WASHINGTON STATE SOCIETY FOR

CLINICAL SOCIAL WORK

NEWSLETTER

Winter 2015
In this issue:

From the President

Looking out from the Summit

By Eric G. Huffman

I was excited to attend the national summit for clinical social work in Washington DC, the first weekend in October. Our national organization, the Clinical Social Work Association (CSWA) gathered Society presidents from across the country. (I'm not sure who traveled farther, Washington or Arizona.) There were some specific contributions I wanted to bring to the conference table and some specific experiences I wanted to learn about.

Diversity

I brought up diversity as a major issue we have been working on for some years in our State Society. I wanted to know how this is addressed by our sister groups. Interesting contributions were made. The overall impression I got was that this is an ongoing challenge in a few areas. New York has a unique problem in that Latino and Black social workers have their own organizations and, as always, dual membership is a possibility but also an expense. One piece of information I wanted to share was the vital point that commitment to diversity is not enough. We have to be aware of how we present ourselves to the world. For instance, how does the website look? This is our public face - is diversity mentioned, promoted, acknowledged? We are re-doing our website here in Washington and diversity will have a much more prominent position. I also mentioned the importance of having diversity considered in our State mottos. We will be working on this too.

Outreach, Students and Agencies

This is another area of special concern for us in Washington. Our Society is bigger than it has ever been. We have a strong financial base. We have student members, agency members, new Associate members and private practice members. We can be proud of ourselves for achieving this breadth of the clinical social work community; it wasn't always so. At the same time, if we want to continue as a viable Society over the next decade, we need to improve our contacts and our support among younger clinical social workers in all areas. I learned a great deal from the Pennsylvania Society about how they do outreach to agencies and the interesting and creative dues structure they employ. I asked that we find a way that CSWA can act as a clearinghouse for this kind of information so we are not reinventing the wheel in isolation, here in Washington or anywhere. As I have mentioned in the last newsletter, expanding our membership and reaching out to new social workers, who are frequently in agency settings, is a goal. It is also crucial for diversity.

Problems and Challenges

Our breadth of membership is our lifeline and our future. It is also a true challenge. If we think of the membership as being students, agency social workers and private practice social workers we can see the challenges. Each group needs something slightly different. Some need mentoring. Some

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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.

FROM THE PRESIDENT

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need networking. Some need skills building. Some want to know how to adapt more in depth clinical thinking to an agency setting. Some need community. Some need practice building. Some need help with insurance. Some are intent on getting referrals. Some are pros with social media and some do not own a smart phone. How do we address the needs of each group so everyone gets the most out of membership? How do we become as creative, inventive and supportive as we can be? How do we make sure we are not too focused on one segment of our membership? Or, does one segment require more focus? How do we know? How do we have this discussion?

Here is another challenge. Looking at the breadth of membership, we can also see a parallel spread in age distribution. Over half of our membership is older and in private practice. These members have been the heart and backbone of the Society. They are the ones who got us organized, weathered the fights, and turned us in new directions, such as working with students and agency social workers. They recognized our challenges with diversity and reoriented us legally (the by-laws) and structurally (creating a Diversity/Membership Chair). These are our elders and they are slowly retiring. We have a smaller middle layer of members and a still smaller layer of young students and recent graduates. How do we manage this transition to a broader leadership and new blood in a conscious, mindful way?

Let me be a bit blunt. As we wrap up our membership renewal drive, I have had the opportunity to speak with members who are not renewing. There are many reasons and there always have been (as past Membership Chair, I know!). However, the reasons that disturb me the most are the perceptions that we are "old, white, privileged and in private practice." Clearly that is not who we are or what we intend. At the same time, it is not fanciful. The real problems that this perception reflects costs us members. Some non-renewing members would stress one of these adjectives over others but taken as a whole it is a challenge we need to acknowledge.

Solutions?

This brings us full circle to the Summit. We need five steps and one big leap.

1. We need to talk about our concerns. What do we need that we are not getting? What problems do we see?
2. We need to offer viable solutions that recognize our real constraints.
3. We need to recognize the many stakeholders and the many needs in our decisions.
4. We need to deeply understand that making changes requires planning and it is like trying to turn a battle ship quickly...there is no quickly.
5. We need to have these discussions with courtesy and compassion—no easy task when there is a sense of urgency.

The big leap we need is you! We simply do not have enough members stepping up to help with the changes. We need bigger committees so we can accomplish more. The more help we have, the faster we turn. Please watch the listserv and the newsletters for volunteer opportunities. It is only by sharing the views of the best and brightest in the clinical social work community (that's you) that we can have diversity, breadth, growth and creative change.

