More Than a Biller: The Ramifications of Productivity Requirements for Mental Health Professionals

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More Than a Biller:
The Ramifications of Productivity Requirements for Mental Health Professionals

by

Dana Williams

A Banded Dissertation Proposal
In Partial Fulfillment of the Requirements for the Degree of
Doctor in Social Work

University of St. Thomas
School of Social Work

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Abstract

The focus of this banded dissertation is the examination of the ramifications of productivity-driven outpatient mental health management systems from the perspectives of mental health professionals. The author takes a deeper look at this understudied phenomenon to uncover the ramifications on mental health professionals and the clients they serve. This banded dissertation is comprised of three products, two of which are article and one is a poster presented at a peer-reviewed conference.

The first article posits that using a systems theory approach to management to ensure job satisfaction, adherence to ethical standards, and quality of client care would be a more effective approach than productivity-driven management systems. Such a shift is warranted to improve overall functioning and effectiveness of state mental health systems. Productivity requirements are additional pressures on professionals whose work with vulnerable populations already place them at risk for burnout.

The second article is a qualitative research study that gathered insight into the perspectives of mental health professionals’ views of productivity-driven management systems. Twenty mental health professionals participated in interviews and thematic analysis was conducted to identify recurring themes related to job satisfaction and burnout, ethical implications, and service delivery within productivity-driven environments of care. Outcomes indicate an overall theme of dissatisfaction with productivity-driven management systems.

The final piece of this banded dissertation is a poster that the author presented at a peer-reviewed conference, Minnesota’s 2019 National Association of Social Work conference at Brooklyn Center, Minnesota. The poster highlighted preliminary findings of the qualitative research study of 12 of the 20 total participants. The preliminary findings were consistent with
the final analysis related to ethical implications and job satisfaction. The overall feeling of
discontent with the use of minimum billing requirements are perceived to have a negative impact
on ethical performance and job satisfaction according to the findings depicted on the poster
presentation.

This banded dissertation serves as a starting point for further exploration of the
ramifications of productivity-driven management systems in outpatient mental health. The
findings demonstrate the need for ongoing research and discovery of improvement in mental
health management systems for the welfare of the providers, the clients, agencies, and the mental
health system.
Dedication

I would like to dedicate this dissertation to the mental health providers and mental health administrators who successfully balance the challenge of competing loyalties while continuing to provide quality mental health services to the individuals, families, and communities they serve. I also want to dedicate this dissertation to the social workers who strive to improve the quality of life, not only for their clients but for their fellow practitioners. Your tireless efforts to advocate for policy change at all system levels are beacons of hope for the mental healthcare system in our country.
Acknowledgments

I would like to thank my parents, Michael and Malinda McEntire, and my husband, Deon Williams. They have patiently supported me through my journey in this program and throughout my ever-evolving career. They have endured and assisted me through my long work hours, absence from family gatherings, or being called away while fulfilling my clinical and administrative duties during my time working in the community mental health system.

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Productivity-driven mental health practice is agency-centered, rather than client- or person-centered. It is a revenue-based accountability plan for mental health professionals measuring their direct service billing practices. In productivity-driven practice, mental health professionals and paraprofessionals’ income, benefits, and employment status are determined by the amount of billable hours obtained over a prescribed period of time. For the purposes of this study, mental health professionals were the focus and are defined as Licensed Master Social Workers/Licensed Certified Social Workers, Licensed Associate Counselors/Licensed Professional Counselors, Licensed Associate Marriage and Family Therapists/Licensed Marriage and Family Therapists, Licensed Psychological Examiners, and Licensed Psychologists.

Most of the research that exists related to this topic is several years old and is focused on the impact of managed care, Medicaid billing systems, or in the context of the larger system. The purpose of this banded dissertation is to focus on the perspective of how productivity requirements impact mental health professionals (MHPs) in positions in outpatient mental health centers. Few scholars have explored the impact of billing practices on mental health professionals and the clients they serve. The question is, how do these requirements impact the professional satisfaction and professional ethics of providers in clinical positions, and do they conflict with social work’s stated values and the service delivery to clients? The goal of this dissertation was to begin the exploratory process of addressing the perspectives of MHPs and how these practices impact the clients served, as well as to discuss how agency goals can be achieved while preserving the core values and ethical responsibilities of social work practice.

After deinstitutionalization and the Community Mental Health Act of 1963, Medicaid became a primary payer for mental health services in many state mental health systems (Frank,
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Goldman, & Hogan, 2003). Because of the amounts of state funding spent on Medicaid for mental health services, many states began using managed care agencies to curb spending and oversee service delivery (National Alliance on Mental Illness [NAMI], n.d). In addition to community mental health centers, some states expanded the number of mental health providers to include private, for-profit agencies and individuals who were also able to utilize Medicaid funds. This expansion in the number of agencies and the Medicaid billing activities set into motion a productivity-driven mental health model for agencies in many states. The Integrated Performance Management System developed by David Lloyd (2002) is one model used by productivity-driven systems. In this model, it is recommended that agencies require a minimum of 100 billable hours per month to maintain employment. In his book *How to Deliver Accountable Care*, Lloyd outlined his reasoning and discussed the feasibility and benefits to agencies who adopt his model.

Regarding the ramifications to clinical staff, ongoing billing pressures and fear of income or job loss could have a negative impact on their professional codes of ethics. For example, the National Association of Social Work’s (NASW) *Code of Ethics* must be followed by all licensed social workers. Billing requirements may shift focus from the ethical obligation to their clients to billing expectations by their employer. Additionally, the MHPs’ perceptions of their role within their profession, satisfaction with their role, and the services provided to their clients will be explored through the lens of the practitioner in the role of a “biller.”

There is limited research regarding work satisfaction among mental health professionals. In a study conducted about legal practice in Australia, the findings indicated a lower quality of work life as the result of billable hour requirements (Omari & Paull, 2014). In one systematic review measured with meta-analysis, the results indicated that one of the most significant
correlations with burn-out was workplace setting duties (Lim, Kim, Kim, Yang, & Lee, 2010). Those who work in agency settings were more likely to experience burn-out than those who worked in private practice. This finding was attributed to long work hours, high workloads, and administrative duties (Lim et al., 2010). These findings are consistent with the assumption that billing pressures from agencies would contribute to dissatisfaction and burnout because of the increased hours and number of clients needed to maintain the minimum number of hours required.

Strom (1992) conducted a study regarding the impact of the growing demands on reimbursement for social workers in private practice. Strom explained how reimbursement by private insurance companies have increased the number of those entering private practice. With this trend, the involvement of third parties in the treatment process may alter the way social work is implemented. The author suggested that this moves toward the abandonment in social work philosophical underpinnings such as the ecological perspective and the social work belief in serving all of those in need. Additionally, the push towards obtaining reimbursement to survive in the field is a threat to adherence to the code of ethics (Strom, 1992). Although Strom wrote about social workers in private practice in 1992, this topic remains timely in the structure of today’s mental health systems.

In Arkansas alone, there are more than 50 outpatient Medicaid providers in the state (Arkansas.gov, 2017). Productivity-driven mental health agencies fund their operations through the billing services of mental health professionals. In Arkansas, for example, mental health services are billed per unit (1 unit = 8 to 24 minutes; Medicaid Saves Lives, 2016). The rates per unit vary per service (individual/family therapy, group therapy, and collateral intervention). Both
community mental health centers and private for-profit mental health agencies throughout Arkansas use a form of productivity-driving practice.

**Conceptual Framework**

The framework that I used to guide this banded dissertation is a combination of systems theory in relation to foundational social work identity, professional ethics, and job satisfaction. For the purposes of this study, professional ethics and job satisfaction included the foundational ideals and purposes of the research subjects’ respective professional disciplines, the ethical implications, and satisfaction with their professional role as mental health clinicians. How professionals may consolidate or manage these issues while working under the requirements of productivity standards, is an overarching concept. Additionally, I studied the compatibility with the social work ideal that social workers empower client systems “to enhance their competence and create social structures that relieve human suffering and remedy social problems” (DuBois & Miley, 2019, p. 2).

Systems theory is integral to the framework of product one. In this article, I posited the need to use systems theory to analyze and respond to the trend of productivity-driven management systems in outpatient mental health. I outlined the integral role of systems theory in foundational social work theory and how productivity-driven practice may diminish clinical social workers’ use of their professional knowledge related to working with clients at all system levels. The need to consider the entire system is essential to achieve equilibrium and improve both client care and professional satisfaction with higher retention of qualified professionals. A productivity-driven environment may place too much emphasis on financial gain and not enough emphasis on quality care and the healthy work environments needed to maintain a healthy workforce. Additionally, productivity is not a good yardstick by which to measure the
performance of mental health professionals in terms of their professional worth to the agency and community.

Satisfaction with work and professional ethics was a central focus of the culmination of my three research products. I identified how productivity-driven practice may conflict with the mental health professionals’ professional identities and the field of social work as a whole. I explored the impact that billing pressures have on role satisfaction. Do clinicians feel like an integral part of the professional team or have they been reduced to billers or producers for their agencies similar to factory workers participating in a prescribed set of activities to reach a financial goal? Does this framework of productivity allow clinicians to advance their skills and utilize their strengths, or do they just go through the daily motions with a prescribed set of evidenced-based activities? The productivity driven environment is an environment that can breed feelings of clinicians being trained workers, rather than skilled professionals. Professional autonomy is more difficult in this type of environment.

