WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

Fall 2014

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From the Desk of the President

Changes in the Road

By Ann DeMaris Davids

I was on a road trip recently, taking my youngest son to college in Minnesota. We saw a lot of great sights on the way: Mt. Rushmore, the Crazy Horse Memorial, the geysers and animals in Yellowstone Park, the Badlands, Wall Drug Store, and even a huge statue of the Jolly Green Giant in Blue Earth, Minnesota. I had a lot of road time for some quiet contemplation, and what came to mind was the work of Lewis and Clark, the team that was tasked with mapping the Northwest Territory by President Jefferson. I realized that there have always been explorers who have gone ahead and mapped new territory for the settlers who followed after. It occurred to me that we might be in a time where our maps are being revised, reworked and maybe even, in some instances, redone.

A lot of my road trip consisted of wide open expanses of land...open stretches where we could see very little except an occasional cluster of farm houses. Some of my ancestors made this journey, taking part in the pioneer/settler dynamic. But that was way back when. When I become comfortable using a trusted map, it is very unsettling to realize that it has become outdated. Our profession has experienced changes over time, such as licensure, mental health parity and more recently, the Affordable Care Act (ACA). When we're asked because of changing circumstances to deal with a new map-making activity, we may have to dig down inside ourselves to find the courage to neither shrink in fear nor swim away in denial, but rather to participate with the changes and discover how we can have a voice in helping to make the new map.

One of the characteristics of change that necessitates a new map is that it happens regardless of whether or not we are ready and desirous of participating in it. Even if you don't download the latest info for your GPS, you are still going to be facing changes in the road. I have never thought of myself as a political person but here I am. I accepted the presidency, thinking of it as not being so different from other leadership roles I've had - but the Society has an important voice in helping to shape what our future as Clinical Social Workers will look like. I've had my letter on mental health parity accepted by the Seattle Times for publication, something I scarcely could imagine prior to becoming your President. The choices we face are not about whether we will but HOW we will interact with the changes, and what will our voice sound like as we participate in shaping the future.

This shaping will need all levels of support in time, energy, creativity, money. Thank you for continuing to pay your membership dues and donating to lobbying and MH-PAC. We need you all to participate in any and every way you can in our efforts to harness the winds of change so that they power well the work of the future.

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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 professions to mid-range, seasoned, and retired citizens.

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.

Editor's Note

We're pleased to present a variety of topics in this issue, and we expect the articles will be food for thought, as David Parnes suggests in his article comparing the Slow Food movement and fast food to current trends in mental health treatment. There's more food for thought in Jill Dziko's article, a passionate call to action that stems from personal experience but tackles a huge subject — racism. It's a topic we all struggle with and often find hard to discuss. Another area many of us find difficult to discuss openly, the monetary value of social work, is explored in a very comprehensive article by Andrew Bryant.

Laura Groshong's incisive review of how the rise of "evidence-based" practice is impacting our profession originally appeared in the Clinical Social Work Association's national newsletter, **Access.** The newsletter is a perk of membership to the CSWA, the "National Voice of Clinical Social Work." In a separate article about in-network versus out-of-network payments to providers, Laura helps those of us who are struggling with reimbursement in an Affordable Care Act world.

Denise Gallegos, co-chair of the Membership and Diversity committee, has written about the new scholarships our society has created to advance diversity in clinical social work. We think you'll be very impressed by the accomplishments of this years' recipients.

There are important questions raised by the articles in this issue. We invite you, as interested readers, to continue the discussion today. Our listserv provides an open forum to initiate and join discussions, to thank authors for sharing their thoughts, and to hear what fellow members have to say on topics that matter to each of us. We invite you to post your thoughts on the listserv about articles that get your juices flowing.

We encourage every member to consider writing for the newsletter. Short or long, serious or light, we look to represent the diversity of our membership in these pages. How about submitting your thoughts on a clinical issue that comes up in your practice, or a movie or book review — or maybe a social work-themed poem? As Ann says in the President's letter, we are all subject to changes and we each must grasp opportunities to participate in them.

Finally, we encourage anyone with an interest in editing to get in touch — extra eyes are essential before we publish. That can entail as little as a few hours every three months. And if you have ideas for improving the newsletter, let us know. Email Lynn at Wohlers13@gmail.com or Sara at saraslaterlicsw@gmail.com to inquire about the Newsletter committee.

Lynn Wohlers and Sara Slater

WSSCSW newsletter is mailed quarterly to members of **WSSCSW**.

