hospital that currently provided inpatient and partial hospital services. He also visited four other counties, two of which had privatized their services and two that were exploring privatization. He also read articles and attended a seminar on developing a Public Benefit Corporation. The Commissioner began informing the staff of his plans in March of 1995 and shared the results of his explorations in a series of meetings with them over the next year. In June 1996, the staff notified the Commissioner that they felt confident that creating an independent organization was the best way to privatize. They did not want to lose their identity by merging with a larger out of county agency. This small county is fiercely independent and staff wanted to maintain their own sense of identity. Merging with the local community hospital was not what they wanted, either. The local hospital did not have a good reputation and had been going through transitions of its own, with outside management and then a number of different CEO's. Developing the Public Benefit Corporation was abandoned as well, as the staff kept insisting upon the development of the private not-for-profit. The Commissioner felt that the staff's

proposal would maintain the same level of mental health services for the county residents while at the same time producing the effect the County Executive wanted, protecting the taxpayers from assuming financial risk.

After the decision to create the not-for-profit was made, the staff and the County Commissioner actively recruited a Board of Directors comprised of local business people and executives of other community agencies who could bring their expertise to creating this new organization.

### *Self-Awareness*

On the dimension of self-awareness or the amount of knowledge the organization has about why they like or dislike something they are experiencing, CFS staff, clients, Board members and government officials also rated high. The staff and the Board knew what they wanted. They had worked in committees to develop a strong mission statement and a listing of goals and objectives for the new agency. Staff and Government officials worked together to select the Board of Directors. Board and staff were actively involved in the selection of the Executive Director. They all were clear about their needs and the direction in which they wanted the agency to go. Most of the staff involved in the privatization effort were professionals and could clearly articulate their ethics and values. Of utmost importance to them was the continuation of services to those in the County who could not afford to pay. They knew why they did not want to merge with or be acquired by an existing agency. Staff and Board were disappointed with the services of the local community hospital and felt that joining that organization would not improve their service provision or their

agency's reputation as a community provider. Staff, clients and Board members wanted their independence and they were insistent on following their own vision and mission.

### *Personal Closeness*

A high rating on the dimension of personal closeness results from an agency's desire and ability to trust someone enough to lead them successfully through the change process. On the dimension of personal closeness, CFS also rated high. This group of staff and clients had been looking for a leader. Before the privatization, they had been leaderless for a long time and had been struggling to provide good services with little help from anyone in charge. They longed for someone to lead them to what they knew they could accomplish but lacked the skills to operationalize. Although there was much animosity between the government officials and the staff, the staff were able to band together, form informal leadership groups and develop good working relationships with each other, with the Board of Directors, and subsequently, with the Executive Director. Prior to privatization, with the limited leadership the county provided, communication with the staff and among the staff was not encouraged. The county services had been a group of unconnected programs that were located in various facilities across the county. A few years before the privatization, all the programs had been moved to one building but they continued to function independently of each other and there was animosity among the services. When I became Executive Director, I knew that CFS needed a strong leader and I made it clear that although they had previously been a disparate group of

services and programs, now we were one organization with one mission and if we were to survive, we had to work together. I opened channels of communication, began to hold staff and management meetings, sent out informational memos and shared the concerns we were having developing CFS. The staff were open to hearing the problems that would confront them in the new agency and they were willing to work on them as long as they had a leader who would help them to change their practice to meet the demands of privatization.

### *Developing Readiness to Change*

Collins (2001) talks about the Hedgehog Concept and describes it as “a simple, crystalline concept that flows from deep understanding about the intersection of the following three ‘circles’: 1. what you can be best in the world at...2. what drives your economic engine...3. what you are deeply passionate about” (Collins, 2001, p. 95-96). In order to be a successful mental health agency, CFS had to grow past the negative feelings produced by the governmental officials’ decision to privatize and clarify and embrace the three circles described by Collins. As the new Executive Director, who began by assessing CFS’ readiness to change, I was able to discover what the staff were best at, to share with them the economic constraints of the newly privatized agency and to clarify what we were all truly passionate about so that we could not only survive this change but become a better organization.

I then began to implement the activities required to develop CFS’ readiness to change. I *processed readiness* by reviewing the ORRD results and

thinking about next steps. I *chose a direction* and then began to *develop awareness* and *mobilize environmental supports* by developing a variety of activities to increase exposure to alternatives so that knowledge and understanding and thus readiness would be increased.

To increase CFS' *commitment to change* and the belief that change was possible, positive and would be supported, I began to open lines of communication by setting up meetings and supervisions. Previously, under county auspice, program directors were not regularly supervised and did not have an opportunity to meet together. I set up weekly management meetings where the Program Directors met with the Executive Director and the Finance Director to discuss problems and issues and to brainstorm solutions. We discussed all aspects of the changes that the privatization brought and developed solutions to problems as they arose. Together, we identified gaps in service provision so that grants could be written. We developed billing and accounting procedures to maximize revenues. As the revenues increased, we expanded and hired new staff in the programs where waiting lists were developing. We worked together to develop clinical as well as administrative procedures. Each Program Director began a weekly meeting with his/her own staff to discuss clinical case related issues and to share the administrative policies and procedures being developed in the management meeting.

We began to break down the barriers between the programs as well, encouraging staff from different programs to work together for the benefit of the client. I sent out newsletters regularly and instituted a quarterly all staff meeting

that was filled with information about everything that was going on at the Agency, from the changes in the clinical work to the development of the Board of Directors. I made it clear that all of us were in this transformation together and that we could be successful if we worked together. Prior to the privatization, information about the process had not been shared with the staff and much of their fear was based on a lack of knowledge about what would be required of them. As their knowledge increased the staff began to feel that they were in this situation together as one agency, and CFS' commitment to change began to increase as the staff, clients and Board began to understand that this change was possible, very positive for them, and it was definitely going to be supported.

The areas of *environmental awareness* and *self awareness* were also developed with a number of activities. Within the first six months of operation, I began a staff development program and began to expose staff to new techniques that they had not previously had the opportunity to learn. We began training in topics like Psychiatric Rehabilitation, Dialectical Behavioral Therapy, Crisis Intervention, group interventions and children and family work. Staff were encouraged to visit other programs in other counties and see what they were providing. We invited other agency personnel to our trainings so that staff's knowledge of community services would be expanded. We invited mental health consumer leaders into the agency to talk with staff and clients about recovery and the possibilities that it offered. We purchased computers and set up Internet access so that staff and clients could research job opportunities, medication

education, clinical techniques and interventions and other agency websites to expand their knowledge past the boundaries of this small and insulated county.

To assure the continuation of CFS' rating on *personal closeness*, administratively I was an extremely active and present leader, making sure that I was not only clear in my direction but also that I was visible to all program staff. I never asked anyone to perform a task that I had not already done myself. I met with each program to develop productivity standards and explained that more services meant more revenues, which meant more staff for that service. As long as there was someone in charge, and they understood why the changes were needed, the staff were willing to do what was needed for the Agency to survive. Through these activities we created a shared vision for CFS and then I clearly stated the steps that we would need to take to accomplish that vision. Some staff, who did not agree or who could not move along with us, left the agency. The majority of the staff, and the new staff we subsequently hired, shared that vision and began to work together to achieve it. As a leader, I made it clear that I was ready to take on the "multifaceted challenge [which] involves recognizing the need for change, understanding the particular setting and its potentialities, and proactively and effectively managing the change process" (Perlmutter and Gummer, 1994, p.243). As we began to achieve some small successes, CFS' self-confidence increased and I accomplished the last element of Developing Readiness. I *personalized accomplishments* by helping staff, clients and Board to see that they had acted in a way that was personally meaningful to them.

### *Summary Analysis of the ORRD*

“Change is a constant....Leadership is needed to lead us through the introduction of new concepts, principles, settings and systems” (Anthony, Cohen, Farkas and Gagne, 2002) p.293). A summary analysis of the Organizational Rehabilitation Readiness Determination conducted with CFS suggests an agency ready for change and staff who are ready for a leader who would support them through this change. What CFS needed was “leadership that creates the climate in which people turn challenging opportunities into remarkable successes” (Kouzes and Posner, 2002, p.xvii).

The privatization altered both the culture and the process of service provision at CFS. Using Psychiatric Rehabilitation theory to explore readiness to engage in a change process helped me to more clearly assess CFS’ readiness to come through the privatization and engage in the hard work required to survive as a not-for-profit agency. The results of both the CFR and data-mining portions of this study that follow, present an agency that emerged from a privatization process without experiencing the dire consequences so vividly outlined in the literature. Using Psychiatric Rehabilitation practice to inform my administrative practice and assess and develop this agency’s readiness to change was one mechanism that helped me to lead CFS through the turbulence created by privatization.

## Chapter VII

### *Data Analysis: Efficiency and Cost Effectiveness*

The intent of data analysis “is to produce a reading that accurately represents the raw data and blends them into a meaningful account of events” (Weiss, 1998, p.271). Also, “the researcher seeks order within the data and tests hypotheses that have ‘driven’ the research” (Royse, 1991, p.173). Much of the data from this study is descriptive and the analyses in both Chapter VII and Chapter VIII compare similar data before and after the privatization. Here, as in other evaluation studies, “Comparison is the heart of the evaluation enterprise” (Weiss, 1998, p. 286).

#### *Introduction to the Analysis of the Consolidated Fiscal Report (CFR)*

Data analysis should begin to provide answers to the questions driven by the program theory (Weiss, 1998). The question raised in this study was: did CFS become a more or less efficient and effective agency after experiencing the privatization? For the longitudinal study of cost effectiveness and efficiency, information gathered from the Consolidated Fiscal Report was recorded on the data extraction form (Appendix B) and a univariate analysis of a number of descriptive variables at different points in time was conducted. Comparing discrete variables from the CFR before, during and after privatization provided evidence of changes in the agency’s production of services and provided insight concerning whether or not those changes affirmed posited program theory. Factors considered in the CFR analysis included: sources of revenue, the percent of revenue to gross costs, gross and net unit of service costs, numbers

of clients seen per year, numbers of units of service delivered per year and the number of units of service delivered per full time equivalent staff (FTE).

This study was formative and, although it provided considerable insight into the privatization, it could not discount the impact on the agency of organizational maturation or other outside events (Epstein and Tripodi, 1977). As a result of the possible influences of maturation and external events, the analysis of the CFR variables alone leaves room for debate on the cause/effect relationship between privatization and the results that emerge. However, the results can still provide a window into the effectiveness and the efficiency of CFS and offer some validation as to internal and external expectations regarding the outcomes of the privatization (Weiss, 1998).

