CSWP NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. SPRING/SUMMER 1987 • VOL. XVIII, NO. 1

Federation: CHAMPUS Results Awaited on California Project

CSWs Advocate Inclusion in HMO Services

Report by Adrienne Lampert, CSW
NYS President

The spring meeting of the National Federation took place in Washington, D.C. on May 1-3, with NYS president Adrienne Lampert, president-elect Robert Evans and treasurer Hillel Bodek representing the Society. A full agenda included an update from Ken Adams, Federation advocate in the capital, and national committee reports.

Legislative Report: Ken Adams

"Significant developments" are anticipated in the next six months in the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) plan, catastrophic health coverage for Medicare recipients and in HMO legislation. Aggressive efforts are required this year by CSWs for inclusion as independent providers in both Medicare and Medicaid covered programs.

The HCFA (Health Care Financing Corporation) will report to Congress on the demonstration project ongoing in California regarding costs/benefits of including clinical social workers as direct providers. To date Congress would not seriously consider such inclusion; the final report will allow such consideration. Crucial during the next year will be strong lobbying efforts to win Congressional representatives to such recognition and consequent mandatory inclusion for CSWs. Lampert, Evans and Bodek called on NYS Representatives Norman F. Lent and James H. Scheuer, who agreed to support CSWs pending the outcome of the California project.

CHAMPUS is proceeding with plans to award contracts to private contractors for delivery of all inpatient/outpatient services, including mental health, in three demonstration areas (two states in each area). New York is not included. Successful bidders will have a year to gear up to provide services, including peer review. Although the subcontractor for psychiatric and psychological services has a peer review system in place, it is less clear who will review clinical social work services since the profession has not developed a specific organization or expertise in this area. By the end of this year the Federation will require an external peer review structure to evaluate outpatient services by CSWs.

It appears that Congress may be ready to amend the Federal HMO statutes to include CSWs as independent providers when services are rendered through an HMO structure.

Strong support is growing in Congress for catastrophic health care coverage, and the Federation is working with a broad

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"Brief Psychotherapy" Topic at Annual Meeting

Speakers Describe Specific Modalities

Report by Carole Ring, Psy.D.

The Annual General Membership Meeting of the NYS Society took place on Saturday, May 9, at the Gramercy Park Hotel in New York City under the direction of Philip Banner who, after a social hour and brunch, opened the meeting. Welcoming those present and reviewing the spring Federation meeting, President Adrienne Lampert presided.

Reporting on progress closer to home, the NYS Society has stepped boldly into the electronic age — we are computerized, allowing a more timely communications system between board and membership; we are on the way to launching a professional public relations program; a successful conference addressing current vendorship issues was presented this spring. In addition, the National Registry of Health Care Providers has been established as the national credentialing body for Board Certified CSWs. Not a bad year, all in all.

Following committee reports, the afternoon's program began. The first speaker, Monica Pierrepointe, is a Society Fellow. She described brief psychotherapy as a treatment mode attractive to those who do not wish long-term psychotherapy for whatever reason. Goals in short-term therapy are of necessity limited and, though changes may be minor, they may also precipitate further change in the future.

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EXECUTIVE REPORT

Achievement: The Many Layers from Past to Future

Having attended our annual general membership meeting and the Federation meeting in Washington before that, I asked myself: Why do they do it? Clinical social workers from all over the country gather twice a year; on our own state level we gather once a month at board meetings. This does not include committee meetings, chapter meetings and all those unseen dues-paying members who quietly and continuously support our Society.

For me it all started in 1972 when I joined the NYS Society. Although I was — and am currently — a member of other professional groups, I knew then, as I do now, that I would support the organization that best represented my profession of clinical social work. The NYS Society has boldly and forthrightly moved clinical social work to a place of respect, recognition and identity. This organization has insisted on high educational, experiential and ethical standards; achieved licensing and mandated vendorship; co-founded a network of states now known as the National Federation of Clinical State Societies. From this group was spawned an independent board called the National Registry of Health Care Providers that produced the first national registry of advanced clinical social workers. We will shortly have one national credential: Board Certified Clinical Social Worker; one independent credentialing board; and a workable process for identifying and certifying advanced clinical social workers nationally. We have come a long way.