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

EDITOR'S NOTE

By Emily Fell and Lynn Wohlers

As Eric outlined, our organization has been greatly challenged in recent months. The newsletter has not escaped from these difficulties unscathed. This issue reflects some of our struggles; it's thinner than usual. The voices of several important committees are absent. As members, through contributing content, you have the privilege to steer our organization's focus! This can be accomplished through creating new content for the newsletter, responding to others through a letter to the editor, or a listserv discussion.

In future issues we hope to feature pieces about the history of the Society. We think that sharing narratives from long-time members can build a better understanding of where our organization began. Being mindful of where we came from can help us as we make changes and move the Society forward.

Let us follow Eric's lead of being blunt, and most importantly, being involved in the process of growth and change.

Posting Mindfully

By Robert Odell, LICSW

Almost all WSSCSW members have everyday experience with our member e-mail group, a/k/a the 'listserv." Our listserv was established on Thanksgiving in 1998. I was the original Moderator until 2008, and then Karyn McKenzie took over and did a famously great job. Recently I agreed to volunteer in an interim capacity, through the end of 2015. Fortunately, I am happy to announce that Marti Hickey, LICSW, has agreed to take over the Moderator position in December.

The listserv is 17 years old, though this isn't a "17th anniversary" piece. Rather, I thought I would render some observations about this internet resource of ours, how it's grown and might grow further.

What We Post

Much of what is clinical social work is reflected in our dialogue. We publish, announce, inquire and dialogue in many areas: professional education, insurance, legislation, social action, office availability, publications and more. We process case referrals, locally and out-of-state. Inquiries relative to clinical cases are raised (though not as peer supervision). We use the listserv to address social needs, as well as shared values.

Virtual Culture

Anyone who's spent time reading our posts knows that the listserv does indeed express our organizational culture(s). We have successfully maintained a professional, civil and non-judgmental atmosphere. There is a togetherness that binds us into a virtual community, operating alongside our practices, through a concentrated 'here and now' professional resource.

We value being present and authentic and "in the moment." Reflection and analysis on any professional issue now makes the listserv read like a daily journal of clinical social work.

A Learning Curve

This wasn't always entirely the case in earlier years. The listserv would get barraged by chain mail jokes, virus warnings, and some rather slight conversation threads. At times the listserv read like a transcript of a three or four-person phone call. It was treated like a personal convenience or messaging tool, not so much a resource. The process of determining what is most essential and purposeful to our work, and how to express it, has developed over time.

Steward Resources

Today, we strive to have every post reflect not only a current matter, but also a contribution to our "intellectual capital" and "institutional memory." As members of a small professional association, we must steward 'free' resources like these to enhance the membership experience.

Local Research

Most members don't know that the listserv is also a researchable database. Yahoo Groups makes the research easy. Enter your Yahoo ID at groups.yahoo.com to see how it works. If you are looking for resources, enter key words in the listserv's home page search window, and it will retrieve all posts using those subject words! For example, enter "DBT", "mindfulness", or "office for rent" in the "Conversations" search window, and the site will pull up

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Update on Regence Campaign to End Reimbursement Cuts

By Laura Groshong, LICSW, WSSCSW Legislative Chair

As many of you know, in addition to the Society, I work for an organization called the Washington State Coalition of Mental Health Professionals and Consumers. This group has members from all mental health groups and is helpful when we have a broad-based problem like the one we have had with Regence. The Regence reimbursement cuts affect all clinicians; the more we have all six mental health groups involved in the effort to stop the cuts, the better.

The Coalition has been hard at work with our efforts to prevent the cuts that Regence has been proposing to their behavioral health reimbursement for psychotherapy services. Here is a summary of what has occurred so far and current efforts.

June 28, 2015 – Regence announced its plan to combine rates for 90834 and 90837, lowering reimbursement for 90837 by 30% and raising the rate for 90834 by 4% starting October 1, 2015

July 11, 2015 – Coalition held a meeting to discuss the problem with 80 clinicians attending, including many Society members

July-August, 2015 – Coalition worked internally to create six committees to stop the Regence cut: legislative, press, social media, connecting with other mental health groups, connecting with consumer groups and externally to connect with other stakeholder groups — all committees had volunteers and plans for becoming viable — survey sent to members on plans to leave Regence panel with 25% of clinicians planning to leave and 50% more considering leaving – contacted Office of the Insurance Commissioner which responded positively to our concerns

August 15, 2015 – Coalition held a second meeting to strategize on how to enact the plans that were discussed with 20 present, including several Society members

August 26, 2015 – Coalition press release called "Regence Slashes Behavioral Health Reimbursement Rates" sent out - supportive article in response from Puget Sound Business Journal

August 31, 2015 – Regence withdraws plan to combine reimbursement rates

September 1, 2015 – Regence announces plan to reduce reimbursement rate for 90837 by 25%, beginning December1, 2015