What differentiates the social work profession from allied professions, in addition to the Social Work Code of Ethics, is how social workers work from the person-in-environment perspective and use of systems theory, which means that social workers work with the entire client system. When clinical social workers work in a setting in which productivity drives their practice with clients, are they able to work with all the client systems or meet for brief sessions focusing on a single component of the system, the clients themselves? I posited that clinical social work has been shaped into an entity that deviates from its original purpose and has been reduced to a job that is centered around economic production through a prescribed set of evidence-based practices that may or may not be in line with the foundational responsibilities of social work.
Summary of Banded Dissertation Products

The purpose of this banded dissertation was to explore the impact of productivity-driven funding on the field of social work and allied fields through three products. The first product is a conceptual paper exploring productivity-driven practice through the lens of professional values and ethics and the benefits of using a systems theory approach to reform mental health management systems. While there is limited literature related directly to productivity-driven mental health management systems, I used literature exploring job satisfaction and social work values to highlight the need for a systems theory approach to mental health management. Literature related to the onset of managed care and related pressures indicate that billing pressure may contribute to burnout and job dissatisfaction. A systems theory approach addressing systemic issues at all levels and that allows social workers to practice on all system levels would better serve everyone involved and also improve the overall functioning and efficiency of the agencies in which they work. The increased ability to practice within their entire scope of practice may increase these professionals’ job satisfaction as well.

The second product was a qualitative research study that I conducted using semi-structured interviews with mental health professionals who currently work or have previously worked in a productivity-driven setting. This product focused on the mental health professionals’ perceptions of productivity requirements and the impact these requirements have on their job satisfaction and ethical principles. Twenty mental health professionals participated in the interviews and provided insight regarding their experiences working in productivity-driven outpatient mental health practice. Participants’ overall sentiments reflected mostly negative views of the practice of measuring clinicians’ worth by the number of hours they bill. They also identified associated ethical dilemmas and concerns about quality of care being impacted by the
pressure to bill. The findings were consistent with literature that outlined how work environments with billing pressures and lack of professional autonomy may contribute to job dissatisfaction and burnout.

The third product is a poster that I presented at a peer-reviewed state National Association of Social Workers conference using the preliminary research findings of product two. Initial findings, which were presented at the conference, were consistent with the completed findings of the research study. Practitioners identified job dissatisfaction, impaired quality of service delivery, and ethical concerns related to productivity-driven management systems. Participants’ responses were presented to highlight the identified preliminary themes, as well as the participants’ demographic information. I discussed the literature that I used to support the research in the poster abstract, as well as recommendations for a move to holistic approach to management.

**Discussion**

Some of the overarching findings from this body of research indicated the need to reconsider mental health management systems to increase sustainability and systemic equilibrium. Throughout this research study, the existing literature suggests that mental health professionals are at risk for job dissatisfaction and burnout simply because of the nature of their work. However, increased work hours, high billing expectations, competing loyalties, and management mandates place these professionals at an even greater risk. With that risk comes an increase in turnover rates and a decrease in client care. The literature is consistent with the findings of the qualitative study from the perspective of mental health professionals included in this dissertation.
Participants indicated ethical concerns related to service delivery, fraudulent billing, and job dissatisfaction. They attribute these concerns to increased billing pressures derived from productivity-driven management systems. These pressures have led to many participants leaving these settings and leaving the field of mental health altogether or considering leaving the field of mental health altogether. None of the participants indicated a preference for working in productivity-driven environments if given the choice. By all indications, this preference is not driven by a desire to have less responsibility or work requirements but out of concern for the clients they serve as well as their own mental and emotional well-being.

My research findings suggest the need for reconsideration of the use of productivity-driven management systems as a means for measuring professional performance. While requiring providers obtain a minimum number of billable hours per month may increase financial profit, it is indicated by participants in my research that such requirements increase job stressors for a job that is already inherently stressful. Measuring productivity may indicate how much work a clinician has done over the course of a specific time period, but it does not provide a true indication of how much success they have achieved in terms of client outcomes. Additionally, responses suggest that there is an increased risk of fraudulent billing and unethical clinical practices in response to the fear of losing income, full-time benefits, or employment.

The literature supports participant responses that increased workloads related to productivity-driven practice, increases job dissatisfaction and burnout. The findings suggest that the most qualified professionals leave productivity-drive environments to work for agencies without such requirements, enter private practice, or leave the field of mental health altogether. Such outcomes leave agencies in the precarious position of being a training ground for novice professionals without the support qualified therapists for mentorship and guidance, thereby,
leaving some of the most vulnerable citizens with serious mental health diagnoses without the benefit of the high quality mental healthcare.

Returning to or employing foundational social work theory and assessing performance, outcomes and needs at all system levels and throughout system types, would likely yield an overall improvement in the functions of mental health systems’ services to the communities at large. Motivating clinicians to provide quality services rather than the most financially lucrative, would prevent overutilization of Medicaid and other public monies, improve client care while eliminating unnecessary services and treatment short cuts, improve retention of qualified professionals, increase employee loyalty, improve agency reputations within their community, and create a fiscally sound organization because of the increase of community trust.

These exploratory findings uncover the need for further research on the topic. While I continued some of the work in the literature related to navigating outpatient mental health while adhering to professional ethics, agency guidelines, insurance requirements, and managed care oversight in this banded dissertation, I expanded upon existing research to include the added billing pressures in settings with productivity requirements. The productivity component only serves to increase the dilemmas clinicians experience while balancing the multitude of competing entities. Because of the nature of the work and the need to maintain evidence that the clients are being served effectively while maintaining fiscal responsibility, there is an ongoing struggle between state funding sources, mental health agencies, the clinicians, and the clients to find the balance and measure outcomes. No one disputes the need for outcome measurement and financial oversight; however, I posited that a more holistic approach to mental health management systems is necessary to decrease the sometimes-adversarial nature of productivity-driven approaches.
Through a review of the literature for all three products of this banded dissertation, I identified factors related to burnout in mental health professionals that were consistent with the responses from the participants of the qualitative study. Some of the similarities between the literature findings and study responses include lack of autonomy and long work hours under stressful conditions both contributing to job dissatisfaction and burnout. Additionally, the literature supports the idea that compassion satisfaction helps prevent burnout, and respondents consistently indicated that the pressure to bill impaired their ability to provide the quality of services they desire to the clients they serve.

**Implications for Social Work Education**

In composing questions for the qualitative interviews, I added an additional question for future research related to social work education, as well as for other clinically oriented graduate programs. Participants were asked how their graduate programs prepared them for productivity-driven practice. None of the participates remembered any preparation for navigating productivity-driven management systems. One participant did indicate that learning better time management skills while in their graduate program provided some preparation in terms of balancing the demands. The need for better preparation for these settings is essential in improving students’ career success. While a change is needed regarding the use of these management systems, this remains a predominant method of operation for most agencies. Improving or managing students’ job expectations and increasing insight related to the limitations they will face in real world practice settings is something to which social work education strives. It is likely, however, that there has been a lack of preparation related to the business of social work and mental healthcare.
There are many opportunities to incorporate practical knowledge and financial expectations in agencies for which students will work upon completion of their education. Even at the bachelor’s level, there are jobs which require minimum billing expectations such as Qualified Behavioral Health Professionals in outpatient mental health centers in Arkansas. Even agencies without direct productivity requirements may require some adherence to fiscal responsibility for the agency, such as keeping beds filled in inpatient units and acquiring donations for continued operations.

Providing students with this realm of practice knowledge can be approached in many ways. An elective course could be developed and offered, an interprofessional collaborative approach with university business programs could be used to bridge the gap, or related content could be strategically interwoven throughout the social work curriculum particularly in practice courses and field education seminar. The purpose of this added knowledge is two-fold: (a) to better prepare students for practice in settings where they are held to fiscal accountability standards and (b) to prepare them for management positions in the field.

**Implications for Future Research**

The research in this banded dissertation is preliminary and exploratory, using a sample of 20 mental health professionals in Arkansas. Due to the lack of related research in the existing literature and the small-scale approach of these initial findings, more research is needed to substantiate the existence of these themes across a larger population. Additional research is needed across markets in the United States to identify additional concerns related to productivity-driven management systems. Comparative analyses across states’ mental health management systems and mental health related policy could provide additional insight into the challenges that exist in balancing the competing entities. Additionally, identifying agencies and
state systems that have better outcomes and facilitate improved job satisfaction and service
delivery could inform the replication of the policies that are most effective.

Additionally, studying other disciplines to identify effective and healthy working
environments may provide a lens through which to view mental health management. Cross-
disciplinary practices and leadership skills can be derived from experts in the field and applied to
outpatient settings to improve overall quality. There is a current movement toward research
about the impact of neoliberal approaches to commoditizing mental health and social work
services. The findings that I present in this banded dissertation provide further support for
continued research in that area. The research currently being done in the field of social work—
combined with experts such as Sinek, who study successful management and leadership
strategies—is much needed to improve the overall state of the mental health system in the United
States.

The findings of this study reflect a possible link between mental health management
systems, particularly productivity-driven management systems, and an increased risk of ethical
violations both with regard to service delivery and billing. There is also the clear identification
by the participants that productivity-driven management systems only increase job dissatisfaction
and burnout in environments where burnout is already a concern. If mental health professionals
leave outpatient mental health settings to pursue employment without billing stipulations such as
to enter private practice or leave the field of mental health altogether as indicated in this study,
the equilibrium of the entire system is at risk of remaining destabilized. To support a sustainable
mental health system and retain a qualified workforce, further research and consideration of a
more holistic approach to management is needed.
Comprehensive Reference List


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The Pressure of Productivity in Outpatient Mental Health Agencies

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Abstract

Productivity-driven mental health practice is a revenue-based accountability plan for mental health professionals that measures their direct service billing practices. These accountability policies are agency-centered, rather than client- or person-centered, and this quantitative, linear system is used to measure clinicians’ monetary worth to organizations. In this conceptual paper, the author examines the components of the systems theory as a method to provide solutions to the challenges this management system presents for social work practice. Few researchers have explored the interactions between various systems in productivity-driven practice. The author argues for holistic approaches, as opposed to narrowly focused quantitative financial measures, to determine clinical success and to increase compatibility with professional ethics and professional identity for improved client care and increased retention rates of mental health professionals.

