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THE NEWSLETTER OF THE NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

Clinical Social Work Federation Joins the National Guild of Medical Providers

The first national mental health professional group to unionize

By Helen Hinckley Krackow, MSW, BCD, Past President

On May 8, 1998, Elizabeth Phillips, President of the Clinical Social Work Federation, signed an agreement with Michael Goodwin, President of the Office and Professional Employees International Union-AFL-CIO, to affiliate to protect our clients and our clinical social work practitioners. The concept of a medical guild was developed by OPEIU in order to unionize without violating federal anti-trust laws. The Federation Board voted overwhelmingly in favor of affiliation at our national meeting in Washington, D. C. on May 2, 1998. The agreement will be in effect for a trial period; if our expectations are not met, we can withdraw in two years.

Asked what CSWF's first priorities and goals are, Dr. Phillips responded that we need help in getting ERISA contracts (when OPEIU is negotiating them), help with issues affecting clinical social workers that arise at the national Health Care Finance Administration, which administers Medicare, and help with a variety of state level issues. We need to be a player in the development of national health care policy, she said, and in the regulation of managed care, now and in the coming years. She felt assured that these are realistic expectations.

The New York State Board is also resoundingly in favor of the agreement. As a test prior to affiliation, the State Board asked OPEIU for

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President Allen A. Du Mont and Past President Helen Hinckley Krackow visited Capital Hill on April 29th to thank Congressman Ed Towns for his sponsorship of the Medicare Social Equity Act. Mr. Towns is a social worker as well as a Representative from Brooklyn.

EXECUTIVE REPORT

Of Self Esteem, the Guild and the Image of Clinical Social Work

By Allen A. Du Mont, CSW, BCD, President

Reflecting on the enthusiastic response of our membership to the proposal to affiliate with the National Guild for Medical Providers and the OPEIU of the AFL-CIO, I am proud to be President of our Society. Of the 365 votes received as of April 21, 1998, 94% voted in favor of affiliation! Appreciating our own worth and the value of the services we render, we no longer can be passive as forces outside the profession determine our fate. It is time for us to champion, as do the other professions, our interests and those of our clients in ways that will check and repel the incursions of managed care.

It is widely recognized that in the name of cost savings and therapeutic efficiency, need-

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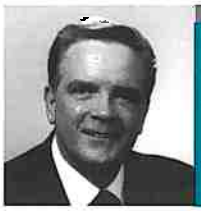

Executive Report

Allen A. Du Mont, CSW, BCD
Society President

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ed benefits have been denied and health care dollars have been taken from the practitioner to be put into the pockets of the managed care industry, corporate executives and corporate shareholders. The public is told to have faith, not in the professional who is guided by a code of ethics and practice values, but in the businessman in pursuit of heftier quarterly profits. Confidence in us is undermined, because control is placed in the hands of those far removed from the therapy.

> It is time for us to claim our rightful place, to empower ourselves as we would empower our clients, and to assert our right to earn a decent living in the provision of service to others.

Essential to the therapeutic process is client confidence in us, our own positive self-regard and a mutual valuing of the services we offer and the process itself. Giving generously of ourselves in this process requires a feeling of inner well-being that is influenced heavily by the extent to which we are free to determine how best to help our clients, how frequently, for how long, and the compensation we should receive. If we should decide to work for less because the needs of our clients warrant it, our self-regard impels that we do so freely. For managed care to control the market, and yet to tell us we are free to reject panel participation if we don't like the terms, is equivalent to saying we are free to starve. Why should we leave the provision of clinical services to those whose basic interest is to reap maximum profit for minimum service?

Managed care, however, is not the only threat to the clinical social work profession. We also must face the sometimes stated, but often implicit, criticism — whispered even among ourselves — that the private practice of psychotherapy means that we are turning our backs on the poor and that we are moving away from our traditions and our roots. Some who secretly believe this assertion, yet want to pursue their clinical interest, may resolve the conflict by referring to themselves as "psychotherapists," never mentioning that they are social workers. They thereby avoid facing the problem of public ignorance of our profession, including the fact that we account for 60% of mental health treatment across the nation.

For too many people, social work is equated with welfare and concrete services for the poor, without the understanding that such services, if delivered most effectively, require clinical savvy and sophistication. As a newly-retired public servant with 32 years of service to the poor, I find nothing to be ashamed of in the delivery of concrete or clinical services, in public or private settings. Our services are no less valuable when we work to help the economically disadvantaged. In fact, in view of how we might improve social functioning, bolster social supports, facilitate client growth and empowerment, we deliver a great service to society as a whole. In working to curtail the growth and proliferation of social ills, we help our clients, significantly improve the quality of life for all and reduce social costs.

Some may not choose to work in agency or public settings. Should they be faulted? Social workers are no more and no less responsible for the provision of help to the poor and disenfranchised than any other profession, though we do have a tradition of such work, and most of us have spent at least a portion of our careers in these settings. Like other professionals, we are free to work where and how our interests and opportunities take us. We have a long tradition of delivering high caliber services in a variety of settings under very difficult conditions. We bring a unique perspective, a storehouse of practice wisdom, and skills sharply honed. It is time that the public knows about it and about us. We owe no one an apology.

It is time for us to claim our rightful place, to empower ourselves as we would empower our clients, and to unabashedly assert our right to earn a decent living in the provision of service to others. If we do not esteem and respect ourselves, how can we expect others to do so—the public or other professions?

We all hope that Guild affiliation will serve this end, that in the halls of Congress and of our State Legislature our case will be heard. Regardless of the outcome, we will have gained from taking a stand. We will have gained strength and pride in the knowledge that we can act vigorously on our own behalf, and that we can go on generating creative solutions as we enter the 21st Century. ■

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Mentor Group Offers Support to Recent Grads

IN BRIEF

by Wendy Bloch and Martha Crawford

What makes social work school so special is the easy access to the support and feedback of classmates and teachers. After graduating, all this ends abruptly and these everyday experiences become luxuries. The frantic pressures of the job search and agency life leave little, if any, time for relaxed networking and clinical dialogue.