September 19, 2015 –Contacted OIC about new reduction in Regence rates – OIC responded that they have no oversight regarding rates paid to clinicians (September 26)

September 29, 2015 – Coalition sent another clinician survey to see what the mental health community planned to do in regard to the planned reimbursement cut

October 12, 2015 – Coalition collates clinician survey (284 responding) which has almost identical results to first survey, i.e., 25% leaving, 50% more considering leaving

October 14, 2015 – Coalition Board meeting to decide next steps:

- **Meet with the Health Care Authority** which oversees the Public Employees Benefits Board (PEBB) and has given Regence the contract to provide health care services
- **Meet with legislators** to see if there is a way to stop this cut legislatively
- **Meet with Attorney General Bob Ferguson** to see if there is a parity violation here that he can prosecute

I will be representing the Society and the Coalition at the above meetings.

Below is a summary of the second survey. The Society and the Coalition will continue to oppose the Regence cuts.

Coalition – Survey of Regence Clinicians Summary – 10-12-15 (N = 284) Survey Open Dates = Sept. 29, 2015 to Oc. 11, 2015

1. **What is your mental health license?**
   LICSW = 46%; LMHC = 30%; Psychologist = 10%; LMFT = 5%; ARNP = 7%; Psychiatrist = 2%
2. **Do you plan to leave the panel after October 1, 2015?**
   Yes = 27%; No = 22%; Maybe = 51%
3. **Have you already left the Regence panel (given notice)?**
   Yes = 13%; No = 87%
4. **Are you currently on the Regence behavioral health panel?**
   Yes = 81%; No = 19%
5. **Comments:**
   Regence making profit more important than care (50)

   Regence too hard to work with to get needed coverage (43)

   Still on panel but not taking any more Regence patients (89)

   Still on panel but restricting number of Regence patients I accept (36)

   Can't afford to stay on Regence panel (68)

   Can't afford to leave Regence panel (72)

   Regence used bait and switch by opening panel and then lowering rates (39)

   Don't want to leave because will be abandoning current patients (66)

   Don't want to leave because patients need coverage (80)

   Feel too insulted by the 25% cut to stay (31)

   Don't know how they can do this under mental health parity laws (20)

   Left within the past 5 years already because Regence so restrictive on coverage and intrusive in treatment reviews (19)

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

Reflections on Community Mental Health

Including an Interview with Sarah Durham, LMHC, CDP

By Emily Fell, LICSW

I recently left my position in Community Mental Health after five years in the agency setting. The decision has been filled with reflection and mixed emotion. Mine has not been a unique path for mental health counselors; many graduate with their masters, work in Community Mental Health, obtain licensure and move on to another mental health setting. My frustrations with agency work are also not unique. Factors such as overwhelming caseloads, endless paperwork, frustrating bureaucracy, low pay and exposure to the tremendous amounts of trauma, poverty and disadvantage that exist in our country, contribute to burnout and high turnover in agencies. These things certainly took a toll on me.

For all its faults, the Community Mental Health setting provides clinicians an invaluable training ground and the privilege to work with diverse clients who may not otherwise have access to services. Many Community Mental Health clinicians justify their highly demanding and under-compensated work because of the tremendous opportunities for growth it affords. Although compelling, staying in Community Mental Health on principle was not enough for me. I leave the arena with a longing to find personally sustainable ways to continue working with people who are diverse and disadvantaged.

In reflecting on my hope for improved working conditions in agency settings, in order to retain talented clinicians and provide high quality services, I thought I would talk with a former coworker, Sarah Durham. Sarah is a Licensed Mental Health Counselor and Chemical Dependency Professional. She was hired by a local Community Mental Health agency in 2003 as a case manager, shortly after graduating with her masters. Sarah and I worked together on the adult services team at this agency for about a year in 2012, until Sarah was promoted to a different site. In my experience working with her, Sarah has a contagiously positive, light hearted and practical attitude. She also has a knack for providing on-the-job guidance that can make things seem magically simple.

Sarah says when she first started working at the agency she didn't know what a case manager was, however looking back she "lucked into the ideal situation." Sarah says the work "provides the freedom to offer the client what they need in that moment;" resources, safety planning, brainstorming or therapy, to name a few. She says working from this lens allows her to truly serve clients in the Community Mental Health setting. Sarah believes offering therapy alone would be limiting, as talk therapy is minimally therapeutic to someone who is hungry or homeless.

