WASHINGTON STATE SOCIETY FOR
CLINICAL SOCIAL WORK
NEWSLETTER

SUMMER 2007

In this issue:

PRESIDENT'S MESSAGE

Comings, goings, and gratitude

BY MARIANNE PETTERSEN

We had our annual party at the end of June and not only did many turnout, but we enjoyed a touching, warm and humorous evening. Traditionally at this event we say goodbye to our departing board and committee members as well as others who have given so much to the organization. The evening really showed how much connection happens between people when they have involved themselves in the Society. Someone referred to us as "transgenerational." With people attending who were members in the '70s to those who joined us that very night, we truly were and are a transgenerational group of clinical social workers. And though many of you were in there to help celebrate those we honored during the evening, I want to share some of my own thoughts here.

Kevin Host is leaving the board as his past president role has come to an end. I am unceasingly grateful

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Karen Hansen, John Powers, and new member Cathy Hayashi at the WSSCSW annual party

WSSCSW

The Washington State Society for Clinical Social Work was established in 1973 and incorporated in 1988 as a 501(c)(6) to promote and advance specialization of clinical practice within the social work profession. It is an organization of clinical social workers practicing in a variety of settings including mental health clinics, family service agencies, hospitals and medical clinics, and private practice in the state of Washington. Its members span the professional life cycle from students and new professionals to mid-range, seasoned, and retired clinicians.

WSSCSW offers its members continuing educational opportunities, legislative advocacy including lobbying, network and professional growth opportunities and special programs for new professionals.

WSSCSW is a nonprofit tax-exempt professional organization with a board of directors composed of officers elected by the membership and chairpersons of the various committees. It is affiliated with the Clinical Social Work Association, which represents clinical social workers on the national level and actively works with them to represent local as well as national concerns.

PRESIDENT'S LETTER

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for his outstanding contributions to the Society and as an important mentor to me in this position. The whole organization works so amazingly well thanks to generous and astute people like Kevin because they nurture the organization by participating in our transitions when one leaves and another begins in a position. This working model provides such great stability and continuity—one of those benefits of membership that are hard to describe in words. We wish Kevin all the best as he continues his stint as CSWA president.

Honoree Wynona Morrison was the very first contact I had in the Society back in 1993 when I took over as treasurer for her. I had just joined and now was going to be on the board, a little intimidating. Her warmth and positive regard allowed me to feel like I could succeed, and I am grateful to her. She has given so much to the Society and to other organizations like the Alliance. She has always been keenly involved in education and training for clinical social workers. Wynona mentioned at the party that there really is no other place to experience one's clinical social work identity, something she values as a long time Society member. The connections seem to go on and on.

I want to thank everyone on the board, Mary, Shirley, Eric, Karen, David, Laura, Carrie, and Lisa for the great work and camaraderie this year. We have to say goodbye to a few people and say hello to the new folks joining us. We bid a fond farewell to Carrie Smith, our treasurer for the past five years. Carrie so graciously stayed an extra year when it was needed. She has been ultra organized, is a stellar communicator, has kept us perpetually entertained with her fabulous sense of humor, and takes such great care in everything she does. We are happy she is staying on the New Professionals Committee and hopefully will continue to be our unofficial "wine steward" of the Society. Thank you, Carrie! Taking over her position is Carolyn Sharp. We are so very excited to have Carolyn join us and are really looking forward to working together. Having already worked on our budget with us, Carolyn is clearly ready for the job and comes equipped with the requisite great sense of humor!

David Bird, who has been our Ethics chair for the past couple years is stepping down. David is one of those members I mentioned above who have stuck with the Society for nearly thirty years. He was quite involved in bringing good continuing education through the Society back when there really were not many post-graduate training opportunities for social workers in Seattle. It has been a pleasure to have him on the board, to tap into his sense of organizational history, and to benefit from the valuable perspective he brought to many issues. Thank you, David! We are welcoming Deborah Woolley as our new Ethics chair, who comes with a special interest in ethical issues. We are so pleased to have her on board.

Lisa Benner, our departing secretary, also will be sorely missed. Besides doing a wonderful job as secretary, CEU coordinator, UW Scholarship coordinator, and New Professional Committee member, Lisa has brought an important voice as a new professional to our discussions and planning in the Society. She helped shape our new professional gathering last fall and led the fishbowl discussion that furthered our understanding of the issues facing this group. We want to welcome Lyla Ross, also a new professional, as our new secretary. We are thrilled to have her.

Lastly many thanks go to Rob Odell who was our first Veteran Outreach Project coordinator. Rob has laid so much of the groundwork for this new community project of ours. There is much relationship development to do, and Rob with the help of the committee was up to the task. We welcome committee member Frank Kokorowski as our new coordinator and will look forward to more progress in being able to help our returning Iraq and Afghan war veterans. ♦

Scenes from the WSSCSW annual party

Top: Wynona Morrison, one of the evening's honorees.

Middle: Past president and honoree Kevin Host with his wife Kathy Johnson and Laura Groshong.

Bottom: David Bird, outgoing Ethics chair, talks with Pam Powell and Bill Etnyre.

calendar

AUGUST 2007

Early August

- Membership renewal

Friday, August 17, 12 – 2 pm

- WSSCSW Board meeting

SEPTEMBER 2007

Saturday, September 15

- Membership renewal deadline

Friday, September 21

- WSSCSW Board meeting

UPCOMING EVENTS

Later this year

- Look for a full calendar of the year's events, seminars, and dinner meetings in the upcoming fall newsletter
- If you have additions you would like included in the calendar, please send them to Aimee Roos at *aimeeroos@yahoo.com*

WSSCSW Newsletter is mailed quarterly to members of WSSCSW. Deadline for the next newsletter is **Sept. 15, 2007**. Articles should be emailed to Mary Ashworth at **mary.ashworth@att.net**. For advertising rates see page 11. Newsletter design: Dennis Martin Design, 206-363-4500.

Articles expressing the personal views of members on issues affecting the social work profession are welcome and will be published at the descretion of the editor and WSSCSW board. Articles reflect the views of authors and Society endorsement is not intended.

Check us out online:
wsscsw.org

Join the WSSCSW email group!

Now in its ninth year of operation, with 153 WSSCSW members currently on the roster, WSSCSW's email group is one of your membership's prime benefits. It is a valuable, prolific source for making and receiving referrals, consultation on practice and clinical issues, professional education programs, available office space, and other information of interest to clinical social workers.

It's easy for current members to join. You can email Eric Huffman, our Membership Committee chair at *eghuffman@earthlink.net*, or Rob Odell, the group's moderator, at *odellicsw@clearwire.net*. Once your membership status is confirmed, you'll be quickly added to the roster so that you can send and receive messages. (If you change your email address, contact Rob Odell with the new address. Otherwise, the new address will not receive or send messages successfully!)

Have you moved?

Please let us know your new addess. Email your name and address to: aimeeroos@yahoo.com

TREASURER'S REPORT 2007

Here we go again . . .

BY CARRIE SMITH

I really am not going to be the treasurer anymore, really! All teasing aside, I know I wrote in the newsletter at this time last year that I was leaving as treasurer. Last year my replacement had a sudden change of plans in their availability, so I decided to stay on and help out for a fifth year. The new treasurer, Carolyn Sharp, will begin on July 1, 2007. I wish her the very best in her new position. This year has been a great one! It has been my pleasure to serve alongside such a talented, creative, fun and dedicated group of people on the board. I will miss you! I look forward to witnessing the organization's continued growth.