For an hour and a half each month, Mentor Groups create an opportunity for graduating social work students and new professionals to indulge in camaraderie among peers while receiving valuable guidance from seasoned clinicians. The groups offer an important outlet for the anxieties that come with unemployment, interviewing, and searching for the right "clinical" position. Other topics they cover include navigating agency and organizational life, exploring continual clinical education, delving into private practice and resolving ethical dilemmas. Time is also set aside each month for case presentations and clinical supervision. Members share not only resources and referral information, but also a sense of optimism about the field and their futures.

Mentors generously give of their time, experience and expertise, offering encouragement of and interest in the professional development of group members. When important professional decisions arise, mentors are available and accessible.

Mentor groups meet one evening per month and are free of charge to NYSSCSW members (there is a $5.00 fee per group for non-members). Contact Barbara Bryan, Mentorship Committee Chair, at 212-864-5663, for more information or to locate the Mentor Group in your area.

Wendy and Martha have been members of the Midtown Mentor Group, led by Helen Hinckley Krackow, for the past three years, and are currently in private practice together.

Vendorship & Managed Care

COMMITTEE REPORT

By John Chiaramonte, CSW, BCD, Chair

The focus of the Vendorship/Managed Care Committee (VMCC) is to promote the utilization of clinical social work services in the State of New York. The committee has responded to member complaints about problems of non-reimbursement or non-inclusion of clinical social workers in health plans as well as the varied problems that arise when working with managed care systems. This includes helping members who have experienced difficulties getting on panels, getting treatment plans approved, and denial of payment. Members who are not familiar with managed care systems have been provided with a general orientation to the managed care system, a list of managed care companies and help completing applications. The Clinical Social Work Federation Hotline has also been very helpful in assisting members facing managed care issues and difficulties: (800) 270-9739.

The Committee has responded to member complaints about problems of non-reimbursement or non-inclusion of clinical social workers in health plans as well as the varied problems that arise when working with managed care systems.

We continue to hope that Washington will act on behalf of the consumers of health care by passing the Patient Access To Responsible Care Act (PARCA) H.R.1415/S644. However, while we are hopeful, we also remain cautious that our legislature will pass this bill which is geared to override several important provisions in the Employee Retirement Income Security Act of 1974 (ERISA).

PARCA would allow, among other things, the right to sue managed care companies for malpractice when they make medical determinations and would also prohibit benefit plans from excluding classes of provider groups. This latter provision would make much of the work of the VMCC moot in that it would forbid self-insured companies from denying payments to clinical social workers or from mandating that they be supervised by an MD or Ph.D. in order to be acceptable providers.

Our committee now has a new marketing brochure developed by the Clinical Social Work Federation (CSWF) geared toward these self-insured companies and will continue efforts to educate these companies as to the benefits of utilizing clinical social workers in their benefit plans. Some companies which continue to not reimburse independent clinical social work services are: PepsiCo, Tyson Foods, TGIF, Mercedes Benz, First Health, Sun Chemical, Unisys, Mark Hotels, Chemed Corporation, Highmark, Bear Sterns, UICI, IIT Research Inst., Ford Motor Credit, Ford Motor Credit, and Local 3.

Some VMCC Issues of the Membership

Alliance PPMC

Some of the issues raised by members to the Committee were quite interesting. In addition to identifying another non-reimbursing self insured company, Highmark, administered by BC/BS of PA, we were also asked to find out more about a company which is marketing itself to many of our members, Alliance PPMC. I contacted one of the partners of this company, Sam Eisenburg, to clarify exactly what their offering was really about. In a nutshell, they had developed a "universal HMO/PPO application form," which they were requesting clinicians to fill out. If you sent this form in with $2,250 they would forward it to 150 networks; for $1,600, 100 networks; and for $950, 50 networks. When I reviewed the companies to which they were offering to forward these applications, I noted that many of them are dimly relevant to many NY clinicians' practices (as reported to the VMCC in the last several years), and that several of those that were highly relevant were closed to new providers. When I addressed this, Mr. Eisenburg made it very clear that nowhere in the application or materials does it state any guarantees of acceptance by PPOs or HMOs, only that Alliance will make the applications and provide other credentialing as the HMO/PPO requests of the applicant.

In summary, if you do not want to be bothered filling out applications and would pay to have someone else to take care of this chore, Alliance PPMC is one option. However, considering the cost of mailings and the fact that clinicians are being more discriminating in the panels they apply for, the "do it yourself" method might be the economical choice.

Managed Care Office Visits

The Committee received several calls from concerned members who had received notice that one or more of the managed care organizations (MCO) they belong to wanted to visit their office and examine records. These companies provided lists of what would be reviewed in these visits. They were not interested in having names of any patients and were content with looking at notes in which all identifying information was whited out. They also wanted to see the layout of the office, among other things.

These visits are a part of the requirements set down to the companies by NCQA, the MCOs' reviewing and credentialing organization. Although this feels like an intrusion into the therapist's domain, it is in fact allowed by law and written in most contracts that clinicians sign with MCOs. However,

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Revised Medicare Clinical Social Workers

Fee Schedule

NEW CODES FOR 1998
EFFECTIVE JANUARY 1, 1998

CODE	DESCRIPTION	LOCALITIES			
		1	2	3	4
90804AJ	Individual psychotherapy, insight oriented, behavior modifying and/or behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	45.90	44.33	40.67	43.97
90806AJ	Approximately 45 to 50 minutes	71.42	69.02	63.02	68.45
90808AJ	Approximately 75 to 80 minutes	121.97	117.65	106.94	116.69
90801AJ	Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other medical or diagnostic studies; in certain circumstances other informants will be seen in lieu of the patient.)	106.25	102.77	94.55	101.92
90846AJ	Family medical psychotherapy (without patient present)	77.17	74.43	67.96	73.84
90847AJ	Family medical psychotherapy (conjoint psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated)	86.17	83.31	76.46	82.62
90853AJ	Group medical psychotherapy (other than of a multiple family group) by a physician, with continuing medical diagnostic evaluation and	27.31	26.25	23.85	26.06

LOCALITIES

1. Manhattan
2. Brooklyn, Bronx, Westchester, Richmond, Rockland, Nassau and Suffolk Counties
3. Putnam, Sullivan, Orange, Duchess, Ulster, Columbia, Delaware and Greene Counties
4. Queens County

NOTE

"Interactive" codes have been left out of this schedule as they do not apply to verbal psychotherapies. For further explanation of codes and fees call Mary Cooper of HCFA (Health Care Financing Administration) Coding Section at: (410) 787-5302.