Sarah was formally promoted in 2013 after ten years with the agency, though she had been functioning as a supervisor for many years. Regarding her promotion Sarah says, "People would ask me if I wanted to become a supervisor, my answer was always no. I want to work with clients." When I asked Sarah if she had feelings about taking on a leadership role for so many years without recognition in title or pay, she said no. She deeply believes in her work and nonchalantly shares that "the money piece has never been an issue...I can figure out how to live off of almost no money." Sarah also points out that "if you choose to work for a nonprofit agency, you go into it knowing that they cannot compete with the private sector money."

Regardless of whether one agrees with Sarah's outlook, what I hope will become apparent is that she has a perspective that I believe Community Mental Health needs to cultivate in order to thrive. Yes, agencies have gotten by for decades with high staff turnover, but I would argue that it is not working well; it diminishes quality client care and reduces the number of qualified candidates for leadership roles. My hope is that sharing my discussion with Sarah will provide a framework for thinking about agency work, for current and future clinicians. I will speak for those who have worked alongside Sarah when I say she has a way of commanding others to believe in their work, and do a damn good job.

In 2010, Sarah was one of four clinicians serving about four hundred clients at the agency. When two of these clinicians resigned, the team was reduced to two. As the senior-most clinician at the time, Sarah took the brunt of the responsibility for serving about four hundred clients with severe, chronic mental illness for more than a month before the team was fully staffed again. Sarah admits this time was stressful, her to-do list was impossible and services became quite crisis oriented. However, her tone is both warm and matter of fact as she says, "You do the best that you can do. All of the clients knew [that the two of us] were it. If you need us, come here and we'll help you. You might have to wait, but

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somebody will help you. Just come in." Sarah says months later, when management was reviewing the year, they told her that they probably should have found someone to come help out. Sarah views this as a non-issue, "It's not like there was anyone extra around that could have come help us!" Other clinicians may have felt defeated by these circumstances or blamed the agency. Sarah reports no such sentiment; instead of focusing on how difficult the job was at the time or how it altered the types of services that were available, she says "Our clients are such remarkably resilient people, they've had to overcome things that most people have never encountered. They don't get nearly enough credit for how strong they have to be." In response, I point out that many of these clients have had to deal with chaos and insufficient support all their lives. Yes, they are good at it, but why should they continue to put up with this at the place they come to for treatment? If they had more income, or private insurance, their services would be quite different.

Sarah's response to me, I believe, is a highlight of our discussion. She says the expectation that Community Mental Health agencies can provide services that look similar to private psychotherapy clinics puts a huge burden on clinicians. She says this mindset partly stems from our training; many graduate programs prepare counselors for private practice. Case management is not always framed as a valuable, legitimate type of service for clients or the ultimate career path for masters level clinicians. Sarah recalls a friend's story about a professor describing case management, "When you first start, you'll probably have to do some case management. But you'll work through so you can get past that. Like it's some introductory hazing process that new hires go through." Sarah implied, and I would agree, that this mindset can lead to a lot of disappointment in the Community Mental Health world.

Sarah views agency work in a way that makes the services available in that setting feasible. Clients are approached with the assumption that they do not need to be seen by the same clinician weekly. Some clients may be ready for and wanting therapy, and in those cases Sarah thinks there is nothing wrong with providing sessions every other week or less. "How can you take what we talk about, process it, try to implement and assess how it's working for you? That can be a lot to do in a week." This mindset has the potential to be very empowering for clinicians and clients; looking at clients as already quite capable of knowing what they need and being able take a little bit of help a long way. Sarah says that agencies need to maximize what they offer, providing groups and social events to supplement individual meetings. Sarah explains that once you let go of the mindset that treatment has to look a certain way, there's a lot of space for what you can provide.

When we talked about how Sarah developed her perspective, she pointed to having supervisors with a healthy outlook, educating herself, reading the agency's monthly reports and asking questions. Sarah found answers to make her work make sense. That way, she could get behind what she was doing and not just do things because they were required.

In the years leading up to her promotion, Sarah's supervisor told her that they would work on strengthening her leadership skills, regardless of Sarah's desire for a promotion. Sarah says that is what needs to happen more in the agency setting; managers need to train talented staff not only to be good clinicians, but effective managers of people.

In the program Sarah now coordinates, she oversees fifteen clinicians, each with a caseload of over one hundred clients. Sarah describes the team's relationship as familial. One of her clinicians had a family member pass away and had to leave the office abruptly for several days. Sarah said without hesitation, the rest of the team contacted this clinician's clients, let them know what was happening and told them to call if needed before their clinician returned. This particular clinician prized having an organized desk, so the team straightened up her desk and sent her a condolence card.