Board Certification will establish national identification for advanced standing.

In spite of our mandated vendorship laws, however, we still are not included for coverage by out-of-state and self-insured companies; we are not covered for Medicare and Medicaid services; our schools of social work are not providing an adequate clinical core curriculum.

We must educate ourselves for the new health care delivery systems, exploring opportunities for participation in HMOs, PPOs, IPAs, as both providers and collaborators in delivering these services. In addition, we must continue to refine and clearly identify clinical social work, both within the profession and in the community at large.

CSWs must participate in the new health care delivery systems.

If we want the full attention we deserve, it is necessary to keep our thoughts and actions clearly pointed in that direction. Can this be the reason that so many of us participate so actively in the workings of this professional organization? I know I have grown and, through the experience of working with my professional colleagues, feel less frustrated and more in control of where our profession is heading, and how to get there. I invite each of you to become an active participant in moving our work along:

- get a new member to join
- attend your chapter meetings
- become involved in committee work
- let us know what you are thinking

You are the centerpiece that makes the State Society the locus of leadership. Obviously, we all share the same objectives and goals — a strong professional identity, freedom to do our work in all settings, respected and recognized.

I guess the answer to why we belong and actively participate in our organization is that we are the professionals in clinical work. We are the leaders in our discipline.

Adrienne Lampert, CSW
President

Society Explores Medicaid Reimbursement for CSWs

By Marsha Wineburgh, CSW
Legislative-Chair

For the past several months, the Society's legislative committee has been exploring the possibility of pursuing Medicaid reimbursement for qualified clinical social workers. Currently, the New York State Medical Assistance Program (Medicaid) provides reimbursement for services rendered by individual psychologists and psychiatrists in private practice. It does not reimburse individual certified P and/or R social workers in private clinical practice. The legislative committee has concluded that these practitioners should also be included as eligible providers under the Medicaid umbrella.

The New York State legislature has already determined that certain social workers are qualified to provide diagnosis and treatment of mental and nervous disorders. Further, effective January 1, 1985, the patients of such clinical social workers are to receive medical insurance reimbursement if such services are covered for psychiatrists and psychologists. This assists a segment of employees covered by company policies who otherwise could not seek mental health care.

The primary method of payment for this same diagnosis and treatment of mental and nervous disorders for the poor is Medicaid. This social welfare benefit program serves as medical insurance coverage for the poor. By including qualified clinical social workers as Medicaid providers, such coverage would extend the opportunity to obtain mental health services from a quali-

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ANNUAL MEETING *(continued)*

Three categories are noted as suitable for brief psychotherapy: 1) Emergency Care (e.g., an individual needing protection; 2) Crisis Intervention, as with an individual who feels he/she is decompensating; and 3) those individuals experiencing inner conflict and maladaptive behavior problems who can achieve quick rapport and transference with the therapist.

This model provides, in approximately 12 sessions, a corrective emotional experience in which symptom resolution is fostered by predetermining the precipitant event and its latent meaning, establishing the central focus, i.e., separation, loss, low self-esteem, etc., and organizing the recurrent issues around the central themes. This is not a treatment of choice for fragile people with brittle defenses and/or families with closed systems.

The treatment process consists of three phases. In the initial three to four sessions, while the patient reveals past history to the therapist, unambivalent transference is encouraged. The patient experiences a reduction in anxiety and symptoms. In the mid-phase of the next four to five sessions, the patient undergoes disappointment and despair as the problem resurfaces. During this stage the therapist must avoid joining the patient's despair, at the same time noting the patient's disappointment in light of expectations of the therapist, as well as similarly held feelings with significant objects in the past who also appear to have failed the patient. Here the therapist can reinforce for the patient that, despite such experiences, the patient can now use his efforts on his own behalf to meet adult reality. By so doing, the therapist supports the patient's ego expansion and self-autonomy.

The termination phase takes at least three sessions; here, the patient comes to terms with his disturbed image as well as the anticipated loss of the therapist. The clinician's active management of these issues helps the patient to address the negative transference in the "here and now" and in similar endings; central to the struggle is the patient's reluctance to relinquish childhood wishes.

