Lest We Forget, We Are Clinical Social Work *Psychotherapists*

By Marsha Wineburgh, DSW, President Elect

This we already know: the practice of social work is more than 100 years old and highly diversified, across many settings, across several levels of education, and many areas of interests. One- eighth of all the social workers in the United States live here in New York State. We, the members of the NYSSCSW, are a self-selected group of clinical social workers within this very large profession. We are not defined by the setting we work in; rather we are defined by our interest in and/or our expertise in mental health and the treatment of mental illness with all its derivatives and nuances. Our knowledge base draws from distant as well as allied professions, from psychiatry and sociology to spirituality and the creative arts. We are the clinical social work *psychotherapists*, whether we have a special interest in psychoanalysis, grief counseling, EMDR, or marriage and family therapy. There are nearly 26,000 LCSWs in New York State, all potential members, whose interests we advance and protect.

Ironically, after the passage of the licensing law for clinical social work (2002), wherein the function of LCSWs was explicitly described, confusion grew about what clinical social workers actually do and, consequently, whose interests the Clinical Society should represent. Many social workers believe that any direct contact with a client/patient is a *clinical* intervention. If one subscribes to this belief, then the mission of our organization could expand to include this wider base of direct practice professionals and might include medical social work, child welfare, or case management. One of the problems with this

expansion is that there would be no professional social work organization representing the particular interests of social work *psychotherapists*. And there would be internal conflicts of interest within the organization about financial and legislative priorities stemming from the legitimate tensions between these different groups.

KEEP IT SIMPLE: My preference is to respect our history and stick to what we know best. We are the only social work organization specifically representing social work *psychotherapists* in this state. There is no other professional organization that is able to represent and advocate for our particular needs without encountering conflicts of interests with other social work specialty groups. The history of our organization validates the effectiveness of a narrowly focused agenda.

Let's review: in 1968 the New York State Legislature legally recognized social work as a profession through the passage of a title certification law which created the title "certified social worker." Title certification, since it only creates a **title designation, CSW, is a weak form of regulation and there is no requirement for an MSW** graduate to have this designation (and many as one-third of MSWs did not bother to get it). Further, the description of the functions of social workers was so **generalized and vague** it made it difficult to prosecute ethical and professional practice violations. This statute, however, was a beginning for legally defining social work as a profession.

The Clinical Society (NYSSCSW) originated in 1968, in part as a result of national NASW's embracing the BSW as the entry level into social work. Here in New York, the leadership of the psychology professional associations had introduced hostile legislation to require social workers providing psychotherapy services to be supervised by psychologists (the Biondo bill). Founding members of the Clinical Society were social work *psychotherapists*, graduates of advanced training institutes, who opposed national NASW's decision to lower professional entry standards and also actively disputed this psychology bill. From the beginning, the mission of the Clinical Society was to have clinical social work recognized by state and federal authorities as one of the traditional mental health disciplines – along with clinical psychology, psychiatry and psychiatric nursing.

The New York State legislature, in the 1970s, was not amenable to licensing additional professions, so passing legislation for a clinical social work license was not a viable option. Instead, the Clinical Society prepared a bill to amend the Insurance Statute that would allow employers the option to cover mental health services rendered by certified social workers (the "P" law). Employees could request this coverage from their employers if it was not already available in their health insurance contract. The services of CSWs who had three years (20 hours/week full time) of supervised *psychotherapy* experience would be eligible for insurance reimbursement. This legislation was finally passed in 1978.

Optional coverage was a start, but we wanted mandatory coverage for our mental health services within the state. The rise of peer review for mental health services and managed care's acceptance of social work psychotherapists on their panels was important to the field. Consequently, using the insurers' cost experience of covering mental health services by P- CSWs, we were able to go back to the legislature and change the statute requiring reimbursement by any group policy that already covered psychologists and psychiatrists. This is the "R" statute, which requires three additional years of supervised *psychotherapy* experience. It was passed in 1985, and still identifies the most experienced LCSWs. (Note that both legislative efforts were initially drafted by the Clinical Society and initially opposed by the other social work professional groups.)

Time passed as we waited for an opportunity to pass a scope of practice licensing bill that fully described the functions of the clinical social worker providing mental health services. Finally, in the early 1990s, the State Education Department **indicated the time might be ripe for legislative consideration of a social work licensing bill.** The Clinical Society promptly drafted and introduced the LCSW legislation. NASW was invited to add an LMSW level. Fifteen years later, after hundreds of hours of meeting with the BSWs, both chapters of NASW, the deans of the social work schools, and other social work groups, we all agreed to the legislation: two licenses for the social work profession, LMSW and LCSW.

In meantime, the State Education Department and the Higher Education Committees of the Senate and Assembly decided to license the practice of psychotherapy in New York State. Until then, anyone could use the title "psychotherapist," including a barber, bartender, or psychiatrist who lost his

medical license. To license individuals to practice psychotherapy would mean licensing all those who were currently legitimately offering these professional services. Psychoanalysts without mental health backgrounds, MFTs, mental health counselors and creative arts therapists had been lobbying for decades for legal recognition. If clinical social work and clinical psychology were granted a scope of practice license, it would be illegal for these groups to continue to practice psychotherapy until they were granted the same authority. The state ultimately recognized four new professions under a new Board of Mental Health Practitioners.

When the smoke cleared in 2004, there were six newly licensed groups providing *psychotherapy* services, i.e., diagnosis or diagnostic assessments, treatment and treatment planning. The only psychotherapists who could practice autonomously, without physician consultation, referral or supervision were LCSWs and clinical psychologists. These two licenses were subsequently found by the Supreme Court of New York to be equivalent, which unquestionably establishes LCSWs as one of the four traditional mental health professions.

The Clinical Society has succeeded in establishing a legal identity for clinical social work psychotherapists. We have parity with the other mental health groups, a more comprehensive license than exists in most states, and insurance reimbursement for our services. Attempts to erode these gains are continuous from forces both within and outside of our profession. I believe the mission of the Clinical Society is to protect and advocate for our continued right to diagnose and provide psychotherapy services autonomously.

I invite your written comments about this issue and the Clinical Society's future direction. Please e-mail your thoughts to: mwineburgh@aol.com.

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