June 2003

Greater Washington Society For Clinical Social Work NEWS

Contents

GWSCSW Annual Meeting

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CSWF and the Guild: Re-Affiliation or 'Divorce'?

Margot Aronson

It was 1998 when the relationship between the Clinical Social Work Federation (CSWF) and OPEIU (Office and Professional Employees International Union, part of the AFL-CIO) began; a formal Affiliation Agreement was signed in October 2000, and OPEIU's Guild 49 was created to represent social workers. The Agreement provides that the affiliation will become permanent unless either party gives notice by October 15, 2003, of intent to terminate.

Until a few weeks ago the plan had been for the Federation Board of Directors to vote yea or nay on continuing the affiliation at the May meeting. (More on the Federation Board and the May meeting in the President's Letter, page 2.) Unexpectedly, however, the president of OPEIU, Michael Goodwin, has requested a delay of the vote until the October meeting, in the expectation that OPEIU will by then have completed negotiations providing for the settlement of all claims in the health insurance debacle. As we go to press, it seems likely that the CSWF Management Committee will recommend accepting the delay if there is a possibility that a settlement adequately meeting the needs of harmed members can be reached.

The Guild has strong supporters, especially among our colleagues in the Virginia and Maryland Societies. However, OPEIU's inaction for the past eighteen months has led to much disillusionment among the Federation leadership and in Societies where members found themselves with useless insurance and multiple unpaid medical bills. Further, a number of Societies have experienced a dramatic loss of membership, which may be a result, at least in part, of the addition to each member's annual Society dues of close to another $100, with something like 93% going for OPEIU dues, and the remainder to Guild 49.

There are lots of unknowns: What will happen to the Guild if the CSWF decides to cut the connection? And would permanent affiliation mean mandatory union membership?

By the time this is in your hands, a decision on re-affiliation will have been made, or, more likely, a postponement will have put the vote off until the October meeting in New Orleans. (Check the CSWF website, *www.cswf.org.)*

In preparation for the re-affiliation vote in May, each Society president was asked a series of questions about that Society's experience with the Guild. The response submitted by our GWSCSW Board can be found on page 4.

For advertising rates see page 31.

The next issue will be published September 2003 and the deadline is August 1.

President's Message

Margot Aronson

As I write, the presidents of all our Clinical Social Work Societies are preparing for a five-day meeting of the Federation's Board of Directors in Alexandria, Virginia. The Board is made up of presidents, committee chairs and the Management Committee—MANCO—which in turn is made up of the CSWF president, president-elect, secretary, treasurer, past president, executive director (ex-officio), finance committee chair, and, not voting, the president and secretary/treasurer of the Guild 49 of the OPEIU.

The agenda is more than full: reports from the officers and executive director, reports from committees (membership, marketing, bylaws, education, professional standards, government relations), reports from the editors of *access* and the *Clinical Social Work Journal.* An afternoon will be devoted to visits to the Hill, with each delegate lobbying his or her Senators and Congressmen, and returning for debriefing. There will be a reception welcoming new presidents, a dinner with an auction to raise money for the Capital Reserve Fund, and possibly a post-meeting reception on Saturday, hosted by GWSCSW, with a showing of the social work training video featured in the March newsletter. The conference ends early Sunday afternoon, after an Open Forum which, if last fall's forum is any indication, will be very lively indeed!

Two major issues will be debated during the meeting: restructuring of the Federation and Guild re-affiliation. Whether or not the Federation is to be restructured will not be determined at the May meeting; rather, a committee will present findings and offer ideas. A major concern is that a number of States have too few members, in some cases spread over too extensive a geographical area, to sustain a viable Society. Further, a more centralized Federation would make it easier on leadership to make decisions, develop programs, and provide support where needed. Societies like ours that are thriving will be reluctant to lose any local autonomy, while New York, which has many more members than the rest of us, plans to withdraw unless there is a more balanced distribution of voting power. An interesting discussion– to be continued when we've learned more.

As for the issue of Guild re-affiliation, a discussion can be found on the front page of this newsletter. Needless to say, the session devoted to the vote, or to a delay of the vote, is likely to be a heated one.

In any case, by the time this is in your hands, some decisions will have been made. We will have let you know via the e-list, and the Federation website *www.cswf.org* should have information as well.