Vendorship & Managed Care

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according to most senior MCO clinicians with whom I spoke candidly regarding these visits, the MCOs are more interested in showing NCQA that they are making these visits than they are in scrutinizing the providers to see if there is an exit sign, wheelchair accessibility, good penmanship in progress notes. Neither are they interested in sanctioning any clinician. Clinicians should understand that such visits are to be expected when working in a managed care arrangement. Knowing your rights according to NYS Law S7553, knowing the requirements of record keeping in NYS, and knowing the CSWF code of ethics should assist any clinician in traversing the territory between patient, clinician and MCO's needs.

No Cause Authorization Denials

It seems that Merit Behavioral Care has come up with a way around the NYS Law 7553. As a result of that law, it is much harder for MCOs to terminate panelists without cause, due to the rights of appeal of the panelists and the protections of that law. However, we recently received a call from a member who was told that while she is still on the panel, she has been chosen to be one of the panelists who will not be reimbursed for any new, future MBC patients that might seek services. In other words, she was told "you are not off the panel, we are just not going to authorize any new patient payments to you." The VMCC will be advocating for this member and will apprise our legislators of this most recent maneuver.

There is a new 800 number for providers to call when MCOs or insurance companies pay their bills in excess of 45 days past due: Late payment complaint number at the NYS Department of Insurance: 800 358-9260. ■

IMPORTANT PHONE NUMBERS

Dept. of Health Managed Care Complaint Line		(800) 206-8125
Dept. of Insurance Late Payment Line		(800) 358-9260
NYS Attorney General's Healthcare Hotline		(888) 692-4422
NYS Public Advocate's Healthcare Complaints		(212) 669-7606
NYS Department of Insurance	(212) 602-0203	(518) 474-6600
YOUR State Senator		(518) 455-2800
YOUR State Assemblyperson		(518) 455-4100
Clinical Social Work Federation Hotline for Heath Systems Problems		(800) 270-9739

Society's Statewide Survey Suggests Members Have Extensive Clinical Training & Experience

By Jacinta Marschke, PhD, Research Committee Chair; Joseph Ventimiglia, DSW; & P Carmichael, PhD

Jacinta "Cindy" Marschke, Ph.D., CSWR, is a full-time Assistant Professor at Fordham University's graduate School of Social Service and maintains a private practice in New Paltz, New York. She is a Past President of the State Society and the current Chair of the Research Committee.

Over the summer of 1997 the Research Committee conducted a statewide membership survey to learn more about the current demographics and activities of State Society members, to solicit members' input regarding the current and future direction of the Society, and to explore to what extent members evaluate their practices. In this article we will describe the survey method and final sample, highlight those preliminary descriptive findings that characterize the Society's membership and compare our preliminary demographic findings with those generated by a similar national member survey conducted by NASW during the same time period. A summary of our members' opinions about the current and future directions of the Society is offered in an accompanying article.

Method and Sample Characteristics

A 112-item-questionnaire, which elicited demographics, member interest and needs, and involvement in practice evaluation (these results will be reported in the next *Clinician*), was mailed to a stratified, randomly-selected sample of 501 members. Overall, this prospective sample represented approximately 20% of the total membership of 2,200, with a larger portion of the sample solicited from smaller chapters (chapters with less than 100 members) to insure good representation from the Society at large. Ultimately, 222 questionnaires were returned, reflecting a statewide return rate of 43% and a return rate by chapter ranging from 31% (Western New York) to 56% (Syracuse). The selection process successfully generated a representative sample of large and small chapters and appeared representative of the overall membership. The chart above provides the membership and sample totals for each chapter. The initial larger solicitation from smaller chapters was later balanced by the larger return rate from the bigger chapters. In addition, the demographics of the final sample compared favorably with the demographics of the membership-at-large. In both the survey sample and the membership-at-large, the modal social work member was a 51-year-old Caucasian female with over ten years of full-time clinical experience who held either fellow or diplomate status within the Society.

Membership Totals & Sample Representation For Each Chapter

CHAPTER	TOTAL CHAPTER MEMBERSHIP (6/97)	% OF TOTAL ORGANIZATION	% OF FINAL SAMPLE	# OF CHAPTER MEMBERS SOLICITED	# OF CHAPTER MEMBER PARTICIPANTS	% OF QUESTIONAIRES RETURNED
METROPOLITAN	925	41.7%	33.0%	185	73	40%
NASSAU	351	15.8%	11.7%	70	26	37%
WESTCHESTER	324	14.6%	15.8%	65	35	54%
SUFFOLK	135	6.1%	5.9%	27	13	48%
BROOKLYN	114	5.1%	5.4%	23	12	52%
ROCKLAND	102	4.6%	4.5%	20	10	50%
SYRACUSE	68	3.1%	6.8%	27	15	56%
QUEENS	61	2.8%	4.1%	24	9	38%
STATEN ISLAND	61	2.8%	4.1%	24	9	38%
MID-HUDSON	50	2.3%	4.1%	20	9	45%
WESTERN NY	16	0.72%	2.3%	16	5	31%
CAPITAL	8	0.4%	1.8%	8	4	50%
UPSTATE	3	0.14%	0.45%	3	1	33%
TOTALS	2218			512	221	

Demographics

GEOGRAPHIC DISTRIBUTION

The survey validates that the Society continues to draw the overwhelming majority of its members from the New York Metropolitan Area. Seventy-three percent (73%) of the respondents earned their MSWs at New York City schools and about 47% continue to practice and reside in the same area (Manhattan, Brooklyn, Queens, Staten Island). Fully 90% of the total membership are accounted for when the members from areas within commuting distance of New York City (Long Island, Westchester and Rockland Counties) are added.