#### *Diversifying Revenue Streams*

One of the County Executive's reasons for privatizing mental health services was to remove the burdens and constraints imposed by government auspice. One of these constraints was the over-reliance on Medicaid revenues and the inability of a government agency to collect other than state and county net deficit funded (NDF) revenues. In Figure 3-A, sources of revenue for 1995, two years before privatization, are presented. In Figure 3-B, the same sources are shown for 1999, two years after privatization. The most telling finding is that while total agency revenues increased by 24% from 1995 to 1999, the revenue mix changed, with reliance on Medicaid revenue decreasing from 86% of total revenue in 1995 to 79% of total revenue in 1999. In addition, the percent of self-pay revenue increased by only 2%, Medicare remained about the same and the

Figure 3-A. Sources of Agency Revenue Prior to Privatization (1995)

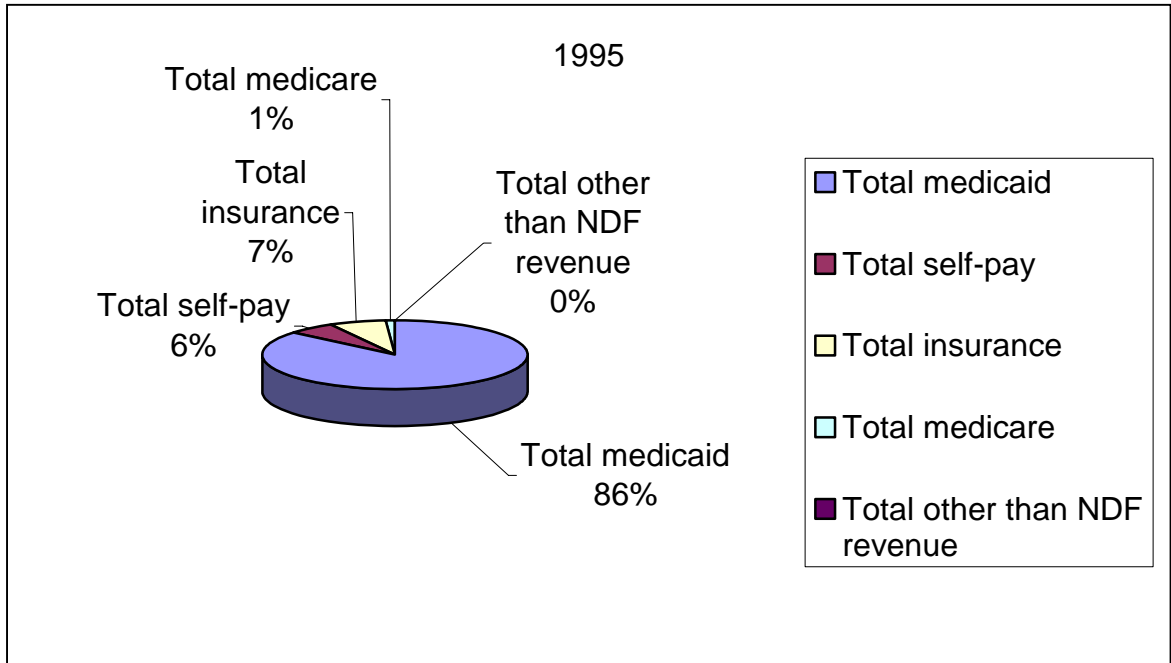
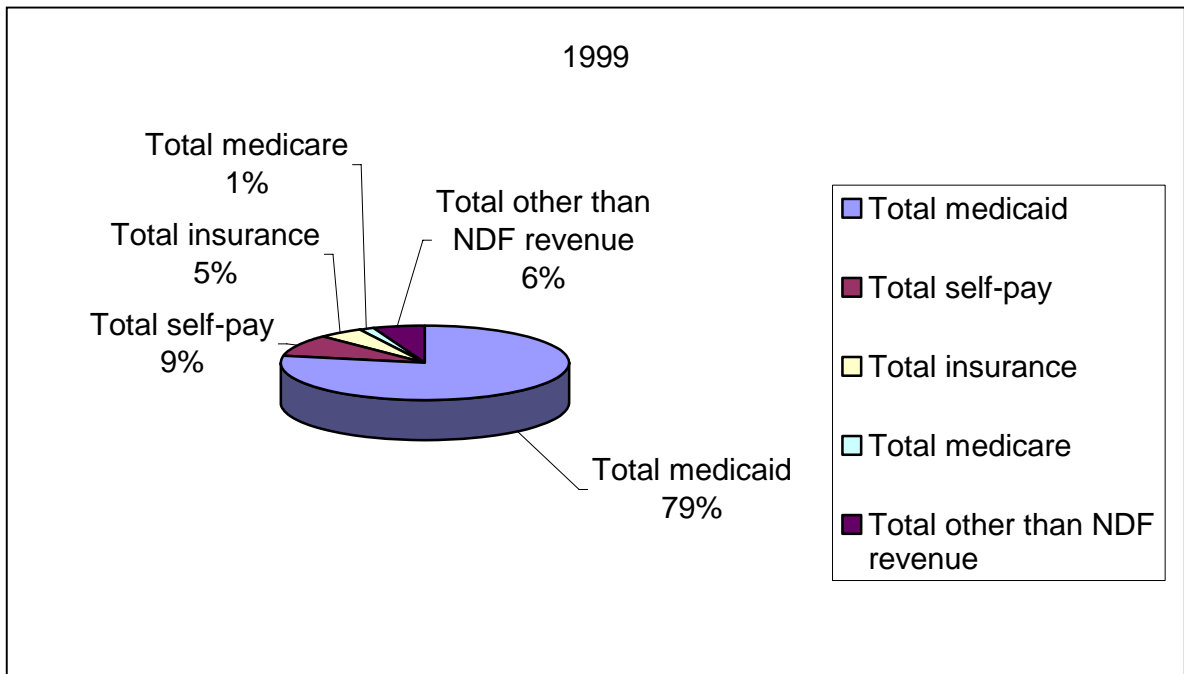


Figure 3-B. Sources of Agency Revenue After Privatization (1999)



percent of revenue from insurance decreased by only 2%. As the County Executive had hoped, after privatization, revenue collection increased and diversified, with the percent of Medicaid revenues to the total revenues collected decreasing by 7%.

The small decrease in the percent of insurance revenue may have been due to collection problems as the agency struggled to reapply to managed-care networks and insurance panels under its new name and auspice. Transition to computerized billing and intake systems delayed collection of third party revenues as well. Another factor affecting revenue collection was that, at the time of privatization, the agency had no computers; billing information was kept by hand and then forwarded to the County billing department which then billed Medicaid by computer. Other billings were completed manually at the County billing department. The County had purchased a billing software package prior to privatization, but had not left CFS a computer powerful enough to run it. After the privatization, computerization and modernization of billing systems took place over a period of years, with CFS requesting one-time end of year funding from the County and the New York State Office of Mental Health to purchase the needed equipment.

The first of these funds became available in December 1997, when CFS received permission to purchase its first server and five computers. The computers were allocated to the Finance Director, the Executive Director, the billing clerk, the front desk receptionist and the office manager/statistical staff member. CFS engaged a computer consultant who wired the building, set up the

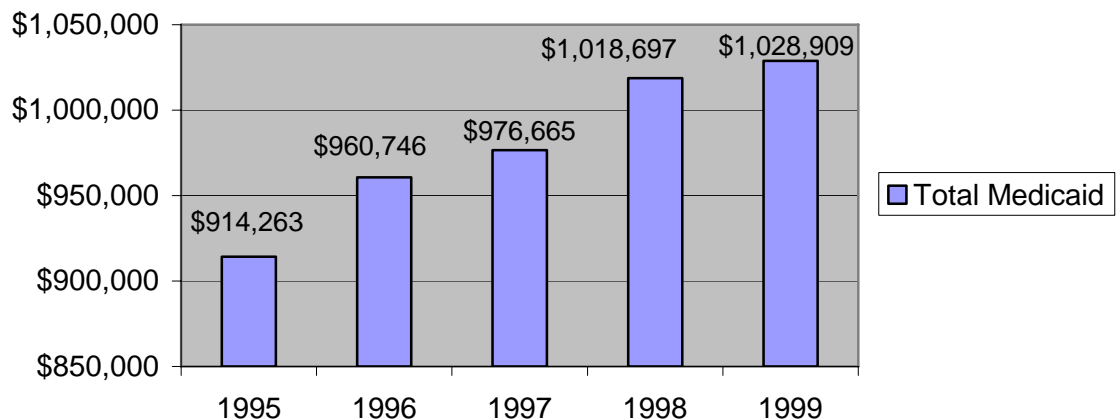
network and installed the billing software. Electronic billing did not actually begin until 1998. In December of 1998, the Agency once again received one time State funding to expand the computer system and in January and February of 1999, computers were added for clinical staff.

When I became Executive Director in July 1997, there was no accounting department and the Finance Director had not been hired. One of my first acts was to hire a Finance Director, and he began in late August 1997. The salary that had been allocated for the Finance Director by the County prior to privatization was not high enough to hire someone with sufficient mental health accounting experience. As a result, the newly hired Finance Director had to learn the mental health system and its rules and regulations. In January 1998, a consultant with experience in mental health billing and the computerized billing package was hired to assist the Finance Director in setting up the billing and collection systems. CFS inherited a billing clerk from the County who continued to collect billing information manually after privatization as she had done before. As CFS developed procedures for maximizing billing efficiency and collection, this clerk could not keep up, and she resigned in August 1999. In September 1999, a new billing clerk was hired who had experience with computerized billings and with maximizing Medicaid and Medicare revenues.

Since Medicaid has always represented the largest part of agency revenues, the most time and effort was spent obtaining the required Medicaid provider billing codes specific to CFS' new auspice and setting up the electronic claiming procedures that would assure that the collection of Medicaid payments

was maximized first. Figure 4 shows the outcome of the Agency's beginning efforts with an increase in Medicaid revenue of 12.5% from 1995 to 1999. This increase netted the agency an additional \$114,646 in Medicaid revenue.

Figure 4. *Comparison of Medicaid Revenue Prior to During and After Privatization*

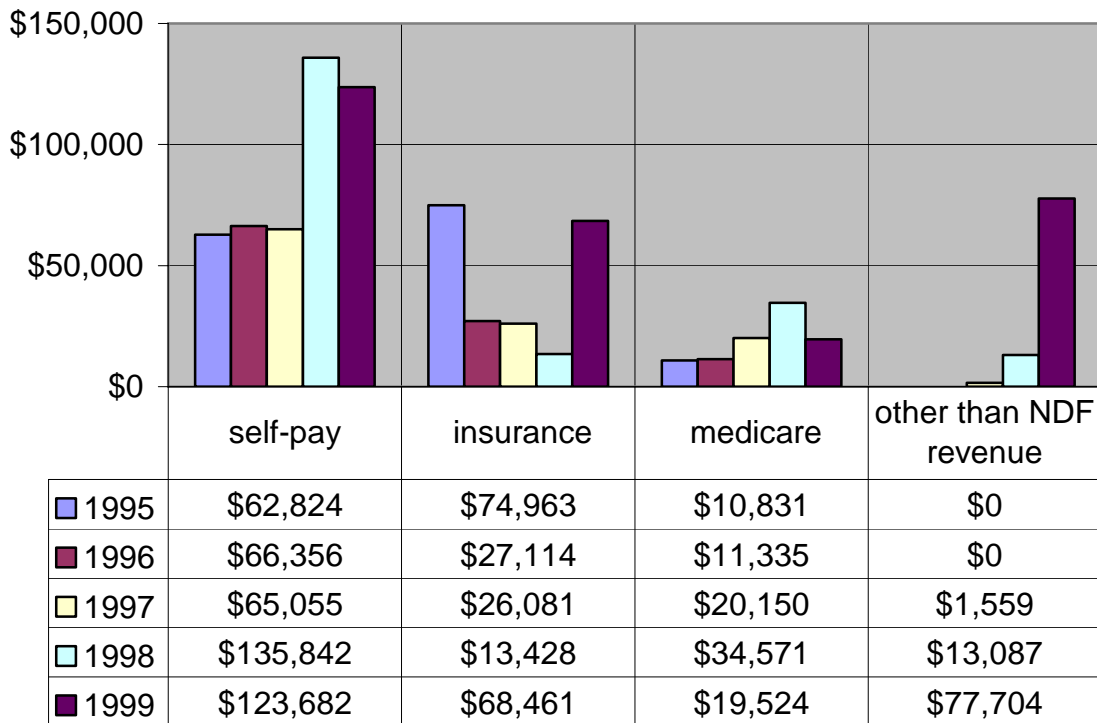


Medicaid billing codes that allow the agency to bill Medicaid for services rendered are assigned after an agency is incorporated and then approved for licensing by the New York State Office of Mental Health (NYSOMH) and the New York State Office of Alcohol and Substance Abuse (NYSOASAS) to provide Medicaid eligible services. Although CFS had valid Medicaid billing codes assigned to it under County auspice, prior to privatization the County applied to transfer the NYSOMH and NYSOASAS licenses but did not apply for new Medicaid billing codes. Therefore, when CFS opened its doors on July 1, 1997, it could not bill Medicaid or Medicare for services. As Executive Director, I applied for valid billing codes immediately. After the application was accepted, CFS was allowed to bill for services retroactively to July 1. As a result of the delay in

obtaining accurate billing codes, the first Medicaid check was not received until the end of December 1997, creating cash flow problems for the agency.