If anything can compensate for a heavy workload and low salary, it seems to be a sense of camaraderie with a team. Sarah's team celebrates birthdays, licensure and other achievements. Sarah sits down with her clinicians and helps them set a daily schedule that works for them. One clinician gravitates toward intake assessments, so that is primarily what he does for the team. This frees up more time for other clinicians to focus on counseling. Sarah asks them, what's the best time of day for you to do paperwork? Would setting some drop-in hours free up your schedule? How about doing paperwork with clients during sessions, saving time and helping clients drive their treatment? As I have observed first hand, Sarah has an open door policy; she's available not just during formal supervision,

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REFLECTIONS ON COMMUNITY MENTAL HEALTH

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which clinicians get an hour of per week, but for on call support as well. Working for a team with a leader who believes in the work, and empowers both clients and clinicians to make things work for them, can help make a seemingly impossible job, doable.

I leave Community Mental Health feeling frustrated by the mental health system, inspired by the clients and better off for the experience. I hope to continue to find ways to serve people who are diverse and disadvantaged. As for Community Mental Health, I believe the setting needs more leaders with a mindset like Sarah's. This may help clinicians form more realistic expectations for the agency setting and to believe in all the ways they can help clients. When asked about burnout, Sarah claims that after twelve years in an agency, she has never been there, "Tired and stressed yes, ready to leave, no." I ask her to divulge her fantasy, plan B, career. Sarah says she wouldn't go anywhere else in the mental health field, but would choose something entirely different, "Botany. Botany sounds good. Plants don't talk." We share a laugh and I learn that Sarah has yet to start her plant collection.

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

POSTING MINDFULLY

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all prior posts on the topic! Lots of them.

Guidelines

Soon after the listserv was started in 1998, as it was evolving into a central membership asset, the Board decided that approved guidelines were needed to ensure its collegial content and consistency. The term 'guidelines' seemed to best fit this new piece of governance. Today, our Guidelines are open for inquiry, dialogue and change, but they remain our 'rules of the road.' Inquiry and discussion would precede any approved changes.

Posting Mindfully

The main reason for having guidelines is to identify what members should be mindful of when they post. "Post mindfully" sounds borrowed from the mindfulness movement, but the traditional definition is what's meant: when we post to the listserv, we must be "mindful" of the environment we are communicating in, who we choose to reach with our message, and how accessible our efforts will be to others.

Consider Parsimony

Think about how you are writing your post, or replying to another member's post. Parsimony is really the principle involved: the best connection is the simplest. If you address everyone, make sure 'everyone' is the right audience. Not everyone must know if you are simply grateful for someone else's effort. Or that you have enough replies to a referral request (reply to late responders individually).

Take Extra Time

The listserv provides many good things, quickly and conveniently. But to keep it that way, there are situations where members must take a little extra time, rather than sending a message out of personal convenience that's meaningless to the great majority of members.

Where It's Going

In most ways, the listserv's future is pretty well determined. I have some wishes about its future directions.

1. The connection between the listserv and the Ethics Committee could be more frequently used. The original idea was that a member could post about an ethical dilemma or question, and the Ethics Committee would take the matter into its own consult process and reply back to the member (and the membership).

2. I would love to see a member take on the idea of uploading local and other resource information to our Files section. What a great clinical resource that could be!

3. I hope that the listserv will be a venue in which member's social work projects can be announced, and support garnered.

Let's hear your ideas for improving our valuable connection!

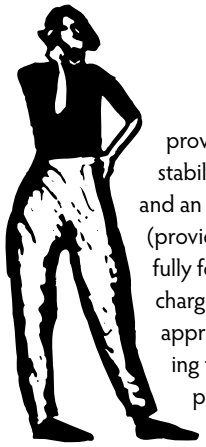
We invite you to respond to the author's ideas and continue the discussion with letters to the editors, and on the listserv.

Keep your eye out for upcoming announcements about Diversity Trainings and our Spring Conference!

BEST OF THE LISTSERV

"BEST OF THE LISTSERV" is a recurring series in our newsletter, highlighting relevant and thought provoking conversation threads from our listserv. The listserv is an important benefit of membership. As a go-to tool in our clinical toolbox, it keeps us connected and enables us to support one another as we request resources and referrals, discuss challenging subjects, and share what matters to us as engaged social workers.

Billing for a Telephone Session



Requests for therapy sessions by phone are common, especially now, in an age of sophisticated technology with seemingly endless communication platforms. Practitioners are tasked with handling these requests in a way that ensures quality care, appropriate compensation, and attention to confidentiality and privacy.

Recently a member asked about billing insurance for a therapy session conducted over the phone. Here are members' responses to the question.

[In answer to your question] I don't know of any insurance that pays for phone sessions. I'm paneled with Regence and know that phone sessions are not reimbursable. It's something I make sure clients know beforehand so it's an informed choice.

Best,

Jenny Pearson, LICSW

I suggest that anyone who wants to be able to offer phone sessions for a situation like this one make sure you have a section in your disclosure statement about it. It would say that if a session must be held over the phone, the patient is responsible for paying the cost of the session, unless covered by insurance.