NATURE OF PRACTICE

The organization continues to appeal to social workers interested and employed in direct clinical practice. Virtually all (99.1%) elected a clinical concentration alone or in combination with another specialty while in their masters programs. Currently, about 75% specialize in mental health, with 49% in private practice and an additional 24% employed in either in-patient or out-patient mental health agencies. The remaining 2% who do not specialize in mental health practice are in other health (4%), school (5%), or social service (8%) settings serving diverse client populations.

Over half of the respondents have extensive post-masters full-time clinical practice experience (52% have more than 10 years) and continue to commit most of their time to direct practice. Sixty-five percent (65%) are engaged in an average of 21 hours or more of direct service per week. Surprisingly, these workers appear to have plenty of work and are not heavily involved with managed care. Only 32% reported that more than a quarter of their direct service work involved managed care. The remaining 68% have less than a quarter of their caseloads involved in managed care. It may be that clinical social workers who practice in more advantaged communities, like the New York metropolitan area, are serving more clients who do not depend on third party reimbursement and are able to pay for service "out of pocket."

POST-GRADUATE TRAINING

An overwhelming number of members have pursued and completed post-masters educational training. In this sample, all most half hold certificates from institutes, 10% have earned PhDs or DSWs, and 8% have qualified as certified alcoholism counselors. An additional 22% reported that they had completed postgraduate training for work with special client populations or problems (e.g., childhood and adolescence, aging, weight control, sexual abuse, eating disorders, AIDS), in specific treatment modalities (e.g., group, EMDR, neurolinguistic programming, hypnosis, brief interventions), or in preparation for new or specialized social work roles (e.g., supervision, administration, public health). These findings suggest that Society members may have more postgraduate clinical training then most masters-level social workers. This should spur the Society to continue and/or intensify its commitment to postgraduate clinical education.

THEORETICAL ORIENTATION

A wide range of theoretical orientations is represented among members' practices. Because of social work's biopsychosocial orientation, it is not surprising that the greatest number of respondents favor a psychodynamic perspective (79%). However, it is surprising that many members note that other or additional perspectives inform their work. These perspectives include family systems (46%), object relations (45%), cognitive-behavioral (43%), and psychoanalytic (41%) theories. Solution-focused theory (31%) and self psychology (24%) are also noted, but less frequently. This diversity among members counters the prevailing misconception that the Society appeals primarily to clinicians who rely exclusively on psychoanalytic theory.

POST-MASTERS STATE CERTIFICATION AND OTHER DESIGNATIONS

It was surprising to find that almost a third of the sample did not have New York State CSW (32%) or CSWR (31%) designations. In an age when the Society is supporting a licensure bill to protect the public with more rigorous scope of practice standards, it is disconcerting to find that many members have not substantiated the fact that they have met minimum standards. With the passage of licensure, social workers would be required to meet minimum standards, not only if they wish to be identified as licensed, but if they wish to practice social work at all.

Theoretical Practice Orientations

THEORETICAL PRACTICE ORIENTATIONS	FREQUENCY	PERCENT
Psychodynamic	176	79.3%
Family Systems	101	45.5%
Object Relations	99	44.6%
Cognitive/Behavioral	95	42.8%
Psychoanalytic	91	41.0%
Solution Focused	69	31.1%
Self Psychology	54	24.3%
Other	23	10.4%

After electing to qualify for state certification, sample subjects often pursued advanced professional designations. The same number of subjects hold the Board diplomate designation awarded by the Federation of Societies of Clinical Social Work (n=60) as hold the equivalent designation awarded by NASW (n=59). Almost half of the sample elected to qualify for one or the other. The fact that there was no clear preference for one designation over the suggests that subjects are either unaware of or unconcerned about the differences between them.

State Society for Clinical Work and National NASW Surveys

In late 1997, NASW analyzed interest surveys generated from 1062 of their members nationwide (59% of those solicited). While the NASW survey was more limited than our own, there are some interesting comparisons to be made (NASW News, March, 1998).

The respondents in both studies appeared to be comparable to be in gender and age. Both samples were predominately female (Society= 82% female, NASW= 79% female) which is typical of the profession. Those canvassed in both studies appeared to be experienced professionals. The median age in the NASW group was 46 years and the mean age in the Society group was 51 years. Other differences between the two samples reinforce the prevailing assumption that Society members are engaged in private practice more than are NASW members. Society members were more apt to

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Society's Statewide Survey
Results of a Needs Assessment

by Joseph Ventimiglia, DSW, BCD

A needs assessment is a means for collecting valid and reliable data bearing on the need for services, products, or information, which is used to better target services and efforts. Some common reasons for needs assessment include justification for funding program activities, resource allocation and decision making, providing timely information about the membership being served, and assessing the needs of specific, under-served groups within a population.

Many business corporations and professional organizations employ needs assessment as a kind of decision-making tool. A needs assessment can provide valuable information to guide an organization. This is often of paramount importance for survival and growth, as well as for effectiveness in fulfilling the organization's mission, goals and objectives (Soriano, 1995).

How Important Are The Following Membership Activities To You?

The Society can best serve its members by providing important activities that members need. Although not an exhaustive list, 13 activities were identified as currently involving Society sponsorship either on a state level or chapter level. Members were asked to rate the degree of importance of these activities on a 4-point scale—least/somewhat/ very/most. The "very/most" categories were collapsed to reflect a strong degree of importance. A majority of members indicated a strong degree of importance for the following activities:

Legislative Advocacy (71%), Educational Programs (69%), State Newsletter (67%), Clinical Social Work Journal (66%), Malpractice Insurance (64%), Networking (64%), and Affiliation with other Professional & Business Organizations (52%).

The following activities were rated to a lesser degree of importance: State Membership Directory (47%), Mentorship Program (43%), Chapter Meetings (40%), Annual Society Conference (37%), National Federation Conference (31%), and Speaker's Bureau (27%).

Members were also asked to indicate whether they participated in any of the above activities during the past year. The top three participant activities were: Educational Programs (56%), Networking (54%), and Chapter Meetings (36%). All other activities received less than one-third of membership participation. However, there appears to be some correspondence between the degree of importance of an activity and participation in that activity. For example, Educational Programs were high for both degree of importance (69%) and participation of activity (56%), whereas the Speaker's Bureau was low for both degree of importance (27%) and participation of activity (11%). Intuitively, this makes sense; members are more likely to participate in activities that they perceive to be more important to them.