The 2006/2007 fiscal year concluded in the black! We have 183 members, 28 of whom are new professionals. Thank you to everyone who joined and thus helped the organization grow, change, and provide all of us with more enriching opportunities.

Our financial budget for this year breaks down as follows:

Income

The largest percentage of income generated this year came from member dues representing 50 percent of our total income. Twenty percent of our budget's income came from cash reserves that we carried over from last year which was money we had remaining in our checking account at the end of 2005/2006.

We raised 13 percent of our income from our spring conference with Judith Nelson on "Crying: A Theory of Attachment." Six percent of our income came from lobbying contributions made by our membership.

Our dinner meetings raised 4 percent of our income and we produced 3 percent of our income through our status as a credentialing organization that is able to grant CEUs to other organizations for professional events that they hold. Our short course from Diane Zerbe generated 2 percent of our income, and another 2 percent of our income came from ads placed in our newsletter or from the sale of our mailing list to other professional organizations.

Since we are a nonprofit organization, we are not allowed to show a profit. Therefore, our books are kept on a cash basis. This means that whatever we earn in income, we must balance with an equal amount of expenses.

Expenses

Shifting to the expense portion of our budget, our largest expense was our legislative expense representing 26 percent of our total expenses. This was what we paid for the time and operating costs of our lobbyists, Lonnie Johns-Brown and Laura Groshong.

Our next largest category of expense, 24 percent went towards communication operations. This paid for our web developer to create our database and to make more changes to our website. It paid for our program administrator to assist the board and committee chairpersons with their responsibilities. Lastly, it paid for the production of all our expanded newsletters, including photos too!

The executive expense category, comprising 22 percent of our total expenses, paid for our telephone, our post office box, CSWA membership fees, taxes, our end-of-the-year party, the volunteer recognition dinner, our director's and officer's insurance, processing CEU applications, the scholarship we award yearly to a MSW graduate at the School of Social Work, and expenses from the Ethics Committee and from the Veteran's Outreach Project.

The professional development expense category, 18 percent of our total expenses, paid for our spring conference, our dinner meetings, our short course, and our student paper award winners. The new professional expense category, representing 5 percent of our total expenses, paid for the annual fall new professional dinner reception at the University of Washington, as well as presentations made to MSW students at the School of Social Work and for our mentorship groups program.

Our membership category expenses, which were 3 percent of our total expenses, covered costs derived from servicing our membership and for creating our membership roster.

Lastly, the marketing category, with 2 percent of our total expenses, covered our outreach and public relations activities.

I hope this produces a helpful financial picture of our budget this year. Feel free to contact me or Marianne Pettersen with any questions you may have. ♦

MEMBERSHIP

Shrink to fit

BY ERIC G. HUFFMAN

Our wonderful administrative assistant, Aimee Roos, was helping me with material for the new members packet that I send out to new members (of course). Our new and improved web page has a list of membership benefits and I wanted to get it all in a one page readable format. I was playing around with Aimee's draft and realized the only way to get everything on one page was to use the "shrink to fit" option in Microsoft Word. It was a remarkable realization that our volunteer driven Society had so much to offer that I couldn't just simply format it! Here's what I'm talking about:

Benefits of membership

- Develops and promotes the highest standards of quality in clinical social work through adherence to a strict code of ethics, and endorsement of the standards set by our state in its licensure procedure.
- Lobbies in Washington State and Washington, D.C., for inclusion in any new health care initiatives and to protect clinical social work on your behalf.
- Protects your licensure.
- Provides public relations/marketing to enhance our professional identity and promote clinical social work to the public.
- Provides educational offerings and CEUs: yearly clinical conferences, ethics and supervision conferences, and short courses.
- Provides professional, clinically oriented dinner meetings (CEUs provided for attendance).
- Lists you in our membership roster and circulates it to managed care and EAP companies to increase your referrals.
- Lists your practice information, by location, on our website for referral purposes.
- Offers free membership to the Society's email group where referrals can be obtained and questions answered by colleagues.
- Keeps you abreast of state and national issues which affect your practice through the WSSCSW newsletter and email group.
- Continues to increase the number of insurance company provider contracts.
- Continues to monitor managed care policies.
- Provides you with the 1-800 number Managed Care/Forensic Hotline.
- Co-sponsors educational events with other clinical organizations.
- Provides you with networking opportunities through involvement in ongoing committees working to help shape the future of clinical social work.
- Provides free individual and group mentoring to new professionals.
- Offers the Outstanding Student Paper Award each year to the best clinical paper by a social work student at three Washington campuses.
- Provides a $1000 yearly scholarship to a student with an interest in clinical social work at the University of Washington School of Social Work
- Provides liaisons with NASW, schools of social work, and other professional associations for educational and legislative purposes.
- Gives back to our communities through activities such as the Veterans' Outreach Project.
- Provides opportunities for low-fee consultation and psychotherapy to new professionals.
- Provides informal social gatherings for members throughout the year.
- Allows reduced fees and admissions for all Society sponsored events.
- Provides for a discounted rate on your malpractice insurance through CPH & Associates.

Why is this important?
There are five reasons:

1. Renewal time is coming up in August and these are the reasons you should get ready to mail in your renewal (same cost as last year).
2. Renewal time is coming up and your renewal makes these benefits available to our members, our communities and our profession — even if you can't personally take advantage of all of them.
3. The new renewal year is beginning soon and this column is a

quick way to show your clinical social work colleagues why they should join the Washington State Society for Clinical Social Work, if they haven't already.

4. Your renewal makes it possible for us to grow, improve our web page, and hire an administrative assistant such as Aimee.
5. Lastly, it reminds us that we rely on members to volunteer and step up to create this growing list of benefits. While your renewal makes all this a possibility, only your volunteering makes it possible. Please join a committee … or chair one! *And renew!*

Welcome to new members

Kea Carpenter
Kea received her MSW from Tulane University in 1989. She worked in a number of clinical social work positions in New Orleans and maintained a private practice there as well. Kea is currently a supervising therapist with Family Services of King County. She was a member of a Clinical Social Work Society in New Orleans and has been impressed by the clinical expertise of Washington State Society for Clinical Social Work members she has met here. Kea also has a master's degree in English and is a member of NASW. She holds the LICSW in Washington State.

Cindy Taketa
Cindy received her MSW from Smith College in 2002 and is a therapist at Seattle Mental Health. Cindy first learned about the Society after joining a mentorship group that she found invaluable in connecting with other recent graduates. She then completed a two-year certificate program in advanced psychotherapy. Cindy wants to join the Washington State Society for Clinical Social Work because she wants to be part of "an organization that practices and believes in social work values and ethics." Cindy also hopes to get advice on starting her private practice. She holds the LICSW in Washington State.

Sara Slater
Sara is a returning member who received her MSW from the University of Washington in 2001. When Sara was beginning her private practice a few years ago, she realized she could not attend many of the Society's functions and let her membership lapse. Sara states it all quite clearly, "After three years in private practice, I am now well aware how isolating this can be … I recognize that the WSSCSW is about a lot more than evening programs, that it offers me a 'professional home' and an advocacy arm and a group of committed, inspiring colleagues." Sara holds the LICSW in Washington State. Welcome back! ♦

The fate of the world hangs by a thin thread and that thread is the human psyche.

— Carl Jung

Of all the creatures of Earth, only human beings can change their pattern. Man alone is the architect of his destiny. The greatest revolution in our generation is that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives.