Even with these operational problems, as the County Executive had hoped, after privatization, agency revenue diversified and collections increased. Figure 5 provides a comparison of changes in other than Medicaid revenue by source. Between 1995 and 1999, commercial insurance revenue decreased slightly, by 0.87%. However, Medicare revenue increased by 80% and self-pay fees almost doubled, with an increase of 97%. Self-pay fees include client co-pay for insurance coverage. Under the prior County auspice, collection efforts for self-pay revenues, including insurance co-pays, were not actively pursued. Before privatization, many viewed the agency as a government service that was

Figure 5. Comparison of Revenue Sources Other Than Medicaid



free. There was a sliding-fee scale but it had not been updated in many years. Sliding self-pay fees were assigned, but appropriate financial documentation was never requested. If clients did not pay insurance co-pays or self-pay fees, there were no consequences.

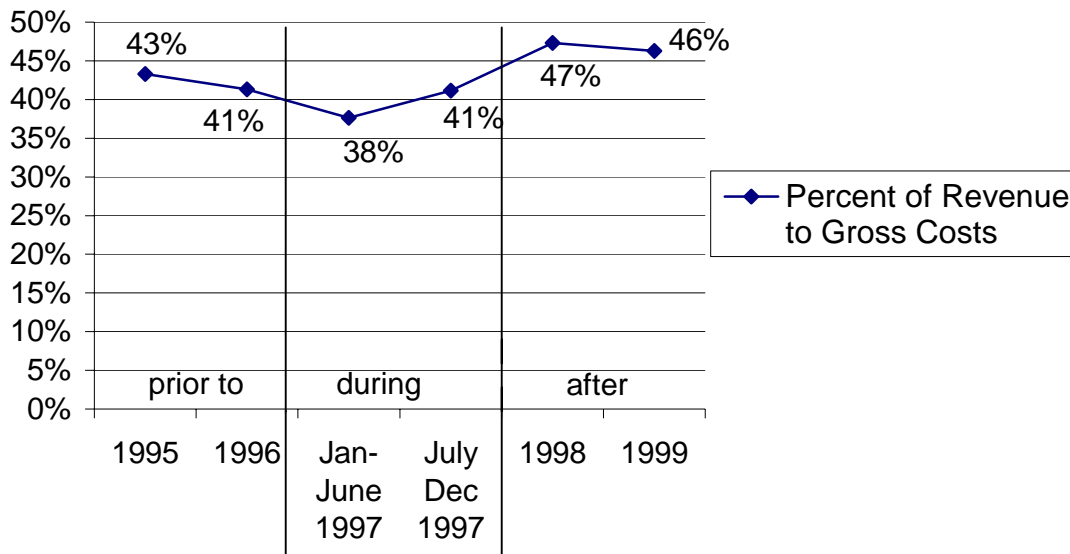
After privatization, with the consent of the licensing State agencies, CFS revamped its sliding-fee scale to reflect both the Federal poverty level and the usual and customary charge for mental health services. No one was ever denied access to service based on an inability to pay, but clients were expected and asked to commit to their treatment by paying for their services at a level that they could afford. During 1998 to 1999, the agency applied for, and was added to, many insurance panels, increasing access to clients with insurance. If the client could not afford the insurance co-pay, an appropriate fee was determined through the sliding-fee scale. Receipts were developed and given to clients, and they were made aware of balances that they owed to the agency when they came in for their visit. Procedures were established to alert clinicians when fee balances became too high, so that they could deal with issues of non-payment within the therapeutic process. CFS discovered that clients were very willing to pay for services when they were affordable and respectfully delivered. As the number of services increased and the procedures for better collection of client fees improved, revenues increased. The 24% increase in total revenue resulted in an increase to the agency budget of \$255,399. Included in this figure was an increase in other than net deficit government (NDF) funding. As the County Executive had hoped, free of its government auspice, CFS was able to fundraise

and receive federal and foundation grants. In 1999, \$77,704 in revenue was received from funding streams that were not possible when CFS was under County auspice.

*Decreasing the Cost of Service Delivery*

Service efficiency or superior cost/outcome can also be demonstrated by a decrease in the cost of delivering a unit of service and an increase in the percent of revenue generated to gross costs. Figure 6 presents a comparison of the percent of revenue to gross costs prior to, during and after privatization.

Figure 6. *Percent of Revenue to Gross Costs Prior to During and After Privatization*

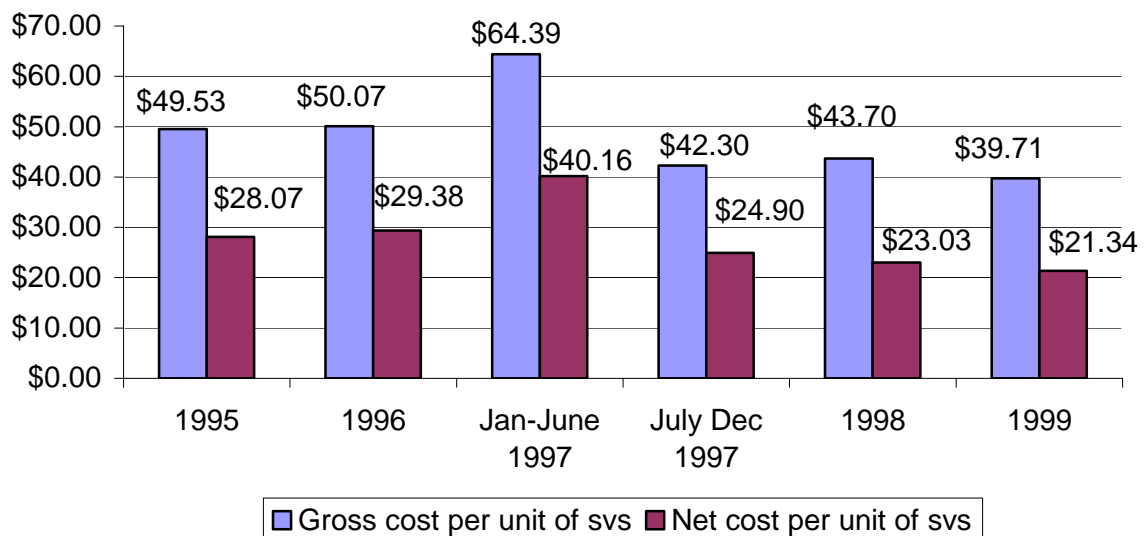


The percent of revenue to gross costs had been decreasing prior to privatization and began to increase as soon as the not-for-profit took over. During the period directly prior to privatization, a good deal of staff time was spent on privatization planning rather than on service provision; staff joined committees to work on agency mission, selection of the Board of Directors and the Executive Director search. Although it appears that initial changes to

revenue policy and procedure resulted in increased revenue generation in the two years after privatization, further analysis of future years would be required to substantiate continued increases in revenue collection.

A comparison of gross and net unit of service costs for the same period prior to, during and after privatization reveals another aspect of service delivery cost. As can be seen in Figure 7, both gross and net costs increased in the six

Figure 7. *Comparison of Gross and Net Unit of Service Costs Prior to During and After Privatization*



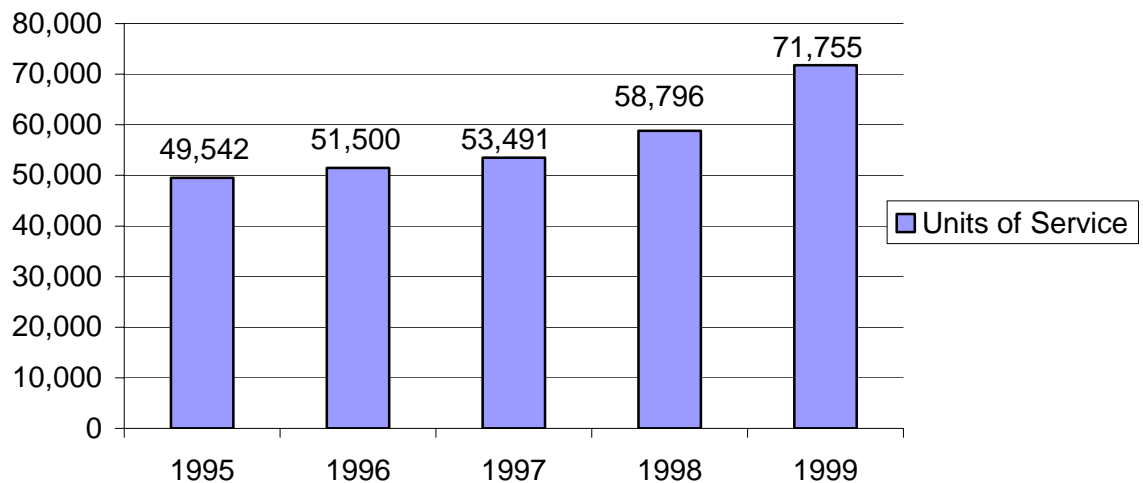
months of 1997 directly before the privatization, and decreased dramatically July to December 1997, right after the privatization. In 1998, in comparison to the first six months of operation, July to December 1997, the gross and net unit costs changed minimally. However in 1999 both the gross and net costs of delivering a unit of service decreased again, with gross costs decreasing 24.5 % over the 1995 rate and the net unit of service cost decreasing 31.5% for the same period. As previously described, this may be explained by the fact that it took CFS at

least two years to develop an accounting office, and to computerize and implement policies and procedures for billing and revenue collection. Further study would be needed to assure that these dramatic changes continued.

### *Increasing Productivity*

The positive program theory implicit in this study posits increased productivity after privatization. Increased productivity can be demonstrated by increases in the number of clients served and the number of units of service delivered. In addition, increased productivity would be evidenced by the number of units of service delivered per full time equivalent staff (FTE). In 1998, the first full year of operation for the not-for-profit, units of service rose to 58,796, 18.6% above 1995's deliverable units. By 1999, the second full year of CFS' operation, units of service increased by 44.8% above 1995's deliverable units. Figure 8 reflects productivity by comparing the total units of service delivered prior to, during and after privatization. After privatization, for the first time in its history, CFS program staff developed and instituted productivity standards. Funding mechanisms were described to staff so that they would understand that increased productivity would result in increased revenues that would then allow the hiring of additional staff. They came to understand that this would enable the agency to provide new and innovative programs that staff were interested in and that the clients needed and were asking for. With the knowledge that their hard work would result in increased staffing, they developed acceptable productivity standards for themselves and proceeded to meet them. In addition, CFS staff were writing grants for new programs and services and to obtain new funding.

Figure 8. *Total Units of Service delivered Prior to During and After Privatization*



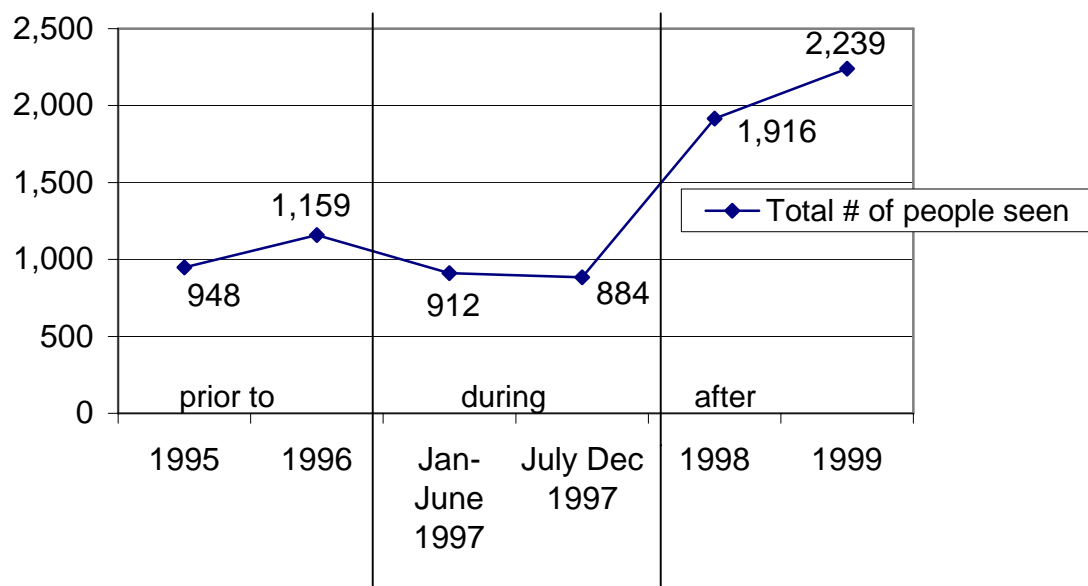
In 1998, the agency received a Federal AIDS Institute grant that would not have been possible for the county agency to receive. As the revenue increased, CFS started to hire children's clinicians and, for the first time, began to offer mental health clinic services to children and adolescents. Services in area schools were expanded as well, through contracts with the local school districts.