It is not a perfect solution but it is a reasonable compromise.

Regards,

Laura W. Groshong, LICSW, WSSCSW Legislative Chair

Has anyone read through this senate bill on telemedicine that was enacted in July in Washington state?

Web address for a PDF of the bill: http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/5175-S.SL.pdf

Leon Monroe, MSW

I have read this bill.

The LICSWs covered by this bill must work in the following locations:

Sec. 3(3) An originating site for a telemedicine health care service subject to subsection(1)of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Community mental health center;

(f) Skilled nursing facility; or

(g) Renal dialysis center, except an independent renal dialysis center.

This does not include clinicians in private practice. At some point that will probably come about.

Of course, any LICSW who works in any of the locations listed in the original post will be covered if they provide telemedicine psychotherapy services. Please be mindful of using servers that are willing to sign a Business Associate Agreement.

Regards,

Laura W. Groshong, LICSW

This question has come up many times in my private practice as well, so I've finally shaped a policy with which I'm completely comfortable.

Clients are made aware that 1) insurance will not cover phone sessions and, 2) there are limited circumstances under which I may consider offering one.

To the second point: If a client's inability to make the appointment is due to circumstances well beyond their control, and the need for a session is somewhere near urgent, then I will provide one on the phone for purposes of stabilization, crisis management, resourcing, and an action plan until the next appointment (provided the client is in a position to be fully focused on the conversation). I agree to charge only the specific insurance contract-approved rate for the phone session (including their copay) with the expectation of payment asap.

My rationale for not otherwise offering phone sessions is if we are NOT meeting face-to-face I lose the 80-85% of my client's communication normally conveyed non-verbally, including clinically-relevant data I gather from his/her somatic responses to session content. I feel clients get too little "bang for their buck" (or therapeutic benefit) if I'm unable to observe and work with the more nuanced aspects of our exchanges in a session.

Before I got clear on that last point it was often hard to say no to a request for a phone session. It is almost effortless now that I frame the question in terms of what choice cost-effectively maximizes the therapeutic benefit to the client.

My two-bits, and all that...

Cynthia Shaw, MSW, LICSW

I am left wondering whether we (LICSW or LASW) are considered by the state to be "other healthcare providers," or not.

Robert Odell, MSW, LICSW

It depends on the insurer and the plan. Some plans require that they will only cover sessions held in a physician's office. This should be clarified with each client.

In general I have found that the "other healthcare provider" clause refers to providers who can fill the primary care physician role, i.e., DOs, sometimes ARNPs or naturopaths.

Best,

Laura W. Groshong, LICSW

Thoughts On Supervision

By Jennifer Lee, LICSW and Joan Willemain, LICSW

After graduating and securing your first job, one of the biggest challenges for an associate is finding and being able to afford good quality supervision. Possibly, in your hunt for employment you've had to take a position where there is little or no supervision, even for clinical work.

Social work environments can be complicated and difficult to navigate, especially for the new social worker. Outside supervision provides a safe space for discussing these concerns. Meeting with a professional outside of your place of employment allows you to explore ideas that you may not be exposed to in the workplace. Although there is accountability involved, it is not performance based, and we have seen many social workers thrive with this kind of support. For social workers in private practice, it provides emotional and practical support as experience is gained.

Associates reach out to us on a regular basis, both confused about the supervision and licensing requirements and looking to see if we are taking new supervisees. You may find yourself in a lower paying job than you thought you would have after graduate school. And now you may also find that you need to pay out-of-pocket to become licensed, in order to ultimately earn a more livable wage. If you are supporting a family, the cost of supervision oftentimes is even more difficult to afford.

If you are having difficulty paying for supervision, here are some suggestions:

1.) If you are in an agency, ask your employer to pay. This is one of the first discussions we have with social workers who approach us for supervision. Some have not broached the subject or are afraid to challenge a policy. It's Good Practice!! We have known numerous social workers who have been successful in getting at least partial reimbursement. Some agencies will contract with a supervisor directly and others will reimburse the supervisee. Don't hesitate to ask your supervisor if he or she is willing to help with this process, if it's approved by your employer.

2.) Group Supervision: You may not have realized that group supervision is one of your options for working towards licensure. Social workers are permitted 70 hours of group supervision. This is a great value, lots of fun, and an opportunity to learn strategies, resources and approaches from both the supervisor and colleagues who are in the process of becoming LASW's or LICSW's.

Groups are stimulating because members come from many different places of employment and backgrounds. For example, attendees will typically get exposure to cases that involve children, adolescents, adults, mental health settings, medical social work settings, housing and school settings. It's nice to be able to hear about a wide variety of clients and settings, when typically, your work may only focus on one population. Groups allow you to connect with others who are new in the field and going through similar experiences.