— William James

PROFESSIONAL DEVELOPMENT

The work of Pat Ogden: "Trauma and the Body"

BY MAUREEN SAWYER

How many times have clients commented, " I am aware of my problems and understand why I am this way. So what?! Nothing's changed." We, as therapists, have our own powerful feelings and reactions too. Pay attention! How often do we experience butterflies in our stomach, constriction in our chests, etc., and yet ignore our own body sensations in the therapeutic hour?

Dr. Pat Ogden addresses this dilemma with her colleagues, Kekuni Minton and Clare Pain, in their book, *Trauma and the Body*. According to Ogden, "The body, for a host of reasons, has been left out of the 'talking cure.'" Ogden has noted that traditional therapeutic practice focuses on emotions and feelings but ignores body sensation, i.e., somatic experience. Her therapeutic approach very elegantly combines the relationship between cognitions, emotions, and bodily sensation.

Allan Shore writes, "Ogden's outstanding work in sensorimotor psychotherapy focuses not just on the devastating effects of trauma-induced alterations on mind but also on body and brain. Asserting that the body has been left out of the 'talking cure,' she offers a scholarly review of very recent advances in the trauma, neurobiology, developmental, and psychodynamic literatures that strongly suggests that bodily-based behaviors, affects, and cognitions must be brought to the forefront of the clinical encounter."

Dr. Ogden provides clinicians with a model of how to work to with the three major brains. These three systems developed sequentially over the millennium and are organized hierarchically. At the bottom is the reptilian/subcortical brain stem, followed by the mammalian/limbic brain, and finally the cognitive/neocortex brain.

This multilayered system is designed to promote optimal functioning. However, trauma can severely interfere the functioning of these systems. Pat Ogden states that for "traumatized individuals the debilitating, repetitive cycle of interaction between mind and body keeps past trauma alive, disrupting the sense of self and maintaining trauma related disorders … because events are encoded and processed at a subcortical level. Past, present, and future are not differentiated, and aspects of previous traumatic experiences are confused with current reality."

The brain's hierarchical system lends itself to both top-down and bottom-up approaches. However, traditional psychotherapy has generally limited itself to top-down approaches. Ogden advocates a blend and integration of both top-down and bottom-up interventions, particularly in cases of trauma. Top-down approaches typically use cognition to regulate affect and sensorimotor experience, focusing on meaning making and understanding, while bottom-up approaches, use the body sensation and movement as the entry points.

Daniel Siegel, author of *The Mindful Brain*, writes of Ogden and her colleagues' book *Trauma and the Body*, that they "offer us deep experiential insights that can awaken our minds to the wisdom of the body" and that "mindful awareness of the body enables the individual to move more directly into previously warded-off states of activation, which left the body out of the experience of mental life following acute or chronic traumatization."

Pat Ogden was scheduled to come to Seattle in September to present on this topic. She has been a presenter for the past two years at the UCLA Attachment Conference and has been very well received. Unfortunately this workshop (which was to be co-sponsored by the Northwest Alliance for Psychoanalytic Study) is being postponed due to unforseen circumstances.

We are very much hoping to reschedule Dr. Ogden when her schedule allows. At that time she will discuss how sensorimotor psychotherapy integrates cognitive and somatic interventions in the treatment of trauma, emphasizing body awareness, practicing new actions and building somatic resources. This approach will be demonstrated through videotaped excerpts of sessions with clients so that the audience can observe nuances of movement and watch how the body

changes during therapy with real-life issues. Key components of sensorimotor psychotherapy will be illustrated: uncoupling trauma-based emotions from body sensations, promoting collaboration between client and therapist, teaching mindfulness, building somatic resources, and developing a somatic sense of self. Since clients with complex trauma can be easily triggered by interventions that access the body too quickly, attention will be given to pacing, boundaries, and safe, gradual reconnection with the body. The videotapes show how to help clients discover and describe how past traumatic experiences are affecting their current bodily experience—which in turn contributes to difficult emotions and beliefs—and also show how to integrate cognitive and somatic interventions to change the meaning of traumatic event(s) and regulate both emotions and arousal.

We are very much looking forward to a time when Dr. Ogden's presentation can be rescheduled. Watch for more information in upcoming newsletter calendars. ♦

PROFESSIONAL DEVELOPMENT

Dinner with Dr. Kane: "The Impact of Race and Culture on the Therapeutic Environment"

BY SHIRLEY BONNEY

Dr. Michael Kane's presentation, "Racial/Cultural Transference and Countertransference: The Impact of Race and Culture on the Therapeutic Environment," on May 8, 2007, at the University of Washington School of Social Work was interesting and stimulating. By far the highest attendance of a dinner meeting this year, Dr. Kane's presentation was of interest to many in the community. There were approximately sixty people in attendance, many of whom were not members of the WSSCSW. It was a pleasure to have a broader group of social work colleagues at one of our dinner meetings.

Dr. Kane had a wealth of information to present and used clinical vignettes, as well as examples with historical reference, to illustrate the impact of racial transference/countertransference in clinical work as well as in society in general. Using comic relief, Dr. Kane also included pertinent cartoons bringing some levity to a subject that has had, and continues to have, such serious consequences.

My hope is that Dr. Kane's presentation will act as a catalyst for more presentations and ways to dialogue about racial issues in treatment, as well as in society.

Having just returned from New York where the diversity in America is far more apparent than here in Seattle, I was moved by the first museum exhibit of the paintings of Henry Taylor at the Studio Museum of Harlem. The exhibit was entitled "Sis and Bra" and portraits of his friends and family members exemplified the extent to which racism is alive and well in the United States today.

I think it important that we all appreciate something a song in the Broadway musical, *Avenue Q*, acknowledges: "We all (no matter what race we are) have a little bit of racism, even if we don't think it's right." WSSCSW has little racial diversity which is not the way many of us would want it to be. Hopefully we can use Dr. Kane's presentation as a jumping off point to look more closely at these issues. If people have ideas about forums for doing so, please email me at *shirleybonney@hotmail.com*. ♦

SPOTLIGHT ON THE BOARD

Our president: Marianne Pettersen

BY MARY ASHWORTH

Society president Marianne Pettersen generously agreed to speak with me last month for the first in our series of board member profiles. She spoke about her experiences with the Society and particularly in her role as president over the last four years. Marianne joined the Society in 1993 motivated she says, "to get to know my colleagues better and to network with other clinical social workers." Prior to her presidency she served as treasurer for six years as well as the PR/Marketing Committee chair for a time. She says she especially enjoyed the fun and playful attitude the marketing committee members brought to their work!

Marianne describes coming to the presidency somewhat reluctantly, for though she had long been involved on the board, she had not thought of herself as a leader. In fact, she remarks, "I couldn't imagine myself speaking in front of a small group of people … let alone the entire graduating class of UW School of Social Work!"—a necessary task of the presidency. However with help and wonderful support from her predecessors, Marianne says she has enjoyed diving in and learning how to do things … breaking down a challenge and figuring how to take care of it … including public speaking! She tells me she is glad to have taken a turn as president and to have discovered parts of herself of which she was unaware.

Marianne described to me how she sees the Society and the position of president as being "all about relationship development." She says she has most enjoyed investing in growing the Society in her years as president. She has also valued the work done to nurture those coming into the profession with our new professional programs. In her years as president, she explains she has come to truly recognize and value the importance of the Society's leadership and advocacy for the work we all do. The behind-the-scenes discussions have been particularly interesting. Watching Laura Groshong and Kevin Host, their "sense of politics and how to protect the profession" has opened worlds Marianne describes never having known. She appreciates the opportunity to be more aware of and engaged in, as president, issues at the national level. She likes the continuous relationship development required of her position both within and outside the organization.

