WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

FALL 2012

In this issue:

From the Desk of the President

BUILDING A "REDOUBT" FOR PARITY IN MENTAL HEALTH COVERAGE

By Karen Hansen

You may wonder why the picture below is included in my first President's message. It was taken while vacationing with my husband on San Juan Island, and touring the American Camp Historical Park on our bikes. We came across this exhibit about the 1859 Pig War between the British and the Americans, which actually was triggered by a pig stolen by an American from a local British farmer (a territorial conflict). Lt. Henry M. Robert was commissioned with the task of building a Redoubt, and this site is now called "Robert's Redoubt". You may wonder, as I did, what the heck is a Redoubt? Here is the dictionary explanation:

redoubt (ri'dout), noun • a temporary or supplementary fortification, typically square or polygonal and without flanking defenses
• an entrenched stronghold or refuge

Robert's Redoubt was built in such a strategic manner that there was no way the British could fire upon the Americans and threaten their position at American Camp. In fact, no guns were fired and the resolution of this "war" was the peaceful cohabitation of San Juan Island by both the Americans and the British.

This is where we cross over to the issues of Parity and Mental Health Coverage in this state. We are building our own Redoubt, through the actions of the Society, and especially Laura Groshong, our lobbyist and legislative advocate. We are building a case that will solidify our position as Clinical Social Workers, protect it from erosive attacks and denials by the insurance industry, and preserve the coverage our patients deserve.

Recently there was a Senate hearing in Olympia on the Mental Health Parity issue. Many of you attended. Former Society President Keith Myers spoke, as did psychologist Samantha Slaughter, and Sue Weidenfeld PhD, representing the Washington State Coalition for Mental Health Professionals and Consumers. The session was opened by Randy Revelle, former King County Council Executive who spearheaded an 8 year effort which resulted in passage of the Washington State Parity Act of 2005. He is also a long time mental health services consumer, having had a bipolar disorder which he has publicly spoken about. His thoughtful and persuasive comments were well received by the legislators.

The insurance industry sent one representative, Sylvia Azarra, of the Washington Health Care

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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 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.

President's Message

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Association, who spoke briefly, saying she was there to listen and learn. Washington is one of four states in the country that has voted into law the reality of funding mental health at full parity with physical health. In addition, there is a Federal Parity Law that the Clinical Social Work Association helped pass. The problem is that these laws are not being implemented by the insurance industry in the spirit in which they were intended.

Many of you know that Laura Groshong created the Washington Association for Mental Health Treatment Protection, WAMHTP, to challenge the problems of parity noncompliance with Regence, Premera, Group Health, and other insurers. WAMHTP has collected information about denials of mental health treatment (171 and counting), and on outcome tools, developed information on how to write an appeal, created a definition of what psychotherapy involves and the length of time it can take, and is looking into a possible lawsuit if insurers refuse to comply with parity laws. Some of our members are staffing work groups that are part of this organization. The work of WAMHTP adds an important dimension to our Mental Health Parity Redoubt, and currently data and case examples are still being sought to further document the problem. No one can build this case alone. Only through working with an organization such as ours, along with similar groups, can an effective stronghold for our profession be secured. This may not be the reason you joined our organization, but it is becoming an important reason now. I am proud to be part of this process at such a critical time.

By the time you receive this Newsletter I will have traveled to Washington D.C. to represent Washington State at a summit sponsored by our national organization, the Clinical Social Work Association, along with other state societies facing similar struggles. I will support Laura Groshong in her current work and learn how we might join forces for an even stronger Mental Health Parity Redoubt at the national level. I will report any relevant developments through the listserve. The WSSCSW "I Googled You" ethics conference will have taken place at the UW School of Social Work, a cutting edge topic that is relevant to changes taking place in our practice lives due to the presence of the Internet. I hope you will have joined us to learn together how to manage this influence and maintain our ethics and professional boundaries (and to fulfill ethics requirements for licensure). If not, you can purchase a disc made of the proceedings at the WSSCSW website.

Now, a word about our organization from the Board perspective. We have had many new members appointed to chair Board committees, with new ideas and energy to contribute. Read carefully through this Newsletter and you will discover new talent and unique voices. Sarah Slater has remained as Chair of the Professional Development Committee (an important committee to our yearly programing) and is currently seeking a replacement. We must support and help Sara, who worked tirelessly for MANY years and deserves a break. If you are approached to lead this committee I hope you will accept! You will be joining a Board that is doing important work for the profession. I am excited to be working with such quality talent and generous hearts.
I'd like to thank our new Membership chairs, Molly Davenport and Sukanya Pani, for running

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

their first membership drive, which was a success. This is a complicated process with many moving parts and our organization depends upon the income that it generates. Molly and Sukanya stepped up to this task and ran a smooth drive. Thanks to them and to the other Board members who are learning and conducting their appointed tasks. This newsletter has two new editors who will be contributing their talent and new ideas. If you like what you see please thank them yourselves as well.

A word about myself. I am a long standing member of WSSCSW who previously served on the Board as chair of the New Professional Program (now the New Associates Program). I have maintained a private practice for three decades, working with adults, adolescents, and couples. Through the years I have found my closest colleagues and friends in the Society, and have felt that it truly was my "clinical home". I have grown clinically during my time as a member of WSSCSW. I now feel honored to serve as your president. I hope that we can not only continue to put the "social" in Social Work (having meaningful events to get together for work and play), but that we can continue to support the Professional Life Cycle of our members, and firmly build our Mental Health Parity Redoubt. And by the way, Robert wrote the classic "Robert's Rules of Order", which I must now study to learn the protocol of running a meeting. Robert was a military strategist, and a man of civil discourse who developed a system for running meetings utilized for over 150 years.

May our efforts as a society and in our professional lives have just the staying power of Robert's Rules. And may our Mental Health Parity Redoubt hold firm for those who are to follow us as Clinical Social Workers.