A follow-up plan is activated three months later by meeting with the patient to assess whether the goals of treatment have been integrated. Case histories illustrated the methodology of brief psychotherapy as described.

Monica Pierrepointe is assistant director of field work, Columbia University School of Social Work; former supervisor and instructor, Jewish Board of Family and Children's Services and faculty member, Wurzweiler School of Social Work, Yeshiva University. She is in private practice.

Photo: Phyllis Gordon, CSW

Featured speakers Arnold Winston, M.D. and Monica Pierrepointe, CSW

The second speaker, Arnold Winston, M.D., is director, department of psychiatry at Beth Israel Medical Center and director of Brief Psychotherapy; professor of clinical psychiatry at Mt. Sinai School of Medicine; and a prolific writer of articles and books.

Winston continued the discussion on Brief Therapy by introducing "Short-Term Dynamic Psychotherapy," a conflict model approach which rests on psychoanalytic principles and aims at symptom remission and character change.

He also presented an historical review, describing contributions by Freud, Ferenczi, Rank, Alexander and French and then David Malan, Peter Sifneus and Habib Davanloo. Their concepts are used as a frame of reference to help the therapist work with oedipal patients in such a way as to foster the patient's self-understanding and self-reliance.

In this modality weekly sessions consist of approximately 40 structural interviews, 50 minutes each. Trial treatments begin with evaluation interviews by two independent clinicians for an initial period of one to four hours. Patients selected must have had a "give-and-take" relationship with someone in their childhood; possess average intelligence; be psychological minded and strongly motivated for change.

Essentially, the patient must exhibit a mature personality wherein emotional

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Robert Lampert, Ph.D., Dies: First President of Society

With regret and sorrow we report the untimely death of Robert Lampert, Ph.D., a founding member and first president of the Society (1968-1970).

Together with colleague Charles E. Smith, Ed.D., who served as first vice president, a small group gathered almost weekly to organize what was to become NYSSCSWP.

The major issues of the earliest efforts concerned the lack of resources for private social work practitioners. Further, advanced education and training became criteria for the new organization, whose nomenclature would reflect its clinical focus. Later issues involved establishing clinical social work as a separate and independent discipline and setting standards for its practitioners. During the 1970s, the group sought certification as a qualifying criterion and consequent recognition as independent clinicians using psychotherapy.

Over the years Bob Lampert remained active in the Society, maintaining the thrust toward professional excellence.

From those few who gathered almost 20 years ago, the Society has grown to more than 1,000 members and to a position of leadership within the profession.

Bob is survived by former wife Susan and a daughter. He will be missed by friends and colleagues.

ANNUAL MEETING *(continued)*

conflicts are due largely to unresolved oedipal problems. Further, the patient must present with a complaint that is concisely expressed; needs the capacity to form a therapeutic alliance; and possess the ability to express feelings freely in this demanding modality.

Among the strategies employed are the therapist's activities both in stance and specific aims: establishing a strong therapeutic alliance; using highly provocative questions, confrontations and clarifications to maintain the focus of treatment in which the anxiety generated produces affect throughout the process; and finally, engaging the transference of the therapist/parent link to drive the therapy. Throughout this process, the practitioner must avoid the development of a transference neurosis, as well as materials pertaining to preoedipal and characterological problems.

As sessions are connected and anxiety continues to mount, the therapist works toward having the patient elucidate feelings in as detailed a manner as possible. The purpose is to identify and analyze the attitudes and behavior that impede the patient's ability to use himself in a more satisfactory manner. The art of bringing the patient's resistances into the session and to the therapist/parent link allows the clinician to identify the affect in the transference to the current object (the therapist) and link this to persons in past relationships.

Maintaining the vigorous use of transferential learning within a controlled number of interviews, and paying particular attention to patients' reactions (especially in termination) will provide skills necessary for the patient to continue the process of self-investigation and working-through after therapy. (Total resolution of conflicts probably will not result from this type of therapy during the process.)

This short-term therapy is not meant for those who are suicidal, destructive, phobic, psychotic or for those with pronounced characterological disorders. It is, however, an effective method for the "healthiest" patients: those with good ego strengths, intelligence and the ability to tolerate anxiety, depression and guilt. □

Members have a chance to socialize at annual meeting . . .