I cannot end my letter without a huge thank-you to all the Board members, advisors, committee chairs, and numerous volunteers who have worked so hard this year to turn our Society into the lively, growing professional organization we want it to be. Special thanks to Treasurer Ann Aukamp and Secretary Anna Taft, both of whom complete two year terms this Spring; we will miss their excellent and efficient work, and their thoughtful input on our Board discussions.

New members will be introduced at the June 6th potluck celebration dinner, as will the GWSCSW officers for 2004 (some new, some continuing) who begin their term on July 1, 2003. Join us on Friday the 6th, think about what role you might enjoy in the Society, and speak up—new faces and new ideas are more than welcome! ❖

Report from the Treasurer

Ann Aukamp

As I write this I realize that this will be the last report of my term as treasurer of the Greater Washington Society for Clinical Social Work. I am happy to report that our Society thrives. The budget has been my particular responsibility, but leadership generally is no longer lacking.

Two years ago, only isolated areas in the Society functioned at a profit. In 2003, we have an active vital leadership group that presents timely continuing education, holds interesting dinner meetings, participates in political activism, and is active in the National Federation. This is largely due to enormous volunteer efforts on the part of our Board, but we have had administrative support through our agreement to share administrative staff with the Clinical Social Work Institute.

Our income has become more predictable as we have moved to a one time renewal date, and we are approaching a time when we can step away from the cigar box method of budgeting we used in our emergency period (pay what we can as long as the cigar box has cash). Even though we are not yet at the point where expenditures and income can be predictably budgeted, we have had no difficulty functioning in the black for my entire term. Exact balances for our checking and money manager accounts are not presently available, but I expect that by the time we next bill for dues in October, we will have about $20,000 remaining in the combined total of our accounts. This is a dramatic change from the balance of about $5,000 with which I began my term two years ago. In addition, we have satisfied all outstanding obligations, including fines for unpaid FICA taxes and the large debt of deficit Federation dues. Our Federation dues are current, and if we chose to deplete what we have accumulated towards our Rainy Day Fund, we would be able to meet the Federation's request to pay our 2003–2004 dues in full in July.

While we easily can afford to spend a bit more to support our volunteer leaders, we haven't yet fully replenished our Rainy Day Fund. Depending on the new Board's decision about Federation dues (whether payment in full or by quarters), we could have about $20,000 towards our Rainy Day Fund. In past years the fund was about $50,000, slightly over half a year's operating expenses at our present rate of expenditures.

We must be careful as we go forward, but we are more than solvent. I appreciate the opportunity to have served as your treasurer for this crucial period in our Society's history and I am proud to have played a role in the Society's regeneration. ❖

Guild Re-Affiliation Questionnaire: GWSCSW Response

See "CSWF and the Guild" on page 1 for background on the questionnaire and the issues.

1. How is your state structured with regard to the Clinical Social Work Guild? How would you describe the working relationship between the state society and the Clinical Social Work Guild?

The Greater Washington Society (GWSCSW) is not a member of the Guild. The GWSCSW held two referenda (in 1999 and in 2001) to assess member sentiment regarding affiliating with the CSWG. On each occasion, the Board offered both sides of this issue equal time/space to present their views in meetings (1999) and in mailings (1999 and 2001). In both cases, our membership voted against affiliation by over a 3:1 margin. Since that time, we have continued to monitor the Guild's activity in order to explore matters where we may have common ground.

2. What is/was your understanding of the purpose of the Guild? Locally? Nationally?

We understood that the Guild had several purposes: to form an economic alliance to fight the abuses of managed care, to form a political alliance with the labor movement to lobby for professional concerns on a state and national level, to open new opportunities for referrals to union members, and to provide membership services such as health insurance for self-employed clinical social workers.

3. Has the Guild met, exceeded or not met your expectations? Please give a brief assessment of the CSW Guild in your state.

The majority of GWSCSW members live in either Maryland or Virginia, and we have carefully monitored the activities of the Maryland and Virginia CSW Guilds. Our members are able to join the Guild by affiliating with the MD or VA Clinical Society.