Marianne says the president's role has allowed her opportunities to "look out for the reputation of the Society and struggle with the organizational ambivalence about holding to a psychodynamic frame or making room for other theories … the worry about dilutions … very challenging." She explains finding the content of the job interesting but realizing the relational experiences have made the job so rewarding. Given the clinical social work membership, she describes being surprised at times by the conflicts she has sometimes had to help manage. In these times she describes having learned it is as important not to brush aside feelings as it is not to get derailed by the minutia. When asked about the most stressful aspect of the position, Marianne responds "not having someone to succeed me in the position of president" has been the most unpleasant and difficult part of the job for her.

As our conversation comes to a close, Marianne comments "although the Society has grown tremendously in the last four to eight years, the growth has not been without hardship. By hiring an administrative assistant (a sign of a more professional organization) the hardship associated with the growth has been vastly mitigated. Now someone in the role of president can and will have more time to devote to creatively moving the organization forward without having to get bogged down in minutia and reinventing the wheel."

When asked about what has brought her the most satisfaction as president Marianne responds she is most satisfied when she thinks of the accomplishments of the last four years: 1) the increased mentoring of new professionals, 2) an increased diversity of membership, 3) dealing with the conflicts inherent in increased diversity, and 4) the hiring of an administrative assistant which the Society was able to do slowly so as not to wreck the stability of the organization. Lastly Marianne

replies that before her term is up she hopes to have a written record of all protocols thus making transitions and handoffs more seamless! Clearly, Marianne has brought and continues to bring so much to the organization.

Finally I cannot help but add an editor's note. Secretly — or perhaps not so secretly — I suspect Marianne also hopes that prior to the end of her term, a member will step forward to become president-elect. I think I can safely speak for all the board that we hope so too, as this position should have been filled a year ago. Thanks to Marianne for her outstanding contributions to the Society and for sharing her experiences with us! ♦

He who would know the world, seek first within his being's depths; he who would truly know himself, develop interest in the world.

— Rudolph Steiner

NEW PROFESSIONALS

Mentorship group ends after a successful year and a half

BY MARY KAY BRENNEN

In response to the new professionals' thoughtful and enthusiastic support in developing mentorship groups for graduate social work students, Mary Kay Brennen recruited Jacqui Metzger in the fall of 2005 and together they began organizing a group.

We quickly learned that the logistics in getting a group off the ground takes time. School schedules and demands are priority for students; Thanksgiving and the holidays slowed the process. In January 2006 we met for the first informational meeting. Seven students arrived that evening. Mary Kay set us in motion — we went around and introduced ourselves and talked about what we hoped for in our monthly meetings. We clarified that this was not a supervisory group, rather a place in which members could sort out experiences in a field that can be emotionally challenging. We discussed areas of concern related to being students and what they hoped to get from this group experience.

The members varied in age, life experience and professional experience. All were second-year students and all had concerns about the impending transition from student to "being-out-in-the-world." We decided to meet monthly and agreed on a time and place. Since there were several students who couldn't make the first meeting but were interested in joining the group, we decided to meet once more before "closing" the group.

It took time to find a rhythm among us. Several members came and left. There was a core group that formed and connections strengthened. Comfort and trust evolved over time. "Check-ins" included school, placement, and personal challenges and successes.

Keith Myers from Family Services and Gayle Forslund from Compass Health attended a meeting; their presence generated a spirited discussion about working at agencies that offer different services to the community. Members talked about their internships and found ways to support and be helpful to each other. Information was shared and new resources were discovered.

Graduation approached and then was past — the group morphed from students to social workers and new professionals. We all witnessed individual development and growing confidence as members were challenged and grew in their work. Professional identity was evolving and the group supported this evolution. Most members found work; others were looking. The range of employment was impressive — community mental health, hospitals, adoption agency, school counselor, school advocate. At this time all are working or have interviews. Laura Groshong is scheduled to talk with us about licensure. We have set our final meeting for June.

Ending is bittersweet. This has been an experience of coming together, finding purpose and meaning in meeting as a group, and finding good support during a challenging and often confusing ongoing period of time. The members seem ready to move on yet our connections have been established, and as social workers our paths will cross. ♦

SPECIAL FEATURE

An interview with Edwina Uehara, dean of the University of Washington School of Social Work

BY MARY ASHWORTH

Editor's note: In March of this year the CSWA's Journal for Clinical Social Work featured a number of articles pertaining to the history and possible future direction of master's level clinical social work education. In April of this year, Dean Uehara graciously agreed to speak with me to share her thoughts on social work education and the role schools of social work play in shaping practitioners. Below is a transcript of our conversation.

Mary: First of all I want to thank you for taking the time to talk with me today. I was hoping you might comment on the recent articles in the March issue of the *Journal for Clinical Social Work* about social work education. Have you had the chance to read them?

Dean Uehara: I have read them, though not with as much depth as I would like.

Mary: I found the articles interesting as they describe a core connection uniting all social work practice and education. The authors discuss the history of how two camps have developed within our profession and have an idea that core fundamental precepts connect these two camps. One of the articles in particular suggests how we can build from these precepts to provide a more unifying educational experience for our students to be fully prepared for life after graduation. The two core principals discussed are person and situation as the first and the concept of relationship as the second. They suggest these precepts support any and all of the work we do on a micro or macro level. How might these ideas relate to what is happening here at the University of Washington Social of Social Work … and what is happening? How are these ideas being discussed here at the university?

Dean Uehara: I went to the University of Chicago and am a macro person in my orientation, however (I don't know how much you know about the University of Chicago) but it is a program with a very strong clinical focus as well as a very strong emphasis on policy. The graduate program has an orientation toward great depth and advanced skills for applied practice situations. So coming as an assistant professor out of the University of Chicago program, my orientation has always been a great respect for both the macro and micro. I have no sense that clinical work is somehow at great odds with the world of policy. I always have seen them as connected. Seeing them as connected, there are different ways to think about how those connections work. I certainly have great respect for and warmth to the clinical framework. I have sort of come to a place where I believe there is urgent need in social work to refine the advanced skills whether they are macro, micro, or mezzo. The world is in need of social workers to have very sophisticated skills to deal with very complex situations and problems now and in the future. There are many reasons why I think that's true but the bottom line is I think there is an urgent need for the schools of social work to step up to the plate and make sure that their graduates can connect to the needs of the rest of the world. The dean of another school of social work and I were talking at a meeting last summer about our perspectives on what the field needs to do and what the schools of social work need to do to connect with issues in the field. He used this term, and I think it fits, that the problems are the result of a "disconnect."

Mary: What were some of the ideas about what the schools need to do and can you say more about the disconnect?

Dean Uehara: Yes, the disconnect. He and I both agree that top schools in social work have spent a lot of years garnering respect for our research and in becoming defined as social scientists and so forth and that's been necessary and important in a lot of ways. The knowledge generated out of this work has been critical. We have however tended to have what he calls a "disconnect" to industry.

It's like, is the work that we do helping social workers to practice every day? Is the education we are providing connecting to the needs of agencies and clinicians and stakeholders? Are we really connecting to the needs of the field? I think he is concerned, and I share this concern with my colleague, that we are not doing enough about it. In this generation where we have top schools, as good of research as in any other discipline, our responsibility is not to just continue to do a kind generalist education but to really connect in the field. So I think in this school, as well in other top schools, what you will see is a refocus and a recommitment and a rejoining with practitioners and the commitment to practice.