*Keywords*: productivity, accountability, mental health, clinicians, billing, ethics, quality, quantity, measures
The Pressure of Productivity in Outpatient Mental Health Agencies

Productivity-driven mental health practice is a revenue-based accountability plan for mental health professionals measuring their direct service billing practices (Hicks, 1984; Lloyd, 2002). In productivity-driven practice, mental health professionals are encouraged or are required to bill a minimum amount of time spent in face-to-face sessions per month or per week in order to keep their job or receive bonuses. Some agencies even base their pay on a percentage of the services billed from service provision (Lloyd, 2002). Due to productivity-driven management systems in behavioral health agencies, clinical social workers might experience professional challenges such as adhering to the values, ethics, and purpose of the profession because the pressure to meet billing expectations in order to survive professionally may take priority. While it may be possible to remain true to the values and purposes of social work in a productivity-driven environment, a more holistic approach for accountability could be a better approach for yielding positive clinical outcomes for clients; achieving compassion satisfaction, which is defined as pleasure gained from good work (Professional Quality of Life Measure, 2019); and job satisfaction for individual practitioners.

Productivity-driven practice may not be the best approach for setting the standards of care in mental health systems either at the agency level or for society at large. Caring for employees is essential for agencies tasked with serving vulnerable populations and who are at risk for compassion fatigue, secondary trauma and other client-related factors of burnout (Ni, Qian, & Crilly, 2014; Smullins, 2015). There is a lack of current research addressing the impact productivity has on job satisfaction and burnout, and productivity-related stressors are accepted as a routine part of clinical practice. Strict productivity requirements, however, only add to the stress and burnout of these at-risk professionals (Strom, 1992).
Social workers who experience burnout and job dissatisfaction may have a difficult time adhering to the values and ethics of social work. Additionally, productivity-driven practice may be viewed as antithetical to the purpose and values of mental health professionals, which only adds to the levels of stress-related burnout. Foundational values that must be embodied in all levels of social work practice include the National Association of Social Worker Code of Ethics, including the six core values of social work: Service, dignity and worth of the person, the importance of human relationships, competence, integrity, and social justice (NASW, 2017), and the prescribed ethical principles that correlate with each of these values. Accreditation requirements are used to ensure that social work programs produce competent, ethical social workers with a solid generalist foundation to uphold the values and purpose of the profession (Council on Social Work Education [CSWE], 2015). However, there is no evidence that they are taught how to effectively maintain these standards in the context of productivity-driven management systems.

There are numerous descriptions of the purpose of social work as a profession, which shape social workers’ professional identity. At its core, the key components that social workers must acquire to be sufficiently prepared for practice include knowledge and adoption of generalist practice skills, the NASW Code of Ethics, a sense of social justice, a desire to help vulnerable populations, as well as cultural awareness and an understanding of systems theory, and the person-in-environment perspective (Dubois & Miley, 2019). Generalist social work practice is the foundation from which social workers draw, regardless of the occupational roles that they fulfill. Social workers must gain a solid generalist foundation upon which to grow their professional career. These skills remain essential for the foundation of specialty practice areas, including clinical social work practice.
Systems theory is central to that foundation. The purpose of this conceptual article is to use systems theory to explore the concept of productivity-driven practice through the lens of the social work profession exploring the impact on burnout, job dissatisfaction, and retention as well as the impact on adherence to ethical standards and the professional standards of the social work profession. Developing alternative, more holistic approaches to accountability in agency systems or through parameters set forth by state mental health systems will likely benefit all systems at each level of the mental health system and its subsystems, including mental health professionals and their consumers.

**Theoretical Framework: Systems Theory**

Systems theory, viewed through the lens of the person-in-environment perspective, is an integral component of social work practice. “A system is a set of orderly, interrelated elements that forms a functional whole” (Kirst-Ashman & Hull, 2018, p. 13). Social workers use systems theory to identify “the range of social systems in which people function and the ways social systems help or deter people in achieving personal and community well-being” (CSWE, 2015; Kirst-Ashman & Hull, 2018, p. 13). Systems theory is also a useful tool of evaluating how productivity-driven management systems promote or deter people in maintaining healthy professional identities, organizational well-being, and the ability to provide quality client care while honoring social work’s professional code of ethics.

Dubois and Miley (2019) discussed the interplay of human systems as a central concept in generalist social work. These systems interact at all levels of human relationships and resources including families, communities, and policies. A generalist social worker works within all systems at all levels—micro, mezzo, and macro—and is charged with improving the well-being of vulnerable individuals and groups (Dubois & Miley, 2019). Generalist practice
curriculum equips prospective social workers with a foundational set of skills, knowledge, and values grounded in systems theory and the ecological perspective, with a focus on assessment and intervention across the spectrum of practice at the BSW curriculum as well as specialty practice areas (Leslie & Cassano, 2003).

It is imperative for clinical social workers to retain their foundational identity to preserve the purpose of the profession. Though students enter specialty areas in MSW programs, the overarching context from which their practice is framed is the context of the interaction among systems and within the environment of the individuals they serve. When clinical social workers are employed in a productivity-driven practice, productivity dictates their practice with clients more than social work theory. Social workers are tasked with focusing on what can be addressed in the 50-minute hour allowed for individual or family therapy while also worry about whether or not their next client will show up for their session so that the day’s billing is not negatively impacted.

In this paper, I use systems theory to examine the productivity-driven environment in outpatient mental health systems and their interrelated components referred to as “set of elements,” the constantly changing dynamics involved, and how those systems interact with each other (Kirst-Ashman & Hull, 2018, p. 11). In mental health systems, those elements include the agency itself, the mental health professionals and paraprofessionals, the clients, referring agencies, other agencies involved in the client system, and the community at large. Other points of focus include the inputs and outputs related to the energy flow between the systems, as well as the ability or inability to maintain a state of homeostasis within the systems at the micro, mezzo, and macro levels of the mental health system. I consider systems theory’s concept of equifinality
allowing for flexibility in possible solutions to systemic problems related to productivity-driven accountability systems.

**Compatibility of the Profession and Productivity-Driven Practice**

I propose that clinical social work has been shaped into an entity that deviates from its original purpose and has been reduced to a job that is based on economic production through a prescribed set of evidence-based practices that may not be compatible with the foundational responsibilities of social work. Additionally, billing pressures prevent mental health systems from reaching a healthy equilibrium, as defined in systems theory. Through a review of literature, I will explore the professional identity and purpose of the social work profession and incorporate not only the core values. I will also review the purpose of social work defined by numerous sources, including the Council on Social Work Education. I will examine trends related to difficulties of maintaining the unique identity of the social work profession and adherence to the code of ethics. Through an exploration using systems theory, I will highlight how accountability using billing alone as a measure of professional worth is incompatible with social work’s identity and code of ethics.

**Literature Review**

After deinstitutionalization and the Community Mental Health Act of 1963, Medicaid became a primary payer for mental health services in many state mental health systems (Frank, Goldman, & Hogan, 2003). Additionally, Medicaid is the largest funding source for these services nationwide (National Council for Behavioral Health, 2019). In 2014, treatment for mental health and substance use disorders consumed 85 percent of Medicaid and Medicare funds (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). As a result of the massive amounts of state funding spent on Medicaid mental health services, many states
began using managed care agencies to curb spending and oversee service delivery (NAMI, n.d.). As states responded by instituting cost-saving measures such as managed care oversight, agencies countered by instituting productivity requirements for their clinical staff to ensure ongoing financial viability.

Hicks (1984) outlined an early plan to implement a billing incentive plan in an outpatient mental health setting. The plan that Hicks described provided incentives in the form of bonuses based on a two-part point system: Measuring billable services and measuring service to the community and agency. Since Hicks’ model, modern productivity-driven practice has become increasingly focused on revenue generation as the primary basis for measurement and incentives. One example of a modern productivity-driven management system is Lloyd’s (2002) Integrated Performance Management System. Lloyd’s book is published by the National Council for Behavioral Health.

Carpenter (1999) found that professional social workers’ values, ethics and professional identity have been negatively impacted by the changes in service delivery and mental health policy including the billing pressures that have resulted from these changes. There is a gap in the research concerning productivity-driven mental health practice, particularly related to the impact productivity-driven management systems have on the mental health professionals and client systems. Most of the related publications are focused on commercialized claims of how productivity requirements financially benefit the service agencies such Lloyd’s management system. There is also limited research suggesting alternative management systems. Rubin and Sternberg (2017) proposed a method for practice evaluation that provides an empirical measure for clinical outcomes without the focus on financial gain. These authors introduced the idea of
benchmarking which allows for measuring outcomes of clinical practice with specific steps for calculating improvement.

Ni, Qian, and Crilly (2014) found that taking care of employees or internal stakeholders impacts the sustainability and interactions with external stakeholders. In the mental health system, external stakeholders include clients with mental health diagnoses, their families, and community stakeholders such as law enforcement, court systems, social service agencies, and other medical and mental health agencies. Systems theorists would use the term systems to describe these stakeholders (Kirst-Ashman & Hull, 2018). Each system type and the interaction between systems is important for the overall functioning of the agency. Healthy interactions between these systems are important to the outcome of the services provided by the agency.