At your Service,
Karen Hansen, , LICSW
WSSCSW Board President

WAMHTP & YOU: Protecting Our Patients Through Mental Health Parity

By Laura Groshong, WSSCSW Legislative Chair and WAMHTP Chair

For the past year, the Washington Association for Mental Health Treatment Protection (WAMHTP) has been working for WSSCSW members, and all Washington mental health clinicians, to keep patient mental health benefits strong. But wait, you may be saying, wasn't there ANOTHER organization or two which had that mission?

In fact, WAMHTP has had four names in its brief history, as the organization evolved. What started out in August of 2011 as a task force to deal exclusively with Regence Blueshield, then became a task force to address restrictions placed on mental health benefits by all major insurers. Then as we prepared to become incorporated as a non-profit organization, we hoped to use the designation of Partnership, conveying the fact that we were made of many individual organizations. Alas, in its wisdom the Department of Licensing does not allow non-profit organizations to use the term "partnership" in a title. Thus we settled on the new and final name of the group, now an association, which is registered as a non-profit group in Washington and has applied to become a 501(c)(3) in Federal tax codes.

"We hope all WSSCSW members will consider making a donation to support this important group"

Now that you have the history of the group, here is what WAMHTP has accomplished:

1. Developed a website which will go 'live' shortly;
2. Collected $7,030, including $1500 from the Society, with $10,000 more promised, to cover the expenses which include hiring an attorney, setting up the website, future hiring of expert witnesses, and travel for Sue Wiedenfeld, PhD, Vice-Chair, and myself to the Federal Parity Is Personal hearing in Los Angeles next month to testify;
3. Hired Ele Hamburger, JD, of the law firm Sirianni, Youtz and Spoonemore, who has won 10 cases which violated parts of the state mental health parity law;
4. Developed a list of restrictions that include use of Milliman Guidelines, restriction by diagnosis, length of treatment, and frequency of treatment;
5. Worked with legislators to create a mental health parity hearing which would make insurers explain how the restrictions being placed on mental health parity benefits are in compliance with our parity law;
6. Been in discussion with the Insurance Commissioner about the potential violations of mental health parity laws;
7. Collected 169 cases of denials of mental health treatment, one of which will be the case used in legal action; and
8. Developed materials on how clinicians and patients can file appeals when treatment is denied.

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While much remains to be done, we hope all WSSCSW members will consider making a donation to support this important group. WSSCSW is a major supporter of WAMHTP and is entirely in agreement with its mission. The other eight groups that make up WAMHTP are working with the WSSCSW to present a broad-based mental health community approach to the problems that we face in making mental health parity a true reality.

Watch for information on the website, the State Hearing, and legal action over the next 1-2 months and give WAMHTP your support!

CONNECTIVITY VS. CONNECTEDNESS: THE 2012 ETHICS CONFERENCE

By Melissa Wood Brewster

This year's ethics conference, sponsored by WSSCSW with WSCMHPC and titled "I Googled You": Staying Clinically Centered in an Online World, was both critical and timely. We are living in a world in which digital media and electronic communication increasingly shape human relationships. Laura Groshong, LICSW, presented an excellent overview of issues to consider in the context of the clinician's social and professional presence on-line, and the impact that electronic communication with clients can have on the therapeutic relationship.

Like most ethical dilemmas, we discovered that there is no absolute answer, and there are many important factors to consider. For starters, much depends on our age. Laura divided us into digital "natives" and "immigrants" depending on who grew up with the internet in their daily life.

Several impressive case presentations elucidated the diversity of perspectives and experience clinicians have had using email, text, and video services (such as Skype) with patients. The presentations helped clarify whether and how using electronic communication can support clients' clinical needs and goals, and what boundaries may be appropriate. Later, participants broke into groups to discuss 16 provocative questions exploring privacy on the web, therapist websites, encrypted servers, and more. We found there was a lot to learn from one another's experience – or lack of it – with electronic media in a practice setting. Finally, Laura familiarized us with state and federal laws to keep in mind when choosing to engage with clients electronically.

The most popular take-away from the conference was probably the goal to include a Communication Policy in our self-disclosure statements, clearly stating our boundaries for the use of electronic communication in our practices. Perhaps the most meaningful message Laura sent home with us, however, was the reminder that as clinicians, we are the "keepers of human connectedness." No matter how effective the digital world may be, it will never replace face to face human empathic connection. It is our job to model that to others. Here are a few comments from participants:

"I thought the conference was excellent. I feel more informed about how to handle current technology as it relates to clinical practice, but I also came away from the conference with questions and thoughts that will likely lead me toward further exploration." -- "The conference exceeded my expectations. It helped me to see better into the future and how to incorporate the new reality of little or no privacy and the increasing encroachment of regulation on my practice." -- "The ethics conference was very helpful in exploring current technological environments being used in clinical social work and providing legal and ethical insights around how we can use these in our work while protecting our clients, ourselves and the integrity of our profession as social workers." -- "Every social worker absolutely needs to know what Laura presented in 'I Googled You'."

For those who were unable to attend the conference, DVD's are available and can be obtained on the WSSCSW website.

ETHICS COMMITTEE REPORT

By Ann DeMaris Davids

It's a season of change on our Ethics Committee (EC). I recently accepted the position as chair of the committee, while one of our hardworking members, Carolyn McArthur, has found that she is not able to continue. She will be missed as she contributed much energy and thoughtfulness to the process.

Many of us may have attended our Fall Conference, "I Googled You!" and are left trying to figure out how to incorporate what was presented by our very own Laura Groshong, LICSW, BCD. The EC might be a place where conversations get started - first within the EC, as we begin to think about things, and then into the WSSCSW organization at large, as we expand the conversation. In this way, ethics might not be reserved for those mandatory six licensure continuing education hours every two years, but will become incorporated into how each of us thinks about our ongoing practices.