Mary: Are you saying that you expect to see this recommitment to practice begin to occur nationally as a trend?

Dean Uehara: Yes, it happened with nursing. Our school is a top nursing school and they have a similar narrative. Well, we have chugged along and have become extremely accomplished in our research, and now we must own and embrace the important work that clinical social workers do as a part of embracing what it means to reconnect in the world of practice.

Now, do we think that we have certain things to bring to that dialogue? You bet. We are concerned about things like cultural competence, we are concerned with how a wide variety of skills play out in different environments with different kinds of cultures and systems and so forth. We are concerned that the overall impact of practice has some macro effect of redistribution and social justice and so forth. So I think there are ways that we bring things to that dialogue that clinicians need to hear and so forth. But, what we cannot bring to the table is an old generalist curriculum when the needs of the clinical field are highly skilled, highly advanced, highly refined practice. So we have things to learn, things to say, and we have changes that we need to make. I think it would be an enormous exciting partnership don't you think?

Mary: I think so. Certainly the community of social workers within Washington and in this region is full of a tremendous variety of highly skilled practitioners in all types of practice. How do you envision these partnerships happening?

Dean Uehara: If you look at us as a whole. I was talking to Kip Tokuda and we were talking about the incredible wealth of social work talent that happens to exist in the Pacific Northwest and particularly in Seattle. We have incredibly talented social workers in all sorts of leadership positions from hospitals and clinical work all the way to the state legislature and in the private sector. So we have such a powerful set of leaders and people who do incredible work. We also work in an environment (relative to other parts of the country) that is very supportive of social work, both in terms of some kind of understanding (even in the press) about complex issues around child welfare work and in terms of even large foundations that have redistributive justice as their goal. We live in a progressive place. We also live in a culture where seeing outside of the box, cross-sectoral relationships, public private blendings and that kind of stuff is just kind of part of the culture. We are also highly innovative. Pike Place Market came out of a public-private partnership predating all of the fuss and muss of downtown. So that is all a part of our culture. If social workers with all this talent, innovation and cross-sector partnering can't bring together macro and micro elements of practice then we are pretty pathetic, aren't we?

I have never had encounters with clinical society representatives who haven't said of course we are committed to social justice. We are trying to create important dialogue in what we do. We are struggling with issues like where and how those goals come into clinical practice. So it is not as if we are talking about a group of people who are at odds. The field needs us to come together and I think this faculty wants and desires to do that. We are in a place where we want to reach out. We want to be able to support good social work practice. I see a commitment and an excitement about that.

Mary: I have heard the School of Social Work is creating some new positions which may relate to some of what we have been discussing.

Dean Uehara: Well, Margaret Spearmon's position is a new one and her title is associate dean for student and professional development. It was created because we may have lacked, in the dean's office, a high commitment to the field that says, "We are serious." "We support social workers from the time they even know they are

bound to the school all the way past graduation and into practice." We want to create ongoing deep relationships with the profession from the beginning to the end. Margaret's position is about developing that set of relationships.

Mary: So how will that happen? Do you have a sense of how the relationships would develop between the school and professionals out in the community?

Dean Uehara: Well, we have a couple ideas about how to make that happen. If you think about every practitioner, Margaret isn't going to connect with everyone, however we must think strategically. One idea is to further develop the relationships with practicum agencies in which our students intern. We need to support the development of practicum instructors and to actually figure out how what we do in terms of research and so forth can be of benefit to the agencies. Close that circle.

Mary: Recently, as a supervisor of interns in a clinical setting, I have been thinking about how helpful it would be to have a more lengthy and ongoing conversations between our agency and the institutions training interns to talk about what students/institutions expect to gain in their practicum experiences as well as to discuss what training our agency expects interns will receive prior to their placement.

Dean Uehara: If you think about it we have relatively thin ties. You have a practicum and we have a student there. What if we had thicker ties of continuing education? You teaching us and we teaching you. What if we did joint clinical research together? What if you influence the way that our students are prepared and in turn we prepared those students. So Margaret's job is to thicken those ties and to think about how the school can play a role throughout the lifespan of a practitioner's professional development? We have also talked about other things. I worry about the age demographics of social workers. Just when demographers suggest that the world will have its biggest explosion of human needs due to in part to the graying of society and the maintenance level of need everywhere. I worry about the complexity of those needs and the great demand for skilled clinicians and professionals. I worry about society's commitment to pay social workers what they need in order to advert disaster. I worry about the pay scales and career ladders. What the professional life looks like, and I am exaggerating, but there is a wealth of very experienced older social workers who are nearing retirement age and retiring earlier. Then we have younger workers who come in and leave much more rapidly. That is not a great program. How we will invest in the needs of society in the twenty first century?

Mary: Part of that cycling in and cycling back out really has to do with compensation and on a more macro level how we think about the services that we provide to people and the value of services to society.

Dean Uehara: Exactly. I don't have great ambitions to influence the federal direction however, I do think that going back to the progressive environment we inhabit in this region allows us to work right now to think about how the schools get together and think about serious goals in raising and strengthening pay and career ladders for social workers. Could we actively have a campaign where we actually lifted the standing and public acknowledgement of what social workers do? That is a campaign we could handle. The school needs to put money in this direction and the dean and the school is committed. We need to partner with practitioners in this conversation.

Mary: Do you see other social work programs around the country doing similar kinds of things?

Dean Uehara: I do think it is really important for schools like Washington and Michigan and other places to take the lead and say we are recommitting to practice. We have to be serious about joining our hands, harmonizing our energies, preparing the very best generation of social workers and get over the turf wars. I am not a person that believes that no matter how much distribution of wealth you get that you can do away with suffering. So there is always a need in society for wonderful, fantastic social workers. We not only need to recognize, just like we do with education and other things, you have to recognize the need, the deep need society has for some or another form of clinical work. It is like education, people deserve this. That's part of my world. If macro folks want to work on a good world they should work on a world in which our relationships and our values are such that the clinical work is valuable. That each human being has that right to that kind

of (social work). God bless you if you don't need it but if you do, you have the right to wonderfully skilled clinicians to work to you. As a society we value and pay that person to do that work because the person that they are working with is so valuable.

Mary: Taking off on your ideas, I think it is incumbent upon those of us who do work in clinical practice, not only to work behind our closed doors but as well to know what's going on, and to advocate, and to be involved.

Dean Uehara: Exactly. And if you are working under conditions of society where your work is not valued that says everything about the people you are working with and that's not acceptable. That's outrageous. It gets back again to having a society that values those relationships, that values those people in those situations, and respects and honors those who do that kind of work because that existential something is real. Then you live in a society that is more just and compassionate. That's the society I want.

Mary: That seems like a wonderful note on which to pause our conversation. I say pause because I hope we can continue the conversation over the coming year and hear more about how the University of Washington School of Social Work is moving forward in this exciting endeavor. Thank you so much for sharing your time and thoughts with us.

Dean Uehara: Thank you for your interest. It has been my pleasure. ♦

LEGISLATIVE NEWS

Background on unlicensed independent mental health practice

BY LAURA GROSHONG, WSSCSW LEGISLATIVE CHAIR

[This article was adapted from an article written for Access, the newsletter of the Clinical Social Work Association. Used with permission.]

