

# NEWSLETTER

## SPRING 2006

### **President's Message** **By Sharon Williams**

This will be my last letter as President of the Illinois Society for Clinical Social Work. It has been a challenging four years with many changes. These changes have run the gamut from national to personal.

Four years ago, we discontinued our affiliation with the guild after many members nationwide suffered from unpaid medical claims, when the insurance plan members purchased through the guild failed. Illinois was the hardest hit group in the nation and the slowest to recover as our State Department of Insurance prevented the insurance company from settling the claims at a rate they deemed unacceptable. The insurance fiasco created an aura of distrust and intense disappointment in the Society. This is a breach that has been difficult to repair, because of a lack of enough resources within our own Society, and the incredible length of time it has taken for our harmed members to have financial resolution and restitution. We are hopeful, however, that we are able to find a way to mend this.

This year we disaffiliated with the Clinical Social Work Federation (CSWF). The CSWF is trying to reconstitute itself and endeavoring to emerge with a different structure, similar in governance, to the NASW. This change was cause for concern for some of our members. However, the changes that have occurred with the CSWF have been long in coming. Our members will be kept abreast of new developments.

Many endings certainly hold the potential for new beginnings and new growth. As we know clinically, change is always difficult and not without resistance, even when it is very much needed and wanted. We are growing again, but it has been a slow process. However, we have "stayed the course," and we have some exciting new benefits for members.

Our new website which is "mostly" up and running should be an effective marketing tool for our members. In fact, members may have their own web page through our website which will be linked to professional search engines. We will be providing pertinent literature and references, a forum or discussion board and links to government departments relevant to our profession. A membership directory will be located on-line. However, members may have a printed version by request. The web site is accessible.

We have developed a number of continuing education projects, including clinical seminars at open meetings and our co-sponsorship of the Allan Schore conference on April 29, 2006. We are also developing an annual supervision training program.

The majority of the current board will be continuing into the next term, and the nominating committee is developing a slate for open seats on the board and for officers. Members are invited to nominate potential board members.

It has been an honor and a privilege to serve as President of our Society.

# Original Clinical Paper

## **It Takes Two to Tango: A Conceptual Framework for a Relational Approach to Supervision**

by Eric Ornstein, M.A., L.C.S.W.

Even in our current clinical climate of evidence-based practice, billable hours, manualized treatments and internet therapy, there is still no substitute for a strong supervisory relationship, which is an essential ingredient for social workers to develop clinical competency and skills. Despite the continuing importance of clinical supervision, relatively little has been written about supervision from a contemporary psychodynamic perspective. The purpose of this article is to summarize and expand upon key concepts of a psychodynamic relational approach to supervision, as developed in two previous articles I co-authored with Carol Ganzer, Ph.D. (Ganzer & Ornstein, 1999, 2004) and in a recent ground-breaking book by Frawley-O'Dea and Sarnat, *The Supervisory Relationship: A Contemporary Psychodynamic Approach*. According to Frawley-O'Dea and Sarnat (2001), a relational approach to supervision is defined by mutuality, shared and authorized power, and the co-construction of knowledge.

Mutuality refers to the possibility that both supervisor and supervisee bring special expertise to the supervisory encounter. The supervisor has conceptual knowledge of the field and agency treatment approaches, as well as invaluable experience working with clients and client systems. Supervisees bring their own past experiences in life and in the field, as well as expertise about the client or client system, including what it is like to be in the room with the client and invaluable data about the emotional ambience of the session.

Mutuality also suggests that in a relational approach there is significant emphasis on mutual influences and interactions occurring among supervisor, supervisee and client. In other words, conscious and unconscious experiences of any of these three parties (supervisor, supervisee and client) might be the appropriate focus of supervisory attention at any given point in time in the course of a case. This view on mutuality requires supervisors to reflect honestly on their own participation in the interactions with their supervisees, and to be aware of the possibility that their own issues, blind spots and vulnerabilities might be operating in a given situation. From this perspective, it might often be appropriate for the supervisor to self-disclose his reflections on his participation in an interaction with the supervisee.

Shared and authorized power refers to the different role of the supervisor in a relational approach, compared to a more traditional model. In a relational approach, the supervisor is encouraged to relate to his or her supervisee in a more egalitarian, less hierarchical way. A relational supervisor does not view himself as an expert authority or as the final arbiter of truth. Instead, what is "true" about the supervisee, his or her work with clients, and the relationship between supervisee and supervisor, is negotiated and co-constructed by the supervisor and the supervisee based on their mutual but different expertise mentioned above.