Classified ads are $10 for every 25 words, $20 for 50 words, etc. Articles and ads should be emailed to Lynn Wohlers at wohlers13@gmail.com.
Newsletter design: Stephanie Schriger, stephanie@designandgraphics.biz

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

Advance Diversity Scholarship Recipients

By Denise Gallegos Leavell, MA, MSW, LSWAIC

In the pursuit of our commitment toward diversity, the Board of the WSSCSW has taken a concrete step to address the disparity between the number of clinical social workers identifying as minorities and clients identifying as minorities. One step toward this goal was to establish two $1000 scholarships for Students of Color working on their MSW degree at the University of Washington. This years' recipients were chosen from a competitive field of worthy applicants. Alan Wong and Jennifer Given Helms have shown their commitment to social work through their educational pursuits, as well as significant social work experience in the field. In addition to financial assistance, they will receive mentorship and networking opportunities within the WSSCSW. This will include attending professional development events and personal support from the Membership and Diversity committee as they complete their social work education.

Alan received the attention of the committee describing his first practicum at Youth Eastside Services, which allowed him to develop counseling and clinical skills working with youth experiencing interpersonal violence, homelessness, and deep mental health challenges. His ability to draw on his own experiences as a person of color from an immigrant family was critical in building alliances with youth from similar backgrounds, who often leave therapy pre-maturely, as they do not feel understood. Jennifer struck us as a caring, knowledgeable advocate for those facing life-ending illnesses. Her dedication to social work in general, and the needs of those receiving palliative care, along with their families, was evidenced by her own personal experience and the fact that she works full time while attending the University of Washington. She also is engaged in practicum at Massey Counseling where she practices one to one counseling and facilitates support groups for children who have lost parents to suicide or cancer.

Alan Wong is a life-long Seattleite who has dedicated his life to service, creativity, and social change. Growing up as part of a multi-racial family in South Seattle, Alan has been committed to bringing diverse cultures and communities together since his early days. His Chinese name, 平 "Peng," means "peace" and "balance" — qualities he strives to embody himself and share with the communities he serves.

Alan Wong

Jennifer Given Helms

Alan attended Denny Middle School and Garfield High School in Seattle before heading to Olympia to attend the Evergreen State College. After graduating from college Alan worked as a reading tutor at Sanislo Elementary School. The following year he began working with the innovative arts-empowerment and education organization, Power of Hope, where he served for many years. Alan is currently building on the facilitation and non-profit leadership skills he's already developed by working towards an MSW with a focus on clinical social work.

In addition to his empowerment and service work, Alan loves to make music, write poetry, practice meditation, and cook creative cuisine.

Jennifer is in her third year of the UW MSW Extended Degree program and will graduate with her Master's Degree in Social Work, Integrated Health/Mental Health Concentration this coming June. She also received a Master's in Education from the University of Washington in 2006. Jennifer has over fifteen years' experience working with children and young adults, with a specialty in supporting youth through life transitions. She chose to pursue her MSW to go into the field of palliative care. Jennifer is especially passionate about working with those who are facing end-of-life or life changing illness and their loved ones, and people grieving the death of a loved one.

Last summer Jennifer interned at Gilda's Club, facilitating a group for parents living with cancer, assisting with family programming, and taking the lead for Camp Sparkle Tacoma. This year for her Advanced Practicum she is working at Massey Counseling, facilitating support groups at Cancer Lifeline and The Healing Center, and staffing the monthly Harmony Hill Extended Cancer Retreats. She sits on the board of the UW Palliative Care Center for Excellence, is assisting with planning the National Association of Oncology Social Work Conference, and recently received a scholarship to attend the 2015 Social Work Hospice and Palliative Care Network Conference.

Outside of work and school, Jennifer loves to spend time in the trees, practice yoga, garden, cook, read, and travel. She has plans to go to Paris and Iceland next summer. She also co-parents a 13-year old son, which keeps her weekends pretty busy.

Please join us in celebrating their achievements and welcoming them as soon-to-be peers in clinical social work, and to WSSCSW.

What's the Worth of Our Work?

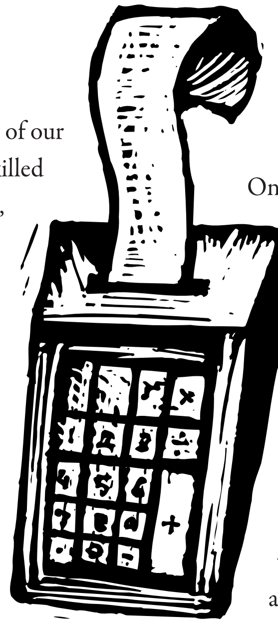
By Andrew Bryant, LICSW

Earlier this year, the Seattle City Council passed a $15 minimum wage, to be implemented gradually over several years. This means that soon, Seattle's minimum wage will be within a few dollars of the starting wage for master's level clinicians providing mental health care at many local agencies.