The Ethics Committee is composed of: Ellen Wood (ellenbwood1@gmail.com); John Walenta (johnwalenta@hotmail.com); Melissa Wood Brewster (woodbrewster@gmail.com) and Ann DeMaris Davids (ademarisd@yahoo.com). Please contact one of us if you'd like to start talking about ethics.

THE CLINICAL SOCIAL...BLOGGER

By Robert Odell

This article is about my experience beginning and maintaining a blog for my practice. If you are considering starting a blog, I hope this article will be helpful to you. I should clarify that my blog is a one element of my practice's larger website. I have tried below to distinguish clearly when I am discussing blog(s) or website(s).

One other note: I've elected not to excerpt my blog directly in this article. It's simply more effective to refer you to the blog itself. You are invited to read any number of posts, as the way to illustrate the points made below. The address is seattle-counseling.com. I also reference some other blogs. They are all more sophisticated than mine (so you can see some possibilities) but their core content is very worth reviewing.

Background

Many clinical social workers have websites that promote their private practices, including professional or public education offerings. Yet relatively few maintain a "blog", which by now most people know is short for "web log", an online log or journal where anindividual or business can post anything in writing and/or audio-visual media, for anyoneto read and comment on. It can be about one's personal or family life, business, political views and current events, music or culture, culinary creations - the possibilities are limitless. As of October 2011, there were 173 million blogs worldwide (NielsenWire, Mar. 2012).

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Many business and personal websites have blogs which are integrated into a larger website, made visible simply by clicking on a page tab. Website owners use a blog to provide updates to their service or product, or to add some personal or familiar values.

For example, a woodworker's website might use a blog to market a handmade chair to describe each day in its manufacture. The blog might also show the artisan teaching a child how to stain wood. For over six years, I have maintained a website (seattle-counseling.com) dedicated to promoting my private practice. It's evolved slightly over the years, but it's fairly typical. It describes the services I offer, and the professional offering them. In addition, it offers a downloadable intake form, links to driving directions and public transportation trip planning, and links to clinical resources and information (including the WSSCSW website!)

Website marketing & referrals

Websites for therapists operate alongside traditional word-of-mouth and other non-internet based forms of practice marketing. A website is the best way for an individual, no matter how they are referred, to learn more about the clinician, especially on a weeknight at 10PM. A website and a blog can complement a traditional referral process.

Imagine a prospective client who has received a therapist's business card from an M.D., and wants more information about that practice. The site ideally offers enough information to confirm that the referral fits the client's problems or desired approach.

On my site, I've tried to keep all information brief and focused on what I actually do, not on outcomes. A website should try to be visible (high search engine ranking) and engaging to clients for whom the search engine (like Google or Bing) is the means of referral. The value of a therapist's website is not limited to how easily the site can found on the internet by someone using a search engine, or whether the site persuades an internet visitor to become a client.

Once this prospective client arrives at the site, the prevailing marketing wisdom is that the site should succeed at "holding" that visitor, i.e., encouraging a lengthier visit, because that increases the chance that the visitor will select that therapist. Blogs have been shown by several website studies to increase the duration of the average site visit.

My blog

Just over a year ago the addition of a blog was part of a technical overhaul of my website. I had been attracted to blogging through my experience with blogs including Sexual Intelligence (sexualintelligence.wordpress.com/),The Couples Institute (couplesinstitute.com) and Stan Tatkin (http://stantatkinblog.wordpress.com). My designer referred me to a specialist who converted my old site to the Wordpress "platform", one of the more popular (and free!) ones available.

Going ahead meant a continuing effort in both internet marketing and professional writing. I did some due diligence by visiting as many additional therapist blogs as I could Find. What a variety! Some sites are quite frequently posted, others gather dust. They reflect aspects of clinical practice, including specializations, educational or development offerings, and audio/video (radio/TV) interviews. I decided that focusing on the therapist-client interaction would be an interesting challenge. Mapping the therapist's position is interesting to me and, I thought, helpful to visitors.

Blog development

I support the responsible, thoughtful development of therapist blogs as a form of practice marketing and an ongoing exercise in professional development. In the digital age, blogs strike a good bargain by allowing clients to get a deeper understanding about clinicians, but only within a professional context. They also give an otherwise static website a current, fresh feeling. Site content is important, but the self of the therapist emerges more robustly in a blog. Over time and multiple blog posts, the clinician takes on a wide range of professional topics, allowing the site's visitor to go beyond the more general and static content in the rest of the website.

With each posting, a blog is a forum where the clinician chooses to identify, research (to some extent) and articulate salient and significant aspects of clinical practice. The blog displays the therapist's apparent scholarship expertise or empathy, but what is evident over months of blogs is hopefully an ongoing commitment, even passion, to practice.

A website or blog is not necessarily a good fit with every clinician. Clinicians may decide that they don't want to publicly write about or market their practice. There is an element of self-disclosure that does not comport with every clinician's theoretical orientation or individual style. What is selected for the blog, and the way those subjects are written about, are very important. A therapist's writing style may be intellectualized, passionate, humorous, even tangential. The blog may be the closest thing to

an in vivo preview of what it's like for a client to be with you in your office. The blog is about the clinician, but not necessarily at the expense of the therapist's purpose, flexibility or latitude. It is personal, but it is not Facebook - which is a far less controlled environment (I do not link my blog to any social media like Facebook or Google+: their content is difficult to manage or control adequately). Does the clinician communicate material in a revealing way that explores his or her thoughts, feelings and decision-making? Does theory get treated in everyday language? If one decides to proceed, there will be a learning curve that's likely to be time-consuming and burdensome, as the clinician finds his or her very public voice and style.

