(e.g., family, friends, neighbors) as well as other formal community agency resources.

While deciding together what resource would be the best match for the clients' needs, respect the clients' right to self-determination. Encourage clients to express their feelings about seeking additional help elsewhere as well as their feelings about the specific agency or professional being considered. Deal with any doubts, fears, or misconceptions about the resource being discussed. If brochures or pamphlets are available, share these and other information, but be careful not to make promises about what this agency or professional will do.

If the nature of the referral means that a client will have no further dealings with you, and if you sense that the client is feeling a sense of loss or ambivalence about terminating work with you, acknowledge that the time the two of you have spent together has been meaningful. Take pains to prevent the client from feeling that he or she is being rejected or betrayed. Do not sabotage the referral by giving covert messages that no one will be as caring as you are.

In the second stage of the referral process—referring and aiding clients in making the linkage—you will need to estimate the client's ability to make the necessary connections. "Some clients can be given full rein to make a contact and complete the procedures on their own. Some clients need to be carefully rehearsed and escorted" (Siporin, 1975, p. 314).

When possible, use a multipronged approach. For instance, you may have the client schedule the necessary appointment from the phone in your office so that you can be there to assist. You may follow this by making a written request or report, getting the client's permission to share pertinent agency files, or helping the client complete an application form.

Weissman (1976) suggests the use of the following connection techniques:

1. Write out the necessary facts: the name and address of the resource, how to get an appointment, how to reach the resource, and what the client may expect upon arriving there.
2. Provide the client with the name of a specific contact person at the resource.
3. Provide the client with a brief written statement addressed to the resource, describing in precise terms the nature of the problem and the services desired by the client. Involve the client in composing the statement.
4. In case the client is apprehensive or diffident about going to the resource alone, arrange for a family member or friend to accompany the client. You may choose to accompany him or her yourself. (p. 52)

The third stage of the referral process consists of following up with the client. There are several ways to go about this. You might ask the client to call you after the initial contact. Or, with the client's permission, you may call the client at a date after the scheduled first contact with the referred resource. Another approach is to plan a session with the client before and immediately after the scheduled appointment with the resource.

Your field instructor may need to assist you when making referrals that require a consultation or a collaborative arrangement. At times, your student status may work to a disadvantage because your authority is not equal to that of other professionals with higher status.

Case Example

An adolescent who has been having a difficult time with his parents is one of your clients. He is a bright 16-year-old who is attractive and personable. You like him a lot and suspect that he is more open with you than he was with his previous social worker. He is rather moody, however, and seems to be very depressed on occasion. Today, he seems more depressed than you have ever seen him. You suspect that he is planning either to run away from home or possibly to commit suicide. When you try to probe, he becomes uncooperative. You ask him to sign a contract agreeing not to commit suicide. He refuses, saying that it is unnecessary. At the end of the appointment, he gets up and says, "Maybe I'll see you next week."

Questions

1. Should you inform the adolescent's parents that he is potentially suicidal?
2. Should you arrange an inpatient hospitalization?
3. Is it necessary to involve your agency supervisor?

WHAT IS MANAGED CARE?

Managed care is a collective term for several approaches to controlling costs and improving quality of care. Although some of these approaches have a long history, others are new. Several trends in the American health care system created the need for managed care. These included (1) unnecessary and inappropriate utilization of services; (2) unlimited access to high-tech equipment and expensive procedures; (3) a lack of incentives for controlling costs; (4) an overemphasis on ongoing treatment of diseases and disorders with no attention to prevention; and (5) an excessive focus on insight, awareness, and exploratory factors, rather than goal-focused symptom reduction (Browning & Browning, 1996). Many different organizations are involved in managed care, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Employee Assistance Programs (EAPs).

HMOs are closed-group systems in which patients receive care *only* from providers employed by the HMO, usually at its facilities. The HMO is paid by the insurer on a per capita basis, and it provides prepaid comprehensive care (as spelled out in the contract). A primary physician determines which services will benefit the patient and thus also functions as a gatekeeper.

PPOs are less restrictive on who provides services. Instead of employing practitioners and maintaining their own facilities, PPOs contract with local providers who serve the insured clients in their own offices. Practitioners join the network as "preferred providers." This means they must agree to reduce their fees to negotiated contract levels and limit the length of services in a cost-effective manner as determined by the PPO's case managers.

EAPs use case managers to assess the problems of employees, provide minimal intervention, and refer them to independent providers. "EAP Managed Care is handled by trained clinicians and is one of the gentler forms of external control" (Browning & Browning, 1996, p. 6). However, there is often an understanding that short-term cost-effective services will be rewarded with future referrals.

Concepts underlying managed care are Utilization Review (UR) and case management. UR requires a detailed written justification for treatment, a comprehensive treatment plan, and planned discharge goals. These are scrutinized