Without effective transitions from the referral source to the agency, a client’s needs may go unmet. If there is conflict between systems or a lack of communication, a disruption of client services may not only harm the client’s recovery, but it also decreases future interactions between the agency and subsystems, in turn negatively impacting the monetary outcome for the agency. For example, one of the referral sources—or client subsystem—may stop referring clients to the agency because of the lack of attention to building professional coalitions among systems because providers are too focused on back to back client appointments to cultivate other relationships.

Additional systems and subsystems involved in outpatient mental health systems include agency programs, insurance agencies, Medicaid, Medicare, regulatory bodies, state agencies, and managed care companies. Again, if these system interactions are disrupted through events such as regulatory violations because of attempts to gain high numbers of billable hours, the implications for the agency may be a loss of financial gain or recoupment of funds. Focusing
narrowly on the production of professionals and neglecting other systems, then defeats the original purpose for productivity requirements.

**Professional Identity**

Dubois and Miley (2019) discussed the purpose of social work as described by the National Association of Social Workers and the Council on Social Work Education. Both descriptions of the purpose of social work highlight the importance of serving all people at all system levels, with an emphasis on those who are vulnerable and impoverished from an ethical and values-driven perspective. In contrast, productivity-driven practice settings place emphasis on serving those who produce a higher source of revenue for the agency such as individuals with Medicaid as well as pressures to provide services that are more financially advantageous to the agency over meeting client needs (Lloyd, 2002; Reid & Popple, 1992; Strom, 1992). Medicaid often covers more mental health services than private insurance companies (NAMI, n.d.), which may exacerbate the trend towards overutilization.

Many of the early criticisms of the professionalization of social work can be said of today’s mental health systems focused on productivity. Reamer (1992) quoted James F. Gustafson (1983), who argued:

A calling without professionalization is bumbling, ineffective, and even dangerous. A profession without a calling, however, has no taps of moral and humane rootage to keep motivation alive, to keep human sensitivities and sensibilities alert, and to nourish a proper sense of self-fulfillment. Nor does a profession without a calling easily envision the larger ends and purposes of human good that our individual efforts can serve.

(Reamer, 1992, p. 4)
This quote speaks to literature findings that compassion satisfaction may counter the possibility of burnout, and job dissatisfaction. If the pressure of meeting productivity standards take precedent over purpose, burnout and dissatisfaction are unlikely (Stamm, 2002).

Reamer highlighted the dangers of distributive justice, social control, and fee-for-service as a profit-making activity, and explained how these ideals threaten the purpose of the social work profession. Some of the problems that may arise from the pursuit of profit include incentives to manipulate lengths of stay, diagnosis, and treatment protocols to increase reimbursement. Reamer further posited that social workers may have exchanged their desire for the public good and social justice for professional gain. Social workers may be driven to pursue more affluent clients than those who are the most vulnerable and in need of services. In profit-driven practice, modern mental health systems have turned a form of public aid into a capitalist investment seeking a large number of clients with Medicaid in order to increase their investment outcome.

**Exemplar Model of Productivity**

In Lloyd’s (2002) model, the Integrated Performance Management System, the scholar addressed many aspects of the mental health system and various levels of accountable care. While he developed an accountability plan that addressed adherence to all governing bodies and quality of care, he tied compensation-related outcomes to a billing formula. Lloyd stated that the goal is to move agencies toward a dichotomous “black and white” accountability plan and eliminate the “gray,” citing today’s capitalist economy as his reasoning. He also promoted strict adherence to the billing standards, with no allowance for exceptions based on individual circumstances.
Lloyd’s (2002) model decreases autonomous professional decision-making. He argued that his plan is empowering to the professional and the clients, but he stressed stricter monitoring of all clinical activities. Lloyd outlined detailed plans to control and account for all aspects of the roles of mental health professionals. Despite these drawbacks, many of his ideas would benefit the system and achieve the same goals without the need for implementation of the problematic piece of his model, productivity requirements. These beneficial ideas include eliminating duplicate paperwork, decreasing “no-shows,” monitoring outcomes and client satisfaction, monitoring nonclinical staff performance, improving treatment plan development, reducing travel time, and improving time management.

**Ramifications for Clinical Social Workers**

Comparisons must be drawn from other disciplines, because there is a gap in the research related to the impact of productivity requirements for mental health professionals. A systematic review using meta-analysis indicated that one of the most significant correlations with burn-out was workplace setting (Lim et al., 2010). Those working in agency settings were more likely to experience burnout than those who work in private practice. Lim et al. attributed these findings to long work hours, high workloads, and administrative duties. These findings support the assumption that billing pressures from agencies contribute to dissatisfaction and burnout because of the increased hours and number of clients needed to maintain the minimum number of billable hours required. In a study conducted about legal practice in Australia, the findings indicated a lower quality of work life as a result of billable hour requirements (Omari & Paull, 2014). Fleury, Grenier, Bamvia, and Farand (2018) additionally emphasized the importance of job satisfaction in Canadian mental health professionals, positing that increasing knowledge about factors that improve job satisfaction could lead to improved client care.
Lloyd (2002) provided anecdotal examples regarding how his plan has improved agency revenue, and he discussed how to reach compliance by the mental health professionals; however, he did not provide any data regarding job satisfaction and retention rates after the enactment of such measures. The absence of these data should concern agencies interested in employing this type of management system. Retaining skilled mental health professionals is essential to providing quality care to individuals diagnosed with a mental illness. Lloyd identified that staff turnover as an issue that needs to be addressed, without acknowledging that his plan could be a contributing factor. He disparaged the use of leave time as well as time off for additional training and professional growth opportunities. Lloyd argued that an individual who has received more PTO or vacation days as a part of their benefits package should be held to the same standards for billable hours when using those days, in order to be fair to employees who do not have the same amount of vacation days accrued. This viewpoint negates the agreed-upon benefits of employment and punishes the seasoned clinician for longevity and commitment to their employment at the agency; this could serve as a barrier to retaining skilled clinicians. A better outcome could be achieved using individualized billing and performance plans and evaluations.

DiFranks (2008) explored the disjuncture between social workers’ beliefs in the NASW Code of Ethics and their behaviors in the workplace by using a qualitative descriptive study. This author concluded that while social workers tend to behave in accordance with the code, workplace setting had some correlation with disjuncture. The disjuncture was described as their beliefs in the workplace not being congruent with their professional code of ethics. DiFrank’s findings support my argument that agencies following productivity-driven accountability protocol may impact clinicians’ adherence to the social work code of ethics as the findings are indicative of the importance of the impact of workplace settings. I predict that the high-stress
environments of maintaining a minimum number of monthly billable hours increase the likelihood of not only a disjuncture in ethical beliefs, but a risk of unethical billing practices such as overutilization of Medicaid funding.

Strom (1992) conducted a study regarding the impact of the growing demands on reimbursement for social workers in private practice. The findings indicated how compensation by private insurance companies increased the number of those entering private practice (Strom, 1992), which translates into movement away from public service agencies. With this trend, the involvement of third parties in the treatment process may alter the way social work is implemented. This practice moves toward abandonment of social work philosophical underpinnings such as the ecological perspective and the social work belief in serving all of those in need highlighting the shift from service to commodity. This trend of commodification is a threat to adherence to the code of ethics (Strom, 1992). Although Strom wrote about social workers in private practice in 1992, this topic remains timely in the structure of today’s mental health systems because of the continued trend of mental health agencies’ capitalizing on the services of mental health practitioners. Despite the emergence of commoditization of mental health services through productivity requirements as early as 1981 (Hicks, 1984), researchers have not fully investigated the impact of productivity-driven practice in mental health agencies.

**Discussion**

Productivity-driven mental health practice may produce challenges for social workers who provide clinical mental health services. The shift of clinical social work from service to commodity negates the purpose of the profession, of which *service* is one of the core values. The disconnect between the purpose of social work and the social work code of ethics may interfere with professionals’ ability to achieve compassion satisfaction and job satisfaction. This, in turn,
may result in professionals leaving public service agencies to move into private practice or settings without a productivity requirement.

The literature supports the notion that being overworked in agency settings leads to burnout and job dissatisfaction. Researchers have suggested that job satisfaction is linked to workplace setting (Lim et al., 2010), which, in turn, also impacts the disjuncture in beliefs about social workers’ professional code of ethics (DiFranks, 2008). Other possible ramifications for social workers in productivity-driven practice include less involvement in social justice activities (Mattocks, 2017), loss of incentive to strive for longevity and agency loyalty (Lloyd, 2002), and damage to the purpose of the social work profession (Reamer, 1992).

While some financial accountability measures may be necessary, incorporating more outcome-based or client-centered measures would shift clinical focus back to client care, rather than billing. Such a shift would refocus clinical social work practice on the purpose of social work and would empower workers to adhere to the code of ethics rather than merely trying to meet hourly billing guidelines. Rubin and Sternberg’s (2017) method measured the outcomes of the interventions that clinicians use in clinical practice. Although there is a need for continued research with this proposed measure, a similar measure could serve as a vehicle for a directional shift when combined with other performance measures such as leadership skills, adherence to ethical guidelines, documentation, and relationships with other systems and subsystems.

A systems theory approach to management would look beyond the simplistic, dichotomous management plan of productivity-driven practice and include all systems in evaluating the efficacy of clinical staff to ensure quality care. Systems theory would consider all areas of inputs and outputs (Kirst-Ashman & Hull, 2018) such as quality of services to the client, client satisfaction, relationships with outside agencies, depth of knowledge, and overall
contribution to the agency, which provides flexibility in determining the overall value of the practitioner to the agency’s core mission. Furthermore, agencies should consider the value of money saving efforts such as diverting hospitalizations, accurate and thorough record-keeping, and maintaining positive relationships with referral sources instead of solely focusing on the ability to create income.