Why are social work salaries at agencies so low, even while hospital social work positions are competitive; and private practice rates start out at 5 or 6 times the level of hourly wages at agencies? While this situation is frequently lamented in our field, there is little research or writing out there that provides a clear explanation. Nor do we seem to be doing much to change the situation.

Money is a touchy subject in our field; in some cases, almost taboo. Are we supposed to want it? Or are we doing this work for a higher purpose? Are we supposed to make a living? Can we get rich, or just get by? At my graduate school, the words "Private Practice" were spoken with disdain. Its "for-profit" nature was considered by many to be antithetical to the foundations of the field. Meanwhile, it was essentially a given (sometimes even a source of pride) that we would be paid poorly. One fellow social worker told me he was regularly praised at staff meetings for the nobility of his work. Nobility and sacrifice are part of our professional identity.

There are many reasons to advocate for better compensation, besides just wanting more money. Low pay affects how other professionals and the public view our profession; and it affects how we perceive the value of our own work. It keeps potentially skilled clinicians from entering our field, and it drains clinicians away from agency-based work in favor of private practice, and away from direct-service work in favor of supervision and management positions.



Michael C. Barth, in "Social Work Labor Market: A First Look" [1] offers three explanations for low social work compensation relative to other professional fields. First, he notes, social work positions are often held by non-social workers. Second, social workers have a "taste", or inclination for their work, even in the face of low pay. "The desire to be a social worker," Barth notes, "may be so strong that career earning differences will not have a strong effect in drawing people out of social work. It might be said that, for social workers, mission trumps money." Third, budgeting constraints simply do not allow wages to rise, even in the face of high demand for our labor.

Irene Y. H. Ng took a second look at the topic with "What if Social Workers Were Paid More?" [2] Ng uses the "Compensating Labor Differential" model from labor economics to explain how low agency funding, and thus low wages, affect us. While a social worker with passion and altruism, Ng writes, is "more valued than one with less passion and altruism, that passion is hard to sustain when there is more competitive demand for that passion from other sectors that can pay more."

One "other sector" that pays more is private practice. There are various reasons social workers enter private practice, but money plays a part. At least, it did for me. When I moved back to Seattle in 2011 with an MSW and two years of experience in hand, I jumped straight into the job search at local agencies. I wanted to work with and learn from peers and supervisors in a dynamic setting. I was offered a position that I would have enjoyed and been good at but the salary offered was less than $17 an hour. Out of some combination of pride, principal, and a need to pay my bills, I declined the offer. I did so not out of greed or ill-will, but with a sense that I was selling myself and other social workers short by valuing my skills so lowly.

Two months later I decided to open up a private practice. I love the freedom and responsibility of working for myself. But I look back on that "job I almost took" at the agency as a missed opportunity for myself, for the agency and for its clients. My own experience was an example of a broader problem with ramifications for our entire profession, and for the people we help.

It's easy to point to lack of funding for social services and throw up our hands. After all, if there's no money, there's no money. But I believe that there are other factors, internal to our profession, that contribute to low wages. After all other fields, like nursing,

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serve similar populations. Why have we as a profession been particularly unable to advocate for higher pay? Besides the tendency towards sacrifice over self-advocacy, I think another reason is the chasm between the world of agencies and the world of private practice. While social workers in agencies have an interest in pushing for higher wages, private practice social workers are more likely to push for advocacy around licensure and insurance reforms. So at least on the surface, interests and priorities may be somewhat divided within our field.

Another possible explanation is the process of promotion, from direct service to supervision to management. Clinicians become supervisors or managers, opening up direct service positions to new grads looking to get experience and licensure hours. This creates a sort of revolving door of new clinicians who are anxious to get hours for licensure, regardless of pay. The result is a limited contingent of clinicians with a strong interest in improving base salaries.

Never having worked in the budgetary realm of a social service agency, I don't know what flexibility there is in setting salaries. But I wonder if we need a new model for how budgets are set. I'm reminded of a NYC charter school, TEP Charter, in the news a few years back for paying its teachers $125,000 (twice the national average) while holding the principal's salary at $90,000. This was a clear statement of priorities, and based on recent school assessments, it paid off. What would happen if agencies paid direct-service clinicians more than supervisors or administrators? I'd be curious to see.

Of course, there is only so much wiggle room within current budgets, and we need political advocacy to increase funding. Some of this is happening, if on a limited basis. The NASW has proposed a Social Work Reinvestment Act in the U.S. House and U.S. Senate, seeking to set up a commission to investigate how to improve salaries, among other issues [4]. Recently, the New York chapter of the NASW proposed a lower limit of $55,794 per year on annual salary [5]. Unionization for collective bargaining is another option. Scanlon and Harding (2005) discuss the history of social worker unionization, including the successes and challenges of social work organizations partnering with unions like the OPEIU.