During the past five years, we have been unaware of a single accomplishment on a State level by either Guild. Further, several of our members who affiliated with another Society to obtain the Guild health coverage were severely affected by the insurance fiasco.

Our Society shares expenses with the Virginia Society for a lobbyist who advocates for our professional concerns; our members participate as available in Lobby Day and respond to alerts by contacting legislators on important issues. It is not clear whether the Virginia Lobby Day activities are conducted currently by the Society or the Guild, but the net result appears no different from the years prior to the establishment of the Guild. Indeed, with a solidly Republican and anti-labor legislature in VA, union affiliation is, at best, a mixed blessing

In Maryland, our Society joins four other social work organizations on the Maryland Legislative Council to support a lobbyist and Lobby Day activities; here, too, we have not seen any changes brought about by Guild participation.

On a national level, we have been disappointed that the Guild has not seemed to achieve any of its goals over the past five years. While the Guild floated various ideas for addressing managed care, none seemed to have led to any significant implementation, let alone any significant impact. We initially hoped that the research departments of the OPEIU and AFL-CIO might help members stay informed regarding current developments concerning health care policy, but we have seen no evidence of this. And there never seemed to be any coherent statement of policy that might further professional advocacy or lobbying.

Finally, we have not seen any evidence the union affiliation was impacting health care contracts that might affect professional reimbursement rates. Sadly, even the OPEIU itself did not make any accommodations for offering CSWG members better reimbursement rates when serving OPEIU members.

4. What do you see as the potential for the CSW Guild?

We sincerely hope that the CSWG can resolve the legal difficulties concerning the health plan without causing further injury to the Clinical Social Work Federation. Resolving this matter in a way that is fair to injured members would be significant. While the alliance with organized labor holds a theoretical potential, we believe that the human and fiscal resources that have been diverted to the Guild and OPEIU would be much more effectively utilized strengthening the CSWF and the State Societies while building alliances with our professional colleagues in the health, mental health and social welfare arenas.

5. At this point, does your state society tend to support or oppose re-affiliation with the CSW Guild 49/OPEIU? Why or why not?

Lacking evidence of the Guild's utility for clinical social work or expression of member interest, we oppose re-affiliation with the OPEIU. Given the small size of the CSWF, we need to marshal all our resources under a single organizational structure. We are saddened to see the vast majority of Guild dues paid by our colleagues in other states seeming to enrich the coffers of the

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CEU Requirements for Maryland, Virginia & DC

Joel Kanter

As the GWSCSW is comprised of members who practice in Virginia, Maryland and the District of Columbia, keeping track of continuing education requirements poses special problems both for our members and our organization. With this in mind, we have conducted a survey of current regulations to assist our members with these CEU regulations.

First, the GWSCSW is approved as a provider of CEU's by the licensing boards in VA, MD and DC. All educational activities that we offer are eligible for CEUs in all local jurisdictions, though not all programs will qualify for Category I credit under Maryland's new regulations. The specific state requirements are as follows:

District of Columbia: 24 hours of CEUs are required every two years. At least 18 of these hours must be in formal learning activities such as courses, seminars, workshops or conferences. Up to six hours can be earned by serving as an instructor or presenter at a course, seminar, workshop, etc., or by publishing a professional article, chapter or book review.

Maryland: For those renewing their license in October 2003, 24 hours of CEUs are required every two years. At least 12 of these hours (identified as Category I) must be in structured learning activities such as courses, seminars, or workshops. IMPORTANT: Attendance at professional conferences is not considered a Category I activity in Maryland.

For those renewing their licenses in October 2004, 40 hours of CEUs are required every two years, including 20 in Category I activities. Each activity must comprise a minimum of 3 hours; however, two 1.5 hours meetings offered on the same theme as part of a series can be combined to make the 3 hours. Also, at least three hours of the Category I CEU's must be on the topic of professional ethics.

Category II activities can comprise up to 20 hours of this 40-hour requirement (or 12 of 24 hours for those renewing in 2003). These can involve giving or receiving professional supervision by an LCSW (individual and group), structured peer case conferences, journal clubs, paper presentations, authoring publications, course or field instruction, or attendance at professional conferences, etc. There are more details, and members should consult the Board of Social Work Examiners *(www.dhmh.state.md.us/bswe/)*.