How Should The Society Prioritize Future Directions?

The Society can best serve its members by developing effective strategies to fill unmet needs. Needs can be described as discrepancies between an actual condition and a desired one.

The process of a needs assessment is identifying the gaps or discrepancies between what actually is and what ought to be (Queeney, 1995). Therefore, a needs assessment should involve questions about future directions. Identifying priorities helps to guide an organization in the decision-making process of planning for growth and survival, developing programs and activities and allocating resources wisely.

Members were asked to rate on a 5-point scale (from lowest to highest) the degree to which they would like to see the Society prioritize future directions. Fourteen (14) items were selected that reflected a broad range of directions, from some already in progress to others that members expressed interest in pursuing. The following directions are presented in order of highest degree of prioritization:

Passage of Licensing Statute	89%
Promote Image of Clinical Social Work	81%
Provide Educational Opportunities	78%
Broaden Scope of Marketplace Issues	
[This item was divided into four sub-items:	
Managed Care	73%
Referral Resources	70%
Provide Practice Associations	62%
Employment Opportunities	56%
Collaborate with other Organizations	64%
Consult with Social Work Schools	53%
Promote Camaraderie	47%

Summary of Results

1. Membership is very satisfied with the activities of the Society
2. Members view three activities as very important, both currently and for future directions:
   - passing a licensing statute
   - providing educational opportunities
   - promoting the image of clinical social work
3. Members hold essentially similar views, regardless of chapter affiliation

Training

99.1%
CLINICAL &/OR COMBINATION MSW CONCENTRATION

73%
MORE THAN 10 YEARS YEARS SINCE MSW GRADUATION

Provide Mentorship for New Members ____ 42%
Offer Non-Clinical Practice-Related Skills,
e.g., business management, utilization of computer systems/information for practice management ____ 39%
Assist Members in Grant Writing ____ 32%
Conduct Research ____ 32%
Provide Opportunities for Members with Special Interests,
e.g., retired, people of color, gay and lesbian, etc. ____ 31%
Assist Members in Developing Professional Writing Skills/Publishing ____ 29%
Seek Commercial Discounts for Members,
e.g., insurance, credit cards, travel, health benefits ____ 25%

How Satisfied Are You With The Society?

The bottom line for the survival and growth of any membership organization is membership satisfaction. In this assessment, members were asked to describe their overall level of satisfaction with the Society on a scale from poor to excellent for both State and Chapter levels. The following results were based on collapsed categories:

At the State level, 17% of members reported a combined satisfaction rating of "poor to fair"; similarly, 21% of members reported a "poor to fair" rating at the Chapter level.

At the State level, 83% of members reported a combined satisfaction rating of "good to excellent"; similarly, 79% of members reported a "good to excellent" rating at the Chapter level.

Summary

In summary, the results of the needs assessment show basically that members are unified in their views about what current activities are important and what future directions should be considered. In this regard, the top three are: passage of a licensing statute, providing educational opportunities, and promoting the image of clinical social work. Furthermore, members are very satisfied with the Society.

The needs assessment has provided an opportunity for members to exercise a basic and necessary function, namely, to communicate their interests, desires, choices, involvement, and satisfaction with the Society to help the leadership make informed decisions based on empirical data. The results of the survey were presented formally to the leadership at the State Board meeting on March 21st. The process of incorporating these results into specific recommendations to meet the needs of the membership has begun. ■

Queeney, D.S. (1995). Assessing Needs in Continuing Education. San Francisco: Jossey-Bass. Soriano, F.I. (1995). Conducting Needs Assessments: A Multidisciplinary Approach. Thousand Oaks: Sage Publications.

Joseph Ventimiglia, DSW, BCD is a member of the Research Committee (Queens Chapter) and member of the survey project. He is currently on faculty at Fordham University Graduate School of Social Service.

Members Have Experience

CONTINUED FROM PAGE 7

qualify for advanced designations like ACSW (Society, 42%; NASW, 36%), to register for State licensure (Society , 86%, NASW, 76%) and maintain malpractice insurance (Society, 91%, NASW, 42%) than NASW respondents.

The two samples also differed in income. Whereas only 17% of Society members reported incomes of less than $ 30,000 from their primary jobs, 34% of the NASW subjects reported less than $30,000 total income. At the other end of the spectrum, 38% of the Society subjects reported earnings of $46,000 or more from their primary jobs, while only 22% of the NASW subjects reported earning more than $50,000 from all sources. Had the earning totals from all sources for the Society respondents been available, the differences between the samples would have been even greater.

Practice

YEARS OF POST-MASTERS FULL-TIME CLINICAL EXPERIENCE	
5 YEARS OR LESS	20.8%
6–10 YEARS	14.4%
11–15 YEARS	12.6%
16–20 YEARS	19.4%
21 YEARS OR MORE	20.3%
NO ANSWERS	12.7%
AVERAGE NUMBER OF DIRECT CLIENT HOURS PER WEEK IN THE LAST YEAR	
MEAN	24 HRS
S. D.	11.15

Summary

This preliminary analysis of the statewide member survey suggests that the Society continues to attract experienced direct practice social workers who rely on diverse theoretical orientations. Society members have a commitment to post-graduate education and pursued additional training to work with specific client populations/problems, different intervention models and discrete social work roles. A comparison of the data generated by the NASW survey with our own suggests that Society members are more apt to specialize in mental health and to be involved in third party reimbursement than NASW members at large and that other differences between the two groups may emanate more from the diverse practice specialization and/or settings than from different philosophical perspectives.