The idea of co-constructed knowledge, which is fundamental to a relational approach to supervision, requires that a supervisor strive to understand his or her supervisee's experience from within the supervisee's subjective world, which is very different from the traditional stance of the supervisor as an objective expert operating outside of and sometimes apart from the supervisee's subjective experience. In the relational approach,

another implication of shared power and co-constructed knowledge is that differences between the supervisor and supervisee are openly discussed and negotiated, and that more often it will be okay to agree to disagree with the supervisee. In this process, the supervisor needs to question himself: Why is this rule a rule? How important is it to me that this be done in a certain way? Are there advantages to the supervisee's approach that I have not considered? Maybe the supervisee's way of doing something is right for her even if it would not be right for me? Is this for my needs and convenience, or does it really further the supervisee's learning or the progress of the case? Sometimes, after such reflection, the supervisor will decide limits need to be set and expectations need to be enforced, because a personal, professional or ethical limit has been reached. I would argue that if the supervisor has engaged in the kind of reflective process I have just described, he or she will be able to set limits with the supervisee with more conviction and in a way that is more authentic and effective.

There appears to be a major disconnect between the traditional practice of supervision, which locates problems totally within the supervisee, and maintains the supervisor as an expert authority figure who knows best and remains above the fray when difficulties arise; and the social work profession's adoption of family system-ecosystems models that challenge the assumptions of linear causality, and suggest that problems do not reside in individuals but rather occur as interactional and transactional patterns of communication and affective involvement among participants in a system. Sometimes, when the focus is totally on the supervisee's issues and problems, it seems like these important concepts are left outside the office door during the supervisory session.

I would like to focus more specifically on three issues also emphasized by Frawley- O'Dea and Sarnat (2001). As I already mentioned, I contend that selective self-disclosure by supervisors of their own issues and blind spots helps demystify and normalize, for supervisees, the difficulties inherent in direct practice. Such disclosure can help

supervisees feel less alone and self-conscious as they struggle with difficult or uncomfortable feelings stirred up in their work with clients. Such disclosure also acknowledges the unavoidable reality that there are both conscious and unconscious processes at play in both the supervisee-client and the supervisor-supervisee relationships, and that any one of the three participants might not be aware of the exact nature of his or her response at any given moment. In this way, self-disclosure by the supervisor to the supervisee promotes a more collegial atmosphere of mutuality and shared vulnerability. In other words, it conveys a powerful message to the supervisee: We are both in this together.

A second issue of focus is regression. Regression often carries a negative connotation in many approaches to supervision and is seen as something to be avoided and minimized at all costs, because it may reflect immaturity and can be difficult to control. Frawley-O'Dea and Sarnat (2001) suggest that some regression is inevitable in any treatment-related situation, and that we should approach regressive experiences with the same attitude of tolerance, curiosity and exploration as any other therapeutic phenomena. Accordingly, being able to talk about and reflect on regressive experiences in supervision, regardless of whether they originate with the supervisor, supervisee or client, can be a powerful tool to promote change in both the supervisory and therapeutic relationships. Regressive experiences can include intense affective responses, dreams about supervision or treatment, enactments, dissociative experiences or somatic responses. When a supervisor is comfortable focusing on regression (the supervisee's, his own, or the client's), this opens up a whole range of nonverbal behaviors and affective experiences going on in the supervisory and treatment relationships, which otherwise could not be discussed or even acknowledged as occurring.

Finally, the most thorny issue to be addressed is the "teach or treat dilemma," which, according to Frawley-O'Dea and Sarnat (2001), "elicits more doubt and anxiety than any other facet of supervision." The main point is that transference

and countertransference interactions and unconscious enactments are always occurring in every treatment and supervisory situation. Thus, it would not be possible to employ a relational approach to supervision without addressing and investigating these phenomena. A relational perspective does not view the supervisee's dynamics, issues and areas of vulnerability as taboo or off limits, nor does it advocate an "anything goes" approach, but rather a careful, tactful, respectful and reflective investigation of the interpersonal world of all participants (supervisee, supervisor and client).

Investigating the personal transactions in the supervisory relationship should not be an end in itself, but should be used to further the process of the supervisee-client treatment and to increase the supervisee's learning. Furthermore, the supervisee should have the power to limit the focus on his or her personal issues. In other words, the degree and level at which the supervisee's personal issues are discussed are negotiated between the participants and authorized by the supervisee. A definite strength of this model is that it allows for the possibility of self-correction in modulating the depth of self-disclosure, the intensity of regression and/or the degree of exploration of personal issues. In this regard, the strong emphasis of the relational approach on the importance of the supervisor being sensitive to the supervisee's experience of vulnerability and respectful of the supervisee's need for privacy is critically important. Finally, a relational supervisor's obligation to solicit actively ongoing feedback about how the student is experiencing their relationship makes boundary violations less likely to occur (Ganzer & Ornstein, 2004).

The relational approach to supervision I have described is not an easier, more comfortable method of supervision. It demands significant tolerance for ambiguity, complexity and uncertainty on the part of supervisors and supervisees, as well as the courage to reflect on and deal with uncomfortable feelings and reactions that one or both parties might prefer to leave unaddressed. However, I strongly believe that the benefits, in

terms of improved therapeutic capabilities and deepened supervisory and treatment relationships, will be well worth the discomfort and risk.