You may have moved to Washington from another state and have a small number of hours to complete to get your license (if you were already licensed in the state you moved from), or you might be just beginning work after completing your MSW. Either way, group supervision gives you an affordable opportunity to learn about different practice settings.

Numerous times we have heard that after getting past the fact that you have to pay your hard-earned money for supervision, you realize it is extremely helpful. If you are an associate in private practice, supervision is not only required, but will help you to develop your identity and brand as a practitioner, in addition to supporting clinical issues.

We love working with new social workers. This is a rapidly changing field, and as supervisors we need to be sensitive to the needs of new professionals. In doing so, we learn so much from the professionals we supervise. We think it's important to define your needs for supervision. There is an art to RECEIVING supervision. Learn to ask for what you need and then put a value on it. This will give you practice in valuing your own time as well.

Many licensed clinicians continue to pay for private supervision. They often feel it enhances their practice to meet with a trusted person who is totally focused on their work with clients. It can decrease stress and help the clinician to be more present for clients.

Great supervision is a gift, whether you come by it freely or pay for it. We have had great, horrible, and in-between supervision, so we truly appreciate the times when we are helped. The support and education for your career that supervision provides is immeasurable.

A list of approved supervisors can be found on the WSSCSW website

Beautiful, private, one person office with waiting room to sublet two days/week in the historic Securities Building in downtown Seattle. If interested, please contact Mary Jane Golden, MSW, ARNP @ 206 622-6962.

SAVE THE DATE! 2016 Dorpat Lecture:

Holding and Helping Mothers and Babies through Supportive Presence: A Nurse-Family Partnership Program

Sponsored by the Northwest Alliance for Psychoanalytic Study

Friday, February 26, 2016 • 7:30-9 pm • Town Hall • 1119 8th Ave • Seattle, WA 98101

In order to support first time mothers in creating a holding relationship for their infants, a holding relationship must exist for them. The 2016 Dorpat Lecture will highlight the Nurse-Family Partnership Program, a program that relies on a supportive and collaborative relationship between nurses and mothers as they begin this journey of parenting.

The Nurse-Family Partnership is a home visitation program where the nurse visits first time mothers starting early in pregnancy until the child is 2 years old. The families receive regular home visits focusing on parental and child health promotion, development, education and holistic lifelong wellness and self-sufficiency.

The program supports the development of attachment by holding the new parents with their hopes and fears, so that they can be present to the experience in a way that will maximize availability to the infant as he/she develops. The program builds on the strengths and goals of each family to help with intergenerational challenges and future possibilities. The perinatal and infant mental health practices have supported the resiliency and improved the trajectory of the family outcomes. Several longitudinal studies have shown the efficacy of this program.

In this presentation, the nurses will describe why and how this program works, and talk about their own experience as practitioners. Case presentations and videos will be provided to supplement an interactive presentation. We hope that you will be able to attend this **free event, open to the public.** Please share this information with any individual or organization who might be interested in the topic.

Speakers:

is a Community Health nurse and program manager of Nurse Family-Partnership (NFP) at ChildStrive, formerly Little Red School House. She is a reflective supervisor and infant mental health consultant, as well as a preceptor for the University of Washington for Psychiatric Nurse Practitioner students. She is finishing a PhD in early childhood development with a specialty in infant and early childhood mental health and disabilities.

is a Community Health nurse in NFP at ChildStrive with 6 years of maternal child home visiting in NFP. She worked in California in NFP and as a lactation educator. She has developed various educational modules to facilitate learning in home visit programs here in WA and in California.

ATTENTION

All Associate and Student Members of WSSCSW!

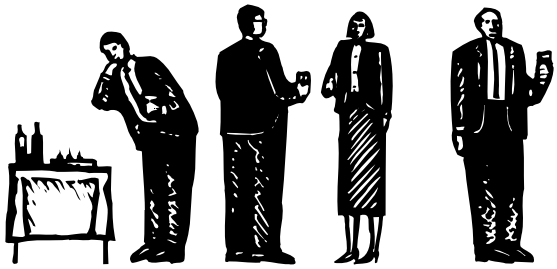
Please join us for our Annual Associates Event

Thursday, January 28th, 2016

7:00-7:30pm: Networking over Food and Beverages

7:30-9:00pm: Program: Addiction and Recovery

University of Washington School of Social Work
4101 15th Ave NE, Room #305A



As clinical social workers, we encounter addiction in every practice setting. Learn how to work with people with addictions and their loved ones and what it takes to become a Chemical Dependency Professional.