Adrienne Lampert, president

Judith Rosenberger

Barbara Pichler and Robert Evans, president-elect

Treasurer Hillel Bodek and Marsha Wineburgh, second vice president

Marcia Rabinowitz and Philip Banner, members-at-large

Charles E. Smith, Ed.D.

Photos: Phyllis Gordon, CSW

FEDERATION *(continued)*

coalition of organizations under the umbrella of the Mental Health Liaison Group to assure that any legislation enacted include mental health coverage.

Licensure/Vendorship: Gary Unruh

The Federation is now a member of the Washington Business Group on Health . . . Wyoming became the 40th state to require legal regulation for social work . . . The District of Columbia and Virginia have recently passed vendorship bills, bringing to a total of 18 those states with some form of vendorship legislation. An extensive vendorship "package" has been developed and presented to Federation for approval. After nine years as vendorship chair, Unruh will be stepping down.

National Registry of Health Care Providers: Judith Holm

A memorandum of agreement has been drawn and endorsed between the National Registry and NASW embodying basic principles for the establishment of a single advanced CSW credential. The development of bylaws, funding, establishing exams and a plan of operation are still to be worked out.

Psychoanalysis: Crayton E. Rowe, Jr.

This committee now has a national membership of 500, with contributions amounting to $13,000. A newsletter is in production, with NYS member Marcia Rabinowitz as editor, and the first national clinical conference is being planned.

Membership: Kris Dove

Federation membership now numbers 37: 34 full members, 3 associates. Continuing outreach encourages states to join.

The Federation is involved in a variety of educational organizations and its state members continuously provide local/state educational programs. The fall meeting will take place in October. □

MEDICAID *(continued)*

fied provider of one's choice to *all* consumers in New York State.

At this time, no state reimburses clinical social workers for psychotherapy services to their Medicaid population. The California Society for Clinical Social Work is sponsoring a bill to add psychotherapy—if performed by a state-licensed social worker—to Medi-Cal, California's version of our Medicaid system. This bill, SB 1570 (Rosenthal) has been held in their Senate Committee on Appropriations. The Society is planning to have a Senate Resolution introduced which would mandate a realistic financial study by the California state administration. National data indicate that there is, at worst, no increase and, at best, a cost savings when the provider base is widened to include social workers.

Member support for parity as Medicaid providers is essential. Stay tuned to how you can help. □

PRACTICE MANAGEMENT

Clinical Referrals

By Barbara Pichler, CSW

Since referrals are often at the core of building and maintaining a successful practice, how clinicians decide to whom to refer patients is of considerable interest. We asked: On what basis do you make a referral — i.e., do you know the practitioner's work? To what degree does personality play a part? How much do training, orientation and discipline enter as factors?

Linda Fleischman, MSW, Westchester chapter ***(full-time private practice):***

There are more and less rational reasons in making a referral. The therapist must be someone whose thinking, orientation and personality I respect. The thinking is the rational part and the personality is the less rational — but just as important — and the two are not easy to separate. I usually know the people I refer to well, through shared cases or presentations of case discussions. Making a referral is a reflection of my judgment, and therefore my reputation — I take referrals seriously.

My analyst was an interpersonalist, and I tend to refer to people with this shared orientation, e.g., I would not refer to a Freudian. Further, I refer to MSWs and Ph.D.s — to M.D.s only when I think medication or hospitalization will be needed. I used to run groups, but I don't refer to them — I consider individual work as primary.

I don't see everybody I refer, but if I don't get a clear sense on the phone, I try to see them. I give out only one name and check with the therapist [I'm referring to] beforehand for availability, fee, etc., and try to eliminate additional runaround for the patient.

Emery Gross, MSW, Metropolitan chapter ***(in part-time practice and part time as Director of Disability Access, Human Resources Administration):***

I make most of my referrals to the people whose work I know best, which is a peer group I've been a member of for 12 years. I am very concerned that the person I refer to be well trained analytically — also important, however, is the receptivity of the therapist to his own process. The therapist must be somebody whom I trust to have integrated theoretical knowledge with self-knowledge. I look for honesty, sincerity and ability to deal with countertransference. Then comes the fine tuning. On an intuitive basis, I may have a feeling of a personality match — a gut feeling about who would work well together. Does this mean I refer to friends? Not exactly — I'd say they are colleagues I'd be attracted to as friends.