Clearly there are significant cultural, legislative, organizational and public relations hurdles to overcome if we are to see wages rise. But the first step is always to ask the right questions, and not take the status quo as a given. Let's hope that the exciting raise in Seattle's minimum wage will inspire a sense of righteous indignation in our own profession around how our skills are valued, and motivate us to demand a more reasonable and respectful compensation for our labor.

REFERENCES

[1] Barth, M.C. Social Work Labor Market: A First Look. Social Work. 48(1), 9-19.

[2] Ng, Y.H. What if Social Workers Were Paid More? Social Work Administration. 34(4), 351-360.

[3] TEP Charter website. http://www.tepcharter.org/philosophy.php

[4] Social Work Reinvestment Initiative website. http://www.socialworkreinvestment.org/

[5] NASW-NYC, "Guidelines for Minimum and Equitable Social Work Salaries. December 11, 2013. Online at: http://www.naswnyc.org/?25

[6] Scanlon, E. and Harding, S. (2005) Social Work and Labor Unions. Journal of Community Practice, Vol. 13(1).

We invite you to respond to the author's ideas and continue the discussion on the listserv.

Certificate Program in Clinical Theory and Practice

October 20 14 – May 2015

Wellspring Family Services has offered the Certificate Program in Clinical Theory and Practice- a 100-hour program in adult psychodynamic theory and practice- since 1991. The program's content is practical and applied through the use of teaching cases. The major influences on clinical practice and an understanding of human development are integrated to provide a comprehensive learning experience. 100 hours of continuing education credits are available which also apply to Associates' CE mandates (approximately 20 of which count towards supervision requirements). For more information: www.wellspringfs.org or Roberta Myers (LICSW, BCD), Program Chair, 425 452-9605

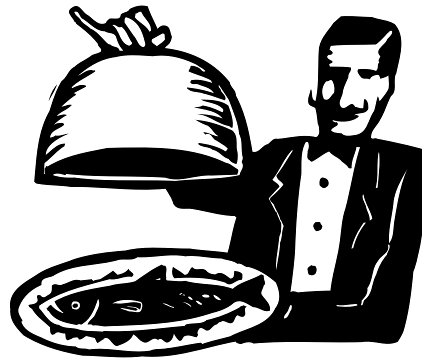
The Slow Food Movement and Mental Health

By David Parnes, LICSW

The Slow Food Movement began in 1986, with a protest against the opening of a McDonald's restaurant in Piazza di Spagna in Rome. The movement was, in part, a backlash against fast food and industrial food production, as well as a call to return to traditional forms of gastronomy and food production. Much has been written in the last decades about how fast food has a deleterious impact on the individual consumer as well as the environment and other macro-level systems. Fast food is indeed fast, cheap and plentiful, but not necessarily good for you. True, one can survive on fast food, but one does not thrive.

One might argue that I am being a nag. They might rebut, "Fast food is convenient and tasty. And be realistic: we live in a fast-paced world." And although these statements are true, they are specious arguments, driven by capitalism, which is indifferent to the nutritional, emotional and aesthetic needs of human beings. Maintaining a fast pace is good for capitalism; a slow pace is not productive. Sharing a home-cooked meal with friends and family is good for the body and the soul, but not for the industrial food complex.

My point here is not to advocate for the Slow Food Movement, but to draw a comparison to the ways in which mental health services are, more and more, being driven by forces similar to those that propel the fast food industry. As a result, the "consumers" and the providers of mental health services are being pushed to adopt a fast and cheap approach to mental health. And here, let me be clear: I believe that psychotropic medications and brief treatments have an important place in the therapeutic pantry. But, as a purveyor of slow therapy, I'm concerned that economic forces



are devaluing what we offer and misleading the public into believing that fast and cheap is all there is… and all they need.

As a child therapist, I often see kids whose parents are so busy that they don't have time or energy to attend to their child's emotional needs. Without the help needed to digest their emotional experiences, these children come to my office showing signs of emotional indigestion. As well, I see an adult patient, a doctor, who feels, under the stress of an increasing caseload, that she can't be both an attentive parent and a good doctor. She worries that in leaving the office in time to spend the evening with her kids, she is not giving herself enough time to review her work and will make a fatal error. In both examples, we can see the impact of our pressured society on the emotional lives of our patients. Of further concern is that mental health providers are being pressured in similar ways, leaving our patients feeling that there is no one available to meet their emotional needs.