RSVP: Melissa Wood Brewster, Associates Chair
woodbrewster@gmail.com or 206-409-1266

If you can't make the annual event, join us for the **Associates Quarterly Meetings for networking, mentoring and licensure resources: **April 24th, June 23rd, and September 22nd, 2016**

NEW MEMBER PROFILES

The Membership Committee wants to welcome these new and returning members. We look forward to meeting and getting to know each one of you.

John Allemand
Nina Armstrong
Susan Bolotin
Ada Lori Brown
Jennie Crooks
Mikaelyn Cottier
Robin Custer
Kayla Henley
Marti Hickey
Susan McKay
Kimberly McKittrick
Amy Murphy
Cynthia Pace
Shayne Pasol
Denise Serfas
Charla Soriano-Jaffee
Aliyah Vinikoor
Melanie Walker
Deborah Weiner
Ashley Wright

SUSAN BOLOTIN

Susan earned her MSW in 1972 from the University of Kentucky and is in private practice in the Capitol Hill area of Seattle. She works with adults and couples and specializes in trauma/PTSD, depression, anxiety, LGBT issues, and substance abuse. Her mind/body work is based on attachment theory and neuroscience. She's a seasoned therapist trained in EMDR, Lifespan Integration, Brainspotting, Energy Psychology, and Sensorimotor Psychology.

Susan loves spending quality time with her partner, grandkids, long-term friends, and her adorable dog. For fun, she enjoys national and international travel, live music, fine dining, and being outdoors camping, hiking, and gardening.

MIKAELYN COTTIER

Mikaelyn received her Social Work degree from Walla Walla University in 2006. Since graduating, she's worked in nonprofit administration and management, hospice, and state government. Mikaelyn currently works as a government contractor while planning to open her private practice in the Greater Seattle area. Her therapeutic techniques include solution focused and cognitive behavioral therapy. When she is not working, Mikaelyn enjoys living in the moment while swing dancing, walking in the woods, reading fiction, baking bread, and planning her next weekend excursion.

ROBIN CUSTER

Robin Custer received her MSW from USC and is a therapist in private practice at Balance InSight, a West Seattle counseling practice. "Clinical Social Work seemed like the natural extension of my former career as an elementary and special education teacher." A therapist and care manager, Robin helps clients heal and build resilience around trauma, anxiety, and family of origin issues. She also has a special interest and talent working with clients and families coping with schizophrenia and other mental illness, and people with autism. In her spare time, Robin is a foster parent to rescued cats and bottle-baby kittens, an avid reader, and tent camper. You can find her online at www.balanceinsight.com.

Have an ethical dilemma or question?

Contact us on the WSSCSW listserv with general questions that can be shared.

SHAYNE PASOL

Shayne earned his MSW degree in May 2015 from Loyola University Chicago's School of Social Work, specializing in clinical mental health. He has direct case management and psychotherapy experiences working primarily with the LGBTQ population. Shayne is currently working towards his independent clinical license, while working as a Mental Health Clinician at Sound Mental Health. When he is not working, Shayne enjoys being a "foodie" and exploring the culinary scene Seattle has to offer.

DENISE SERFAS

Denise Serfas holds a Master's in Social Work from Eastern Washington University. Denise earned her Bachelor's in Human Services from Western Washington University and was part of the initial credentialing group to sit for the Human Services-Board Certified Practitioner exam through the Center for Credentialing & Education. Denise has ten years' experience working in the human services field with families, individuals with disabilities and seniors. She has facilitated marriage education classes in a federal research project and is a Powerful Tools for Caregivers facilitator. Denise has been a social services manager at an adult day health program, family advocate, and outreach manager with various non-profits. She currently works as a case manager serving unpaid family caregivers through Evergreen Health's Behavioral Health program. Denise is a member of the National Association of Social Workers and the Washington State Society for Clinical Social Work.

Washington State Society for Clinical Social Work
Po Box 77264
Seattle, Wa 98177

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This is to let you know that the traditional Society holiday party will not be held this year.

It's a time of transition for our Society. Look for an upcoming announcement on the listserv to explain the issues that we face and *the need to address them* as a group.

The Board will host a meeting early next year to discuss diversity, growth, and creative change within the Society.

CLINICAL SOCIAL WORK ASSOCIATION MEMBERSHIP

WSSCSW is an affiliated group of the Clinical Social Work Association (CSWA). CSWA advocates for our practice at the national level, providing analysis of macro social work issues which affect us all every day. CSWA membership also confers other valuable benefits, such as free consultative service for legal and ethical questions and discounted comprehensive professional liability insurance.

Please consider complimenting your WSSCSW membership with a CSWA membership.

CSWA member dues are $35 for students, $60 for emeritus members, $85 for new professionals, and $100 for general members.

More information is available at http://www.clinicalsocialworkassociation.org.