Tips for websites and blogging

While there is blog content which could "hold" a visitor to the site, our profession has a high standard to meet: both the website and a blog should responsibly facilitate that person to enter treatment with that therapist. Not all content is appropriate, responsible, desirable or relevant. To illustrate, consider possible implications of certain kinds of content:

1. A site might generate lots of new intakes with inflated or unrealistic language about the skill or reputation of the therapist, or by offering prospects of problem/crisis resolution, or diagnostic remission.
2. Seemingly objective or extensive descriptions of psychological theory, or therapeutic methods could create expectations of a "scientific" therapy experience, or the impression of a statistically proven therapy or outcome.
3. Detailed or extensive biographical and personal data can excessively point to the importance of the therapist's personal history in the treatment of the client.
4. Extensive bibliographies suggest that books written by others are a necessary aspect of treatment.

In terms of content, here are some categories that I believe can be part of a model of blog content.

1. The therapist's professional education activities
2. Recent professional books read
3. Possible therapy implications
4. Recent and notable mental health research
5. Perspectives on the process of therapy
6. Discussion of specific diagnoses
7. Observations of specific therapeutic situations or themes

Here are some style guidelines that I believe lend themselves to a more readable blog:

1. Keep postings brief: A post is not a professional journal article. It's a sample of one's thinking and sense of self. Write clearly and without jargon for the general public.
2. Give a clear picture of what you think or believe, or what you might do, and why.
3. Avoid using identifiable case material: It may be tempting to use current, anonymized case material to illustrate an important issue. However, you would likely send an implicit message to visitors that their concerns might become fodder for public consumption.
4. Keep posting steadily: A blog is an open-ended commitment. I don't think it matters how often you post, but don't allow multi-month gaps - that says "lights on, nobody's home." I post about every three weeks.
5. Write with a distinct voice or identity: If you decide to begin a blog, write a few test postings offline, and then read them to see if there's a consistent tone.
6. Blog settings (under the hood) matter: Make sure you have spam protection, and keep it updated. Make sure settings allow you to screen visitors' comments. If you get visitor comments, respond promptly and invite further comment. Learn how to make the blog help your search engine optimization with invisible settings.
7. Avoid or be very careful with personal, non-professional topics. Personal politics, religion and lifestyle may be revealing or persuasive to some visitors, but perhaps not relevant to a practice environment.

"The blog may be the closest thing to an in vivo preview of what it's like for a client to be with you in your office"

Of course, my own blog is one example of how to approach a blog. After reading my posts, if you have feedback of any kind, please do contact me at seattle-counseling.com (every page has an e-mail link) with any feedback!

SOCIAL WORK ON THE JOB: An Interview with WSSCSW Member Eric Huffman

By Lynn Wohlers

Recently I sat down with former Board member Eric Huffman, a psychology associate at the Twin Rivers Unit at Monroe Correctional Facility, to learn about his job, his background and his thoughts about how prison social work differs from what he sometimes calls "outside" social work. First, some background.

What led you to finding work at Monroe Correctional Complex?

"When I was in grad school I had the chance for a practicum placement at the prison, and what sweetened the deal was that back then, the state would pay for some practicum placements. Somehow it just fit me and I was comfortable and I enjoyed it. When my practicum was up and I had my MSW, I applied. I got hired in June 1998."

Did you go right into grad school from college, or was there a "between"?

(Laughing) "There was a big in between – it's kind of an important in between. In the 70's I was very active in the antiwar & Socialist movements – in Junior High & High School. I knew I was going to go to college and I wanted to study history. I wanted to study medieval history since the exposure to Marxism had made that a really interesting period - with a slave mode of production on one side, and the rise of capitalism on the other, there were many things that attracted me to that. So I studied medieval history, took Latin, German & French, and went on graduate school at the University of Chicago. They even gave me a little stipend. It didn't last long. It was 1979, and for somebody who was politically active it was quite a year. There were revolutions in Nicaragua, Iran, and the Caribbean island of Granada. Also, there was a lot of stirring in the labor movement, the steel industry and the coal industry. The association I had been with since I was 13 decided that it was time to get Socialists back into the unions – it had been too dangerous for decades before that. I wasn't happy in grad school. I didn't like the University of Chicago - it was isolating, I was on my own for the first time, I was 22, it was the second biggest city in the country, and I didn't know anybody. So I dropped out of grad school and got a job on the railroad as a brakeman switchman."

You went directly into the heart of the labor movement!

"I did. Absolutely. So I did that. Long story short it was a feast or famine job – I would get laid off, called back. Then I worked at Sloan Valve, which makes most of the industrial toilet valves – so the next time you're using the restroom… Part of the time I was working for the business office of a Socialist newspaper in New York. After years of doing this I realized I really couldn't do that kind of work for the rest of my life. It was a pretty intense lifestyle and it just wasn't working. So I had to figure out something where I felt like I was still making a contribution and could look into the mirror and face myself. I wanted to pull my values together and still make a living. I moved back to Seattle, where I grew up. I was lucky enough to get into the MSW program, the only one I applied to. So here I am."

Can you tell me about your earliest memories of your job at Monroe?

"The thing that really stands out – shortly after I got hired full time in '98 I was working on the Segregation Unit – the Special Offenders Unit. It houses mentally ill offenders who are so acute they can't be housed in any other prisons in the state. They're on lockdown 23 hours a day & can only be brought out of their cell in restraints. Sometimes it's because they're so behaviorally disturbed that they keep breaking the rules - it's a number of things. There was an inmate on my case load – in his 30's, obese. I came to work that morning and the sergeant asked me if "Smith" was on my caseload. I said yes. He said, "Was. He died last night." The inmate had not been well. There was some question about whether the heat in his cell interacting with his psychiatric medications had hastened his death. Since it wasn't considered safe to enter his cell unless officers are present, when they were unable to rouse him during the night, (before I arrived) they had been shouting and throwing wet socks at him & shooting rubber bands at him. This was pretty traumatic for the other inmates because they could hear what was happening. It was a really, really traumatic event for everybody. Everyone wanted to know whose fault it was. It's a fairly punitive environment. There's still some fallout among the staff, some animosity, following that - I remember that more than anything else. It sort of summed up the

problem of mental health treatment in prison: there are higher risks, we're dealing with people who are more disturbed, we're dealing with a population that used to be housed in state hospitals, and we're dealing with mentally ill offenders in an environment that's not meant to treat mental illness."