As most of you know, the Society supported a concerted effort to have educational and training requirements added to the registered counselor category this past legislative session. This effort will be continuing in the 2008 legislative session. Many questions arose about how other states handle the question of unlicensed mental health practice. This article will provide some background on the way other states have attempted to protect the public by requiring some standards for unlicensed independent mental health practitioners or prohibiting unlicensed practitioners from practicing independently and the meaning unlicensed practice has for clinical social workers.

There are growing numbers of unlicensed independent mental health-related practitioners, but these practitioners are "regulated" in only three states (Colorado, Maine and Washington). "Regulation" for unlicensed practitioners in these states is only a title registration with very little or no education and/or practice requirements. One reason this regulation is so limited is that unlicensed practitioners vary widely in their education, supervision, experience, and training. They generally, but not always, provide services which significantly overlap with those provided by licensed independent mental health clinicians, including clinical social workers.

When clinical social workers achieved licensure in all fifty states and Washington, D.C., in 2004—with social work licensure in Michigan—there was a sense of accomplishment within the profession. We could practice independently and were recognized as providing over 40 percent of mental health care in the country (CSWF, 2003). Today there are approximately 285,000 licensed clinical social workers today out of 370,000 over all (ASWB, 2006), roughly a 33 percent increase since 1997 (*SAMHSA Mental Health Report*, Section 4, Chapter 20, 2000). Today there are also approximately 300,000 other licensed mental health practitioners, including psychiatrists, psychologists, psychiatric nurse-practitioners, mental health counselors, and marriage and family therapists (extrapolated from SAMHSA report, 2000).

The provision of mental health-related services has grown exponentially in the past twenty years. A brief web survey shows there are now over 400 systems of psychotherapeutic treatment. About twenty therapeutic theories and methods, e.g., client-centered therapy, psychoanalysis/psychoanalytic therapy, family systems therapy, cognitive behavioral

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therapy, etc., are most commonly used by licensed clinicians. Unlicensed practitioners are more likely to use "alternative" or "wellness" theories and methods of treatment, e.g., life coaching, rebirthing, voice dialoguing, thought field therapy, spiritual counseling, etc. There are also some therapies that straddle the two groups such as hypnotherapy and relaxation therapy.

In general, unlicensed independent practitioners, including many independently practicing registered counselors, are not likely to be identified with the medical model. Unlicensed practitioners have no way to be reimbursed through third-party systems and work in a fee-for-service model of payment. They may also seek education and training outside recognized institutions. The question of whether independent practitioners who are dealing with the emotional well-being of clients should be educated, trained, and regulated is an important one. Clinical social work nationally has clearly answered yes to this question, as have other licensed mental health disciplines. Licensure is the best way, if not a perfect way, to identify clinicians who are qualified to provide mental health services.

The problem presented by the lack of practice standards and regulation for unlicensed independent mental health practitioners is twofold. Because there are no national standards of education and practice for many of the alternative methods used to treat emotional disorders, there is no way to adequately assess the quality of practice provided by these practitioners. Additionally, many unlicensed independent mental health practitioners do not have ethical standards that serve as guidelines for practice the way clinical social workers and other licensed mental health disciplines do. Therefore, the public is at risk because: 1) the unlicensed practitioner has a limited practice base in terms of ethical standards and knowledge of risk to clients, 2) limited knowledge of the scope of emotional disorders may lead to treatment which causes harm and/or is ineffectual, and 3) the state has no basis for regulating the unlicensed practitioner because of the huge variety of methods, education, and practice.

By far the largest identified group of unlicensed independent mental health practitioners exists in Washington. While there are over 18,000 registered counselors, who use this title by paying $40 and documenting proof of having taken a four-hour course in HIV/AIDS, approximately 6000 are providing some form of unlicensed independent practice (the rest are working in agencies under supervision or are pre-licensure candidates.) Approximately half of this group of 6000 have a master's degree in some mental health field but have chosen not to become licensed (extrapolation from Department of Licensure survey of registered counselors, June 2006). There is spotty information on what specific theory bases registered counselors use, what their goals are with their clients, and what standards might be considered to better protect the public, though there was much discussion of these issues in hearings during the 2007 Washington Legislative Session. Registered counselors are overseen by the Department of Health (DOH) and must abide by the Uniform Disciplinary Code of Washington (RCW 18.130), a general guideline for all 57 groups regulated by DOH in Washington, to prevent harm to clients, which is much less rigorous than clinical social work ethical standards of practice. Though registered counselors must give each client a disclosure statement at the first meeting including their level of education as a counselor and their training and experience as a "counselor," this has not prevented registered counselors from having an actionable complaint rate which is four times higher than that of LICSWs (8 percent RCs, 2 percent LICSWs, DOH Biennium Report, 2001–03). Complaints are investigated by DOH and prosecuted by the Attorney General's office.

Maine has 200 registered counselors who have less potential overlap with licensed mental health practitioners than those in Washington State do. The fee for becoming a registered counselor is $75. Registered counselors in Maine must give each client a disclosure statement in the first visit which says that the registered counselor is "not qualified to diagnose or treat mental health disorders." This means that registered counselors must define their work as different from mental health practice. Registered counselor oversight is through the Maine Department of Professional and Financial Regulation (DPFR). Complaints to DPFR trigger investigation and involvement of the Attorney General's Office. There has been consideration of eliminating the registered counselor category for the past two years in Maine ("License to Harm," *Seattle Times*, April 23, 2006) because the category is so hard to oversee and so small.

Colorado has a somewhat different regulatory category for unlicensed independent mental health practice. There are about 1400 unlicensed psychotherapists in Colorado

who are allowed to register with the Department of Regulatory Agencies, which has oversight through their Unlicensed Psychotherapists Grievance Board (CRS 12.43). Unlicensed psychotherapists may not be eligible for a licensed mental health category, e.g., clinical social work, psychology, mental health counseling, etc. The fee for becoming an unlicensed psychotherapist is $160. There is an open book examination on Colorado mental health laws that applicants must pass. The title of unlicensed psychotherapist does not "entitle an unlicensed psychotherapist to practice psychotherapy" but gives them a listing with the Unlicensed Psychotherapist Grievance Board, required by state law. The contradiction between the title and actual scope of practice is quite confusing. Complaints to the grievance board trigger investigation and possible prosecution by the Attorney General's office.

Most states and jurisdictions will investigate a complaint brought to the attention of a mental health licensure board by a consumer or licensee (in Washington this would be the Licensed Master's Mental Health Advisory Committee or the Department of Licensing.) Some states prohibit the practice of psychotherapy by unlicensed practitioners, e.g., Arizona, New York, and New Jersey. Some state social work boards can directly issue cease and desist orders and/or have the state Attorney General prosecute an unlicensed practitioner if such practice is brought to their attention, e.g., Delaware, New York, New Jersey, and Florida. Some states ignore unlicensed mental health practice and leave it to the consumer to figure out that there is no recourse if a consumer is harmed by an unlicensed mental health or "wellness" practitioner, e.g., California and Oregon. The only state that attempts to identify accepted theory bases for mental health practice is Colorado (which has 14 types taken from books written in 1973 and 1980.) In short, the practice of alternative or wellness treatments has outstripped regulation of these practices; the off-the-grid perspective of many alternative practitioners may include opposition to state oversight and regulation.

An interesting perhaps unintended benefit to seeing an alternative clinician may be that client information is better protected. Because all alternative mental health treatment is self-pay, client information is not submitted to health care databases. Additionally, many alternative clinicians do not use the DSM-IV diagnostic system which can "label" consumers with negative consequences for health and life insurance coverage.