Although increases in productivity were expected after privatization, one unexpected result was the increase in units of service for the year 1996, prior to privatization, when it was expected that the planning discussions for privatizing would result in reduced productivity. Instead, as demonstrated in Figure 8, there was a slight increase of 4% above 1995 in units of service delivered. At this time, there was much debate about how the privatization would proceed with the Government wanting the agency to merge with the local hospital or an existing agency and staff wanting to be independent and to develop their own not-for-

profit. There was also much discussion and invitation for outside bidding for mergers. It is possible that staff increased their program efforts in anticipation of privatization, in an effort to demonstrate the agency's worth to those outside bidders. It is also possible that, fearful for the future of their jobs, staff concentrated on increasing productivity and, they hoped, job security as well.

A comparison of the total number of people served by the agency prior to, during and after privatization (Figure 9) provides further insight. With units of service increasing dramatically, we would expect to see the number of people served increasing as well. In 1999, the total number of people served by the agency increased 136% as compared to the number of people served in 1995. As hoped for by the County Executive, after the privatization, CFS expanded its operations and its reach. The agency expanded its hours, opening on Saturdays as well as four evenings a week. It also increased its areas of expertise by

Figure 9. *Total Number of People Served Prior to During and After Privatization*



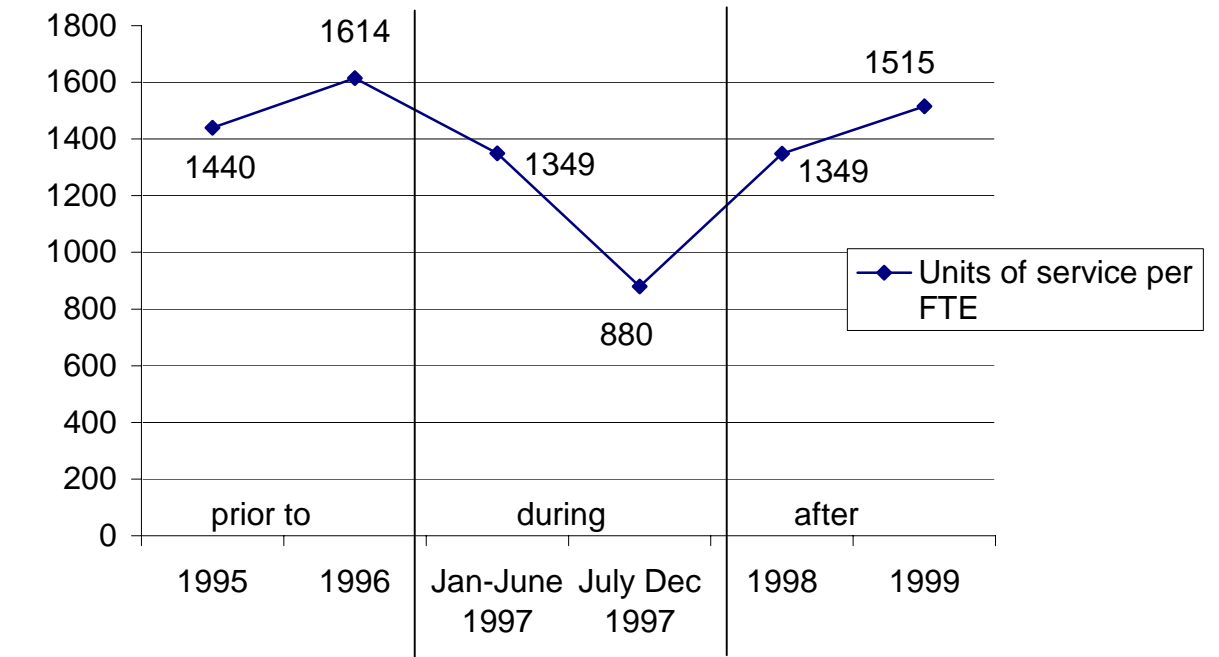
providing mental health services to people with AIDS and people with co-occurring mental illness and chemical dependency, and by providing an array of new services to children and families. After privatization, no longer bound by the constraints of Government auspice, CFS could fundraise, accept donations, and apply for and receive federal grants and private foundation grants. With these new funding streams and the increased revenues resulting from staff productivity standards and more efficient collections procedures, CFS increased programming and increased the number of people who could access it.

The number of clients served decreased slightly directly after privatization before dramatically increasing in 1998. The total number of people served from July to December 1997 decreased by 28 from the six-month period just prior to privatization, January to July 1997. In that six-month period, staff and programs were adjusting to the new auspice and all the administrative and programmatic changes that came with it. Major expansion did not actually begin in full until 1998.

Consistent with the finding in Figure 8 for the year 1996, there was an unexpected increase of 22% in the number of people seen in 1996 as compared to 1995. As previously stated, prior to the privatization, productivity had been decreasing. Consequently, though it was anticipated that, during the planning discussions for privatizing, productivity would continue to decline because staff spent more time planning for privatization than delivering service, quite the opposite occurred. Further research into this result would be necessary in order to explain this unexpected finding.

The final efficiency analysis, Figure 10, is a comparison of the number of units of service delivered per full time equivalent staff (FTE) prior to, during and after privatization. Increased productivity is demonstrated by an increase in the

Figure 10. *Comparison of Units of Services per FTE Prior to During and After Privatization*



number of units of service delivered per FTE. This figure includes all staff, both clinical and administrative support. The units of service delivered per FTE increased by 5.2% from 1995 to 1999. Again, unexpectedly, there was an increase in units of service per FTE in 1996 consistent with the findings reported in Figures 8 and 9. From July to December 1997, directly after privatization, there was a dramatic decrease of 53% in units of service per FTE.

One possible explanation could be that when CFS privatized, the County withdrew all of its administrative supports. The agency had very little administrative infrastructure and had to start rebuilding it. Although staffing began

to increase immediately after privatization, many staff lines were not directly related to service provision. CFS created a number of new administrative staff lines, including an associate executive director, an executive assistant, a controller, an account clerk, more receptionists and a maintenance worker. From the time of privatization through 1999, new grants for programs and services resulted in the hiring of new direct care staff as well.

Despite the increase in non-direct care staff, dramatic increases in units of service delivered did result in an increase of 5.2% in units of service per FTE from 1995 to 1999. As new funding and increased revenue collection continued, CFS augmented its administrative infrastructure and expanded its direct services menu. Each time a new grant was received, it included a small administration and overhead component allowing the agency to hire the needed administrative staff. As these staff were added, they also had an impact on overall agency efficiency and effectiveness by streamlining administrative functions and freeing the clinicians to concentrate more clearly on service provision. Further analysis of future years would be required to document continued increases in numbers in this category.

#### *Summary Analysis of CFR Results*

The findings from the analysis of fiscal and statistical data obtained from the Consolidated Fiscal Report support both the increased cost effectiveness and the overall efficiency of this newly privatized agency. Without the constraints of civil service and government purchasing contracts, CFS was able to expand within its existing contract, hiring new staff, computerizing purchasing and billing,

and maximizing and diversifying funding streams. Increased productivity, expanded hours and new and innovative programming increased the number of people served and the units of service delivered without increasing existing cost per unit of service levels. In privatizing mental health services, the County Executive wanted better client outcomes, increased services at lower costs and, in general, a more effective and efficient mental health system. The results of the CFR study describe a more cost effective and efficient provider. The analysis of case records that follows will consider the quality of services provided prior to and after privatization to determine whether the increases in efficiency and cost-effectiveness that CFS experienced took place at the expense of quality of care.

## Chapter VIII

### *Data Analysis: Quality of Care*

The primary objective of the clinical data-mining portion of the study was to describe the client characteristics and diagnostic profiles, number and type of social work interventions they received, client outcomes and client and clinician perceptions of treatment prior to and after privatization to see whether cost effectiveness and efficiency improved at the expense of the provision of complex quality services to the community. The results of the longitudinal study of cost effectiveness and efficiency described in Chapter VII demonstrate positive changes in the privatized agency's production of services. They suggest a path taken by CFS that closely resembled the ideal one hoped for in the posited program theory. These findings were also consistent with expectations of both the advocates and the detractors of privatization.

As discussed in Chapter III, the anti-privatization literature often posited scenarios in which cost effectiveness and efficiency were obtained at the cost of a reduction in quality services to the community. For example, the study conducted in Massachusetts by Kopito-Motenko, et. al. (1995) looked past cost effectiveness and efficiency at the clinician's and the client's views of treatment and found that, after privatization, the number and array of services decreased while client demand increased. This created a situation where clients' needs often went unmet and their clinical status often worsened. Staff, forced to be more productive and more comprehensive in their documentation, could not adjust to the increased pace of a private non-profit agency and their productivity

and effectiveness declined, resulting in poorer client outcomes. Without being able to serve their clients properly, staff became demoralized, perpetuating a cycle of declining treatment outcomes.

The clinical data-mining portion of this research attempts to address this aspect of the privatization debate by examining CFS' service patterns prior to and after privatization to see if the negative experience of privatized service providers described in Massachusetts and other states, was mirrored at this agency.

#### *Introduction to the Clinical Data-Mining Analysis*

For the clinical data-mining portion of the study, there were 348 client records eligible for review and from this group a sample of 147 client records were reviewed. The data was then recorded on the data extraction form (Appendix C). The results were entered into an SPSS data-set, analyzed, and are presented in this chapter in descriptive tables comparing quality relevant variables prior to and after the privatization to offer some insight into possible changes in the functioning of CFS correlating with privatization. Factors considered in this analysis include:

- client characteristics, including referral source and payor source;
- client diagnosis and length of stay;
- client functionality;
- client use of emergency and hospital services;
- client presenting problems;
- number and array of treatment interventions and referrals;

- progress toward meeting treatment goals;
- reasons for termination and who initiated the termination;
- client and clinician perceptions of the treatment.

By comparing these variables prior to and after the privatization, we can see if there was a change in the kinds of clients who were accepted at CFS and whether the type and quality of services changed as the agency's productivity and cost effectiveness improved. These findings can then be compared, once again, to posited program theory and to previous studies of the outcomes of privatization described in the literature.

#### *Characteristics of the Population*

One of the overriding fears expressed in the anti-privatization literature was that privatization would lead to a multi-tiered system of service provision in which those who were the most ill, and therefore needed the costliest interventions, and those who were uninsured or underinsured, would be excluded from receiving services. To determine if this occurred at CFS, characteristics of the client population were gathered and are displayed in Table 2 and Table 3.

#### *Payor Source*

The finding regarding payor source in Table 2 is of particular interest. Although the number of clients with private insurance increased by 12%, the number of self-pay clients, that is those without Medicaid who are uninsured or underinsured and assigned a sliding scale fee based on their income and the number of dependents in their families, decreased by 10%. Although this finding may suggest, as the anti-privatization literature warns, that clients who are

Table 2

*Primary Payor Source*

CHARACTERISTIC	1995-1996		1998-1999	
	<i>N</i>	%	<i>N</i>	%
<i>Primary Pay Source</i>				
Medicaid	37	47.4	32	46.4
Private Insurance	11	14.1	18	26.1
Self Pay	27	34.6	17	24.6
Other	3	3.9	2	2.9

self-pay were being denied access to services, there may be an alternate explanation. Before privatization, the County agency did not actively pursue joining insurance panels or seeking insurance reimbursement. The clients who were identified as self-pay prior to privatization may have had insurance coverage but may not have been using it since the County agency was not on their particular panel. In fact, CFS' expanded participation on insurance panels after privatization allowed increased access for community clients who wished to receive treatment there.