Income From Current Primary Position

AMOUNT	FREQUENCY	PERCENTAGE
$15000	14	6.3%
$16000–$30000	24	10.8%
$31,000–$45,000	57	25.7%
$46,000–$60,000	49	22.7%
$61,000–$75,000	33	14.9%
NO ANSWERS	19	9.1%

Future Directions

The Research Committee hopes to pursue a more in-depth analysis of the demographic data by chapter. Further analysis of the demographic and needs assessment data will be available by request to chapter presidents and should help local boards identify and address the unique interests and needs of their membership. The Research Committee also will generate a report on the practice evaluation findings for the next newsletter. Finally, the Committee is working on a journal article relating to practice evaluation. ■

Public Relations

COMMITTEE REPORT

By Sheila Peck, LCSW, Chair

On April 5 we held a workshop on building membership and enhancing the professional image of social work for representatives from several chapters across the state. Special thanks to President Emeritus Helen Hinckley Krackow for letting us use her lovely apartment for our meeting.

Although we gave participants a lot of hands-on, nuts-and-bolts methods, the real thrust of the program was to help chapters to empower themselves. The most exciting part for me was to hear the array of sparkling and creative ideas the chapter representatives had to offer each other. If you were not able to attend, we handed out a packet of membership-building materials which is available to any chapter president, membership or public relations chair on request. Just send a stamped self-addressed large manila envelope to the address below.

One pointer which emerged from the workshop was that whenever you attend a professional conference of any sort —no matter who is sponsoring the event — take chapter and state membership materials (and newsletters) with you. It's a no-cost, easy way to publicize the Society and our profession. Do this even if your conference is out-of-state. You'd be surprised at how much interest this can generate.

Several other publications are available to any member sending a stamped, self-addressed envelope. These include: (a) Membership benefits sheets which will tell you and any prospective members how joining may benefit; (b) Two consumer- or patient-oriented pages which were developed in response to a request from the Hospital for Special Surgery: "How Clinical Social Work Can Help" and a check list of symptoms which might indicate the need for therapy; and (c) A legislative fact sheet, "The Universal Mental Health Profession: Social Work." Some members have found "How Clinical Social Work..." especially helpful in their attempts to educate medical professionals about us.

After a recent discussion with President Al Du Mont, we've decided to offer press release writing services to any chapter. We think it's important that, in addition to meetings, conferences and the like, whenever one of our members writes a book, receives an award or other honor or achieves anything noteworthy, a press release be sent to all local media. Even if the information isn't published, it will help familiarize media people with the name of the Clinical Society and the member — so it's a good public relations idea.

Therefore, if you'd like help in writing and distributing such a press release, please send all the relevant information to me at the address below, along with a list of the media outlets to which you'd like us to send it. You don't even need to send their addresses — we have a guide to EVERY newspaper, magazine, radio or television state, etc., in the state. We hope members will follow through.

On May 17th we'll be presenting a practice-building workshop for the Brooklyn chapter, with repeat performances in Westchester on June 6 and in Suffolk on June 20.

Finally, we recently wrote several letters to the New York Times, one of which was in praise of an editorial which praised the efforts of a Brooklyn social worker. ■

Please send all information about press releases or requests for publication (with a stamped, self-addressed envelope) to Sheila Peck, 1010 California Place South, Island Park, NY 11558.

HELEN HINCKLEY KRACKOW CSW, BCD,

has been elected as Treasurer of the CSW Federation, effective July 1st. She will serve on the Federation's Board, along with several other NYSSCSW members: Allen A. Du Mont, President, John Chiaramonte, Chair of the Marketing/ Public Relations Committee, David Phillips, Chair of the Psychoanalysis Committee and Co-Chair of the Professional Standards Committee.

The results of the

Guild/OPEIU Referendum:

92% of 457 votes cast were in favor

New York led the states in voting for affiliations with the guild. A by-laws referendum will be sent to the State Society membership within a few weeks.

More About Managed Care

THE PRACTICAL PRACTITIONER

By Sheila Peck, LCSW

One of the effects that managed care may have on some clinicians, if we allow it, is to lower our self-esteem by devaluing the work we do. After all, it's only "talking," right? (to paraphrase a recent quote from a not-to-be-named prominent New York State politician).

Some of us, especially when we receive only a few sessions from a managed care company, or our request is denied entirely, sometimes feel that it reflects on the value of our work. I recall one aggressive patient who tossed a fee-lowering letter from the insurance company at me saying, "See. That's all they think it's worth!" Both personally and professionally, we need to guard against allowing this to affect how we feel about ourselves and our work.

One meaningful way to counteract this is to realize and remember that the managed care organization (MCO) is in business to make money! That's all! Bottom line! Effective treatment is not a first consideration.

This viewpoint has nothing to do with the importance of our work. If you think about your pro bono patients, current or past, you'll realize that the quality of your treatment is unrelated to the amount you are getting paid (would that this could also be true for MCOs!). If you are good at what you do, no MCO can EVER take that away from you, no matter how many sessions they may deny!

Continue to educate your patients. Most really don't know much about managed care and insurance. Some are surprised that the rules are different for psychotherapy than for physical treatment, even with the new parity law. Teach them at the beginning of your work together.

Because the initial meeting is such an important part of forming the therapeutic bond, I generally add 15 minutes onto the first session so that the patient and I can discuss the insurance situation. I tell them beforehand that this will happen so that they can be prepared.

I also give them material to take home and read about possible loss of confidentiality. In my waiting room I keep copies of "Insurance Quandaries & Questions IQ" a well-written mental health consumer-oriented pamphlet published by the Consortium for Psychotherapy, which specifically explains the differences between self-pay, managed care and indemnity insurance from the client's point of view.

Many patients have been educated about the supposed inviolability of the patient/therapist relationship so they don't initially believe that their confidentiality may be violated. If you work with managed care, be careful about what you put into the Outpatient Treatment Report. Remember, this may be with your client FOR LIFE. Therefore, it's also important to make sure the client knows that you'll be telling the MCO all about them. In my experience, many have trouble believing this.

Help your client to be a good consumer and self-advocate. S/he may want to call the insurance company and complain. That's how insurance worked in the days before MCOs infantilized our patients (and us). Also, if it's therapeutically appropriate, get your patient to inform his/her employer about the insufficiency of managed care to meet consumer mental health needs. Employers are often concerned about the well-being and satisfaction of their employees, particularly if it affects production. So if enough workers complain, they may get the employer—who is the basic purchaser of the health insurance—to back them up.