Another interesting comparison between licensed and alternative unlicensed mental health treatment is that there may be some agreement about the flaws in the insurance and government driven need for evidence-based practice (EBP). Very few alternative methods meet the standard of random double-blind studies or see the need for meeting this standard. Many licensed independent clinical social workers in Washington and elsewhere share concerns about the use of EBP as the best way to determine the effectiveness of mental health treatment.

So … what is the meaning of unlicensed alternative mental health practice as conducted by registered counselors who practice independently to licensed independent clinical social workers? LICSWs have an interest in making sure clients have access to ethical mental health treatment from qualified clinicians. LICSWs can take a stand about the importance of developing standards of practice and regulations for alternative independent mental health practice to protect the public. Knowing our own state laws on alternative mental health practice is an important component of being an informed mental health professional. From a social work perspective, there may be some correlation between the attitudes of alternative practitioners and generalist social workers, but that is another article.

To summarize, the standards for and practice of registered counselors may be harmful to the public, as there are no clear educational, training, experience, supervisory, or ethical standards. LICSWs in Washington should consider how the existence of registered counselors affects us as a profession and as individual clinical social workers. Allowing the registered counselor category to continue as it currently exists is at odds with the practice standards of all other states and clinical social work standards of mental health practice. The Society will continue to work on implementing requirements for registered counselors for the good of the public and of qualified ethical mental health practice. ♦

interfaces

FAQs about mental health parity in Washington

BY LAURA GROSHONG, WSSCSW LEGISLATIVE CHAIR

As of March 30, 2007, almost two million Washington citizens will be receiving mental health parity in their insurance benefits through two groundbreaking pieces of state legislation. The initial parity law, passed in 2005, covered the insurance plans of large businesses (over 50) that are not self-insured. This year's parity law covers small business and individual insurance plans. These frequently asked questions on mental health parity will identify what Washington's mental health parity laws mean in practical terms for clinicians and patients.

Why did Washington need to pass two mental health parity laws?

There are different insurance markets and the first law (2005) only covered one market—large business (over 50 employees) insurance plans. The law passed this year (2007) covered the rest of the state-regulated markets, i.e., small business and individual insurance plans.

When do the mental health parity laws go into effect?

The parity laws are being "phased in." The first phase took place on January 1, 2006. The next phase will occur on January 1, 2008. The last phase will start on January 1, 2010.

What was the first phase of the Washington mental health parity law?

The first phase, implemented on January 1, 2006, applied to non-self-insured plans for businesses with more than 50 employees, all state employee health plans offered by the Public Employees Benefits Board, and the Washington State Basic Health Plan. This phase required all plans to include a mental health benefit and that copays be equal for mental health and medical/surgical benefits. This phase will also be applied to small group and individual plans as of January 1, 2008.

What is the second phase of the Washington mental health parity law?

The second phase, to be implemented on January 1, 2008, will apply to all non-self-insured plans in Washington and will require equal annual and lifetime limits of coverage and equal maximum out-of-pocket expenses for mental health and medical/surgical benefits. In addition, all payments for mental health services will apply to the total deductible for a given plan as well as payments for medical/surgical benefits.

What is the third phase of the Washington mental health parity law?

The third phase, to be implemented on January 1, 2010, will apply to all non-self-insured plans in Washington and will require: 1) a single deductible amount for all services in a given plan; 2) the removal of arbitrary limits on mental health benefits, i.e., outpatient sessions/inpatient days, which are not applied to medical/surgical benefits; and 3) coverage of all diagnostic categories in DSM-IV-TR (or future versions) with the following exceptions: V-Codes, sexual dysfunction disorders, adjustment disorders, court-ordered treatment, residential treatment, custodial care, skilled nursing facilities, and home health care. The formula for comparing mental health and medical/surgical benefits is still under development. Substance abuse disorders are not included in the mental health parity laws, but are covered by the Division of Alcohol and Substance Abuse (DASA.)

Are there any other limitations on how mental health disorders are covered by the new mental health parity law?

Yes. In addition to treatment being available only for covered diagnoses in DSM-IV-TR, an insurer has the right to decide if treatment is "medically necessary," but must make such determinations in the same manner for medical/surgical and mental health benefits.

Does the mental health parity law have any requirements for how much mental health clinicians are reimbursed?

No. Reimbursement schedules are set by insurers. For mental health clinicians, the reimbursement formula is generally the same as that for Medicare, e.g., for the CPT code 90806, and office visit of 45 to 50 minutes, psychologists are reimbursed at 75 percent of what psychiatrists are reimbursed and licensed master's clinicians (LICSWs, LMHCs, and LMFTs) are reimbursed at 75 percent of what psychologists are reimbursed.

What major groups are not covered by Washington's mental health parity law?

The major plans not covered include Medicare, Medicaid, Tri-Care, and the Federal Employee Health Benefits Program.

What agency has oversight for implementation of the mental health parity law?

The Office of the Insurance Commissioner has oversight for implementation of this law. The current Insurance Commissioner is Mike Kreidler.

What can clinicians or patients do if they find a plan is not complying with Washington's mental health parity law?

Clinicians or patients can call the Washington State Office of the Insurance Commissioner, Consumer Assistance Referral, for assistance at 1-800-562-6900 if a plan does not seem to be in compliance with the mental health parity law.

National parity legislation

Can Washington's mental health parity law be changed by Federal mental health parity laws?

Yes, if a law passed by Congress "preempts" state law. Traditionally insurance laws are overseen state Insurance Commissioners and created by state legislatures. Occasionally Congress will override state laws in some areas and could do this for mental health parity.

Are there any current bills in Congress which pose a threat to Washington's parity law?

Yes, S-558 in the Senate would make mental health parity a mandatory offering, not a mandatory benefit, and would require states to have the lower coverage standards which are in the bill instead of creating their own laws on mental health parity. There are eleven states whose laws would be weakened by S-558, including Washington's — one of the strongest parity laws in the country. Almost as many states would improve their current weak or lack of a mental health parity law.

The Washington Coalition for Insurance Parity, a multidisciplinary and consumer organization that had a major role in passing the 2005 and 2007 mental health parity laws, is working hard with the help of Senators Murray and Cantwell to prevent national laws from lowering the parity standards in Washington. Some clinicians in Washington may find themselves at odds with their national organizations, many of whom support S-558.

A better option for Washington is HR-1424, a House bill that would not preempt state laws and will also provide a parity "floor" for states that do not have a mental health parity law.

Questions?

Contact me at *lwgroshong@comcast.net* or 206-524-3690. ♦

conversations

How can generalist and clinical social workers get along?

BY LAURA W. GROSHONG, LICSW

[This article first appeared in Social Work Today—Point of View *(March/April 2007). Used with permission.]*

Through the course of my work on social work licensure, which took me to more than thirty states, I have repeatedly encountered differences between the generalist and clinical views of social work. These differences, not surprisingly, affect the way each group views state social work title and practice regulation. In my experience, generalist social workers have most commonly made title protection of the term social worker a national priority. Clinical social workers have made practice protection their primary goal.

Two other factors to consider in understanding these differences are: the impact of the widespread exemption from regulation of state "social workers" and the drastic cutbacks in clinical social work coursework in schools of social work. Finally, there is the question of what the difference in scope of practice should be for baccalaureate-level social workers (BSWs) and master's-level social workers (MSWs) in generalist and clinical social work practice.