A number of detailed vignettes that illustrate this model of relational supervision in action can be found in Ganzer and Ornstein (1999, 2004), as well as in Frawley-O'Dea and Sarnat (2001), which I encourage the interested reader to pursue.

## References

- Frawley-O'Dea, M.G., & Sarnat, J.E. (2001). *The supervisory relationship: A contemporary psychodynamic approach*. New York: Guilford Press.
- Ganzer, C., & Ornstein, E.D. (1999). Beyond parallel process: Relational perspectives on field instruction. *Clinical Social Work Journal*, 27, 231-246.
- Ganzer, C., & Ornstein, E.D. (2004). Regression, self disclosure, and the teach or treat dilemma: Implications of a relational approach for social work. *Clinical Social Work Journal*, 32, 431-449.

### Have We Missed You?

If you or someone you know has not been getting an ISCSW *Newsletter*, please contact us at 312 346-6991. Ask for Cindy.

## *The Cutting Edge...*

### Reviews from Recent Literature

**The neurobiology of affective interventions: A cross-theoretical model.** Baylis, P. (2006). *Clinical Social Work Journal*, 34(1), 61-81.

Peter Baylis has a unique way of describing the integration of neurobiology and psychodynamic theory. In his article, he observes that, instead of creating a dichotomy, neurobiology and psychodynamic theory participate in an interplay where both are necessary in order to understand what takes place before our eyes as we develop therapeutic relationships with our clients.

Baylis begins with a brief review of the areas of brain function that influence our cognitive and psychological functioning, and especially the stress response. It has been scientifically shown that chronic stress can actually damage regions of the brain such as the hippocampus, the amygdala, and the frontal lobes. Needless to say, such damage affects one's ability to manage his stress response, to self-regulate, as well as to access traumatic memories for the sake of working them through.

"Increasing research...supports the notion that talk therapy is a biological intervention," says Baylis. He is not seeking to reduce psychotherapy to a physical/chemical process, but, on the contrary, is trying to help enlarge an important knowledge base that supports the therapeutic relationship as the best medium for effecting psychological change. Baylis demonstrates the importance of an emotionally attuned response, regardless of the theoretical approach utilized. "As therapists lend themselves to their clients," says Baylis, "the attachment or bond that develops is reflected through improvements in outcome associated with neurological change."

According to the aspect of brain function associated with my auditory system, this is music to my ears, and an article well worth reading.

*Ruth Sterlin*

**Initial treatment choice in depression: Impact on medical expenditures.** Edgell, E.T.; Hylan, T.R.; Draugalis, J.R.; & Coons, S.J. (2000). *Pharmacoeconomics*, 17(4), 371-382.

Although this article may not qualify as *recent* literature, it appeared in a journal that I do not regularly read, and I was so impressed by its findings, I felt compelled to report it. It is well known that providing mental health treatment reduces overall medical expenses. These authors examined one year of mental health costs and total medical costs in a group of over 9000 patients covered by private insurance, whose mental health records indicated that they had been diagnosed with depression. The authors looked at total health costs for patients with no therapy, psychotherapy, drug therapy, and a combination of drug and psychotherapy; and they found that patients with a combination of psychotherapy and medication had higher mental health costs than those in the other three categories. On the other hand, they found that patients who initiated their treatment with psychotherapy had lower total health care costs than other patients. They concluded that psychotherapy may have an impact on comorbid illness and may subsequently reduce total health care costs. In addition, they pointed out that other studies indicate that psychotherapy at the end of treatment with antidepressants greatly reduces the risk of relapse.

This study is important for several reasons. First, it utilizes a naturalistic sample, where psychotherapists in the study were doing what they usually do and not following any particular protocol. The study demonstrates that, even though psychotherapy adds to the cost of treatment, it also reduces the overall cost of medical care; and it is to the employer's benefit to make psychotherapy available to their employees. During the first year following a diagnosis of depression, patients who start treatment with psychotherapy end up costing the insurance company and their employers less money than those who do not have psychotherapy, or those who start with drug treatment.

Unfortunately, many insurance companies are handing off mental health treatment to subcontractors; so if the company is only paying for mental health treatment (and not total medical treatment), it will not experience the financial savings of making psychotherapy readily available to its enrollees.

This has definite policy implications. However, the real reason I enjoyed this study is that the first author is an employee of the Eli Lilly Company, and the second author has an institutional affiliation with Pfizer Inc. When drug companies are funding and publishing studies that show psychotherapy is cost effective, we can feel a lot better knowing that our claims for the efficacy of our methods are *evidence-based*.

*Geoffrey Magnus*

## **Development of the adolescent brain: Implications for executive function and social cognition.**

Blakemore, S., & Choudhry, S. (2006). *Journal of Child Psychology and Psychiatry*, 47(3/4), 296-346.