The Slow Food Movement expanded over the decades, leading to a "slow movement" in other cultural and artistic arenas. The adoption of a slow movement in so many disciplines can be understood as a response to the harried, "faster is better", inhuman pace of our industrialized world. I suppose I'm advocating for a Slow Therapy movement, to counteract the quick fix approach to mental health that is so endemic. And really, it's not a matter of going slowly. It's about taking time. Going at a human pace. Respecting the emotional needs of our patients. And understanding that growth and healing occurs, over time, through consistent therapeutic contact with another human being.

In writing this brief essay, my intention was not to present a manifesto or a diatribe. Perhaps it is a rallying cry. Certainly, it comes from a deeply held belief in the psychoanalytically-oriented tradition of psychotherapy and my interest in upholding and preserving that tradition. I hope my words will be food for thought.

We invite you to respond to the author's ideas and continue the discussion on the listserv.

NEW MEMBERS

Julie Ambrose
Tara Barnard
Laura Betts
Karen Buckley
Christine Caldwell
Robin DeBates
Lisa deFaria
Sarah Frey
Jennifer Given-Helms
Matthew Gockel
Emily Gurley
Sabina Neem
Jennifer Palau
Laura Phillip
Jodi Rubinstein
Frances Schopick
Cynthia Shaw
Joan Ward
Megan White
Alan Wong

The Membership and Diversity Committee welcomes an extraordinary number of new and returning members over the past several months. We're excited to have you! Look for profiles of new members in the next newsletter.

"Evidence-Based Practice" and "Relationship-Based Practice" Paradigms

By Laura Groshong, LICSW

The rise of "evidence-based practice" (EBP) based on the work of David Sackett and others in "evidence based medicine" (EBM), represents an attempt to apply mental health research to mental health practice on strategies for solving mental health problems. The basis for EBM was a stronger tie between research and practice, so that medical practices could be justified through the most rigorous research available. Medical procedures have been readily tested in randomized controlled trials (RCTs) and double blind research tests.

Mental health treatment, however, does not lend itself as readily to these types of research models. Mental health "procedures" are not comparable to medical procedures. Both may have goals of symptom relief and curing of underlying conditions, but the relationship itself is seldom the agent of cure in medical procedures. This paper will question the validity of the EBP paradigm, which assumes that mental health patients improve because therapists use researched techniques and procedures, not because of the healing relationship between patient and therapist. While this paper recognizes the importance of medications as a component of mental health treatment for many patients, the focus will be on the interaction between the patient and therapist and whether emotional healing occurs through a "directive distance" or "mutually engaged" relationship between the patient and therapist.

The type of mental health treatment that is most useful to a given patient will depend on four factors. These include: 1) the degree of emotional development that has occurred prior to treatment, including the capacity for attachment, autonomy, and self-regulation; 2) the physiology and neurology of a given patient, or "hard-wired" physical, including brain, functioning; 3) the patient's subjective experience of his or her own body and emotions, including the capacity for, and prevalence of, pain; and 4) the patient's capacity to accept new emotional experiences with others (Mauer, B. "The Four Quadrant Model and Evidence-Based Practices", Report to the National Council for Community Behavioral Healthcare, 2003.) Generally, the lower the level of emotional development (1) and the higher the level of "hard-wired" physical problems (2), the higher the chances of serious mental disturbance will be. However, the patient's disturbed view of self (3) and others (4) can also create serious emotional disorders, which may or may not interfere with a patient's ability to function successfully in the world.

The more disturbed the patient, the chances are that the patient will have more difficulty engaging as a participant in the therapeutic relationship. All therapists need to be directive if the safety of the patient is at risk, but a directive approach interferes with the development of an emotional attachment in the patient/therapist dyad where both patient and therapist are participants. There is a parallel between healing in nursing as described by Jean Watson and Carol Montgomery, and the mutually engaged healing in mental health treatment. A quote from Watson on "relational communication" illustrates this similarity: *"Relational communication focuses on analysis of a relationship rather than of the individual during a given communication, i.e. the communication is the relationship. An understanding of the report aspect and the command aspect is necessary to the understanding of relational communication. The report aspect is the content of the message, the command aspect deals with the relationship between the parties communicating. For example, a clerk in a hospital might ask a patient for their insurance card. While the content of the message is clear, the clerk and patient will also begin a process of communication which will influence how the patient feels about the care institution."* (Watson, J. (Ed.) (1994). Applying the art and science of human caring. NY: National League for Nursing)

EBP necessarily deals with the "report aspect" of the relationship between patient and therapist. Relationships are not what is being evaluated in most research, or the impact of the relationship on the patient's emotional disturbance. This problem was noted in the *Journal of Consulting and Clinical Psychology* in 2003 that "deciding which therapy to use for a client should entail more than just picking the therapy with the most documented research support" ("Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression." By Watson, Jeanne C.; Gordon, Laurel B.; Stermac, Lana; Kalogerakos, Freda; Steckley, Patricia. *Journal of Consulting &*

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Clinical Psychology. August, 2003, Vol. 71(4) 773-781.)