The terms social worker and clinical social worker often reflect different views about what social work is and should be. Paradoxically, as schools of social work have, for the most part, dropped the clinical social work courses which were common in the '60s and '70s, clinical social workers have become a major part of the mental health treatment system. In various polls, 40 to 60 percent of practicing social workers see themselves as doing clinical social work. But many states are seeing legislative disagreements regarding what generalist and clinical social workers do—i.e., what is the same and what is different? And why does a field that prizes diversity in all forms have difficulty accepting the diverse ways social work is practiced?

Common ground or different strokes?

One thing that makes social work unique is the principles that underlie any practice of social work—i.e., respect for the humanity in everyone, respect for the diverse forms our humanity takes, respect for self, and the ethical underpinnings on which social work is based. This is not a model for practicing generalist or clinical social work: it is a value system. Unfortunately, these principles have become grounds for denying that there are differences in education, training, background, and experience among social workers, which are real and must be understood and accepted.

The practices of what have become generalist and clinical social work are based on different interpretations of basic social work values and how to apply them. The split between Jane Addams, with her view of social workers as "friendly visitors," and Mary Richmond, with her view of social workers as "social caseworkers," during the early years of professional social work has never really healed, for good reasons. The kind of social work Addams espoused was a direct service model, which was based on protecting and providing basic services for those who could not protect or provide for themselves. An additional goal was to advocate for better living conditions through social policy/legislative changes. The inner lives of clients were not addressed directly. Richmond, on the other hand, tried to understand the emotional worlds of her clients, sometimes minimizing what they needed in terms of external support.

It may be that Addams and Richmond were looking at different clients with different needs. Clients who are literally unsafe, whose lives are unpredictable, and who are unstable internally and externally are different from

clients who feel unsafe, insecure, and unstable, but have an income, food, and shelter. Both groups are in need of service and should be respected by generalist and clinical social workers. This may mean both groups need to expand their view of what social work practice means—a difficult task.

Generalist social work identity

Most who consider themselves generalist social workers have a strong commitment to social advocacy, justice, and policy but do not include clinical skills as a major part of their identity. Most generalist social work is done in private or state agencies, including most of the services case managers and caseworkers provide. There is resentment in generalist social work regarding the amount of paperwork required to coordinate and document services, which is obviously not the reason most people follow this path.

The public perception of generalist social work is often negative, leading to further frustration. The fact is that generalist social work is often being done by bachelor-level people who have no social work training. The divorcing of social work education, generalist social work titles, and generalist social work practice is a hill that is hard for generalist social workers with a social work degree to climb.

Many generalist social workers believe they are losing the battle, through exemptions, to link social work education and generalist social work practice. This perspective is validated by statutes that allow untrained caseworkers and case managers to provide direct services independently. Many in the public sector who view themselves as generalist "social workers"—in child protective services and foster care services—often have no social work training and reflect a point of view that social work training, including clinical skills, is not needed to make assessments in these difficult areas. Since many "social workers" in these areas do not have any social work training, the question of what education and training are needed is compounded.

Clinical social work identity

Clinical social workers are committed to providing mental health services to their clients through various treatment modalities and theoretical orientations. They see themselves as one of the six major mental health specialists, including clinical social workers, marriage and family therapists, mental health counselors, advanced registered nurse practitioners, psychologists, and psychiatrists. Most work in private practice or supervisory positions. While most clinical social workers have a basic commitment to social advocacy, justice, and policy, their primary interest is in providing mental health treatment as clinicians. The acknowledgement of generalist social work practice by clinical social workers has been largely reactive—i.e., when generalist social workers seek to legislatively define social work in ways that impact clinical social work practice negatively, they respond to protect their scope of practice. Otherwise, there is not much discussion in clinical social work regarding the way generalist and clinical social work share common ground or work together.

Clinical social workers have worked diligently to become independently licensed over the past forty years and have established scopes of practice, educational, experiential, and supervisory standards in all fifty states and Washington, DC, as of 2005. Identifying the clinical elements of casework and case management has not been a priority for clinical social workers.

The practice of clinical social work may include private practice and the provision of clinical supervision. As in generalist social work, there is resentment in clinical social work about the paperwork required, often for reimbursement, and most do not see triaging, finding services to meet daily needs, or coordination of services as part of their work. Clinical social workers often feel alienated from generalist social workers because clinical skills are not included and/or valued as part of generalist social workers' skill set. Many clinical social workers also have a commitment to maintaining the "frame" (as defined by Robert Langs) in treatment, which means avoiding doing things directly for the client and focusing on the client's inner world and the therapeutic relationship itself. This approach to social work is difficult to maintain in casework and case management—i.e., child protective services, foster care services, etc. However, other applications of clinical social work in these areas could be better defined and developed.

Schools of social work

With a few exceptions, clinical social work as part of social work training in schools of social work, at the BSW or MSW level, has diminished widely over the past twenty to thirty years. Currently, the 142 schools of social work, with oversight by the Council of Social Work Educa-

tion, have a much greater interest in promoting the advocacy and social justice, or generalist, side of social work education at both the BSW and MSW levels. The disconnect between clinical social work as the primary type of work social workers wind up doing and the lack of clinical social work training in social work education is beyond the scope of this paper, but it is a factor in the communication problems faced by generalist and clinical social workers.

Summary

To resolve the disagreements that exist between generalist and clinical social workers, many issues must be considered, including overlapping scopes of practice, state exemptions of social work education and training for social work positions, differences in scope of practice at the BSW and MSW level for generalist social workers, and regulatory ambiguity regarding definitions of generalist and clinical social work practice. I propose some questions whose answers may help us find ways to resolve the existing communication problems.

Questions to consider

Do clinical and generalist social work have areas of commonality in scope of practice?

The question of whether generalist and clinical social work overlap is an important and disputed one. Florida, for example, has social work licensure laws that put clinical and generalist social work under two different statutes. While these laws avoid the attribution of advanced clinical skills to BSWs, they also create an artificial division between casework and clinical social work. An acknowledgment of the clinical elements in casework and case management and the need for clinical supervision when casework is being performed by BSWs should be considered.

Do BSWs who practice casework or case management need clinical social work skills?

There is disagreement about whether the scope of practice for BSW practice, in case management and casework, should include clinical social work components. An additional issue is whether or when BSWs are qualified to practice independently.

Are clinical and generalist social work both part of the social work field, or are they separate professions?

The differences between generalist and clinical social work are significant. The "field" of social work may in fact be a set of values that does not have specific forms of practice. The poorly defined regulations covering social work practice may reflect the fundamental lack of a workable base for social work practice.

I hope raising these questions will help both generalist and clinical social workers in finding common ground and ways to respect and accept each other's point of view. ♦

MARKETPLACE

kudos

WSSCSW lobbying emails and phone calls — 2007

BY LAURA GROSHONG

I would like to thank the following Society members who have responded when I put out legislative alerts this year. It was a very busy year and your support helped give us the success we have achieved. I am only able to include those who let me know they have responded, which has been very helpful. Members marked with an asterisk* have responded more than once:

Audra Adelberger*
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Audrey Shiffman*
Steve Siefert*
Carrie Smith*
Robin Westby
Deborah Wooley*
Sal Ziz*

My gratitude to all of you is unbounded. I hope anyone who I missed will let me know. Our having the ability to make quick responses to legislative issues is a crucial piece of our legislative success.

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- Thanks for getting involved and supporting your society!
- Many exciting opportunities still abound!
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