That's not conducive…

"Yes. So it points up all of that."

What would a typical "day in the life" be these days?

"These days I probably see three or four offenders every day for an hour. I am doing some kind of one to one therapy or I'm doing intake evaluations – transfers into our prison. I'm also interviewing inmates who, if there is any question at all of sexual activity, forced or otherwise, have to be seen by mental health to make sure that they're OK. This is a new federal law. Some of my time is spent doing suicide assessments, some time is spent helping to prepare discharge summaries for DHHS funding for mentally ill offenders after release, and various other reports. There's a lot of paperwork and data entry."

What is on your desk? You do have a private office, right?

(Smiling broadly) "Let me tell you about my office! The Mental Health offices were housed in the Health Services Building for ten years, but then they were saying they didn't have enough room for the medical people. So about a year and a half ago the Mental Health offices were moved up onto the living units. Currently my office is a converted cell on the tier with the inmates. I'm on the second floor, which means I'm not wheel chair accessible. I have an 11 by 11 foot room with bars on the window – the window opens, but then wasps, yellow jackets and flies come in so it's not uncommon in the summer to have to stop a session to swat an insect. Other inmates are looking in the window on the door to see who's in there. There's certainly no confidentiality in terms of whom I'm seeing. Confidentiality in the prison in always a problem because inmates go where they're supposed to go based on printed "call outs", so even under the best of circumstances, it's clear when someone's coming to Mental Health. Or my name may be on the call out so inmates say, 'Oh you're going to see Huffman! Is everything OK? What's wrong?' So it's always been problematic. I'm on a minimum security unit, which means we have only two officers and one is always in the control booth. I'm out of eyesight and definitely out of earshot, so if anything were to happen it would be a bad thing. I have a phone in my office with an emergency button that goes straight to the main control for the prison. However, in main control they have no way of knowing where the call is coming from - there's no caller ID and it's too expensive to correct that. So I have a big sign on my bulletin board that says 'D Unit, C Wing, Room 299'. I hope that if something goes wrong, I can push the emergency button and have the wherewithal to look at the sign and say that, so I don't have to come up with it out of my memory. Yeah, it's not therapeutically conducive."

"If I could change one thing, I would completely remove control over the prisons from the political system and turn it over to trained mental health professionals"

What are the skills you rely on the most in your work?

"Wow. The answer is listening, but isn't that true for all of us in this field? In prison, being listened too, being heard is so important. While that's crucial to all therapy, I think it's especially important in prison. A sense of being listened to, a sense of being understood, being able to tell your story and being able to give your perspective without somebody saying, 'You're lying…Oh, you should… Why didn't you?' or some other pejorative or attacking formulation, which is very common. I think in terms of helping inmates and also in terms of keeping me safe, listening is the most important thing. To really take the time."

What surprised you the most about working within the DOC system?

"I guess I was surprised by how much disdain and animosity and hostility the staff has towards the inmates."

And the next question was, please tell me about the people you work with!

"Can we pause? (After pausing) Prison is a really complicated place to work. The Mental Health staff is well trained and they really genuinely care. The Custody

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staff – officers – are primarily concerned with keeping everybody safe and making sure there isn't a threat or scam or game that's going to hurt other inmates or staff. Where things get difficult is when the attitudes and actions of the inmates are not understood sufficiently by the Custody staff. Mental health issues, trauma, and problems with authority are frequently not taken into consideration. It's much more common to shout at inmates or to berate them. This almost never works well if you're dealing with an offender who has suffered trauma. Some of the estimates in the literature out there suggest that up to 80% of inmates have suffered trauma. So trying to work in an environment with that kind of a divide between Mental Health and Custody is really a challenge. And there are a small number of officers who really delight in tormenting inmates. As a mental health colleague of mine put it, this is the only place you can get paid to beat up people. I spend too much time de-escalating offenders who've had bad interactions with some of these officers. It's also true that there are some exceptionally thoughtful, skillful officers there who do a wonderful job helping inmates literally stay alive."

If you could change one thing in the penal system, what would it be?

"If I could change one thing - it's impossible to change one thing – I would completely remove control over the prisons from the political system and turn it over to trained mental health professionals. Decisions about penology and criminal behavior being made by people who have no training in the field but all the power [is not ideal]."

What are your thoughts on recidivism and life after prison?

"At my prison (Twin Rivers) we have one of the two sex offender programs [in the state]. The population is very heavily sex offenders, but not entirely. I have people on my caseload [all men] who have done everything from drug crimes to sex offense to murder. The recidivism rate in general in the US is very high, somewhere upwards of 50%. There are a number of reasons for that. If an offender has a very serious mental illness - poorly controlled Bipolar Disorder, Schizophrenia, or any Schizophrenia spectrum disorder - they stand a good chance of getting funding for mental health treatment and medications when they get released. The offenders who I think frequently come back are the offenders who have issues like ADHD, PTSD, or complex trauma. They're physically capable but they have problems with executive functioning."

And substance abuse?