Why have relational communications been discarded in considering public mental health policy? Mental health treatment is harder to fit into the public sector than physical medicine because the relationship models of treatment are less amenable to research which can delineate best practices than physical medicine. EBP has apparently given public policy a way to integrate mental health treatment and public policy by focusing on the "report aspect" of what is being communicated and codifying this communication. However, according to one author, EBP "will falter on organizational and epistemological barriers", i.e., the loss of the "command aspect" or what is being communicated emotionally by the patient and therapist ("Evidence-Based Practice in Mental Health: Practical Weaknesses meet Political Strengths." By Tanenbaum, Sandra. *Journal of Evaluation in Clinical Practice,* May, 2003, Vol. 9, Issue 2, p. 287.)

The standards of accepted mental health practice as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA, 2003) have three other ways of identifying methods of treatment. They are (including EBP) as follows:

- ***"Evidence-based practices"*** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.
- ***"Research-based practices"*** means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.
- ***"Consensus-based practices"*** means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.
- ***"Emerging best practices"*** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice, particularly with regard to diverse populations."

The last three categories would support the use of relational-based practices and should be included in any assessment of 'what works' in mental health treatment.

During the past year, SAMHSA and many insurers have made a concerted effort to make evidence-based practice a requirement for all mental health treatment. The impact has been seen in treatment of the seriously mentally ill where 'recovery' treatment, primarily clubhouse and peer counseling, is being implemented rapidly. Correctional facilities use manualized programs such as cognitive behavioral therapy programs with good outcomes.

Outpatient mental health treatment is being redefined as "episode-based" with a return to "baseline functioning" when an acute mental health episode occurs. Many effective forms of mental health treatment meet the "consensus-based practices" and "research-based practices" standards of accepted mental health practice are not based on the 'report' aspect of mental health treatment and are therefore rejected as viable treatment practices.

To summarize, EBP as it is currently being conceptualized, seems to limit treatment of chronic disorders, therefore limiting the development of self-reflection, awareness of the treatment relationship, and the ability to resolve internal conflict. This will limit the effectiveness of the treatment relationship and the treatment. Most clinicians realize the importance of including the relationship as a topic in mental health treatment, based on the assumption that the relationship is a primary factor in what is therapeutic. The inherent limitations of EBP with regard to the therapeutic relationship need to be considered, along with mental health research and practice, so that the quality of therapeutic practice can continue to grow.

*This article is reprinted with permission from **Access,** the newsletter of the Clinical Social Work Association, Summer 2013.*

We invite you to respond to the author's ideas and continue the discussion on the listserv.

A Mother's Call to Action

By Jill Dziko, LICSW

When I met my oldest son for the first time he was 10 days old and perfect. He was a tiny beautiful bundle of baby boy with a head full of black curly hair, perfect long fingers, and the loudest cry I have ever heard. When I met him I didn't know he would become the little boy with a smile a mile wide and so charismatic that strangers would approach us and want to touch him; he was like a miniature diplomat who brought a smile to the grumpiest face. I didn't know that tiny bundle would grow into a smiling toddler who was the most loving and generous little boy I had ever met, or the 1st grader who was so smart his school moved him up to the 3rd grade, or the gracious and handsome young man he has become, whose winning smile and sweet personality continue to attract everyone around him.

When I met my youngest son, we were in the delivery room and I wept as I held him up for his birth mom to kiss. He too was a tiny perfect bundle of boy, much quieter than his older brother and every bit as perfect. When I met him I didn't know he would grow into the little boy who clung to me so much that we took to calling him "Barnacle Bob" and I began to fear my hip would never be the same. I didn't know he would grow into the funniest and sweetest child I have ever met; a kind soul who never has a negative word to say about anyone and who is the playground favorite because he can and will play with everyone. I didn't know he would become the boy who is obsessed with Legos and can make the most amazing Lego gadgets, or the boy who at 11, still sleeps with his baby blanket.

When I look at my beautiful, smart, athletic, caring boys that is what I see but I know it is not always what others see. I know that when we go to the mall they are watched more closely because others see two black boys before they see what I see, and in light of the killing of Michael Brown, that knowledge makes my blood run cold with dread and fear. Dread and fear that I must tell my boys to always behave better than their white peers because if anything happens they will be blamed first. That if they are ever stopped by the police they are to place their hands in the air and say, "yes sir" or "yes ma'am" and to memorize the officer's badge number but not to ask any questions or do anything to cause the officer to fear them, because I would rather they come home humiliated than dead - and once they are home I will take that badge number and raise Holy Hell.