Since CFS is the only not-for-profit in this County where people without funds can obtain treatment, it is important to note that this group of clients who are uninsured or underinsured were never denied access for that reason. The agency is required to keep referral logs on all clients who are not accepted into treatment and the NYS Office of Mental Health reviews these logs during their

licensure visits. Due to its status as an agency that receives State Aid, CFS is not allowed to deny access to treatment to anyone because they are unable to pay for services. The resulting findings are more likely due to increases in the agency's participation on insurance panels and more aggressive attempts to move clients who had commercial insurance from the payor status of self-pay to insurance.

With the growth of CFS' reputation as a quality private facility, more people with other than Medicaid and Medicare coverage began to seek services there instead of at the private, for-profit mental health groups that they had previously attended. As the agency began to participate in more insurance panels, clients with insurance were able to choose CFS to obtain their services.

From 1995 to 1999, the total number of clients served by CFS increased by 136%. This increase reflects the agency's service expansion, the increased opportunities described above for clients with private insurance and the constantly improving reputation of the new not-for-profit. As the total population served increased, a reduction in the percentage of clients who self-pay may not necessarily indicate denial of services to those without funds but, instead, may indicate that the majority of additional clients who were accessing services were those with private insurance coverage. The percent of clients who self-pay and have insurance, added together actually increased 2% after privatization, while the percent of Medicaid and other payor sources decreased by 2%.

#### *Referral Source*

The data, displayed in Table 3, also suggest modest changes in referral

Table 3

*Referral Source and Length of Stay*

CHARACTERISTIC	1995-1996		1998-1999	
	<i>N</i>	%	<i>N</i>	%
<i>Referral Source</i>				
Self	21	26.9	17	24.6
Hospital	17	21.8	16	23.2
Other Agency	9	11.5	11	15.9
Friend or Relative	10	12.8	9	13.0
Community MD	--	--	5	7.2
PFCS Clinician	5	6.4	4	5.8
DSS	5	6.4	2	2.9
Crisis	4	5.1	2	2.9
Other	7	9.1	3	4.5
<i>Length of stay (mean months)</i>	23.1 <sup>i</sup>		32.3 <sup>ii</sup>	

<sup>i</sup>SD= 26.01; range=6—203.

<sup>ii</sup>SD= 34.69; range=9—210.

source. Before privatization, as the only mental health facility in the County, the majority of referrals were self referrals and referrals from the local community hospital. These two sources remained the primary referral sources after privatization as well, but with a decrease of 2.3% in self-referrals and an increase of 1.4% in hospital referrals. Prior to privatization, the county agency was not

considered a quality provider and community referrals were not primary referral sources. After privatization, referrals from other agencies and community physicians increased by 11.6%, as CFS' reputation for quality spread. Outreach to the community also was an important part of CFS' strategic planning as the agency attempted to distance itself from its County auspice and create a new identity.

Another concern voiced in the literature was that clients would be discharged from treatment prematurely because their insurance would run out or their self-pay fee would be too low to allow the agency to provide the services needed to adequately meet their goals. One can see, from the length of stay displayed in Table 3, that this did not occur at CFS. In fact, length of stay, measured in mean months, increased from 23.1 prior to privatization to 32.3 after privatization, supporting that, contrary to the fears expressed in the anti-privatization literature, after privatization CFS clients were being treated for the same or longer periods of time than prior to privatization.

### *Diagnosis*

Another fear of the staff that surfaced in the literature was "creaming", or admitting clients who were less ill to save costs. Comparison of diagnosis is one way to assess the severity of illness of clients receiving services at CFS. One of the ways to help clarify which diagnostic categories are more severe or complex is to compare the prognoses associated with the various diagnostic categories represented among the agency clients prior to and after privatization. According to Kaplan, Sadock and Grebb (1994), "prognosis is an opinion about the

probable immediate and future courses, extent and outcome of the disorder” (p.280). Mood disorders, which include major depressive disorder, bi-polar disorder, dysthymic disorder and cyclothymic disorders (DSM IV-R, 1994), “tend to have long courses and ...patients tend to have relapses” (Kaplan, Sadock and Grebb, 1994, p.538).

In describing psychotic disorders, such as schizophrenia, schizoaffective disorder, schizophreniform disorder and other delusional disorders, Kaplan, Sadock and Grebb (1994) point out that these illnesses are characterized by hallucinations, delusions, insomnia, restlessness, agitation and impaired functioning in social and occupational areas. “The classic course of schizophrenia is one of exacerbations and remissions. Vulnerability to stress is usually lifelong” (Kaplan, Sadock and Grebb, 1994, p.480).

Risk of suicide is another factor that can support a more serious degree of illness and a higher risk factor for treatment. Suicide risk is also high for people diagnosed with mood and psychotic disorders with about 50% of all people with schizophrenia, a psychotic disorder, attempting suicide at least once in their lifetimes. People diagnosed with mood disorders have a 15% lifetime risk of suicide (Kaplan, Sadock and Grebb, 1994; Jacobs, 1999).

Table 4 presents the agency profile of client diagnosis before and after privatization. Prior to privatization, the largest percentage of clients served were those diagnosed with mood disorders, with psychotic disorders as the second most common diagnosis. This remained the same after privatization, with a 3% increase in the number of people with psychotic disorders.

Table 4

*Client Mental Illness Diagnosis*

CHARACTERISTIC	1995-1996		1998-1999	
	<i>N</i>	%	<i>N</i>	%
<i>Diagnosis</i>				
Mood Disorder	36	46.2	31	44.9
Psychotic Disorder	18	23.1	18	26.1
Adjustment Disorder	10	12.8	7	10.1
Anxiety Disorder	6	7.7	9	13.0
ADD/ADHD	6	7.7	1	1.4
Other	2	2.5	3	4.5

The number of people diagnosed with adjustment disorders decreased by 2.7% while those with anxiety disorders increased by 5.3%. According to DSM IV-R (1994), anxiety disorders include anxiety and panic disorders, agoraphobia, social phobias, obsessive-compulsive disorder, post traumatic stress disorder, acute stress disorder and generalized anxiety disorders. Kaplan, Sadock and Grebb, (1994) describe the symptoms of anxiety disorders as very disabling, saying that “generalized anxiety disorder is a chronic condition that may well be life long” (Kaplan, Sadock and Grebb, 1994, p.614).

Adjustment disorders, on the other hand are “a short term maladaptive reaction to what a lay person may call a personal misfortune or to what a

psychiatrist calls a psychosocial stressor” (Kaplan, Sadock and Grebb, 1994, p.727). Prognosis for people with adjustment disorders is relatively favorable with symptoms disappearing soon after the stressor stops or the person adapts to the new situation. Most people with adjustment disorders return to their previous levels of functioning (Kaplan, Sadock and Grebb, 1994).

In general, the findings indicate that, contrary to the anti-privatization theory expressed in the social work literature, a privatized CFS was not “creaming” healthier and less needy clients. Those clients with serious diagnostic criteria continued to be admitted in comparable proportions after privatization.

#### *Functional Ability*

Diagnosis, however, is not the only indicator of severity of illness. Measures of functionality can provide a fuller picture of a person’s ability to obtain success and satisfaction in life’s domains. In almost all categories, after privatization clients presented more serious symptoms of decreased functionality. Table 5 shows a comparison of the percent of clients with co-occurring chemical dependency problems, clients who are labeled seriously mentally ill (SMI), clients’ global assessment functioning (GAF) scales and clients who are deemed functionally disabled. The data indicate that, after privatization, the percent of clients with co-occurring chemical dependency issues increased from 31.2% to 37.7%. Clients were designated as having a co-occurring chemical dependency problem if they presented with chemical dependency issues at intake or if a chemical dependency problem was discovered through the assessment process.

Table 5

*Factors Affecting Functional Ability*

CHARACTERISTIC	1995-1996 (N=78)		1998-1999 (N=69)	
	<i>N</i>	%	<i>N</i>	%
Co-occurring Chemical Dependency Issues	24	31.2	26	37.7
“Labeled” Seriously Mentally Ill	32	41.2	28	41.2
GAF (mean score)	55.1*		51.5**	
“Labeled” Functionally Disabled	31	41.3	32	47.1

\*SD= 9.32; range=30-75.

\*\*SD= 8.96; range=35-70.

Clients who had been in recovery for more than ten years and were not presenting their chemical dependency issues as affecting their lives or their functioning were not considered to be in this group.

To be labeled a person with serious mental illness (SMI), a client must either have had Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) or demonstrated that, over time, they repeatedly required assistance to complete the tasks of daily living. The percent of clients labeled SMI prior to and after the privatization remained the same. As the only not-for-profit mental health agency in the County, if CFS did not admit this client population, they would have nowhere else to go. The private for-profit groups in the County did not treat clients who were seriously mentally ill or who were on

Medicaid. Therefore, CFS remained the only place that provided access to this population.

Scores on the Global Assessment Functioning scale (GAF) below 60 are considered severe; the lower the score the more severe the functional disability. Clients who score below 50 on the GAF are considered seriously mentally ill. The data also suggests that the clients' scores on the (GAF) decreased from a mean of 55.1 prior to privatization to a mean score of 51.5 after privatization. There was slightly less variability after privatization based on the range and standard deviation. Functional disability by New York State Office of Mental Health policy requires that the individual display difficulty in independently functioning in an age appropriate manner in areas of self-care, activities of daily living, self-direction, social functioning, economic self-sufficiency and ability to concentrate. In this last area to be considered, functional disability, the percentage of clients who were considered functionally disabled in various life domains after privatization increased by 5.8%. Usually, people who are functionally disabled have been in the mental health system and either have Medicaid or are applying for Medicaid and are therefore not accepted for treatment by private for-profit groups. As CFS expanded its programming after privatization, people who were functionally disabled had increased opportunities to access needed services.

In summary, after privatization, diagnostic profiles of clients treated by CFS remained very much the same or were indicative of more serious mental illness. Furthermore, clients admitted to services after privatization were more functionally disabled. Once again, the data suggest that after privatization, CFS

was treating clients who were at least as ill as prior to privatization and, possibly, even more seriously ill.

### *Presenting Problems*

Another way to measure whether or not the privatized agency was “creaming” healthier clients is to compare presenting problems at intake prior to and after privatization to see if, after privatization, clients were presenting with less severe issues than they had prior to privatization. If “creaming” occurred, the clients with more serious clinical issues who required more intense, complex and therefore costlier interventions would be referred out. The data in Table 6 show the range of presenting problems prior to and after privatization.

Both prior to and after privatization, depression was the most common presenting problem. After privatization the number of people presenting with depression increased by almost 13%. In addition, after privatization, the number of people presenting with anxiety and/or panic increased by 16%, and the number of people presenting with suicidal/homicidal ideas increased by 2.8%. Presenting problems such as those just mentioned require a complex treatment approach and present a high risk of suicide, prognosis of longer duration and in some cases the need for more complex bio-psycho-social treatment interventions (Kaplan, Sadock and Grebb, 1994). In addition, people who present with these problems have high risk factors for suicide and therefore may require more intense intervention than those presenting with marital or family problems alone (Jacobs, 1999).

Prior to privatization, 39.7% of clients presented with marital and family

Table 6

*Presenting Problems at Intake*

PROBLEM	1995-1996		1998-1999	
	<i>N</i>	%*	<i>N</i>	%*
	(N=78)		(N=69)	
Depression	51	65.4	54	78.3
Anxiety / Panic	26	33.3	34	49.3
Psychotic Symptoms	22	28.2	16	23.2
Suicidal / Homicidal Ideas	17	21.8	17	24.6
Family Problems	16	20.5	9	13.0
Marital Problems	15	19.2	6	8.7
Alcohol / Substance Abuse	12	15.4	7	10.1
Mania	5	6.4	1	1.4
Domestic Violence	4	5.1	--	--
Phobia	3	3.8	2	2.9
Sexual Abuse	--	--	3	4.3
Other	24	30.8	23	33.3

Will not equal 100% as the question is check all that apply; categories are not mutually exclusive.

problems, while after privatization, this number decreased by 18%. These findings suggest that, contrary to what was posited in the literature, after privatization at CFS, the number of clients who presented with problems that required complex and varied interventions such as those with depression,

anxiety, psychosis and suicidal ideas, was higher than prior to privatization. As more clients with complex diagnostic pictures were being seen at CFS, a waiting list began to be formed and those clients who presented with family and marital problems who had private insurance coverage were being referred to private practice groups in the County. As the only place for clients without sufficient funds, to receive treatment CFS was beginning to have to triage clients and refer those who could afford treatment elsewhere.