"That's always there. I tend to think of that as being a symptom, underlying the other issues. You have people who have problems with executive functioning. They look fine, they can carry on a fine conversation, but they are unable to carry on sustained work, they don't deal well with supervisors, they have poor judgment, low frustration tolerance, they are more apt to feel attacked and they don't do well out in the real world. They don't get the treatment they need. They frequently can't afford medications, they don't have case management, they don't have "life coaches" – they don't have anybody to help them with anything! And there are frequently really, really deep feelings of shame with these inmates. For many of them, the way I see it is, prison is a place where they can't fail. In fact, in many ways, prison is a place where they can be successful. People may look up to them there, they may have friends, they're safer than when they're on the streets, they can sort of achieve in prison those things the rest of us achieve in the outside world - relationships, a prison job. They can't fail."

So they land back there.

"They land back there because it's easier in every sense. It's easier emotionally. If you're not a criminal, you think of prison as being shameful and humiliating, but if you've had a criminal lifestyle, being out in the real world and failing repeatedly is much more shaming and humiliating."

How has WSSCSW been helpful to you?

"Oh man...the society has just been spectacular. One of the best things I have ever done was to be on the Board. I learned so much and I had so much fun – the networking, the camaraderie, the sense of belonging to a community, the exposure to ideas, and the sense of being able to contribute something myself, to give something back to the community. I've always wished that there was some greater dialogue between mental health providers on the inside and mental health providers in the community. I wish there was not this divide where prison is such a hidden world."

How do you think people describe you?

"It's ironic. People frequently say, 'You always seem to calm', and inside I really am an anxious mess! A colleague of mine recently said that I was a good combination of compassion and logic, and I found that to be very flattering. I would like to think that in addition to that – somewhere in there, a sense of humor would figure predominantly. I thought

that if I were going to have an epitaph, it would say, 'Socialist Social Worker with a Quirky Sense of Humor'. Or 'Socialist Social Worker with a Quirky Sense of Humor – thanks for stopping by!"

Final words?

"I want to thank the Society for having this opportunity to talk about prison so that people can hear about it. I appreciate the chance to do that. And if anybody's interested in discussing radical politics and prison, I'm always available for coffee."

Confronting Confinement, a June 2006 U.S. prison study by the bipartisan Commission on Safety and Abuse in America's Prisons, reports than on any given day more than 2 million people are incarcerated in the United States, and that over the course of a year, 13.5 million spend time in prison or jail. African Americans are imprisoned at a rate roughly seven times higher than whites, and Hispanics at a rate three times higher than whites. Within three years of their release, 67% of former prisoners are rearrested and 52% are re-incarcerated, a recidivism rate that calls into question the effectiveness of America's corrections system, which costs taxpayers $60 billion a year. Violence, overcrowding, poor medical and mental health care, and numerous other failings plague America's 5,000 prisons and jails. The study indicates that even small improvements in medical care could significantly reduce recidivism. "What happens inside jails and prisons does not stay inside jails and prisons," the commission concludes, since 95% of inmates are eventually released back into society, ill-equipped to lead productive lives.
From http://www.infoplease.com/ipa/A0933722.html

MEMBER PROFILES

By Sukanya Pani

The Membership and Diversity Committee would like to introduce the Membership Profile section in the newsletter to recognize the diversity, varied work and interests that the society members represent in our community. This is a great way to introduce yourself, know your colleagues and connect with fellow Clinical Social Workers. If you would like to introduce yourself and highlight your work, please email Sukanya Pani at sukanya.pani@gmail.com or Molly Davenport at molyush@hotmail.com.

DEBORAH WOOLLEY

After a 15-year academic career teaching writing and comparative literature at the University of Washington and at Oglethorpe College in Atlanta, Deborah attended the UW School of Social Work and graduated with an MSW in 1998. Deborah opened a private practice and began teaching parent education part-time, while getting training in Object Relations and Attachment Theory at what was then COR. As her practice focus shifted to adults with histories of abuse and other trauma, she pursued training in EMDR, Lifespan Integration and somatic methods. Deborah is currently enrolled in a two-year-long training in Pat Ogden's Sensorimotor Psychotherapy, which is re-invigorating her practice. She is returning to WSSCSW after seeing The Invisible War, a documentary film about sexual assault in the US military. She hopes to connect with other therapists who want to work with soldiers who are victims of military sexual abuse.

EVE WRIGHT

Eve Wright is in private practice in the upper Fremont, lower Woodland Park neighborhood of Seattle. She has been practicing for 20 years, and is a graduate of the Advanced Psychoanalytic Psychotherapy Program offered by the Seattle Psychoanalytic Society and Institute. She began her career in the Valley Cities Mental Health Preschool Day Treatment Program. She moved from there to Family Services, (now Wellspring), and then to private practice, where she has continued to work with children and adults. A closet in her office housing child therapy supplies now includes paints and canvases, thanks to a recent shift to working with older teenage and adult clients. In addition to the pursuit of understanding her clients, Eve's interest in portraying the human figure in paint is a focus for lifelong learning. Photos of two of Eve's paintings are above.

BOOK REVIEW

UNLEARNING MEDITATION BY JASON SIFF

By Bill Cooper, LICSW
Bill@BillCoooperCounseling.com

In the last 20 years the impact of Buddhism-- particularly mindfulness meditation-- on psychotherapy has been inescapable. Training abounds for therapists to learn and teach mindfulness to their clients. Serenity and insight are often promised to those who learn and practice mindfulness. In the past, one often had to go to a Buddhist teacher to learn meditation; now there seems to be little doubt that in this country many of our clients prefer learning these techniques from a therapist. And many clients do benefit significantly from these practices. This is all to be expected among the humanistic theoretical orientations, but even some behavioral orientations, such as dialectical behavior therapy and acceptance and commitment therapy, include mindfulness in their clinical interventions to teach clients emotional regulation and exposure training.