These are my boys, the light of my life. The boys I have washed, kissed and cried with for their entire lives. The boys who were entrusted into my care by mothers who love them just as deeply as I but who couldn't care for them. As I watch my boys grow into the men they will become my heart aches for what they will experience as African American men in this country, just as my heart aches for Michael Brown and his family. With tears in my eyes and fear and dread in my heart, I ache that my sweet, sweet boys could be Michael Brown.

As the white mother of two African American boys, I am truly lucky that my life is full of diversity, and that I have people in my life with whom I can honestly discuss race and race relations in this country. People with whom I can be honest and who I know will listen to me without prejudice because they know my heart. People from whom I have learned more than I could ever write on paper about how people of color are perceived and treated in this country.

One of the most important and most difficult lessons I have learned is that as a white person I hold the privilege: I can approach a police officer without fear and with the expectation that I will be treated fairly. This is not the case

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for my sons or the myriad of people of color with whom I share my life journey. Another important lesson is that as a white person, it is incumbent on me to have the race conversation with other white people because we are the people who allow things to continue as they do.

So when horrendous events happen, such as the killings of young black men like Michael Brown, Trayvon Martin, Oscar Grant, Emmett Till and the scores of others too many to mention, we have a choice. We can wring our hands and cry, "oh what do we do, what do we do" all the while posting on Facebook or Twitter but taking no action, or we can make the decision to do something — to take action to rally against the system. To make change. To demand that no mother lose her son to a system that sees him as a monster to be feared simply because of the color of his skin.

In my practice I work with many white parents who have adopted or are considering adopting trans-racially. I also work with the children they have adopted. So many times I hear, "we love our child no matter what, and the color of their skin doesn't matter." Love is a good place to start but it is only the beginning. The color of a child's skin does matter to them, and to everyone around them. To believe that love is enough, or that if you just ignore racism is will go away only perpetuates the idea that race and racism are not important enough to talk about or to change.

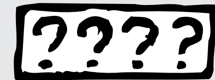
I see this played out in the children of color I work with who are being raised by white parents and have no connection to their ethnic heritage and no idea who they are, except for what they see on TV! Many of these children are being raised by well-meaning parents who are afraid to discuss race. It's not that they don't love their children or value who their children are — more often than not it is because they want to believe they can live in a color blind world. No such world exists, and by ignoring or minimizing the importance of a child's race, we in fact give the message that they are not important enough to be noticed — or worse, children get the message that the color of their skin is something so scary and ugly, even their parents can't talk about it. This message is often internalized by children as the perception that they are scary and ugly. If children aren't prepared to live in this world where racism is alive and well, the ignorance may get them killed.

What can you do, you ask? Here are six things I believe white people, both parents and clinicians, can do:

1. Examine your own internal racism and how it manifests itself on a daily basis — the things we think but never say.
2. Begin having honest and uncomfortable conversations with our children, our families, our friends, our co-workers and yes, even our clients. When you hear a racist joke or remark don't ignore it, say something.
3. Talk to children about racism: what it is, what it looks like, its history and how to stop it.
4. Find out what children are taught at their school about the history of this country in general, and specifically about how people of color have been treated in this country; talk with them about what they learn.
5. Get to know people who don't look like you and who don't live like you. It is much more difficult to vilify a group of people when you have personal connection with someone from that group.
6. Be the change you want to see...

This is my call to action for every white person to ensure the protection not only of my sons, but of all the sons of this country: to truly and honestly take a look at your own racism and begin talking about it. Don't diminish it, don't deny it, and don't avoid it. Talk with people of color about their experiences of racism and truly listen with an open mind and heart; don't diminish it, don't deny it and don't avoid it. And most importantly, don't perpetuate it. Talking about racism is painful and difficult, but absolutely necessary to begin to change how we see each other. And remember, no mother should live in fear every time her son leaves the house...

We invite you to respond to the author's ideas and continue the discussion on the listserv.



Have an ethical dilemma or question?

Contact the WSSCSW Ethics Committee:

Melissa Wood Brewster:
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Mary Roy:
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Albert Casale:
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Or, contact us on the WSSCSW listserv if your question is general and can be shared.