### *Clinical Interventions*

Anti-privatization theory offered another concern, namely that, in privatized agencies, staff would be held to productivity standards resulting in larger case loads which would increase their paperwork burdens and necessarily force them to curtail providing appropriate clinical assessments and interventions. If this problem had materialized at CFS after privatization, and staff were unable or unwilling to provide appropriate clinical assessments and interventions, we would be seeing a decrease in the number of treatment recommendations at intake and a decrease in the number and array of clinical interventions and referrals that were offered during treatment.

Again, the data suggest quite the contrary. Table 7 reveals the mean number of treatment recommendations at intake prior to privatization at 2.65, increasing to 3.06 after privatization. The number of clinical interventions and referrals during treatment increased from a mean of 1.84 prior to privatization to a mean of 2.09 after privatization. Although this increase was small, it suggests that the array of clinical interventions was at least as complex after privatization

Table 7

*Number of Treatment Recommendations and Clinical Interventions*

CHARACTERISTIC	1995-1996 (N=78)			1998-1999 (N=69)		
	<i>M</i>	<i>SD</i>	<i>Range</i>	<i>M</i>	<i>SD</i>	<i>Range</i>
Treatment Recommendations at Intake	2.65	1.03	0-5	3.06	1.25	1-7
Clinical Interventions/ Referrals during Treatment	3.24	1.84	0-8	4.35	2.09	1-9

as it was while the agency was under government auspice.

*Staff Development*

Another fear associated with privatization was that, in order to increase cost savings after privatizations, staff development activities would be curtailed and new, more costly state-of-the-art services would be eliminated. Under the County administration, staff were each allotted a small stipend to attend trainings. Their choices were not monitored by the administration and when new techniques were learned at conferences and workshops they were not implemented at the County agency in any comprehensive fashion. After privatization, in order to increase the technical knowledge base of the clinical staff and therefore attempt to improve service provision, I encouraged staff to regularly attend outside workshops and trainings. A staff development program was designed and implemented with ongoing training in cultural competence,

crisis intervention, safety issues, family therapy, chemical dependency issues and recovery based principles of service provision. Specialists were invited into the Agency to teach staff how to provide interventions such as Assertive Community Treatment (ACT), Psychiatric Rehabilitation, Dialectical Behavioral Therapy (DBT), and Eye Movement Desensitization and Reprocessing (EMDR). Time was set aside in staff meetings to discuss trainings and pass along new techniques. Peer supervision groups were formed to support those clinicians who were practicing these new techniques. Staff performance evaluations reflected positively on those who sought to learn and implement new state-of-the-art intervention techniques. The student intern program was expanded and staff productivity expectations were decreased for anyone who supervised an intern or attended the required course to allow them to be eligible to supervise social work interns. These staff development activities continued and expanded as the agency stabilized after the privatization.

The data in Table 7 reflect this increase in clinical interventions. However, continued examination of future years would be necessary to see whether CFS staff continued to expand their clinical knowledge base and increase the array and complexity of services offered as they became more comfortable with the innovative clinical interventions they were learning.

### *Client Outcomes*

In Mental Health, quality of care and effective service provision can be difficult to measure. Anticipating privatization, CFS staff were concerned that after its implementation, treatment would not be as effective as prior to

privatization. Analysis of clients' attainment of treatment goals is one way of determining whether or not this concern was substantiated.

At CFS, as in all New York State Office of Mental Health licensed programs, when a client is admitted, client and clinician set discharge criteria based upon initial assessments and evaluations. Treatment plans are then developed to assist the client in meeting those discharge criteria, thus allowing for completion of treatment and termination.

Table 8 shows the percentage of CFS clients who met their discharge criteria at termination prior to and after privatization. The data provide evidence

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Table 8

*Treatment Goal Attainment Prior to and After Privatization*

	1995-1996		1998-1999	
	(N=71)		(N=69)	
<i>TREATMENT GOAL ATTAINMENT</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
Met discharge criteria at termination	17	23.9	26	37.7

---

that, after privatization, the percent of clients who met discharge criteria at termination increased by 13.8%. It is possible that with the additional training after privatization in both client record keeping and improved clinical interventions, staff were becoming better able to meet client needs by setting more realistic discharge criteria and using more varied clinical tools to help the client meet those criteria. In any case, all indications are that clients had better treatment outcomes after privatization.

Reasons for termination and who initiated termination did not substantially change after privatization. Table 9 data indicate that reasons for termination prior to and after privatization varied only slightly. Both prior to and after privatization, most clients terminated treatment by simply stopping coming to the clinic. After privatization, clients who terminated by not coming to the clinic decreased by

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Table 9

*Reasons for Termination*

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	1995-1996		1998-1999	
	(N=74)		(N=69)	
REASONS FOR TERMINATION	<i>N</i>	%	<i>N</i>	%
Client stopped coming	32	43.2	27	39.1
Completion of treatment	8	10.8	5	7.2
Client moved out of area	8	10.8	9	13.0
Client expressed desire to end services	8	10.8	12	17.4
Client referred to alternate level of care	8	10.8	10	14.5
Clinician left agency	4	5.4	5	7.2
Other	6	8.1	1	1.4

---

4.1%. However, those who terminated by completing treatment decreased as well, by 3.6%. The greatest change was in the percentage of clients expressing a desire to end treatment. There was an increase in this variable from 10.8% prior to privatization to 17.4% after privatization. Concurrent with this finding, there

was a 3.7% increase in the number of clients who were referred to alternate levels of care. Possibly, after privatization, clinicians were more open to discussing the client's desires about their treatment and were working in tandem with them on issues of termination. More research would have to be conducted on this variable to assess the reasons for the changes or to assume causality.

It is common in mental health programs for clients to drop out of treatment without engaging in a formal termination process (Mirabito, 2001). Although these data do not show increases in the number of clients completing planned terminations, they do not suggest an increase in numbers of clients asked to leave treatment prior to completion, as the literature warned might occur. Neither do the data suggest a situation after privatization in which clinicians are terminating difficult clients prematurely for the purpose of cost saving.

In addition, if cost saving were driving treatment, CFS would demonstrate a post-privatization increase in the use of hospital and crisis services as difficult clients were referred out of treatment if they temporarily needed a higher level of care. Table 10 data show that there was no substantial change in the use of

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Table 10

*Use of Hospital, Emergency and Crisis Service Prior to and After Privatization*

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	1995-1996			1998-1999		
	M	SD	R	M	SD	R
USE OF HOSPITAL/CRISIS		(N=78)			(N=69)	
Hospital/ Emergency/ Crisis	0.72	1.72	0-10	0.72	1.92	0-10
Services Usage						

---

hospital and crisis services for the periods prior to and after privatization. Both prior to and after privatization, the mean number of times a client was referred to a hospital or crisis services, was .72 during their episode of treatment.

The data also show slight differences in who was the initiator of the termination prior to and after privatization. Table 11 displays the treatment terminations initiated by the client and the clinician. After privatization, client initiated terminations increased by 2.3% and clinician initiated terminations decreased by 2.3%. This is consistent with the finding in Table 9 of the increase in clients who expressed a desire to end services.

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Table 11

*Initiator of termination*

	1995-1996 (N=71)		1998-1999 (N=69)	
INITIATOR OF TERMINATION	<i>N</i>	%	<i>N</i>	%
Client	56	78.9	56	81.2
Clinician	15	21.1	13	18.8

---

The data in Tables 9-11 do not reflect an agency in which, after privatization, clinicians were terminating treatment or sending clients to hospitals and crisis services to effect cost savings. In contrast, after privatization, clients were more likely to be the ones initiating termination. Contrary to the fears of the staff and the dire consequences outlined for privatized mental health agencies in

the literature, there did not seem to be negative changes at CFS with regard to quality of treatment.

### *Perception of Treatment Effectiveness*

Another important indicator of success in mental health treatment is the attainment of the goals clients entered treatment to work on and their perception of whether or not the service they received was effective in helping them meet treatment goals. Table 12 describes the client's perception of the effectiveness of treatment at CFS prior to and after privatization. Prior to privatization, 54.2% of clients found their treatment very or moderately effective while 45.8% found the treatment minimally or not effective. After privatization, the number of clients who found the treatment very or moderately effective increased by 1.1% and the number who found the treatment minimally or not effective decreased by 1.2%.

Table 12

### *Client's Perception of Treatment Prior to and After Privatization*

	1995-1996 (N=48)		1998-1999 (N=65)	
CLIENT'S PERCEPTION OF TREATMENT	<i>N</i> *	%	<i>N</i> **	%
Very effective	14	29.2	22	33.8
Moderately effective	12	25.0	14	21.5
Minimally effective	5	10.4	21	32.3
Not effective	17	35.4	8	12.3

On a scale (1) "very effective to (4) "not effective":

\*M= 2.5; SD= 1.26

\*\*M= 2.2; SD= 1.06

Although, the changes are small and do not demonstrate much difference, once again the data reveal an agency where clients' perceptions of the effectiveness of their treatment have not declined after privatization.

One result that is interesting to note is that the number of clients who found their treatment minimally effective increased by 21.9% after privatization while the number who found their treatment not effective decreased by 23.1%. While coding these responses, clients who considered their treatment minimally effective were those who felt that less than 50% of the symptoms of their presenting problems had abated but they were still experiencing problems with functioning and their discharge criteria had not been met. Those who perceived treatment as not effective were still experiencing the symptoms they presented with, were still having problems with functioning and did not meet their discharge criteria. It appears, that after privatization, more clients were perceiving that treatment was helping them with at least some of the issues that they had come in to work on but were not perceiving the treatment as effective enough to meet the criteria for moderately effective. Part of the vision for a recovery oriented approach to mental health care is the ability to celebrate small incremental changes in behavior as being meaningful to the client and the practitioner (Anthony, Cohen, Farkas and Gagne, 2002). After privatization, as this philosophy was becoming adopted at CFS, clients may have been getting the message that although they had not completed treatment and met their discharge criteria, they still got something positive from the therapeutic

experience. Further study on this variable would be needed to further explain this finding.

Finally, data were also collected regarding the clinician's view of the effectiveness of the treatment, and the results are displayed in Table 13. These

Table 13

*Clinician's Perception of Treatment Prior to and After Privatization*

	1995-1996		1998-1999	
	(N=72)		(N=69)	
CLINICIAN'S PERCEPTION OF TREATMENT	N*	%	N**	%
Very effective	16	22.2	20	29.0
Moderately effective	17	23.6	16	23.2
Minimally effective	15	20.8	24	34.8
Not effective	24	33.3	9	13.0

On a scale (1) "very effective to (4) "not effective":

\*M= 2.7; SD= 1.17

\*\*M= 2.3; SD= 1.05

data indicate a 6.4% increase in the clinician's perception of very and moderately effective treatment from 45.8% prior to privatization to 52.2% after privatization.

The change in clinician's perception of minimally effective to not effective treatment decreased 6.3% from 54.1% prior to privatization to 47.8% after privatization.

Similar to the findings in Table 12, clinician's perception of minimal effectiveness of treatment increased by 14% and the perception of treatment as not effective at all decreased by 20.3% after privatization. As in the finding in Table 12, it is possible that after privatization, in keeping with a psychiatric rehabilitation perspective (Anthony, 2002) a philosophical change was occurring and clinicians as well as clients were becoming more hopeful that small changes in behavior were better than no changes at all. It is also possible that clinicians and clients were setting more realistic treatment goals that clients were more able to reach. Further research on this variable as well, would be necessary in order to explain the unexpected finding.

Although it appears that both the clients' and the clinicians' perception of the effectiveness of treatment improved after privatization, the results for this variable should be viewed with caution. The clients' perceptions were mined from the record that was written by the clinicians. Some clinicians documented the client's perceptions and comments often, while others rarely entered any thoughts the client actually shared with them. Even when included in the record, the client's perceptions were being recorded by the clinician and therefore filtered through the clinician's reality. Although clients signed their treatment plans and often wrote in them, "I agree with this plan", no client record was found in which a client recorded their perceptions of their progress themselves. Still, the results of this variable offer us an opportunity to observe the staff's perception of the changes that were occurring in treatment provision at CFS after privatization.