My interest in this article actually stems from a running argument I am having with one of my co-therapists. Together, we run several groups for children and adolescents with Asperger's syndrome. I maintain that as children go through puberty they are impelled to be nasty to each other, and that this nastiness is a necessary step in social development. This aspect of puberty is very similar to the *terrible two's* in which children seem impelled to goad their parents as a necessary step in their acquisition of practical knowledge of human psychology, social skills and affect regulation. Children with Asperger's syndrome very often do not go through the terrible two's. I believe that missing this developmental step contributes to some of the problems these children have with affect regulation and social interaction. In middle and junior high school, a child's attention shifts to their

peers, and they seem to do to their peers what two-year-olds do to their parents. Although there is not yet any evidence, I believe that the *terrible 12's* is a necessary stage in social development, and we need to be very cautious in our efforts to curb it. My co-therapist, on the other hand, is a school psychologist who believes, along with several of the parents of children in our groups, that pre-pubertal nastiness is a societal and system failure. They feel that schools have an obligation to eliminate all bullying.

Thus, I was particularly delighted with Blakemore and Choudhry's article. The authors point out that puberty brings several major changes in the brain. First, there is extensive myelination of axons from the prefrontal cortex, which is responsible for executive function. Myelin, a fatty insulation around axons, speeds up neural conduction; thus, myelination of these axons brings behavior more under the control of the prefrontal cortex. During puberty, the executive brain becomes more tightly wired to the rest of the brain, allowing adolescents to develop the capacity to hold more multi-dimensional concepts in their mind, and making it possible for them to think in more strategic and dialectic manners. There is a similar change in myelination of the parietal cortex, which is responsible for many aspects of the recognition of affect in others.

In addition to these changes in myelination, there are changes in synaptic density. At the beginning of puberty, there is an increase in the density of synapses in the parietal and frontal cortexes, and towards the end of puberty there is a decrease in synaptic density. A decrease in synaptic density generally means that the neural circuits involved have been established to perform sophisticated functions in a more efficient way, *i.e.*, things become well learned and thus automatic.

Also at the beginning of puberty, there is a decrease in a child's ability to recognize facial expressions, which then returns to the prepubertal level by the age of 17. There is some evidence that there is a similar perturbation of executive function during puberty. A child at the beginning of puberty will show a decrease in executive function, which

will then be reestablished at a higher level in late adolescence.

One result of this reorganization of the brain is that when an adult is asked to view an angry or tearful face and to ignore the affect, he or she can turn off the activation of their orbital frontal cortex (responsible for emotional regulation). The adult can ignore the affect and does not need to involve this part of the brain. Adolescents cannot do this. Their brains respond to affect whether or not they intend them to.

Since neurobiological and psychological data indicate that during puberty the emotional and social brain gets rewired, and since 11- and 12-year-olds are far less sensitive to facial expression than children or adults are, they must push harder to get an emotional reaction that they can recognize. Since they are engaged in rewiring their social brain, and are becoming very interested in how they affect other people, their seeming cruelty is a natural attempt to learn on a gut level how people tick. Once they notice affect in another person, it is very hard for them to ignore it. Therefore, they are likely to overreact to peers in social situations and may come home very upset about minor slights. This accounts for adolescents reacting to a minor parental grimace with an angry, "What!"

At my insistence, knowing that children going through the terrible 12's will goad each other and overreact, my co-therapist and I have been permitting some of this behavior in our groups and then processing it with the children and their parents. In therapy and in life, children do what they need to do in order to grow. We will do much better if we understand what is going on with children and adolescents and work with it, rather than attempt to mold them immediately into what we think they should be. I am grateful to the *Journal of Child Psychology and Psychiatry*, and to Blakemore and Choudhry's article, for taking me a long way in that direction.

*Geoffrey Magnus*

**Hypnotic suggestion reduces conflict in the human brain.** Roz, A.; Fan, J.; &

Posner, M. I. (2005). *Proceedings of the National Academy of Science*, 102(28), 9978-9983.

This article clearly demonstrates a dramatic reorganization of the brain with hypnosis. In it, subjects were asked to perform the Stroop Test under two conditions. The Stroop Test shows subjects the names of colors *printed* in different colors, for example, the word *red* might be printed in green. The subjects are then asked to name rapidly the colors that the words were written in. This takes more time and effort to do than it would to name the colors themselves, or to name the colors in which nonsense words were written. When highly hypnotized subjects were asked to believe that the words were written in a language that is incomprehensible to them, they were able to name the colors quickly and effortlessly without interference from the words' meanings. When these same subjects performed the test without this hypnotic suggestion, they showed the same interference that everyone else experiences.