The problem is that the experience of many of our clients has been anything but the tranquility and peace promised to those of who pursue meditation. What do therapists do with frequent refrains from our clients such as the following? "I can't do this…My thinking won't stop…I don't have the time for a regular practice…I'm not getting anything out of meditation." Adding to this, our clients often bring issues of shame and guilt to their meditation and see themselves as "failures." In short, mindfulness for some, if not most of our clients (as well as ourselves), may not be living up to the implied expectations.

What has been missing in much of the dialogue on mindfulness has been an honest critique of some of the ways mindfulness has been taught and practiced. Jason Siff, a Buddhist teacher of many years, has written a compelling book on Buddhist meditation that addresses many of these concerns: Unlearning Meditation: What to Do When the Instructions Get in the Way.

Siff is a true iconoclast. To begin, he turns the usual instructions for meditation back to the meditator for reference: "Meditation is what happens when you decide to meditate." In other

words, meditation is not a particular experience of tranquility or peacefulness--it's whatever is happening when you meditate, including thoughts about lunch, feelings of all kinds and all other so-called "wandering" thoughts. Significantly, Siff broadens the definition of meditation to include all of one's experience. Therefore, all of one's experience when meditating, not just the serene experiences or the experiences we like, becomes accepted as material to investigate and understand. He implies that the authority for meditation is the meditator, not the instructions, not the teacher. Siff's term for his approach is the receptive process of recollective awareness: gently watching and receiving everything that comes to mind, as opposed to meditation instructions he calls "generative," where the goal is to create a particular experience by, let's say, following the breath.

Speaking of following the breath, which is probably the most common instruction in mindfulness, Siff has this to say: "If you've learned, for example, to follow the breath as a meditation practice, this approach isn't about abandoning that practice, rather, it's about doing it without a strong intention." A unique teaching. He's encouraging gentleness rather than discipline.

Another important feature of Siff's approach is journaling. Students are encouraged to occasionally write about their experiences. This becomes an aid to understanding one's process and practice during meditation, perhaps answering questions like: "What's holding this emotion in place? How is it built up, or let go of? What's fueling it? What is its nature?" These questions will sound familiar to many therapists and it's interesting that most approaches to meditation do not include them. Rather, in typical mindfulness practice thoughts are simply noted as "thinking," and attention returns to a chosen object, such as the breath. In recollective awareness, one's thoughts are gently explored, not dismissed.

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AGENCY PROFILE: DESC

By Nicole Macri and Graydon Andrus,
Coordinated by Sukanya Pani and Molly Davenport

DESC (Downtown Emergency Service Center) was founded 33 years ago in Seattle as an emergency shelter for homeless men and women living with mental illness, substance addictions, and developmental disabilities. Today its mission is not merely to offer shelter, but to end the homelessness of the region's most vulnerable people. Through an integrated array of clinical services, shelter and permanent supportive housing, DESC programs allow men and women to reclaim their lives and reach their highest potential.

DESC is a leader in recognizing the unique needs of people with disabilities, and advocating for more opportunities for them. The Housing First movement, of which DESC is a recognized national leader, is a particularly good example of identifying a problem affecting a disadvantaged population (chronically homeless people with mental illness and substance use problems often couldn't obtain housing) and implementing a solution that incorporated their fundamental viewpoints and needs (they wanted housing without having to first stabilize in treatment). All DESC services are predicated on the concept of Housing First and the simple premise that clinical and social stabilization occur faster and are more enduring when the chaos of homelessness is eliminated from someone's life. A safe and healthy place to live should be the first treatment goal. Through this model, DESC has helped thousands improve their housing stability and health status, and has demonstrated significant systems cost avoidance.

On any given day, DESC staff assists over 2,000 men and women in the Seattle area. Stretching the bounds of accepted practices, DESC demonstrates that creative, assertive and holistic approaches work best for vulnerable homeless men and women. DESC prioritizes those who are most at risk and least able to care for themselves. Consequently, the men and women DESC serves are the most visible homeless adults in our community, they are among the highest utilizers of publicly funded services, and they are the least likely to be served by other organizations. DESC seeks out the individuals that many other organizations are reluctant to serve at all.

Professional clinical services are essential to DESC's approach. Many of the men and women it serves have lived with serious, and often untreated, mental illnesses and substance use problems for years or decades. Over 80 of the 450 employees are mental health professionals. One employee, Emily Peterson, received her Master in Social Work in 2010 and has worked on DESC's HOST Team for the last two years, providing outreach and engagement services to homeless women living with severe and untreated mental illnesses who are disconnected from any mental health services. When asked what the most rewarding aspects of social work practice at DESC are, Emily responds, "The most rewarding aspect of social work practice to me here at DESC is that I'm able to work with the most vulner-

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Marketplace

Mark Smaller, MD, will speak on "Treating at Risk Adolescents in a Public School Setting" in a free lecture open to the public sponsored by the NW Alliance for Psychoanalytic Study.
Dr. Smaller has developed a program in the Chicago school system that treats troubled adolescents who have been expelled from other schools, and supports their families. Town Hall, 3/1/13; 7:30 – 9:00 pm. Further information available at nwaps.org.

Awaiting Your Letters to the Editor!

Please write to:
Newsletter@WSSCSW.org

UNLEARNING

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Siff also addresses an issue near and dear to therapist: impasses. Yes, these can happen in mindfulness, too. Siff is trained in psychotherapy and has suggestions for dealing with impasses that are quite consistent with his overall approach. Personal stories fill in the details as to how these issues arise and are resolved.

The final portion of the book sketches types of basic meditative experiences: receptive, generative, conflicted, and three "advanced" experiences - explorative, non-taking up, and connected. There is neither time nor space to discuss these here. Siff's discussion is necessarily technical, but clear and worthwhile for readers who will find it helpful for understanding the experiences one is having or capable of having while doing mindfulness. It could be quite helpful for those of us who meditate, and our clients, to have this understanding about experiences that previously have been excluded from many discussions of meditation. Siff's work in Unlearning Meditation is a valuable contribution to the dialogue about meditation and the teaching of it. Therapists and clients who want to learn more about mindfulness will benefit greatly from what is taught in this book.