Out of Network Reimbursement

By Laura Groshong, LICSW

As many of you know, I have been talking about the likelihood that out-of-network benefits will be diminishing for the past four years. Why? Because the Affordable Care Act included in-network benefits through integrated care as a goal in 2010. This is a problem for many LICSWs who have relied on out-of network payments for their income. There is still wide variation among insurers about whether they will reimburse for out-of-network LICSWs. This article is designed to be a reminder that this move to in-network providers only is likely to be increasing and to prepare your business plan accordingly.

A quick summary of in-network and out-of-network insurance coverage. In-network providers are LICSWs that are 'paneled' with a given insurer and accept the rates that are given for the psychotherapy services provided. Out-of-network LICSWs are not on a given insurance panel and used to get paid their usual and customary rates for psychotherapy services. This system has begun to change as insurers are beginning to end the practice of paying out-of-network providers.

There are many complications in this change to reimbursement, not the least of which is the conflict between the ACA's stand on out-of-network payment and that of the Mental Health Parity and Addiction Equity Act of 2008, which requires that both in-network and out-of-network payments be made. There is no clarity in Washington law about this issue, though rules being developed may provide some guidance in the next year or so.

In the meantime, please be forewarned that out-of-network payments may be curtailed. The clearest example of this policy is that of Group Health who decided in July, 2014, to begin denying coverage of out-of-network providers. This has caused hardships for patients who are seeing an out-of-network provider through Group Health and can no longer get reimbursement.

WSSCSW is working on several levels to stop this change in Group Health's policy. Stay tuned for more information on our progress. But be aware that the times are changing in terms of out-of-network coverage.

We invite you to respond to the author's ideas and continue the discussion on the listserv.

2014 Calendar

CLINICAL EVENING MEETINGS

The Washington State Society for Clinical Social Work holds Clinical Evening Meetings three times per year — Fall, Winter and Spring — at the UW School of Social Work. They are scheduled for 7–9 PM, with networking from 7–7:30.

These are quality presentations given by members and allied professionals. It is a great opportunity for you to get 1.5 CEU's per evening while networking and meeting other clinical social workers. Our well attended and stimulating October meeting featured Dawn Dickson, LICSW, and Daniel Masler, PsyD, presenting *The Use of Story in Clinical Practice: Reframing Personal Narratives About Health and Wellbeing.*

Our next Clinical Evening Meeting will be held on January 14th, 2015.

We are pleased to present a panel discussion on *Critical Incident Stress Management* with John Powers, LICSW, Robert Odell, LICSW, and Seema Mhatre, LICSW. Stay tuned for announcements and more information about this interesting event!

Questions? Topics of interest? Wanting to present?
Contact Dawn Dickson at dawndickson1@comcast.net
or Tanya Ranchigoda at tranch27@yahoo.com.

The **2012 Matt Adler Suicide Assessment, Treatment & Management Act** requires **six hours of mandatory training** for mental health professionals in Washington State. Become more confident in your work with suicidal clients and be in compliance with this new law by attending one of Wellspring Counseling's eleven Seattle 2014 workshops:

Working with Suicidal Clients

January 24 • February 21 • March 21 • April 19 • May 30 • June 20
July 19 • September 19 • October 17 • November 21 • December 6

For more information and to register visit **www.wellspringfs.org/counseling**

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Upcoming WSSCSW Conference:

Beyond Words: Attachment, Trauma, and Implicit Communication

With Pat Ogden, Ph.D.

November 1st, 2014 • 8:30 - 4:00 • 6 CEU's

Swedish Medical Center, First Hill • Glaser Auditorium • 747 Broadway • Seattle, WA 98122

Emphasizing embedded relational mindfulness, this workshop explores the legacy of trauma and attachment experience in determining affect regulatory capacities, procedural learning and implicit communication, and thus in large part, the quality of one's relationships with others and with oneself. Key components of Sensorimotor Psychotherapy will be illustrated using videotaped excerpts of sessions with traumatized individuals and brief experiential exercises: distinguishing interventions for trauma - vs attachment-related emotions; specific skills for embedded relational mindfulness; working with physical actions related to animal defensive subsystems and developmental movement sequences; building somatic resources; and developing a somatic sense of self.

Pat Ogden, PhD, is a pioneer in somatic psychology and the founder/director of the Sensorimotor Psychotherapy Institute, an internationally recognized school specializing in somatic–cognitive approaches for the treatment of posttraumatic stress disorder and attachment disturbances. She is co-founder of the Hakomi Institute, a clinician, consultant, international lecturer and trainer, and first author of *"Trauma and the Body: A Sensorimotor Approach to Psychotherapy"* and *"Sensorimotor Psychotherapy: Interventions for Trauma and Attachment."* She currently working on a third book, *"Sensorimotor Psychotherapy for Children and Adolescents."*

For registration fees, visit our website: http://www.wsscsw.org/clinicalconferences