The investigators monitored brain activity in several different ways while the subjects performed these tasks. Subjects working under the posthypnotic suggestion that the words were written in the foreign language showed no activation of their anterior cingulate. The anterior cingulate is, among other things, involved in the resolution of conflict. When a person sees the word *red* written in green, he experiences cognitive conflict when trying to name the color. When the same person is hypnotized, it can be observed that the anterior cingulate is not active: the subject is unable to read the word and thus has no conflict to resolve. Without the hypnotic suggestion, the subject first activates his visual areas in the occipital cortex (as he reads the words); and then activates the frontal cortex to help him select the aspects of the visual material to which he needs to attend. With the hypnotic suggestion, there is very little activation of the occipital cortex, and a much quicker activation of the frontal cortex. The authors also demonstrated that an electrophysiological marker called the P100 wave, which indicates arousal and conflict, was delayed and muted in the subjects with the

posthypnotic suggestion. This study has since been repeated by another investigator who found that the subject's suggestibility is far more important than the procedure of hypnosis in getting the results. Clearly, suggestion under hypnosis can greatly alter the way the brain functions.

This study is gratifying to those of us who use hypnosis in our clinical practices. However, its real significance lies in the implications it has for psychodynamic therapy. The hypnotized subjects in these experiments did not just think they couldn't read the letters, their brains were actually altered so they could not read the letters. *If a simple posthypnotic suggestion can create such a dramatic reorganization of the brain, and of cognition, it is very easy to speculate that a traumatic experience or a conflict can create a real reorganization of brain function that can result in repression or dissociation.* Those phenomena are far more difficult to produce in the laboratory; however, as techniques improve, it may be possible to demonstrate the physiological correlates of repression and dissociation in clinical situations.

*Geoffrey Magnus*

## **A Fine Friday Evening with Ornstein and Ganzer**

On March 17, Eric Ornstein and Carol Ganzer gave a stimulating presentation on a very important topic: "Relational Social Work: A Model for the Future." Together they piqued their audience's interest by sharing their recently published article, as well as chocolate chip cookies baked by Eric himself.

Eric and Carol have formulated an important approach to educating future social workers at a time when many of our schools of social work have cast out Freudian theory without replacing it with clear psychodynamic principles. They make a strong case for relational theory, using features

from several theoretical contributors in the field. During their presentation, audience participants heard how relational theory can be applied, not only to treatment, but to social work classrooms and field instruction, as well.

This approach encourages the exploration of transference, countertransference and enactments that may be taking place on all levels of the work, especially between client and student, and between student and field instructor. Honesty and openness on the part of the field instructor, for example, regarding his or her own countertransference to the student in the context of supervising a given case can give vital diagnostic information about the treatment dynamic, thereby helping both student and field instructor better understand the client. At the same time, this kind of openness provides a permission-giving model of self-exploration for the student.

Another very important ramification of examining the vulnerabilities of all parties involved, namely the field instructor, the student and the student's client, is that it helps ferret out any projective identification that may be going on, generally originating in the client, but bouncing back and forth among all three parties. Identifying instances of projective identification provides important diagnostic case information, and, even more important, it helps the student learn the concept of projective identification by experiencing and exploring it first-hand.

Eric and Carol explained the application of relational theory to social work education, first by defining the theory's main principles, an important one being the co-creation of meaning in treatment by both the client and the therapist from within the two-person therapeutic relationship. Then, they explored how openness between field instructor and student, where no area of the transference and countertransference is taboo for discussion in the supervisory relationship, ultimately helps shared reflection and exploration unfold in the actual treatment. In the end, this openness promotes a treatment atmosphere conducive to internal flexibility and the development of new patterns of relating on the part of the client.

Following Eric and Carol's presentation, there was a lively discussion of the treatment and supervisory experiences of everyone present. If you would like to read Eric and Carol's latest article, as titled above, be sure and look in October-December 2005 *Families and Society*, 86(4), 565-572.

*Ruth Sterlin*

## ISCSW Website Progress

The ISCSW website, *ilclinicalsw.com*, is in its early stages, but holds great promise for our Society. When it is finished, it will provide two membership directories, a public directory for all website visitors, and a directory with more detailed information for members only.

The public directory will be linked to search engines as a referral source for clinical services. It will also have fields directing potential users to specialty and geographic areas. The directories will be set up so that members can update their own information online.

ISCSW also looks forward to posting our *ISCSW Newsletter*, and providing a Discussion Board and other information of clinical relevance. This website will support all of our practices and our work out in the community.

### Consultation - Openings Available

In-depth group and individual clinical consultation. Case material examined in light of attachment and relational theories. Flexible meeting locations. Reasonable rates. Call Ruth Sterlin, LCSW, at 847 480/9159.



## GREETINGS FROM THE LEGISLATIVE

## COMMITTEE

### Legislative News

*from Judith Ierulli*

*The Social Worker Medicaid Reimbursement Task Force*, sponsored by Departments of Healthcare and Family Services and Human Services, presented their report and recommendation for House Resolution 220 to the Illinois General Assembly on March 1, 2006. In the last few years, it has become clear to the mental health community in Illinois that there is a huge need for more clinical services, especially in the area of child and adolescent mental health. In 2005, the Children's Mental Health Partnership reported that over 20% of children have a diagnosable mental health problem, yet only one in five of these children receive services. "LCSW's are qualified to provide the additionally needed mental health services because their core values and ethics are to serve low income, lower socioeconomic, and non-majority populations. By training, LCSW's are specifically trained to help people represented in the Medicaid population," stated the Task Force report to the General Assembly.