The ability of practitioners to operate successfully among all system levels is germane to the identity of the profession. Under the current productivity-driven system, clinicians may not be afforded the non-billable training time to become fully educated about the proper procedures within the system. Increased system knowledge, clinical training, and job satisfaction would benefit not only the professionals, but agencies, clients, and the entire community. Retaining a workforce of seasoned professional clinical staff, particularly in community mental health clinics, is a matter of public health and safety. Thus, evaluation of performance should be conducted at all system levels including the identification of systemic problems that may impact treatment. Determining the systemic impact of billable hour requirements is a critical component in the overall assessment of the system.

Utilizing generalist social work skills and a systems theory approach could transform marketing into social work instead of spending; Lloyd recommended $60,000 a year in marketing campaigns. Lloyd (2002) recognized the importance of relationships with other systems, though he viewed these relationships as marketing strategies. Agencies that employee social workers have the resources at their disposal to build these relationships and advocate for clients and client systems on all system levels. Proper use of professional resources increases the ability to achieve equifinality highlighted in systems theory. By limiting professional roles to only those services that are billable, agencies waste valuable resources, knowledge, and skills. If
agencies’ end goals (i.e., equifinality) are to provide quality services, maintain fiscal viability, and retain skilled professional staff, it would be advantageous to utilize all of the skills and resources at their disposal. Under the Integrated Performance Management System and productivity-driven practice in general, however, mental health treatment is moving from a service to a business including the commodification of social work practitioners, which only produces financial gain but prevents reaching a state of equifinality.

**Implications**

Client systems are at risk for harm or neglect under the umbrella of productivity-driven practice. The loss of more experienced clinical staff may result in lower quality of care and mental health professionals may be motivated to pursue clients who would produce a greater rate of financial return rather than those with the greatest need. There may also be motivation for overutilization of Medicaid funding and overdiagnosis of disorders that justify high utilization. Shifting the focus from productivity-driven practice to a more holistic approach may prevent such indiscretions.

It is likely that removing the billable hour requirements could protect the agency from fraudulent billing. If an individual’s livelihood is at stake because a set number of hours is required regardless of life’s circumstances, there is a risk of overutilization. Additionally, eliminating the billable hours requirement would allow the agency to use an approach from the systems theory perspective, which expands professional roles for the good of the agency. For example, agencies could use the foundational skills of their social work staff to perform some of the functions that Lloyd highlighted as a part of his plan for improving revenue. Understanding the impact of productivity-driven mental health is imperative to improving the quality of services for individuals with mental health diagnoses, particularly those with serious mental illness.
Improved mental health services in the United States would have widespread implications for public health, such as decreased suicide rates, reduced instances of violence towards others, and improved overall outcomes for individuals with mental health diagnoses.

**Future Research**

Modern mental health systems utilize productivity-driven accountability management systems; therefore, it is important that further research is done regarding the impact on the practitioners as well as clients. A comparative analysis between productivity-driven mental health systems and those that are not, such as state-run mental health agencies, would be beneficial in determining these impacts. Client outcomes between the two systems could be compared to determine the impact on client care. Future research should be conducted with mental health professionals to determine how productivity-driven practice impacts their professional identity, job satisfaction, and service delivery.

**Conclusion**

Productivity-driven management systems are widely used in outpatient mental health; however, the sustainability of these systems is questionable. There is likely a negative impact on mental health professionals’ job satisfaction, retention rates of skilled mental health professionals in outpatient mental health, and on service deliver for the most vulnerable of consumers in the mental health system. Without ongoing research and failure to recognize the possible negative impacts, outpatient mental health systems may not operate at their optimal level because of the superficial view that productivity requirements are fiscally lucrative. Further research, however, will likely indicate that the costs outweigh the benefits.

In fields such as behavioral healthcare, it is reasonable to expect employers to recognize the value of investing in the wellbeing of internal stakeholders or treatment team members. Even nonclinical administrators in mental health settings should have some understanding of the
importance of a healthy workforce and recognize the value in retaining quality providers and improving how those providers interact with the key systems, particularly the client system or consumers. Agencies, therefore, should strive for moving towards a more practitioner-friendly management plan that is more individualized and based on a systems theory approach.
References


Productivity-Driven Practice

Mental Health Professionals Speak

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Abstract

Productivity-driven outpatient mental health management systems use financial measures to incentivize mental health professionals’ services. There is a lack of research exploring how this impacts mental health professionals who work in this environment and their clients. The investigator of this qualitative study explored the impact of productivity requirements from the perspectives of mental health professionals in Arkansas, United States, who have worked in these settings. The results show that the added pressures of obtaining billable hours lead to burnout, job dissatisfaction, unethical billing practices, and decreased quality care for clients. The findings suggest that a more person-centered approach to management may reduce turnover and improve client care.

*Keywords:* mental health, billing, Medicaid, ethics, burnout
Productivity-Driven Practice from the Perspective of Billers: Mental Health Professionals Speak

Outpatient mental health agencies that use productivity-driven management systems to fund their operations through the billing services of mental health professionals. These management systems are also agency-centered, rather than client- or person-centered. In productivity-driven practice, mental health professionals are encouraged or are required to bill a minimum number of units per month to keep their jobs or receive bonuses. Some agencies base their pay on a percentage of the services billed where professionals essentially receive a portion of the revenue from service provision. While the concepts of neoliberalism and commodification are not the central focus of this study, it is important to mention this approach’s link to neoliberalism, which is based on market-driven ideals (Esposito & Perez, 2014). As Cosgrove and Karter (2018) explained, “…within the logic of medical neoliberalism, individual responsibility and competition trump equity and citizenship” (p. 671). Productivity-driven management systems exemplify this idea. Most of the research that exists about this topic is several years old and centered around managed care, Medicaid, or from the perspective of the larger system. There is some emerging research, however, regarding the commodification of social work and mental healthcare, as well as the concept of neoliberalism in the context of the profession.

There is a gap in the research on the direct impact of productivity-driven management systems and professionals and the clients they serve. The goal of this research study is to begin the exploratory process of addressing the perspectives of mental health professionals to fill the gap in the existing literature. Through this study, I began to answer the questions: How does working in productivity-driven management systems impact mental health professionals’ job satisfaction, overall personal wellbeing, and job decisions, and how does this type of system
align with their code of ethics and professional purpose in terms of the clients that they serve? It is crucial to understand how productivity-driven practice impacts the landscape of mental health systems from the perspectives of the professionals on the front lines of service. These perspectives have the potential to provide valuable insight into the ability to retain a professional workforce of experienced clinicians and improve the quality of care offered to the clients.

**Review of Literature**

There is limited literature specifically focused on the impact of productivity-driven mental health management systems. There are myriad studies about the onset of managed care in outpatient mental health and its ramifications. There is also extensive research related to burnout and job satisfaction, and to a lesser degree, research specifically about burnout in mental health and community mental health systems. Most recently, research has emerged related to the commodification of social work and the neoliberal approach to mental health care.

**History**

The evolution into a neoliberal reality in mental health care can be traced as far back as deinstitutionalization and the Community Mental Health Act of 1963. These two events in history spurred the movement toward the use of Medicaid as the primary payer for mental health services in many state mental health systems (Frank et al., 2003). According to the National Council for Behavioral Health (2019), Medicaid is the largest funding source for these services nationwide. SAMHSA (2016) reported that treatment for mental health and substance use disorders consumed the majority of Medicaid and Medicare spending at 85%. As a cost-saving measure, many states contracted with managed care agencies to provide oversight in the form of preauthorization and auditing safeguards.
As states began to curb spending by increasing oversight through managed care, which emerged in the 1980s (Scheid, 2000), mental health agencies responded with increased efforts to remain financially viable by instituting productivity requirements for their mental health professionals, mental health paraprofessionals, and psychiatrists. This type of productivity-driven practice was outlined as early in 1981 by Hicks (1984). Hicks described a plan for outpatient mental health that rewarded high billing clinicians with monetary bonuses based on a two-part point system. The two parts included measuring billable services and measuring service to the community and agency.

**Managed Care**

Existing researchers have linked the impact of managed care to the ability to retain a professional workforce and maintain quality of care to clients. One example is Scheid’s (2000) study, in which the author highlighted the impact of managed care from the perspectives of mental health professionals and identified clinicians’ perceptions of managed care as an imposition resulting in the loss of professional autonomy. Scheid’s qualitative findings further identified professional beliefs that managed care emphasized a preference for less qualified and less experienced professionals, resulted in compromised ethical standards and client-therapist trust, and undermined professional standards. It is anticipated that the addition of productivity requirements only compounds those feelings. Managed care organizations strive to save costs while productivity-driven management systems attempt to make as much revenue as possible from the third-party payers such as Medicaid and private insurance.

Scheid (2000) further posited that these controls undermine professional autonomy and professional prerogative. Additionally, these managed care systems rely on unreliable client outcome measures to determine efficacy. Barriers related to measuring effectiveness by counting
on client outcomes include lack of consensus about the best treatment approaches, defining the nature of the problem, the need for individualized treatment, and commonly occurring phenomena of minimal signs of improvement in those with serious mental illnesses (Scheid, 2000). Scheid concluded that the onset of managed care in mental health has decreased autonomy and professional prerogative.