Virginia: 30 hours of CEUs are required every two years. At least 20 of these hours must be in formal learning activities such as courses, seminars, workshops or conferences. At least 2 hours must involve participation in a class that addresses Virginia social work standards of practice or laws, OR the Code of Ethics of NASW or CSWF (our national organization). (Note: Virginia does grant Category I credit for participation in professional conferences. Also, they allow Category I credit for in-service training at agencies or hospitals.)

Category II activities can comprise up to 10 hours of this 30-hour requirement. These activities can involve publication of book, article, or chapter; presentation of an in-service training, seminar or workshop, field instruction of social work graduate students, holding office or committee member in a Clinical Society or NASW group, attending agency staffing, or independent or group study. Members should review the regulations (also available at the Board of Social Work Examiners web site) for the specifics regarding these activities; only specific numbers of hours are allowable for each. ❖

Guild Questions, *continued from previous page*

OPEIU with little evident return. (Moreover, when we researched this matter in 2001, we were very concerned that there did not seem to be an annual financial report of the Guild; it is unclear whether this apparent financial negligence was related to the problems with the health plan.)

We are also concerned about the OPEIU's willingness to allow affiliation of groups of unlicensed healthcare practitioners. While there seem to be no psychologists and few physicians affiliated with the OPEIU, the OPEIU has encouraged the affiliation of such unlicensed practitioners as acupuncturists, biofeedback practitioners and unlicensed (non-RN) midwives. Each of these groups is controversial with various professional groups that have been our long-standing allies. When the Guild began in 1998, there was the hope that large numbers of physicians, psychologists and nurses would affiliate with the OPIEU. Unfortunately, this has not transpired and this OPEIU affiliation apparently offers no benefit for collaboration on a state or national level with our professional allies.

6. How did you gather the information for your responses to this questionnaire?

We sent this questionnaire to all members of our Board including committee chairs (18 in all) for responses and comments and circulated the draft response for ongoing feedback. ❖

Managing Managed Care: Some Suggestions for Protecting Patient Confidentiality

Stacia I. Super

When I was young and naïve, I used to think that confidentiality was like pregnancy—one couldn't be a little bit confidential. It was all or nothing. Then I went to social work school and realized from my first day of work in field placement that confidentiality, in the strict sense of the word, was breached all the time—in assignment process, case conferences, supervision, and casual conversations in the student room. Later, when I went into private practice and began billing insurance companies, and when my own analyst billed the insurance company on my behalf, my eyes were opened even further. I realized that an outsider—a third party—would not only know my patient and I were in treatment, but also our diagnoses. Little did I realize that within twenty years, name and diagnosis would be the least of the breach. Much more would be demanded of clinicians. Much, much more!

During the time I was a 'provider' for managed care companies, I developed a way to respond to their requests for information, which minimized breaching confidentiality. While it was not ideal—only the absence of providing information would be—it was at least bearable. I kept in mind that the provision of a diagnosis was, and always was, a requirement on insurance claims, and I began providing nothing more than the data that supported the patient's particular DSM diagnosis. For example, if the patient had a diagnosis of Major Depressive Episode, I would list "five or more symptoms... present during the same 2-week period...at least one...either depressed mood or loss of interest or pleasure." (DSM-IV-TR) In this manner, I was describing a diagnosis, not a person, allowing the patient to remain somewhat anonymous.

In preparation for the telephone conversation with a managed care reviewer or for writing a report, I spent time in the session with the patient, discussing what questions the reviewer might ask and what information the patient and I were willing to release. Again, I focused on the diagnosis and mental status. I was not willing to discuss with the reviewer the patient's relationship with her mother or boyfriend, nor her sexual orientation. I also was not willing to report the school phobia she had when she was five years old.

Sometimes the 'voice on the other side of the phone' (the managed care reviewer) would ask for "more details" (which always sounded to me like an invitation to gossip). At such times I would only report the patient's functioning at school or work, and any hospitalizations during the time the patient was in therapy. Doing so, rather then detailing life events, not only helped to protect patient confidentiality, but also maximized the possibility that the insurance company would authorize more sessions. In staying away from anything too personal and focusing on issues which could be linked directly to justifying reimbursement for more sessions, I would inform the reviewer, if need be, that I was providing the information essential to substantiating need.