House Resolution 220 was passed in 2005 to allow LCSW's to bill Medicaid/KidCare directly for services, both in private practice and community mental health settings. This Resolution has particular benefit for rural areas where there may be few existing providers, as well as for people with concerns about the stigma of mental health. Allowing LCSW's to bill Medicaid directly for services provides consistent access for people receiving Medicaid, just as some insurance companies provide for reimbursement for mental health services provided by LCSW's. Until now, LCSW's could receive Medicaid payment for their clinical services only if they worked for a hospital, school or community mental health center, and the funds went directly to the employer. "Use of LCSW's improves access to services for children, adolescents, and adults. The addition of LCSW's could increase the provider pool to serve persons

who meet the mental health definition of medical necessity,” recommends the report.

While this is good news for LCSW's, there is a concern over the Task Force's job of setting rates for clinical services to the state. The Task Force will be responsible for determining which services LCSW's will provide, creating and implementing an enrollment process for LCSW's as Medicaid providers, and proposing rates for services to the state. As many of us know who work with insurance companies, rates will be of particular concern, because the suggested rates for service for many insurance plans fall well below the normal fees of many private practice therapists.

A *New York Times* article from March 26, 2006 addresses the concerns of therapists whose fees have stayed the same or gone down in the last few years. “When you are on a provider list, the insurance company decides what you should be charging,” said Ms. Hinterman, an LCSW who lives in Park Forest, Illinois. Though her customary fee was \$90 an hour, she could charge only \$68 to \$72 for patients insured by the company she had contracted with. About two-thirds of her patients were insured by that company. “I'd get a ceiling on what I was allowed to charge, and that ceiling was unrealistically low.” Like many other health professionals, mental health practitioners like Ms. Hinterman are feeling an economic pinch, partly because of insurance reimbursement schedules that have not kept pace with their expenses. Richard G. Frank, a health economist with a specialty in mental health issues, and a professor at Harvard, said, “Clearly, the earnings of mental health professionals---medical doctors, psychologists, social workers and counselors---have either been flat or been declining for the past five to eight years.”

This is of particular concern for LCSW's who are considering become certified for Medicaid. How will the determination for fees be set? How often will they be reviewed? These are questions that LCSW's should be asking, as they look for ways to inform the Task Force of this concern. Fee ceilings that are set too low will have an impact on

LCSW's and their clients, as low reimbursement rates will force a gradual decline in the number of Medicare/KidCare clients served.

### *Editorial...*

## **Medicaid Reimbursement Task Force**

As we have seen in this *Newsletter's* Legislative News, the Illinois House of Representatives issued a resolution establishing a Task Force to examine the benefits of allowing LCSW's in private practice to be reimbursed under Medicaid (HR 0220). The Task Force was set up as a first step in making what most people see as a necessary change. The project, led by administrators from Health and Family Services and the Department of Human Services, included representatives from NASW, ISCSW, the Community Behavioral Health Association, the Child Care Association of Illinois, and several patient advocacy groups. It is very unlikely that a group this inclusive could ever propose specific legislation; however, it did produce a report on March 1, 2006, representing the recommendations of the various members of the Task Force, myself included, as required by the resolution.

The resolution was in response to some serious problems in Illinois' mental health care delivery system. In Illinois, mental health organizations that are Medicaid qualified, mainly through Department of Mental Health grants, have a virtual monopoly on Medicaid-funded mental health treatment, creating a serious problem in the access Medicaid patients have to mental health services. The existing organizations, generally with high administrative costs, have focused on the most seriously impaired patients, in many cases chronically impaired patients who require extensive case management. Patients needing individual and family psychotherapy for very serious problems, but who do not require case management, are often turned away from these agencies because of funding shortages. Thus, a large proportion of the Medicaid

population cannot get mental health services. The agencies currently delivering the services employ some LCSW's; however, many of their services are delivered by workers without LCSW's, and who are not qualified for that credential.

The Task Force report emphasized the benefits of including LCSW's as Medicaid plan providers, and recommended that LCSW's be included in initial state projects aimed to improve mental health services for children: Two projects, one for preschool children, and the Children's Mental Health Partnership, have proposed to include social workers. It has also been recommended that the Division of Mental Health Services, which is engaged in an effort to restructure the mental health service system in Illinois, include an NASW representative in the group responsible for designing this new system. The Task Force further recommended that the Legislature take steps to establish a pilot project to examine the cost and impact of including private practice LCSW's in the Medicaid mental health care delivery system.

It is certain that the existing system is going to be restructured on a fee-for-service basis, which means that existing providers will be paid for services they deliver, and not on the basis of programs they establish. In other states, this has had the effect of broadening the population of patients receiving services. When an agency is paid per unit service, the agency is more likely to respond to anyone who asks to be treated.