**Modern Management Systems**

Modern productivity-driven practice is increasingly focused on revenue generation as the primary measure of performance, resulting in a more neoliberal approach to incentivizing. One such management system is Lloyd’s (2002) Integrated Performance Management System. In this model, Lloyd recommended that agencies require a minimum of 100 billable hours per month to maintain employment. Agencies who use this model contract with his company for training and the electronic system for tracking billable hours. According to this author, the model has built-in allowances for vacations, illness, and other non-billable work completed by the MHP (Lloyd, 2002). If mental health professionals cannot maintain the number of recommended billable hours required, he explicitly states that the individual should be terminated from employment (Lloyd, 2002).

In systems such as Lloyd’s (2002), practice settings emphasize serving those who produce a higher source of revenue for the agency such as individuals with Medicaid and to provide services that are financially advantageous to the agency more than meeting client needs (Reid & Popple, 1992; Strom, 1992). Medicaid covers more mental health services than private insurance companies (NAMI, n.d.). Thus, contributing to the ongoing battle between managed care companies charged by the state systems to save Medicaid money and mental health
agencies’ goals of fiscal sustainability. Mental health professionals are caught in the middle of these battling entities and are faced with a duality of allegiance.

As the battle wages between the two entities, mental health care continues to move toward a market-based system of commodification that is epitomized in productivity-driven mental health practice. The commodification of services prioritizes economic objectives over health care (Rossler, 2012). This commodification produces a system that is “…governed by a technocratic rationality that often conflicts with the professionally governed value rationality of providers” (Scheid, 2000, p. 700). Scheid referred to the use of managed care as the yardstick by which performance is measured. State systems impose this measure and focus on efficiency and cost containment, while productivity-driven management systems use billing quantity as the performance measure. Because of these competing systems, mental health professionals are likely to experience ethical dilemmas.

**Job Dissatisfaction and Burnout**

“Great leaders would never sacrifice the people to save the numbers. They would sooner sacrifice the numbers to save the people” (Sinek, 2014, 7:28). Sinek wrote extensively about the importance of job satisfaction for employees, their families, the company, and society. He posited that taking care of employees before financial interests results in a more prosperous and financially sound organization in the long term. The findings of his research confirmed his theory that job dissatisfaction is unhealthy and even deadly for individual employees because of the physical toll of stress that creates an unhealthy recurrent and consistent elevation of the stress hormone cortisol. Agencies’ overall health and wellbeing are dependent upon a healthy and loyal workforce (Sinek, 2017). Sinek identified agencies that have successfully overcome hard times
while others failed, and posited that the difference between companies that fail and companies
that succeed is that companies who succeed put their employees first.

Loss of autonomy has been an identified factor in professional burnout and job
dissatisfaction. Lim et al. (2010) cited Maslach and Jackson’s definition of burnout: “Burnout is
a syndrome characterized by emotional exhaustion, depersonalization, and a level of personal
accomplishment” (p. 86). There are numerous studies related to the symptoms and causes of
burnout and job dissatisfaction. There are fewer studies specific to burnout in mental health, but
some studies suggest that there is a high risk for burnout in mental health settings (Green, Miller,
& Aarons, 2011). Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) conducted a
systematic review, finding that as many as 21% to 67% of mental health workers may experience
burnout. Much of the research is related to compassion fatigue. “Compassion fatigue refers to an
acute onset of physical and emotional responses that culminate in a decrease in compassionate
feelings towards others because of an individual’s occupation” (Sinclair, Raffin-Bouchal,
Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017, p. 10). Turgoose and Maddox
(2017) found individual factors that contributed to compassion fatigue in mental health
professionals, such as previous traumas of the professionals themselves and their coping skills.
They also found an organizational factor correlating high workloads to incidents of compassion
fatigue.

Scholars have repeatedly identified both individual and organizational factors. Such
organizational factors include excessive workload, time pressure, role conflict and ambiguity,
lack of resources, limited autonomy, lack of opportunity to participate in decision-making,
unfairness and inequity, and insufficient rewards (Morse et al., 2012; Lim et al., 2010). A
systematic review using meta-analysis indicated that one of the most significant correlations with
burn-out was workplace setting (Lim et al., 2010). Those who work in agency settings were more likely to experience burnout than those who work in private practice. This finding was attributed to long work hours, high workloads, and administrative duties (Lim et al., 2010). These findings support the assumption that billing pressures from agencies would contribute to dissatisfaction and burnout because of the increased hours and number of clients needed to maintain the minimum number of hours required.

The primary area of inconsistency related to workplace burnout is the relationship between working long hours and professional accomplishments. While some researchers showed a positive correlation, at least one study by Rosenberg and Pace was identified by Lim et al. (2010) identified findings of Rosenberg and Pace that there was a decrease in feeling personal accomplishment when long work hours are involved. Their meta-analysis reported agency-settings produced higher levels of burnout often attributed to overwhelming demands and the absence of autonomy.

Green et al. (2011) acknowledged, “In the United States, recent funding constraints have led many agencies to increase productivity and billing requirements, thus adding more stress to already overburdened workers” (p. 373; Morse et al., 2011). Other than these sporadic statements in literature related to productivity requirements, there is a lack of research related directly to the impact of productivity requirements and possible links between the commodification of mental healthcare through these types of management systems concerning how they affect mental health professionals’ job satisfaction, personal quality of life, and perceptions about service delivery.

**Impact of burnout on the larger system.** Ni et al. (2014) discussed how taking care of employees or internal stakeholders impacts the sustainability and interactions with external stakeholders. In the mental health system, external stakeholders include clients with mental
health diagnoses and their families as well as community stakeholders such as law enforcement, court systems, social service agencies, and other medical and mental health facilities. Systems theorists would use the term systems to describe these stakeholders (Kirst-Ashman & Hull, 2018). Other systems and subsystems involved in outpatient mental health systems include agency programs, insurance agencies, Medicaid, Medicare, regulatory bodies, state agencies, and managed care companies. Sinek’s (2017) research is consistent with the findings of Ni et al., indicating that organizations who sacrifice people for the money are at risk for failure due to the inability to sustain long term stability and loyalty in their workforce. Some participants in Scheid’s (2000) study indicated that they considered leaving practice because of managed care. The addition of productivity-requirements could increase that desire for some clinicians. If experienced clinicians are leaving outpatient mental health settings to pursue options that do not require productivity, it suggests that those who are most vulnerable are likely left in the care of less experienced mental health professionals. With this in mind, I used qualitative interviews with mental health professionals to focus on productivity-driven outpatient mental health management practices to better understand the ramifications to gain a deeper understanding of the impact that productivity-driven practice has on mental health professionals and their clients.

**Method**

In this qualitative exploratory study, I addressed how mental health professionals view productivity-driven management systems. Due to the scarcity of research on this topic, using thematic qualitative research is compatible with the goal of the study, as it is an inductive beginning (Boyatzis, 1998). Qualitative research is ideal for increasing understanding of an experience or process (Jackson & Bazeley, 2019). For this study, the experience of working in a
productivity-driven mental outpatient mental health practice was the target of the investigation. I conducted the interviews between January 2019 and May 2019.

**Participants**

The participants \( N = 20 \) in this study consisted of mental health professionals in the state of Arkansas who have worked in productivity-driven outpatient mental health management systems in the past or currently work in these systems. For this study, mental health professionals include Licensed Master Social Workers (LMSW), Licensed Certified Social Workers (LCSW), Licensed Associate Counselors (LAC), Licensed Professional Counselors (LPC), Licensed Psychological Examiners (LPE) (including those with the independent practitioner specifier, LPE-I), and Psychologists. There were no Licensed Marriage and Family Therapists (LMFT) included in the study; however, they were not intentionally excluded. Participants were recruited through emails and in-person contact. Twenty-three participants agreed to participate, but three did not respond to my emails to schedule the interviews, resulting in a total of 20 participants.

**Procedures**

I completed 20 semi-structured interviews over a 6-month period beginning in January of 2019. Before participation in the interviews, participants signed consent forms and returned a scanned copy by email, fax, or in person during the interview. They also returned a completed brief demographic questionnaire, which included their years of practice experience, years of practice in productivity-driven management systems, professional discipline, and current employment status. Interviews were conducted either face-to-face or over the telephone and recorded for transcription. Before the interview, I reviewed the consent with the participant and gained verbal consent to audio record the interview noting that the participant could decline to answer any question during the interview and remove themselves from the study at any time.
Participants chose the locations and times of the interviews based on their comfort and convenience.

Questions followed a semi-structured pattern with a predetermined list of questions to guide the interviews. Questions were focused on the MHPs’ views overarching views of productivity-driven practice, their concerns, impact on their job satisfaction, impact on service delivery, and alignment with their professional discipline. There was also a question related to how their graduate degree programs prepared them for productivity-driven practice, which I included for the purpose of future research. This study was approved, reviewed, and monitored by the institutional review board from a public southern university.

Data Analysis

I conducted thematic analysis in this study to identify and interpret semantic and latent themes related to the ramifications of productivity-driven practice in outpatient mental health from the perspective of mental health professionals. I audio-recorded and transcribed each interview. I analyzed the data thematically using a qualitative data analysis software program (NVIVO 12 Pro). An independent qualitative researcher reviewed the coding to verify validity.

I organized the data by categories based on keywords and phrases to develop themes and subthemes to interpret the findings. I used Boyatzis’s (1998) labeling process to help with the thematic organization. The process included identifying a label, definition, indicators, exclusions, and differentiation for each theme. The codes that I used for this study were conceptual themes related to mental health professionals’ views of productivity-driven mental health practice.
Results

Twenty mental health professionals participated in the interviews. The professional disciplines of the participants are outlined in Table 1. Participants were predominately female, with an average age of 43 years, licensed in the field of social work, with an average of 8.5 years of practice (Table 1). One of the participants has not left productivity-driven practice, and two did not answer the question on the demographic questionnaire related to the number of years since leaving productivity-driven practice.