Please feel free to submit questions on practice management and other non-clinical issues which we can address in future columns. ■

Federation Joins Guild of Medical Providers

CONTINUED FROM PAGE 1

help with our clinical licensing bill, and that help was provided. State Society President Allen A. Du Mont said, "In addition to access to key legislators and policy makers, affiliation with the Guild and OPEIU will help us become part of health benefits for two and a half million AFL-CIO members in New York State. We look forward to working with their EAP programs to provide clinical services."

Marsha Wineburgh, Legislative Chair of the New York State Society, said, "The Guild offers clinical social workers an opportunity to expand their network of influence nationally and also in New York, a state with a very large union presence. There are nearly 100 lobbyists in Albany representing labor's interests. Guild membership will give us access to these lobbyists, who may be able to open up clinical social work reimbursement by New York State Worker's Compensation and improve union members' mental health benefit packages."

Some clinicians expressed the belief that joining a guild will benefit only private practitioners. However, others argued that Medicare and Medicaid are becoming more "managed" by the minute, and that President Clinton is pro-managed care. Hospitals and agencies are profoundly affected by national health care policies. Therefore, we must have more of a national voice to influence national health care legislation, for all our own and all our clients' best interests, and the Guild will give us this voice. ■

Divorce and Separation Groups

Barbara G. Feld, MSW, BCD

Barbara G. Feld, MSW, BCD, is on the faculty of Mount Sinai School of Medicine, Division of Group and Family Therapy, and in private practice in Manhattan. She is a Chair of the Family Practice Commitees of the Met Chapter and the State Society.

This paper will focus on the application of short term group therapy to the special issue of divorce and separation using examples from two groups to illustrate my points. In my experience, the people who apply to enter these groups are fragile and narcissistically vulnerable. They are also angry, hurt, frightened, lonely, ashamed and often isolated. Therefore, the issues of rejection, and wounded self-esteem need to be dealt with first before they can move on to experience feelings of hope and desire.

The aim of a short term separation and divorce groups is to move members out of their frightened stagnation towards a capacity to deal with the rest of their lives. It is important to deal with themes of devastation and hopelessness, chronic trauma, rage, scape goating, fear of intimacy and fear of taking responsibility. Being in the group gives them the experience of making positive connections with people, even though their marriages have failed.

Beginning Phase: Formation

Formation, the first phase of the group, is accomplished by the therapist actively encouraging affiliation. The task for the therapist is to create a safe place in which this can be done. At first, the group is encouraged to affiliate by sharing their experiences, listening to each other, and handing tissues back and forth across the room as each tells his or her story. Commonalities of shared loss and rage are discussed, as are fears that things will not be better in the future.

Formation, the first phase of the group, is accomplished by the therapist actively encouraging affiliation. The task for the therapist is to create a safe place in which this can be done.

After this sharing occurred during the first meeting of Group B, Dot said that she felt very connected to the members of the group and that she had never felt that way before. She said, "I feel like the group is a big Jello® mold. I can almost cut the atmosphere, the feelings are so intense." Hal responded by saying that he'd been cut off from his feelings all his life, but he'd been feeling choked up and upset during the session. He thought that was probably good, but it was painful. The therapist anticipated the possibility that Hal might want to leave the group in an attempt to avoid his strong feelings and raised this at the end of the session for discussion, but Hal missed the next group session. However, he returned for the third session, where this issue was addressed by the group. They all discussed the difficulty they had in listening to others' distress and talked about the upset it caused them. They asked Hal to tell them more about the situation he was in, in which his young wife had asked him to leave. Hal talked in more detail about this and was able to cry about it. He later said that he felt enabled to stay in the group and deal with these feelings.

The theme of working through having been left by the spouse occurs throughout the group's duration, but is handled differently at different stages. Occurring in each stage is the threat that a member might leave the group, rather than stay and work out the hurt of having unmet needs. Most, but not all, members respond to an interpretation by the leader or group that they are taking our their anger on the group by trying to be the first to leave. This is a continual problem in separation and divorce groups.

Another way the group attempts to affiliate during the beginning phase is by finding a common enemy – their abandoning spouses or other members of the group who they perceive as similar to their spouses. When the anger of the group is directed at one member in order to help the others affiliate, the leader has to actively intervene to protect that member and redirect the anger. It is too early in the group's development for the group itself to be able to handle the situation productively.

Group A became enraged with and attacked Aron, the only member who had left his spouse. They were angry at the similarity of his actions to those they had experienced. He, on the other hand, felt that his wife's attacks on him were being reenacted by the group and he threatened not to return for the next session. He was helped to see what in his behavior had encouraged the group's attack. Then the group refocused on their need to affiliate with each other without excluding a member.

Firm leadership and clear structure helps with this task and sets an example for managing life. It is also helpful to investigate the members' fears of becoming too close to each other, or the behavior of an individual member in provoking an attack, as ways of avoiding identification and affiliation.

As can be seen in the last example, the themes of safety and protection surface early in separation and divorce groups. If these themes are not dealt with, then some members will be lost, and the entire group will re-experience feeling unsafe and anxious about loss. Another early theme is avoidance of uncomfortable feelings. This is important to discuss in the early phase, or members will avoid feelings by leaving the group.

In Group A, a few members missed a session due to intensification of their painful feelings and fear of expressing them during a particular session. One member, Bill, almost dropped out because he had felt very angry and feared an eruption of his anger. After this was discussed and he was encouraged to verbalize his feelings, he reported feeling more accepted by the other members, even for his anger. Thereafter he was able to use the therapist and the group to help himself modulate anger while expressing it.

Another theme in separation and divorce groups is the feeling that relationships might not be worth the pain they cause. For example, some of the members of group B talked about thinking of the future without being in a relationship because of how hurt they had been in the past. Being in the group, making connections with and talking to others, espe-

cially members of the opposite gender, loosened the grip of some of these fears. Members began considering dating again by the middle phase of the group sessions.

Middle Phase: Possible Hope

By the middle phase, around session 4 or 5 of a 10-session group, members move from focusing on anger, shame and hopelessness to feelings of relief and possible hope. Feelings of lack of control of former spouses or partners may have grown during separation into feelings of lack of control over life itself. Members need to know that there is life after divorce. Their rage needs to be channeled into recognizing personal capabilities again, and using them to move forward.