I would suggest that, in a few representative geographical areas, LCSW's be included as eligible providers in this restructuring. It would have to be in a few areas initially, because the Legislature would be reluctant to take on unmeasured additional costs. A study would need to be designed to compare costs and quality of services in regions that include LCSW's as service providers, with that of regions that do not.

Several members of the task force, including myself, seem frustrated because we already know the answer. Individuals or small groups in private practice provide their services more cheaply and efficiently than do large organizations, and LCSW's

are more qualified and better trained than many of the people currently delivering services. At the same time, it isn't always easy for private practitioners and small groups to deliver services to patients who require extensive case management. Consequently, a system that includes licensed private practitioners, plus organizations structured to deliver case management services, would be far more efficient and cost-effective than the system we have now.

There are several problems, however, in initiating what seems to many of us the obvious solution. First, the State of Illinois is in enough financial crisis that it cannot afford to increase Medicaid expenditures. Second, the agencies currently delivering services are under great financial pressure, and they are afraid of any changes that would divert funds for the services they are currently delivering. Third, there are many stakeholders in the current system, and legislators and bureaucrats are rarely willing to increase the size of the state budget.

I believe the State of Illinois will eventually get a system that delivers mental health services more efficiently, and it will include LCSW's. However, in politics, change never happens at the pace we would like to see.

Treating Medicaid patients is not going to make anyone rich. Nonetheless, being allowed to do so will enable us to fulfill our mission as social workers and will improve the lives of many of our poorest citizens.

*Geoffrey Magnus,  
ISCSW Representative to the Task Force*

## **First Open Board Meeting a Success**

ISCSW is pleased to announce the success of its first Open Board Meeting. On March 17, immediately following Board business, a table was spread with snacks and drinks, and Eric Ornstein gave the evening's presentation on "Suicide Assessment," based in large part on the work of Shawn Christopher Shea.

According to Eric, Shea has developed very effective interviewing sequences to help the interviewer draw out all elements of suicidality in a client's past, present and near future. Eric recommended Shea's book, *The Practical Art of Suicide Assessment*, and his article, "The Chronological Assessment of Suicide Events: A Practical Interviewing Strategy for the Elicitation of Suicidal Ideation" (1998), *Journal of Clinical Psychiatry*, 59 (suppl. 20). Everyone attending found the material quite relevant to practice.

## Join Us at Our Second Open Board Meeting!

On Tuesday, May 16, ISCSW will host its second Open Board Meeting. Along with a discussion on "Feeding the Professional Self," we will have a potluck dinner. All cooks are welcome to bring their specialty.

The meeting will take place at 30 N. Michigan, Room 1015, in downtown Chicago, at 7 p.m. It's free for members and only \$10 for nonmembers. Please come to chat, learn, and break bread with us!

## Social Work Profession Faces Impending Labor Force Shortages

An impending shortage of social workers threatens future services for all Americans, especially

children and older adults, a new report from the National Association of Social Workers finds. Sponsored by Atlantic Philanthropies, and the John A. Hartford, Annie E. Casey, and Robert Wood Johnson foundations, the report, "Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers," finds that the number of new social workers providing services to older adults is decreasing at a time when the number of older adults who need social work services is projected to increase. Compounding the challenge, the supply of licensed social workers is insufficient to meet the needs of organizations serving children and families.

Social workers treat a broad range of diagnoses, especially chronic medical conditions, psychosocial stressors, acute medical conditions, co-occurring disorders, and physical disabilities. They also are the largest providers of mental health services in the country. However, a steady increase in caseloads, the growing severity of clients' problems, and shrinking resources make meeting clients' needs more difficult than ever. And because more than half of healthcare social workers work in hospitals in metropolitan areas, providing comprehensive services to people living in rural areas is an additional challenge.

"Social workers are one of the largest and most diverse health professions in the United States," said NASW executive director Elizabeth Clark. "They have the education and training to look at how all factors in a person's life — family, work, health and mental health — work together. This study highlights the need to find new and innovative ways for the social work profession to retain the current workforce and recruit new social workers to accommodate the impending demand."

(NASW Press Release, 3/8/06: To read or download the complete report, visit:

<http://fconline.fdncenter.org/pnd/10001308/> social workers. Eighty-three pages, PDF).

## Mentorship Groups Provide Vital Support for New Professionals

Recent graduates are always eager to explore issues related to professional identity and development, so each year two members of ISCSW's New Professionals Committee lead a Mentorship Group for just this purpose. The Mentorship Group provides its members a valuable opportunity to network, get support and receive information they need to move forward in their careers.

Nathan Dougal and JoAnn Brown, Group leaders for the past two years, report that during the past year, Mentorship Group members have discussed a myriad of topics: developing a sense of competence, professional identity in the agency setting, autonomy in the school setting, managing caseloads, self care, and avoiding burnout. Members also focused on career planning across diverse interest areas, and program development. In past years, topics have included job searches, continuing education, compliance issues, licensure, and conflict with peers.