### *Summary of Clinical Data-Mining Results*

Program theory posited that privatization would result in more client participation in treatment, increased access to services, fewer hospitalizations and client crises, more innovative state-of-the-art interventions and increased community collaboration and communication. The results of the data-mining portion of this study describe an agency after privatization where the array and complexity of services delivered expanded and the perception of effectiveness of service provision increased for both client and clinician. Referral sources to the agency, as well as referrals that CFS clinicians made to alternate levels of care, expanded, demonstrating increased communication and collaboration among those both within and outside of the agency.

The County Executive privatized to achieve increased cost effectiveness and efficiency through increased productivity, modernization of administrative infrastructure and diversified revenue streams. The anti-privatization literature consistently warned of achieving this increased cost effectiveness and efficiency at the cost of reducing quality of care. Clinical data-mining results did not substantiate these fears. Lengths of stay did not decrease and clients were not discharged prematurely, as was predicted in the literature. Diagnosis and functionality of the client population became somewhat more severe rather than less severe. There was no sign of “creaming”, or taking in clients who were less ill to save money on costly clinical interventions. The number and diversity of clinical interventions increased as staff were trained in new, state-of-the-art

intervention techniques and began to implement them in treatment. And, finally, client and clinician perception of treatment success did not change.

The one variable that did suggest a change predicted in the literature was payor source. After privatization, the number of self-pay only clients decreased and the number of clients with commercial insurance increased. Further study would have to be done on this population to assure that those who were self-pay only were not denied access to treatment and to see if some of those clients who were self-pay before the privatization actually had insurance but just didn't use it because the agency was not enrolled in their insurance panels.

In combination with the results of the CFR analysis, the clinical data-mining portion of the study describes the effects of privatization on CFS and evidences a community mental health agency that experienced a disruptive organizational change and yet emerged a more efficient and cost effective organization without experiencing the dire consequences to the quality of service provision that has been reported or predicted in the literature.

In Chapter IX, I will suggest some possible next steps for further exploration into privatization as a viable way for government run mental health services to become more cost effective and efficient without compromising quality of care. I will also suggest some future exploration of the issues raised in this study for CFS' future.

## Chapter IX

### *Next Steps*

This study has described the effects of privatization on CFS, a community mental health agency, and demonstrated that this change in structure did, in fact, result in more efficient and effective service provision. In the previous chapters, I have presented data and observations before, during and after the privatization to better understand the multiple and complex phenomena and effects of privatization as organizational change. I have also described my use of Psychiatric Rehabilitation practice as administrative practice that helped me to assess and develop CFS' readiness to change during the planning for the privatization and during the early years after the privatization.

Privatization is a complex organizational change process and, as such, an understanding of Psychiatric Rehabilitation as a theory of change provided me with a useful framework for understanding readiness for change and for facilitating the changes that occurred at CFS.

### *Next Steps for Privatization*

This study demonstrated that not every privatization must result in dire consequences to quality of care. Irrespective of the outcomes, however, privatization of mental health and social services has continued on state and local levels. Further studies should be conducted to describe and demonstrate the processes that other agencies have engaged in and the consequent client outcomes. Rhetoric alone will not help managers to continue to provide quality care to those who are most in need. Further research into the process and

outcomes of privatized agencies can move the privatization debate from politics and rhetoric to an opportunity to offer some positive assistance to others experiencing this organizational change.

*Next Steps for CFS in Evaluating Privatization*

This study presents an example of an agency that not only survived organizational change but also became more cost effective and more efficient as a result of it without sacrificing quality of care. However, CFS is now 9 years old, and both the CFR portion of the study and the clinical data-mining portion as well, were conducted only on the two year period prior to, and the two year period after, the privatization in 1997. Since the last year of the study, 1999 there have been many changes both at CFS and also at the regulatory level of the Office of Mental Health, which licenses the programs and the Department of Health which oversees the Medicaid reimbursement system. There have been numerous changes to the Medicaid reimbursement rates including supplements for children's evening and week-end sessions, a supplement to be involved in a Continuous Quality Improvement program, and shifts from 100% State Aid funding to increased Medicaid supplemental payments, to name a few. In addition, some program types have been eliminated and others have been added. The CFR document has been changed from a DOS based to a windows based document and some of its content has been changed as well.

At CFS, there have been changes in personnel, changes in programming, changes in the way that statistics are kept, changes in the way that financial data are tracked and the creation and completion of three Strategic Planning initiatives

that have guided the direction of the Agency. Because of CFS' growth and change, selecting a "snapshot" of more recent data to be compared to the data in this study would have proven to be difficult. Comparison to the early data reported in this study would not have been valid since there have been too many intervening variables in the more than 9 years since privatization to make comparison to the present meaningful.

Still, further study of these later years should be undertaken to see if the changes that CFS experienced directly after the privatization were sustained. In addition, further research into client outcomes would also be useful. The mission of CFS and most community mental health centers is to improve the lives of those who come to the agency for service. Quantifying that improvement through outcome research would further demonstrate CFS' claim of success.

The change and turbulence of the health care system has continued and further study of CFS' ability to remain cost effective and efficient within this turbulent system could help other administrators to better prepare for and lead their agencies through change.

#### *Next Steps for Psychiatric Rehabilitation as Administrative Practice*

In the last ten years, Psychiatric Rehabilitation has become an established client intervention philosophy and technology nationally and internationally. It has helped countless people with psychiatric disabilities to lead more successful and satisfying lives. There have been numerous research studies, workshops and presentations nationally and internationally, describing and testing its ability to produce positive client outcomes. Further study of the use of this practice to help

managers lead agencies through turbulent change might result in the addition of a very useful tool to the manager's "toolbox". In addition, further demonstrating that a clinical intervention can be helpful administratively, could help to bridge the gap between administrators and clinicians as they realize that their practices may not be as far apart as they think.

The purpose of this study was to describe and demonstrate the effects of privatization on one community mental health center and to describe the way that one manager assessed the needs of that agency to survive despite the turbulence of the change that privatization caused. I have learned that being an Executive Director during a period of fundamental organizational change is a very hard job. Moreover, a friend who is the Executive Director of a large organization once told me that he felt that managing a small organization like CFS was harder than managing a larger one like his own because, although the tasks were the same, in the smaller organization, the manager had much less help in performing them. Managing is difficult in any environment but in our current environment of shrinking funds, increased risks of litigation and excessive government oversight, leaders can easily lose their vision and also lose their way.

"Leaders, through their words and actions, fill in the details of the vision. The metaphors, the anecdotes, the traditions, past successes and failures, these all serve to elaborate on the vision" (Anthony, Cohen, Farkas and Gagne, 2002, p.301). Those of us who have chosen administration as our social work practice have a responsibility to assure that the agencies and programs that we oversee

have the resources they need to provide services to those in our society who are most at risk but who, like every other member of society, deserve a chance to lead productive and satisfying lives. Finding innovative ways to lead our agencies through the turbulence of change can help to insure the continuance of community nonprofit agencies and also assure that the vision of recovery for all people remains foremost on the agenda of mental health care agencies now and in the future.

Appendix A  
*Organizational Rehabilitation Readiness Determination*

**1. Current Environments Analysis:** Indicate the organization's current status. \_\_\_\_\_

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Record the description of specific characteristics of the organization and for each characteristic, record the organization's strengths/limitations and give reasons.

Internal Perspective:(Staff, Clients, Board)\_\_\_\_\_

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External Perspective:(Funders, Regulators, Community)\_\_\_\_\_

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**2. Readiness Ratings:** Based on the Readiness Assessment Criteria Scale (next page), enter a rating for each criteria in the space provided.

NEED FOR CHANGE	
COMMITMENT TO CHANGE	
SELF AWARENESS	
ENVIRONMENTAL AWARENESS	

**3. Interactive Behaviors:** Describe the manner in which the staff of the organization relate with others involved in assisting change. \_\_\_\_\_

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Appendix A  
Organizational Rehabilitation Readiness Determination (con't)

**4. Conclusion and Rationales:** Based on the above information, describe the organization's readiness to participate in a change. Include a rationale. \_\_\_\_\_

**5. Recommendations and Strategies:** Describe recommendations and strategies to initiate the change process or increase the organization's readiness for change. \_\_\_\_\_

**READINESS ASSESSMENT CRITERIA**

Rating	Need for Change	Commitment to Change	Environmental Awareness	Self Awareness
5	Urgent Need Organization is very dissatisfied with current situation and or/others demand change	Very Committed Believes need for change exists Believes change is positive and possible Believes support for change exists	Very Aware Talks about past/future situations in detail. Describes people, places and activities that might exist with change	Very Aware Describes interests values and experiences without prompts. Much experience with other organizations and their activities
4	Strong Need Organization is dissatisfied with current situation and/or others seek change	Committed Any three factors indicated in Level 5	Aware Talks about past/future situations in general. Describes people, places and activities that might result from change	Aware Describes interests, values, and experiences when asked. Some experience with other organizations.
3	Moderate Need Organization and others ambivalent about current situation	Moderately Committed Any two factors indicated in Level 5	Moderately Aware Names some alternative present, past and future situations: Describes a few people, places and activities that might result from change	Moderately Aware Answers direct questions about interests, values and experiences. No experience selecting alternatives/ Some experience making other important choices.
2	Minimal Need Organization is satisfied with current situation, but wants change later and others seek no change at this time	Minimally Committed Any one of the factors indicated in Level 5	Minimally Aware Names more than one present situation. May be able to describe one past situation, people, places and activities that might result from change	Minimally Aware Answers only general interest questions. Vague about values. No experience selecting alternatives. Little decision making experience.
1	No Need Organization is satisfied with current situation and others do not seek change	Not Committed No factors indicated in Level 5	No Awareness Names only present situation or none. Vague about people, places and activities that might result from change	No Awareness Can't answer questions about interests, values and experiences. No decision making exper.

(Adapted from NYSOMH Form 346 MED)

Appendix B  
DATA EXTRACTION FORM  
CONSOLIDATED FISCAL REPORT

	1995 Pre Privatization Talks	1996 Privatization Talks Begin	Jan-June 1997 Implementation of Privatization	July-Dec 1997 Transition to Not-For-Profit	1997 Combined Total	1998 First Full Year As not-for profit	1999 Second full year as not- for-profit
Total units of service	49,542	51,500	23,251	30,240	53,491	58,796	71,755
Total # people seen	948	1,159	912	884	898	1,916	2,239
Total FTE	34.4	31.9	17.23	34.36	34.36	43.59	47.36
Units of service per FTE	1440	1614	1349	880	1557	1349	1515
Total gross costs	\$2,453,740	\$2,578,704	\$1,497,162	\$1,279,205	\$2,776,367	\$2,569,512	\$2,849,718
Total net costs	\$1,390,859	\$1,513,153	\$933,862	\$752,995	\$1,686,857	\$1,353,887	\$1,531,438
Total admin costs	\$169,671	\$172,928	\$72,306	\$95,695	\$168,001	\$297,902	\$396,617
Gross cost per unit of service	\$49.53	\$50.07	\$64.39	\$42.30	\$51.90	\$43.70	\$39.71
Net cost per unit of service	\$28.07	\$29.38	\$40.16	\$24.90	\$31.54	\$23.03	\$21.34
Total costs per FTE	\$71,330	\$80,837	\$86,893	\$37,229	\$80,802	\$58,947	\$60,171
Total costs per person seen	\$2,588	\$2,225	\$1,642	\$1,447	\$3,092	\$1,341	\$1,273
Total revenue	\$1,062,881	\$1,065,551	\$563,300	\$526,210	\$1,089,510	\$1,215,625	\$1,318,280
Total medicaid	\$914,263	\$960,746	\$498,966	\$477,699	\$976,665	\$1,018,697	\$1,028,909
Total self pay	\$62,824	\$66,356	\$25,696	\$39,359	\$65,055	\$135,842	\$123,682
Total insurance	\$74,963	\$27,114	\$23,993	\$2,088	\$26,081	\$13,428	\$68,461
Total medicare	\$10,831	\$11,335	\$14,645	\$5,505	\$20,150	\$34,571	\$19,524
Total other than NDF revenue	\$0	\$0	\$0	\$1,559	\$1,559	\$13,087	\$77,704