Members in the middle phase begin to let go of the missing partner and face responsibility for their own lives. They are often at different stages in their adjustment to separation and can be helpful in challenging and pushing one another.

In group A, Marjory had been unable to motivate herself to obtain a divorce for 10 years. She had come to the group with the goal of being able to achieve this. At the first group session, she looked unkempt and as though she could not cope with her life. After initial sessions focusing on her angry immobilization, in which the group confronted her with possible reasons why she had been so passive, Marjory was finally able to keep a court date and pursue the divorce. She said that the group's focus on her "gave her pause to think for herself" instead of reacting to her husband.

In addition, the middle stage of group development brings more interpersonal conflict in the group. Having already affiliated, the group members are better able to hear different sides of an issue, to fight and then to resolve it. This productive fighting is something they were unable to do in their marriages and is helpful for them to experience as a process with a resolution. This sometimes occurs with humor as an effective tool.

Bill talked about wondering why he said that he would like to meet a nice woman, but never did. He thought about it and said that he did not feel trusting enough in women to become involved again. His wife's affairs and the enmity during the divorce ruined his ability to trust. On the other hand, he said he was tired of relationships just based on having sex. He told of an incident in which he said to a woman he had been seeing, "the only thing missing is the money you leave..." To which Nancy said, "Very nice, Bill," with a sarcastic tone. The entire group laughed, including Bill, who was able to recognize the ambivalence and hostility he had been exuding, which could tend to drive away some women.

While some members are unable to experience the deepening of the group process during the middle phase and need to leave, others will begin to use the group and reveal hidden issues about themselves.

Fran came to session 6 of group A and stated that she was going to leave. She felt that she could not express her anger in the group because she felt the group disapproved of it. The group was upset by this and felt misunderstood themselves, since they valued her for her strength and her anger. This was especially true for Tracy and Nan. Bill said that he would miss having an "angry partner." Fran was surprised and listened as the therapist pointed out that she was not experiencing her power and impact on other people. Although she thought about this and began to see how the group had been helpful and meaningful to her, she continued to feel she had to leave.

On the other hand,

Nan was able to reveal in the sixth session that she had been taking calls from her husband, even though she knew that they were extremely upsetting to her. She would then drink heavily at parties or with friends and would be unable to recall the evening. The group spent a lot of time listening to her. They pointed out her avoidance of angry and hurt feelings by blanking them out, and encouraged her to express them in the group. Since she had not been a heavy drinker before the divorce, the group's concern and confrontation enabled her to stop this behavior.

Termination

During each session of the short term group, termination is discussed and treated as similar to the ending of any relationship—with the attendant re-experiencing of feelings of loss. During the last few sessions, when the group is almost over and the uncertain future looms ahead, members may resist ending and request additional sessions. The leader may need to say that the group may be feeling upset about the imminent ending and may be handling it the way they handled the loss of the spouse—by clinging, depression, withdrawal, and denial.

Some members may again be tempted to leave before the group's termination. Often the group is able to handle these feelings for themselves. They need to see that the experience of loss is part of life and that how they treat the loss of the group is relevant to the task of going on with life. It is helpful for the leader to show that there is a way to deal with loss—one that they have learned within the group. They need to understand that they have made affiliations with other members and that continually making new connections helps enormously with the task of going on. Groups sometimes continue to meet by themselves after the formal meetings are over, or connections between individual members may continue.

In group A, Nan and Tracy had become friends and called each other between group sessions, checking on each other's progress toward being strong enough to keep their ex-husbands out of their lives, so that they could get on with their own. Tracy would call Nan when she felt herself behaving in a way that was not consistent with her developing self-respect. Sometimes, Nan would call her to check-in.

Nan had changed into a model for the group of a person who could separate and go on. Each member mentioned that they had internalized the "group voice" as a source of strength to deal with stressor, and as an encouragement. Most of the members had developed a clarity about what they needed in the future and greater certainty about how to get it.

This type of interaction characterizes the end phase of a separation/divorce group, in which the members have moved to a position of letting go of the spouse, making some changes in other relationships in their lives, beginning to date (for some members), and looking forward to the future. ■

By the middle phase, around session 4 or 5 of a 10-session group, members move from focusing on anger, shame and hopelessness to feelings of relief and possible hope.

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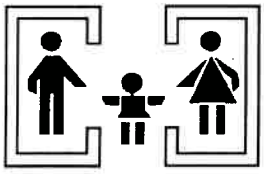

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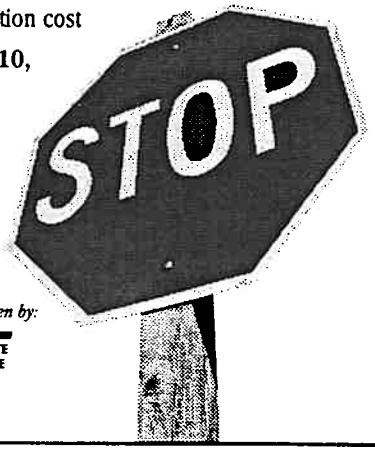

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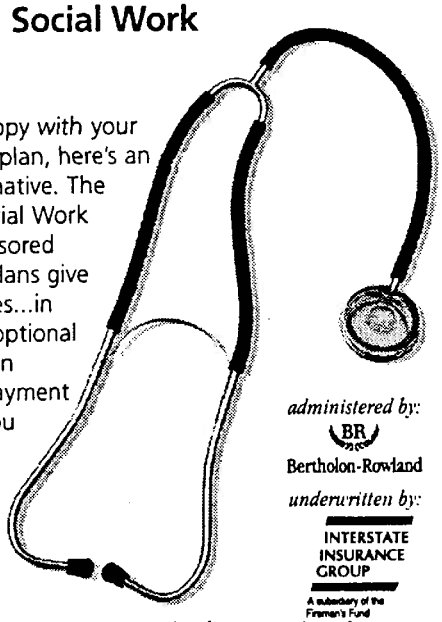

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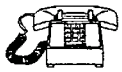

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