Group participants find the meetings extremely helpful and recommend it to other new professionals. If you or someone you know can use this important ISCSW service, contact Nathan at 773/348 1234 or JoAnn at 630/721 9006 for more information.

#### Call for Articles

The ISCSW *Newsletter* welcomes clinical articles, book reviews, media commentaries, and reflections on current clinical literature from ISCSW members and other interested individuals. If you would like to submit an article for our *Newsletter*, please contact Ruth Sterlin at 847/480 9159.

#### *Low-Fee Treatment Referrals*

Treatment referrals are available to new professionals and the community at large through the Society. Experienced therapists with a *sliding scale* comprise many of those in the Society's referral pool. A confidential consultation is the first step in obtaining a referral tailored specifically to the person interested in treatment. A call to Cindy Wiertel, the Society administrator, at (312) 346-6991 will initiate a response from the consulting clinician. The minimum fee for treatment through this service is \$25.00.

#### *Low-Fee Clinical Supervision*

Low-fee and general clinical supervision are available to new professionals and the clinical social work community. The Society prides itself in precise collaboration with the person seeking supervision in considering an appropriate referral. Supervisors have a minimum of 10 years experience in a variety of practice settings and approaches. The minimum fee for supervision is also \$25.00, and Cindy Wiertel is the first contact person for this service as well.

#### LETTERS TO THE EDITOR

snailmail: ISCSW Newsletter  
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## RESOURCES

The ISCSW website is being updated and can now be reached with a new address: **[www.ilclinicalsw.com](http://www.ilclinicalsw.com)**. John Bussert, a webmaster specialist, has been graciously volunteering to create our website.

Please send information you would like to see on the website to Cindy Wiertel at [ISCSWA@aol.com](mailto:ISCSWA@aol.com).

*Sites listed below are not endorsed by ISCSW but are noted as solely of interest:*

<http://www.secondharvest.org>  
Food for disaster victims.

<http://www.socialworker.com>  
Aimed particularly at the new social worker and social work students. Its social work links to other websites (see below) are of interest to all.

<http://www.os.dhhs.gov>  
Dept. of Health and Human Services (U.S.) website.

<http://www.nyu.edu/socialwork/wwwrsw>  
Links to over 53,000 sites in the U.S. and other countries, containing information of interest to social workers.

<http://www.state.il.us/dcfs/index.shtml>  
A DCFS website.

[www.legis.state.il.us](http://www.legis.state.il.us)  
Transcripts of House floor debate on pending legislation. Also, texts of introduced bills and other information.

[www.mentalhealth.com](http://www.mentalhealth.com)  
A mental health information site.

[www.socialworksearch.com](http://www.socialworksearch.com)  
A search engine for social work-related links

<http://www.clinicalsocialworkers.com>

Site posted by Pat McClendon, a social worker in Louisville, KY. "Members" describe themselves and their specialties. Also contains some full-text articles and links to sites of interest.

<http://www.socialworker.com/websites.htm>

About 125 links to professional, self-help and privately posted sites of interest to social workers. Also links to about 50 social work organizations and social work student organizations.

### **[Also, Google Texas State San Marcos Spanish Language Institute]**

Consider this possibility for spending a summer learning Spanish for Social Workers in an immersion program

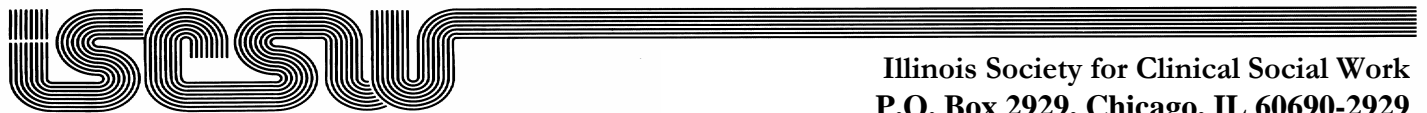
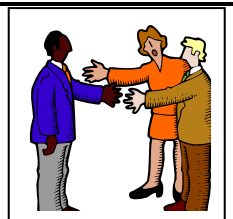
## Call for Speakers

ISCSW is looking for presenters from our membership who would like to speak at future Board meetings. Our organization is planning to offer a wide array of topics useful in our work. If you are interested, please call Ruth Sterlin at 847/480 9159 or e-mail her at [rasterlin@comcast.net](mailto:rasterlin@comcast.net).

**Your Ad could be in this space!  
Call Ruth Sterlin at  
(847) 480-9159**

**CAREER  
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Space is available for  
employment and job-seeking ads.  
Inquiries should be addressed  
to Ruth Sterlin at the address  
given for Letters to the Editors.



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<b>Cultural Competency</b>	

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<b>Administrator</b>	Cindy Wiertel
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