Appendix C  
Data Extraction Form  
Inventory of Demographics and Services

Study Year \_\_\_\_\_ Program \_\_\_\_\_ Client Code \_\_\_\_\_

*Demographics:*

1. Months of Service/LOS: \_\_\_\_\_ 2. Age: \_\_\_\_\_

3. Gender:            1) Male            2) Female

4. Primary Pay Source: 1) Medicaid    2) Medicare    3) Self-Pay    4) Private Insurance    5) No info

5. Referral Source:    1) Friend/Relative    2) Hospital    3) Crisis    4) CFS Clinician    5) Self  
6) Other Agency    7) Community MD    8) DSS    9) Probation  
10) Other \_\_\_\_\_    11) No info

6. Primary Diagnosis: \_\_\_\_\_

1) Mood Disorders    2) Anxiety Disorders    3) Psychotic Disorders  
4) Dissociative Disorders    5) Adjustment Disorders    6) Personality Disorders  
7) Eating Disorders    8) ADD/ADHD    9) Other \_\_\_\_\_

7. Co-occurring Chemical Dependency Issues: 1) yes    2) no

8. GAF Score \_\_\_\_\_

9. SMI:                    1) Yes                    2) No                    3) No Info

10. Functionally Disabled: 1) Yes            2) No            3) No Info

11. Presenting Problems:

1) Depression	1) yes	2) no	3) no info
2) Anxiety/Panic	1) yes	2) no	3) no info
3) Phobia	1) yes	2) no	3) no info
4) Marital Problems	1) yes	2) no	3) no info
5) Family Problems	1) yes	2) no	3) no info
6) Domestic Violence	1) yes	2) no	3) no info
7) Sexual Abuse	1) yes	2) no	3) no info
8) Alcohol/Substance Abuse	1) yes	2) no	3) no info
9) Psychotic Symptoms	1) yes	2) no	3) no info
10) Suicidal/Homicidal Ideas	1) yes	2) no	3) no info
11) Mania	1) yes	2) no	3) no info
12) Other _____	1) yes	2) no	3) no info

*Services:*

12. Treatment Recommendations at Intake:

1) Individual	1) yes	2) no	3) no info
2) Group	1) yes	2) no	3) no info
3) Couples	1) yes	2) no	3) no info

## Appendix C, Data Extraction Form (con't)

- |                           |        |       |            |
|---------------------------|--------|-------|------------|
| 4) Family                 | 1) yes | 2) no | 3) no info |
| 5) Psychiatric Evaluation | 1) yes | 2) no | 3) no info |
| 6) Case Management        | 1) yes | 2) no | 3) no info |
| 7) DBT                    | 1) yes | 2) no | 3) no info |
| 8) EMDR                   | 1) yes | 2) no | 3) no info |
| 9) Vocational Assessment  | 1) yes | 2) no | 3) no info |
| 10) CD Evaluation         | 1) yes | 2) no | 3) no info |
| 11) Other_____            | 1) yes | 2) no | 3) no info |

## 13. Clinical Interventions/Referrals during treatment:

- |                               |        |       |            |
|-------------------------------|--------|-------|------------|
| 1) Individual                 | 1) yes | 2) no | 3) no info |
| 2) Group                      | 1) yes | 2) no | 3) no info |
| 3) Couples                    | 1) yes | 2) no | 3) no info |
| 4) Family                     | 1) yes | 2) no | 3) no info |
| 5) Psychiatric Eval/Treatment | 1) yes | 2) no | 3) no info |
| 6) Case Management            | 1) yes | 2) no | 3) no info |
| 7) Partial Hospital           | 1) yes | 2) no | 3) no info |
| 8) In-Patient                 | 1) yes | 2) no | 3) no info |
| 9) DBT                        | 1) yes | 2) no | 3) no info |
| 10) EMDR                      | 1) yes | 2) no | 3) no info |
| 11) Vocational Assessment     | 1) yes | 2) no | 3) no info |
| 12) CD Evaluation/Treatment   | 1) yes | 2) no | 3) no info |
| 13) Medical                   | 1) yes | 2) no | 3) no info |
| 14) Other_____                | 1) yes | 2) no | 3) no info |

14. Number of times used Hospital/Emergency/Crisis Services during study years:\_\_\_\_\_

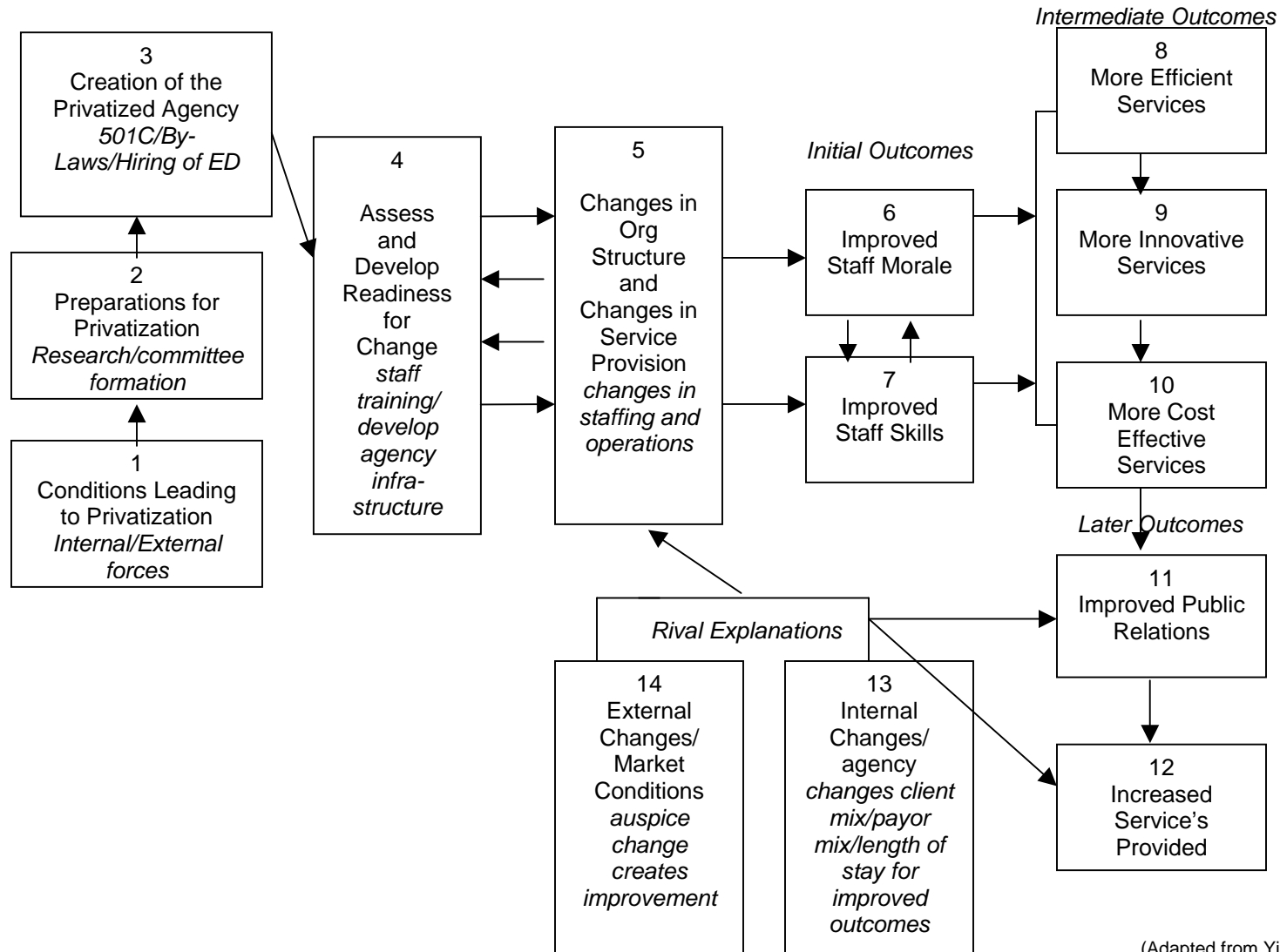
15. Progress Towards Goals: 1) Met discharge criteria at termination 2) Did not meet discharge criteria at termination 3) No Info

16. Reason for Termination/Discharge: 1) Completion of treatment 2) Client moved out of area  
3) Client expressed desire to end services 4) Clinician left Agency  
5) Client stopped coming 6) Client referred to alternate level of care  
7) Other\_\_\_\_\_

17. Termination Initiated by: 1) Client 2) Clinician 3) Family 4) No Info

18. Client's Perceptions of Treatment Effectiveness: 1) Very Effective 2) Moderately Effective  
3) Minimally Effective 4) Not Effective 5) No Info19. Clinician's Perceptions of Treatment Effectiveness: 1) Very Effective 2) Moderately Effective  
3) Minimally Effective 4) Not Effective 5) No Info

Appendix D  
Organizational Logic Model/ Privatization and Change at CFS



(Adapted from Yin, 2003, p 127)

Appendix E  
Code Book for Clinical Data-Mining

<u>Variable:</u>	<u>Extracted From</u>	<u>Definition of variable:</u>
1: Length of stay: (LOS)	Face sheet	Measured in months
2: Age:	Face sheet	During the study year
3: Gender:	Face sheet	
4: Primary payor source:	Face sheet/Billing sheet	At Intake
5. Referral source:	Face sheet	
6 Primary diagnosis:	Intake form	<p>1) Mood disorder includes: major depression, bi-polar, dysthymia and cyclothymia.</p> <p>2) Anxiety disorder includes: anxiety and panic disorders, agoraphobia, social phobias, obsessive-compulsive disorder, post traumatic stress disorder, acute stress disorder and generalized anxiety disorders.</p> <p>3) Psychotic disorder includes: schizophrenia, schizoaffective, schizophreniform, and other delusional disorders.</p> <p>4) Dissociative Disorder includes: depersonalization and dissociative disorders.</p> <p>5) Adjustment disorder includes: all adjustment disorders.</p> <p>6) Personality disorder includes: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, and dependent personality disorders.</p> <p>7) Eating disorder includes: anorexia and bulimia.</p> <p>8) ADD/ADHD was separated out as a category because CFS has a specialty in treatment of this disorder.</p> <p>9) Other includes: all other unspecified disorders.</p>
7. Co-occurring chemical dependency:	Intake form, Core assessment, Progress notes.	If client has been in recovery for more than 10 years and CD is not a presenting problem than code no. If CD presents as a problem or issue for treatment code yes.
8. Global assessment functioning (GAF):	Core assessment/Evaluation	

Appendix E (con't)  
Code Book for Clinical Data-Mining

Variable:	Extracted From	Definition of variable:
9. Seriously mentally ill (SMI):	Core assessment/Functional disability form	Passes established criteria on form.
10: Functionally Disabled	Core assessment/Functional Disability form	Passes established criteria on form.
11. Presenting problem:	Intake form	
12. Treatment recommendations at intake:	Intake form/Initial assessment	
13. Clinical interventions/ referrals during treatment:	Progress notes/Treatment plans/Treatment plan reviews	
14. Hospital/Emergency/Crisis:	Progress notes	Used hospital, emergency room or crisis team.
15. Progress towards goals:	Progress notes/Treatment Plans	
16. Reason for termination	Discharge summary	
17. Termination initiated by:	Discharge summary/Progress notes	
18. Client's perception of treatment effectiveness:	Progress notes/ Treatment plan reviews/ Discharge summaries	<p>1) Very effective- symptoms of presenting problems have abated and are not getting in the way of functioning. Discharge criteria have been met.</p> <p>2) Moderate- more than 50% of symptoms of presenting problems have abated-still some problems with functioning-discharge criteria may or may not be met.</p> <p>3) Minimal- less than 50% of symptoms of presenting problems have abated-still some problems with functioning-discharge criteria not met.</p> <p>4) Not effective- symptoms have not abated-presenting problem still present and persistent-still problems with functioning-discharge criteria not met.</p>
19. Clinician's perception of treatment effectiveness:	Same as above #18	Same as above #18

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