Although I consider myself psychoanalytically oriented, I will sometimes refer outside this orientation. I try to respect the requests of the patient as to the kind of therapist he or she prefers. I may not fully agree with patients' ideas, but if they are strong about their requests, I try to honor them. I refer to all three major disciplines; the discipline is less important than the wishes of the patient and the "fit."

Comments from other practitioners:

"I try carefully to match patients well, but if it's a 'garden variety' kind of neurosis, I consider someone who will possibly return a referral."

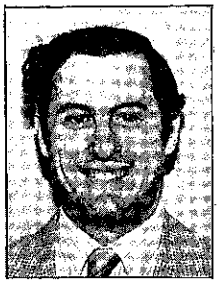
"You never know how someone really works behind closed doors so I do care very much about personality and being well analyzed, because when the going gets tough, the therapist really has to be able to handle it."

"In the end you really do refer to friends. Of course you judge for competence and sensitivity, but then, as you try to make the right match, it's also who you like." □

IN BRIEF

Medical Insurance Claims: Professional Responsibility

By Hillel Bodek, MSW, CSW



The recent criminal conviction of a clinical social worker in Kentucky resulting from her submission of insurance claims signed by a psychiatrist for services she (not the psychiatrist) rendered and the increasing number of inquiries we are receiving from Society members regarding submission of insurance claims prompts a strong reiteration of the information contained in this column some time ago.

The submission of a false or misleading insurance claim by a health care provider can lead to criminal prosecution, to an assessment of civil penalties and to administrative action by the NYS Board of Regents leading to potential revocation of certification/licensure.

A false . . . claim can result in criminal prosecution.

In signing an insurance form as the provider of a service, you attest to the fact that *you* provided the service. In some cases, physician or psychologist supervision or referral is required in order for a claim to be paid for services rendered by a clinical social worker. In such cases, it should be stated clearly on the insurance claim who provided the services and who supervised/referred the patient.

By the same token, as supervisor of another mental health professional, you should not sign insurance forms for services that were not rendered to the patient directly by you. The provider should sign the form, clearly indicating who provided the services in question; if necessary, you should indicate, by attached letter, that you supervised the services on the dates noted for this particular claim form.

For supervisors, an additional word of caution: supervision of another professional or trainee (as opposed to providing consultation) carries with it the obligation of personal professional responsibility for those professional services, the provision of which they supervise. Under the legal doctrine of *respondeat superior,* supervisors can be held liable for the actions — or failure to act — of their supervisees.

Supervisors are liable for the actions . . . of those they supervise.

The ethical and legal standards governing clinical social work practice require that the actual provider be shown unambiguously on patients' claim forms. Further, when clinical social workers claim to have supervised other professionals or trainees, they must actually have supervised the provision of the services in question and assume personal professional responsibility for those services.

Clinical social workers who violate these standards not only subject themselves to criminal, civil and administrative penalties, but damage the image of the clinical social work profession. □

REFLECTIONS *(continued)*

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All of this was possible and flowed from the capable and sensitive direction of Adrienne Lampert, who guided us in defining committee functions and Society goals. There was a great deal accomplished, such as the newly started President's Letter to the membership summarizing board activity and major issues. This resulted in less work for me on the chapter level, for it changed my role to "clarifier" with no need to report in detail on board meetings. The meetings established for chapter presidents were successful in facilitating communication with an exchange of ideas, information and know-how on both chapter and board level issues.

I am gratified that I have had an opportunity to act on behalf of the Queens chapter in shaping the Society into a unified body. I urge all members to attend board meetings to learn how your Society works for you. Also, consider participating on the board to share in attaining the goals of NYSSCSWP. You will be welcomed. □

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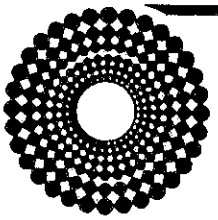

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