Table 1

Demographics of the Participants

<table>
<thead>
<tr>
<th>Response Category</th>
<th>% (N)</th>
<th>M (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>43 (32-66)</td>
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<tr>
<td>Gender</td>
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<td></td>
</tr>
<tr>
<td>Male</td>
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</tr>
<tr>
<td>Female</td>
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<td>Discipline</td>
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<td>LMSW/LCSW</td>
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<tr>
<td>LPC</td>
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<tr>
<td>LPE/LPE-I</td>
<td>10 (2)</td>
<td></td>
</tr>
<tr>
<td>Licensed Psychologist</td>
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<tr>
<td>Years of Clinical Experience</td>
<td>15.5 (4-40)</td>
<td></td>
</tr>
<tr>
<td>Years of Experience in Productivity-Driven Practice</td>
<td>8.5 (2.5-28)</td>
<td></td>
</tr>
<tr>
<td>Years Since Leaving Productivity-Driven Practice</td>
<td>5 (1-12) (n=17)</td>
<td></td>
</tr>
</tbody>
</table>

Data analysis revealed two primary themes: ethical impact and job satisfaction, containing seven subthemes. Subthemes for ethical impact included negative consequences for doing the right thing and clients caught between competing loyalties. While the first question addressing ethics was the sixth question in the series of 15, participants frequently identified ethical issues much earlier in the interview—as early as the very first question. Responses to many of the items continued with an ethical thread woven throughout the interviews. The
subthemes under job satisfaction include professional dilemmas, burnout, turnover, recruiting challenges, and professionals leaving the field of mental health altogether. The findings of this study are described in the following sections.

**Ethical Impact**

**Negative consequences for doing the right thing.** Participants identified significant struggles in balancing agency expectations and ethical standards. Some participants indicated that they did not allow the pressures to impact their ethical behaviors and were able to remain steadfast in their professional values. One participant stated emphatically, “I really haven’t had a problem with it as far as code of ethics is concerned.” Another participant responded to a question about how productivity-driven practices align with their code of ethics by explaining, “It clashes because I'm going to spend what time I need with my people regardless if I get to bill on it or not, because, to me, their needs need to be addressed. This is so contradictory, but that's how it is.”

These professionals also acknowledged concern about the struggles they witnessed in their colleagues and even some unethical, fraudulent behaviors. All of the participants expressed some concern about productivity-driven practice from an ethical standpoint. One participant who expressed a strong sense of ethical practice not deterred by productivity pressures stated,

“I’ve been concerned about billable hours just because, at times, I think it breeds people to be unethical, especially if they’ve got bills that they need to get paid. I think it’s enticing to add 5 or 10 minutes here, 5 or 10 minutes there.

Some of the ethical dilemmas identified related to professional standards included providing unnecessary services; stretching or extending face-to-face client service visits to obtain one more billable unit; cutting corners in documentation such as generic documentation as
opposed to quality, individualized documentation; “padding” time; and lying about providing
services altogether.

I have seen it on numerous occasions from a clinician’s point of view and the point of
view of a program director. It can be very unethical. I mean I’ve fired numerous
employees for turning in billing with clients where they said they were meeting with
them, you know, in an office at a school; and I knew good and well that they were on the
other side of town and not even in the same facility where they said they were billing the
hours.

Another participant explained how the agency coached the professional staff on getting the most
out of their billable hours.

We were required in order to keep our jobs to meet a certain level of productivity. I want
to say like 30 billable hours...we were coached on you know six minutes is one unit,
seven minutes is two units, or 15 min is two units and then 30.

Perhaps one of the most alarming findings of this study was professionals describing
negative consequences for doing the right thing. These consequences ranged from having salary
cuts and being moved from full-time employment status to part-time, thereby losing all
associated benefits such as medical insurance. One participant described feeling threatened
physically for reporting unethical behaviors:

I wasn’t quiet about it, but it don’t [sic] make you popular with the agencies or with the
system…I just wasn’t going to lie for them. I told them you can look at my stuff. It was
documented and did right, and some of them wasn’t. Some of them were making up stuff,
and when everything got looked at, I was blackballed…I knew about some crookedness
at the top, and it could even be life-threatening. I was run off the road one time…that had
repercussions on my [professional] practice too…I suffered from depression, but a lot of it was because I stood up for what I felt was right for the little person, or for the kids.

**Clients caught between competing loyalties.** Participants also identified ways in which productivity-driven practice compromised their service delivery and impact on client systems, particularly the belief that the pressure to bill results in quantity over quality.

…I feel like billable hours, and that overarching thought can take away from quality of care. I found it hard, at times, to completely focus on my client when I was thinking about, “Okay, how many more hours do I need to get, or have I met my hours for the week?” I felt like sometimes my administration were just focused on those numbers, and they weren't as concerned sometimes about…the heart of what we did.

In Arkansas, Medicaid is the most desired pay source for mental health treatment. Many professionals described how individuals with Medicaid could receive services those with private insurance or Medicare could not. Three participants described conflict with colleagues over competition for new clients with Medicaid as a payment source. Others expressed concern that they were limited in the amount of time and types of services they could provide to their clients. One participant described how payment for kids with Arkansas Medicaid (ARKids) with a diagnosis of Attention-Deficit Hyperactivity Disorder changed because of the overutilization of Medicaid funds for this population. There was pressure from the agency to add additional diagnoses that were more financially lucrative. According to one participant,

…it just seemed like the focus was like “Did you meet your direct service time?” and getting people in and out whether you were able to spend an hour, or let’s just hurry up and get some more in even if we just see them 15 min. It was just more focused on how many people you can fit in and out and billable; and then, a lot of times if they were not
Medicaid…you didn’t spend a lot of time with those folks; it was more about who we can bill on rather than who really needs the care.

All of the participants expressed some concern related to organizations losing their sense of purpose to treat individuals with mental illness, and instead commoditizing mental health.

**Job Dissatisfaction**

**Professional conundrums with the billing “machine.”** All participants discussed the negative impact that productivity-driven practice has on their overall satisfaction with their employment, which impacts the happiness in their personal life. Even those who indicated no significant dissatisfaction or who reported satisfaction with their work in these types of settings acknowledged that they would be happier in a position without productivity requirements, or that it would impact their job decisions to have the opportunity to work in an environment free of productivity stipulations. None of the participants indicated agreement that billing was a reliable measure for determining the quality of a professional’s work. There was a shared belief, however, that this is often the measure used to make that determination.

…but for years before that, your job performance was based on “Are you billing your hours?” That was the first thing they asked, and then it was “Is your paperwork getting done?” So, if you were going to be a “good clinician,” you had to be meeting your productivity, and that can be tough…

Several participants expressed an underlying or overt sentiment that mental health professionals feel that they must choose between money or happiness. One participant disclosed that they were making approximately $120,000 yearly for a productivity-driven management system in which professionals were paid a percentage of what they billed; however, this came at a cost to them
personally, including frequently working on paperwork until the early hours of the morning. That participant indicated that this contributed to their divorce.

While other participants discussed strained relationships with colleagues and supervisors related to competition over the clients with particular pay sources, especially over clients with Medicaid. Participants discussed employment and personal distress related to productivity-driven management systems. One participant indicated that it caused depression and anxiety that lasted for many months beyond their time in that setting, stating, “Nothing made me happier than to clear out my desk and leave [agency], and it kind of broke me for a while.”

Three clinical social workers in the study indicated a need to stand as a profession and advocate for changes. While one participant expressed frustration in the degree of what they perceived as cowardly characteristics of mental health professions and one described the productivity-management system as a “machine,” and went on to say,

I’m bothered by the fact that social workers are not standing up and that we’re allowing this to go on. We are allowing this billing stuff, this productivity stuff to be rammed down our throats. We are in a conundrum. We are caught between helping the client and not.

**Burnout.** Another common theme among participants was personal burnout or a description of witnessing burnout in others. They described symptoms of burnout, such as depression, anxiety, and conflictual professional and personal relationships.

I would say it leads to a lot of turnover and burnout. That having a caseload of…50, 60, 70, 80, people, or more. That’s a lot of people to track. There isn’t a lot of time outside productivity to consult with colleagues, to get support. It’s a tough job, and people work
hard. I think it directly leads to burnout and turnover—people looking [sic] for different jobs that value the quality of care over quantity.

Most participants expressed the belief that the level of intensity related to working in a mental health setting, an already stressful environment, with the addition of productivity requirements sets the stage for burnout.

…it’s greatly decreased my satisfaction quite honestly because I end up feeling frustrated that I can’t access the care I need to access or provide the care I need to provide because of money or other resource allocations. I get frustrated, I get angry, and I burn out a lot more easily, which can trigger symptoms of depression; it can trigger anxiety, a whole lot of stuff. It just made me…just not want to work at that place or not want to treat everybody, because I just feel so frustrated that they’re not going to get what they want or what they need. Then I just feel like, ‘why am I doing this anyway,’ and I know it is so important to be conscious of what we are projecting onto our clients because that’s not their stuff, that’s our stuff. If we are not in a healthy environment at work or if work’s constantly being scrutinized to meet some standard, then that’s going to have an impact on our mental health, which impacts our ability to do our job, which impacts our clients.

So, it’s just not okay.

There was a consistent sentiment among participants that their burnout and dissatisfaction were frequently linked to productivity-driven consequences, such as lack of compassion satisfaction and loss of professional autonomy.