More information is available at: http://www.skillfulmeditation.org/index.html

AGENCY PROFILE

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able individuals suffering from a severe mental illness. It is exactly why I spent years studying in undergraduate and graduate school -- working with these individuals and offering them crisis services, counseling, and ongoing case management feels like a great feat to be accomplishing every day." She continues, "I am very grateful to Shirley Bonney, LICSW, who has been volunteering at DESC in offering MSW employees with group supervision once a week. Receiving these group hours has kept me motivated in working toward licensure."

Graydon Andrus is a Licensed Clinical Social Worker and DESC's Director of Clinical Services. He explains the important role WSSCSW members have played by volunteering to provide Approved Supervision to DESC staff: "Multiple MSW graduates have benefited from the generosity and skill of WSSCSW volunteers providing approved supervision in both group and two person arrangements. Without this added resource we would have valued staff considering higher paying jobs so they could afford to buy supervision. We are very committed to supporting professional growth and retaining skilled and committed social workers at DESC. While we continue to build capacity to deliver approved supervision by DESC staff, volunteers are essential to our success."

DESC has also shown leadership in research, advocacy and policy innovation on issues that impact disadvantaged people. For example, DESC does not exclude anyone from its programs based on criminal history, and has been up front in advocacy work around getting policies changed at all levels to diminish the use of criminal histories to keep people out of housing. DESC was responsible for the first published research study showing the lack of correlation between criminal history and housing retention, and has influenced other entities exploring questions around how to give more second chances to people with criminal records. DESC also provides technical assistance to homeless service providers throughout the United States and is the author of the Vulnerability Assessment Tool (VAT).

DESC is actively recruiting volunteers to provide Approved Supervision to staff seeking licensure to enhance their practice. Assisting licensure candidates is a crucial way of helping its underserved clientele. DESC has a large number of professional staff seeking licensure for their professions, typically Social Work or Mental Health Counseling. DESC appreciates volunteer Approved Supervisors willing to provide individual or group supervision (minimum one hour per week) to enthusiastic and dedicated licensure candidates who work in a variety of clinical settings. WSSCSW members interested in providing Approved Supervision should contact Graydon Andrus, DESC's Director of Clinical Programs, at 206-515-1524. For more information about DESC, please visit www.desc.org.

Nicole Macri is DESC's Director of Administrative Services
Graydon Andrus is DESC's Director of Clinical Services

Professional Development calendar of events, 2012-13:

CLINICAL EVENING MEETING SERIES:

STAYING CLINICALLY CENTERED IN A CONSTANTLY EVOLVING FIELD

Springing from thoughts, questions, and reflections raised by our fall conference, "I Googled You: Staying Clinically Centered in an Online World," we are pleased to hold a series of conversations with colleagues: the 2012-13 Clinical Evening Meetings, entitled "Staying Clinically Centered in a Constantly Evolving Field." As in the past few years, the intent of these meetings is both to provide relevant subject matter to our members and colleagues, as well as to create an opportunity for sharing experience in an informal, conversational setting. Our facilitated panel format will start the dialogue, and then will open the discussion to all present, stimulating conversations that have proven to be dynamic, reflective, and personal. In short, these meetings embody the best of what it means to find a "clinical home" in the WSSCSW, because they bring us together in the spirit of inquiry and support. It works best when you jump in!

HERE IS OUR 2012-13 CLINICAL EVENING MEETING SCHEDULE (please mark your calendars!):

Do More with Less, Part 1: Macro Focus Wed. Nov. 14, 2012

Diminished public and private funding is one of the pressures we currently face in all spheres of practice. How do we stay clinically centered when it is hard to tell what's happening in the broader sphere? Join us for a discussion about how we as practitioners stay clinically focused in the onslaught of increasing change in our healthcare provider systems, legislative regulations, and funding streams.

Do More with Less, Part 2: Micro Focus Tues. Jan 15, 2013

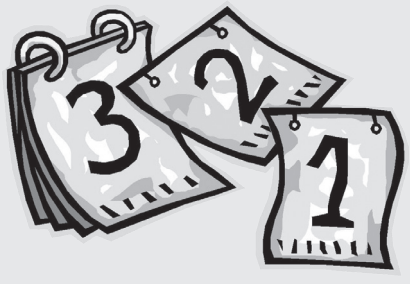
Building on our discussion from Part One, this evening will focus on staying clinically centered, theoretically and ethically, when pressured by constraints of time, money, and overwhelming need. Whatever our practice setting, it is often difficult to feel effective or to determine how to best help our clients when conditions challenge what we might consider "best practice." And how, as providers, do we factor in our own needs to earn a living?

Finding Depth in a Flatscreen World Wed. Feb 27, 2013

Our exploration next takes us to question what defines "therapeutic practice" in an environment increasingly focused on economic and personal survival, where often the pull is toward external solutions over personal exploration. How do we cultivate values of introspection, self-care, and personal growth through self-awareness in an increasingly non-reflective, multi-tasking, stack-ranked world?

The Art and Science of our Profession Tues. April 9, 2013

Join us as we close our "season" with a discussion centered on the unique balancing act of our profession: staying clinically centered in a constantly evolving field. How do we integrate the art and science of practice with evolving treatment approaches exploration. How do we cultivate values of introspection, self-care, and personal growth through self-awareness in an increasingly non-reflective, multi-tasking, stack-ranked world?



We hope many of you will join us in the conversation. Please send your comments and suggestions—we welcome your participation! Contact your chair, Sara Slater, saraslaterlicsw@gmail.com, As ever, we look forward to seeing you soon.

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