Once, when a reviewer asked for more information than I was willing to provide, I said I would not discuss such matters. The next time I called for more sessions, he read aloud his previous note, including the following, "therapist would not provide details." Nevertheless he authorized more sessions. On another occasion, when I no longer participated with any insurance companies, a patient could not get reimbursed unless I provided my clinical notes. I refused. A month or so of letters and phone calls to and from the insurance company ensued. Finally, I wrote a description of the diagnosis and sent it to them. They made the reimbursement.

What would I have done if I had not been able to get the sessions the patient needed? What if the insurance company continued to refuse to pay? There were at least three options: 1) I could have discussed with the patient what more I could reveal; 2) I could have refused to provide the information requested, resigned from the managed care company, and worked out a private arrangement with the patient; and 3) I could have confronted the managed care person, as one professional to another.

This last option is based on the ideas of Larry Sank (1997). He suggests commenting on the managed care worker's lack of respect for one's judgment about the patient's need for more treatment, and if this doesn't work, following it up with a letter to the reviewer's professional licensing body, complaining about their member's lack of adherence to their code of ethics. (He quotes the codes of ethics in his article.) There are, of course, limitations to this, not the least of which is the amount of time and effort it would require. But, it is an interesting idea.

An adjunct to focusing on the diagnosis is to use the SOAP method for writing progress notes. SOAP stands for Subjective, Objective, Assessment and Plan. It is the standard for documenting in medical records. We

continued next page

instituted this system for writing progress notes when I worked in a mental health clinic, which was anticipating being descended upon by what was then JCAH (Joint Commission on Accreditation of Hospitals). We got an extremely favorable review—they loved our notes.

The beauty of this system is that, if used correctly, it prevents one from writing too much. It takes a little getting used to, but here is the basic idea. You head your note with the date and problem, i.e. diagnosis (Anxiety, NOS). On the next line you write the subjective data, *i.e.,* S: anxious, isolating self, etc. The third line is for objective data: tearful, nails bitten, etc. On the fourth line you write your assessment, *i.e.,* A: patient is anxious but doing better with schoolwork. And finally you write your plan, *i.e.,* P: continue psychotherapy to help patient develop ways to calm and soothe self. I found that this system could go a long way toward protecting my patient's privacy from managed care's prying eyes.

There is no perfect way to deal with these characters. So much depends on the particular company, the state of their finances that particular week, the particular reviewer, and perhaps the weather.... Ultimately, doing the best you can for your patients and honoring your own sense of professionalism and code of ethics is what's important. In the end, what we all have to strive for is a change in the system. ❖

Sank, L. (1997). Taking on managed care: One reviewer at a time. *Professional Psychology, Research & Practice, 28* (6), 548-554.

Update on AARP Initiative

Nancy Nollen

In the last newsletter, it was announced that the Federation would be represented in an ambitious national initiative on geriatric care in America sponsored by the American Association of Retired Persons (AARP). While it is exciting for those of us in geriatric social work to learn of the extensive initiative AARP is launching as a central part of its vision for the next decade, there have been some changes in the implementation of the initiative. Originally seven work groups, consisting of persons working in the areas of advocacy, information dissemination and education, volunteerism, community outreach, research, case management, counseling, family care giving, social marketing and policy, were to explore the concerns of the geriatric population and their families. Such concerns include health promotion, prescription management, communities for living at all levels, access to and coordination of care, improvement in end of life care, management of finances for care coverage, improvement in quality of care, and family care giving. The project has had a slow start, however, and at this point, it seems, the work groups will not be meeting on a regular basis.

AARP spokesperson and manager Elinor Ginzler emphasizes that AARP is working out the details of implementation. I was interviewed by Ms. Ginzler as the representative of the Federation. During the interview, I responded to such questions as: What are our visions of success for the aging population? What are the critical pathways to senior care? What are the current barriers getting in our way of providing these services? Ms. Ginzler encourages anyone to email her with input or insights on these questions at *eginzler@aarp.org.* ❖

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~ C. G. Jung, *The Development of Personality*

Just as the great personality acts upon society to liberate, to redeem, to transform, and to heal, so the birth of personality in oneself has a therapeutic effect. It is as if a river that had run to waste in sluggish side streams and marshes suddenly found its way back to its proper bed, or as if a stone lying on a germinating seed were lifted away so that the shoot could begin its natural growth.