Turnover/retention. Six participants interviewed indicated a move to private practice—either opening their own practice or moving into a contract role at their agencies—both directly and indirectly because of productivity-driven management systems. Seven participants work in
mental health settings that do not require productivity after previously working in agencies with productivity requirements. The increased autonomy to do the quality of work desired to achieve compassion satisfaction in their work with their clients and purpose for becoming a therapist were the most cited reasons for leaving productivity-driven settings across the spectrum of participants.

Oh, that’s why I quit. You have to choose. You can take your vacation, or you can keep your job. That sucks because the janitor doesn’t have that choice. The administrator doesn’t have that choice, only the people making the money. That’s almost extortion. For most who left that setting, they reported they would never return to this type of practice again. Others stated that they would if necessary, but it would not be their preference.

**Recruiting challenges.** Another theme identified in this study impacts the ability of agencies to hire mental health professionals. Every participant in the study indicated that they would prefer positions that do not require productivity, and many said they would not accept a position with those requirements. Only one participant in this study currently works full-time in a setting with productivity requirements; however, this participant also indicated that they would prefer an environment without these requirements, further noting that this would be a consideration when determining future job decisions. “I didn’t like it at all. That’s why I got out of it, and I will not work for an employer that requires that.” This statement was common among participants. One individual indicated, “I can’t work for a place that their sole purpose is to make money off people suffering. I cannot do it. I can’t do it. So there.” One individual was so profoundly impacted by their time in a productivity-driven environment that they expressed:

They dangled the money and position in front of me, gave me absolutely no support, and then brought this billable hour’s thing along, and I gave too much too fast. They burnt me
out, and I will never go back unless I’m hungry, and there’s a difference between broke and hungry.

These findings indicate a pattern of seasoned clinicians choosing not to return to outpatient mental health settings because of productivity pressures, which, in turn, impacts the level of experienced clinicians available to see those individuals who are most vulnerable and need the high-quality care.

**Abandoning the mental health profession altogether.** Six participants have left the field of mental health entirely, and all indicated that productivity requirements were contributing factors to their choice to change jobs. Half of the participants have at least considered leaving the field of mental health altogether, mainly because of productivity requirements. A few indicated that they would possibly leave if working in a productivity-driven setting was their only option.

I think because I was fresh out of grad school, I didn’t have a lot of experience, and so probably while I was working there, I thought I do not want to do this anymore. And I left that job, and I did not go directly into another job that had a therapeutic role…and did not pursue that for a long time. So, it did make me think, “If this is how it has to be, is this something that I want to continue to pursue?”

If there is a real trend of seasoned mental health professionals leaving the field of mental health or considering leaving the field, the mental health system is at risk of continued decline in quality.

**Discussion**

The findings of this study identify two primary themes with many related subthemes that suggest that there are some concerns about the sustainability of the productivity model and the impact on the mental health system. None of the participants voiced support for the validity of
productivity-driven management systems, particularly about job satisfaction and quality of care. Further, many participants were asked whether they believe that this is a reliable measure of an individual being a good clinician, and the unanimous response was a resounding no. Despite this inability to measure the quality of a clinician’s skills using billing measures, the participants expressed the perception that productivity is the measure used to determine their worth at agencies that use productivity-driven management systems.

Such findings point to a growing inability to sustain a quality outpatient mental healthcare system for some of the most vulnerable citizens: those with serious mental illnesses. Results suggest that there is concern among the clinical workforce that quantity takes priority over the quality of care. Perhaps even more concerning are the overwhelming reports of concerns about unethical practices that participants report they have suspected or witnessed themselves. As one participant stated, “I just feel like it breeds fraudulent behavior.” Participants often attributed this sentiment to the pressure to bill high numbers or lose their jobs, have their income cut, or be placed on part-time status, thereby losing their benefits such as insurance for them and their families. These pressures and ethical dilemmas then inevitably lead to job dissatisfaction and burnout, which then may result in agencies losing experienced clinicians who seek out opportunities without productivity requirements, move into private practice, or leave the field of mental health altogether.

The responses of the participants support the literature about burnout and job dissatisfaction as well as the literature related to ethical impacts of administrative and billing-related dilemmas. This support is highlighted in the respondents’ assertions that they believe productivity-driven systems produce outcomes that place quantity over quality of care. Rossler (2012) presented the idea that economic objectives often take priority over practice. It could even
be said that such a system exploits both mental health professionals’ billing ability, the state Medicaid systems, and the consumers of mental healthcare. The current responses indicate the participants’ struggle with the competing policies such as pay sources, managed care organizations, the agencies, the consumers, and the mental health professionals.

Scheid’s (2000) views that such measures undermine professional autonomy and professional prerogative are congruent with the findings of this study. Researchers studying burnout have consistently found that this lack of professional autonomy contributes to burnout, while compassion satisfaction helps prevent or decrease burnout. The inability to provide quality services in autonomous professional roles aligned with their professional prerogative is an identified theme in that participants attribute to burnout in their roles as mental health professionals. Sinek (2017) argued that organizations must remember their “why” to be successful and sustainable over the long term. For outpatient mental health agencies, it can be assumed that the “why” is to treat individuals with mental illness, not to make a profit on human suffering as one participant described it. The message consistently expressed by the current participants was that agencies are often preoccupied with how much clinicians bill, rather than how well they are treating individuals’ mental illnesses.

These findings highlight some possible macro-level social work implications. The dissatisfaction of outpatient mental health professionals concerning their roles in productivity-driven environments may be an indicator of poor quality of care for individuals with serious mental illness. There is some indication that as clinicians gain experience, they begin to market their skills to agencies without productivity requirements or even move into their private practices. This finding implies that those most vulnerable individuals are left in the care of less experienced professionals. Additionally, the turnover in the clinical staff makes it difficult to
maintain a healthy, sustainable workforce, with long-term negative impacts on the clients and the agencies. Administrators in mental health settings should consider these factors when implementing such financially driven management systems. There is also a possible opportunity for graduate programs to begin to better prepare students for these systems so that they have realistic expectations of the jobs they enter.

Future researchers should explore the impact of productivity-driven management systems at the macro level. A longitudinal study of productivity-driven management systems would help determine the ramifications on the larger system and its clients. A closer look at the implications for clients and client outcomes through a comparison study of productivity-driven systems and client-centered systems may be needed to determine the efficacy and consistency with agencies’ purpose, which is to treat individuals with mental illnesses effectively. The additional question to participants about how their graduate programs prepared them for productivity-driven environments indicated that graduate programs might not be substantially addressing this topic with their students, which could be another contributor to their dissatisfaction. They often entered systems without knowing that they would be facing these billing expectations. As one participant discussed, it may feel like a betrayal or like they were “duped.”

**Limitations and Strengths**

Some limitations of the present study should be noted. This study was confined to mental health professionals who have practiced in productivity-driven environments in Arkansas. Only one of the participants currently work full-time in a productivity-driven management system; all other participants have left those settings. It is unclear why those who remain in those systems declined to participate. This study was exploratory in nature; therefore, it was impossible to generalize about the perspectives of those that continue to work in these settings. The strengths
of the study include the sample size and the diversity among participants’ years of experience and practice disciplines. All participants have worked in these settings at some point in their careers, and many worked in those settings for many years and have seen how the system has evolved into a more productivity-driven environment.

**Conclusion**

The findings of this study indicate a need to continue research in this area to increase knowledge about the impact and efficacy of such management systems. The participants identified perceived challenges related to productivity requirements in their work environments, such as job dissatisfaction, burnout, emotional distress, and inability to maintain healthy relationships with family, friends, and colleagues. Such problems put a strain on the entire mental health system and its ability to maintain a qualified workforce to serve those who are the most vulnerable. Additionally, participants identified ethical issues related to fraudulent or questionable billing practices that result in overutilization of Medicaid monies, intentional misdiagnosis of clients, and unfair or unequal distribution of service provision based on client pay source. Such practices create more financial distress for the same state systems that use managed care to curb costs. The overall picture of the process is one of an ongoing cycle of the state’s cost-saving efforts battling with agencies’ efforts to remain profitable or even viable leaving the providers and clients in the middle of the competing systems. Social workers and other mental health professionals have an opportunity to advocate for themselves, their colleagues, and their clients to preserve the purpose of the profession and ensure that individuals with mental illnesses receive the high quality of care that they deserve.
References


Clinicians’ Perspectives on Productivity-Driven Practice

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Abstract
The presented findings are the preliminary outcomes of a qualitative study exploring the impact of productivity-driven management systems on mental health professionals through the lens of their professional code of ethics, professional identity, job satisfaction, and career decisions. During interviews, the participants discussed how productivity-driven environments align with their profession’s mission and goals. The author asked questions focused on job decisions to determine whether productivity-driven practice results in more experienced professionals leaving outpatient mental health in search of positions without these oversights, or even movement into private practice. The phenomenon of experienced clinicians vacating these positions may leave the most vulnerable clients in the care of less experienced professionals.

*Keywords*: productivity, mental health, clinicians, billing, ethics, quality, quantity, measures, job decisions, oversight
Not Just a Biller: Clinicians’ Perspectives on Productivity-Driven Practice

I presented a poster at the peer-reviewed 2019 Annual NASA-Minnesota Conference, “I Am Somebody: Inspiring Innovative Practice!” at the Earle Brown Heritage Center, 6155 Earle Brown Drive, Brooklyn Center, MN 55430. I presented the poster on June 11, 2019 from 8:00 a.m. to 3:00 p.m. during breaks between sessions. This presentation was focused on the preliminary results of my research for Product 2 and serves as my Product 3 for my banded dissertation. Through the poster, I provided an overview of qualitative research conducted about the impact of productivity-driven mental health management practices from the perspective of mental health professionals working in those settings. References are listed on the poster.