~ C. G. Jung, *The Development of Personality*

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CareFirst Update

Mary Lee Stein

On March 5, Maryland Insurance Commissioner Steven Larsen issued a decision disapproving the proposed CareFirst conversion and acquisition by Wellpoint. In his decision, Commissioner Larsen found that the CareFirst Board failed to consider its obligations as a not-for-profit company, did not negotiate to obtain the best price for the company, was offering to sell the company for less than its fair value, and did not demonstrate a business need to convert.

In the wake of these findings, the Maryland legislature has passed a bill (House Bill 1179, Senate Bill 772), prohibiting any conversion of CareFirst for five years. The bill also calls for the replacement of ten CareFirst Board members with members designated by Maryland political leaders, and it calls for the creation of an oversight committee to oversee CareFirst's operations in a manner consistent with the public interest of Marylanders. The legislation also requires the company to observe its mission as a non-profit by: offering health care products in the individual market, offering health care products in the small employer group market, and administering and subsidizing the Senior Prescription Drug Program in Maryland. Upon its review of the House Bill, the National Blue Cross and Blue Shield Association has threatened to withdraw the right of CareFirst and Group Hospitalization and Medical Services, Inc. (GHMSI) to use the BlueCross BlueShield trademark.

In response to the actions of the Maryland legislature, DC Insurance Commissioner Lawrence Mirel wrote a letter to the Chairman of the Health and Government Operations Committee of the Maryland House of Delegates stating that the Maryland legislation represents "a usurpation by Maryland of the District of Columbia's primary regulatory authority over GHMSI." Commissioner Mirel has urged Governor Ehrlich to veto the bill. Among his assertions of the negative impact the bill would have on CareFirst, Mirel told the Governor that it appears that the Maryland legislature "wants to force CareFirst and its affiliates, including GHMSI, to insure persons that competing insurers will not insure, and to charge less for its insurance than competitors charge...." On April 21, Commissioner Mirel issued an order directing that there shall be no change in the governance of CareFirst, including the Board and the articles of incorporation, without approval of the Department of Insurance and Securities Regulation.

A recent study of the performance of other not-for-profit BCBS plans concludes that these plans have shown "strong and consistent [financial] performance" in recent years. Experts who have opposed the conversion of CareFirst to a for-profit company insist that it is premature to conclude that no more can be required of GHMSI to comply with its charter as a charitable and benevolent institution. They assert that GHMSI has done very little, if anything, to develop innovative products for the individual and small group markets or to market its legally mandated open enrollment program (a program that is not even mentioned on the CareFirst web site). Among other criticisms of the performance of CareFirst as a charitable and benevolent institution is the fact that its disease management programs are limited (it has no program targeted toward the District's large HIV/AIDS population); it does not participate in the Medicare+Choice program; and it offers no Medigap program with prescription drug coverage options.

In 1997, the Department of Insurance and Securities Regulation authorized the affiliation of GHMSI with CareFirst. That order stated that, "DISR will monitor to make certain that GHMSI does not deviate from the 'charitable and benevolent' purpose required in its charter."

In January, GWSCW joined other organizations with an interest in community health issues on the CareFirst Watch Steering Committee. Our participation on the Committee ensures that there is a voice advocating specifically for the interests of the mentally ill and of mental health providers as this controversy continues. ❖

HIPAA Report

Joel Kanter

Since our Society's HIPAA Training on March 28, many members have contacted me with questions as the April 14 deadline for implementation of the HIPAA Privacy Rule went into effect. Some of the most common are as follows:

Q: I have a "paper-only" office. I send out all my bills by mail and don't transmit any medical information over the Internet. Do I need to comply with HIPAA?

A: Clinicians with "paper-only" office practices are not required to comply with HIPAA. Complying with the existing state laws and ethical codes regarding confidentiality and medical records is, in most respects, a higher standard than the HIPAA regulations. However, the main HIPAA document, called a *Notice of Privacy Practices,* may be a useful document for all practices as it merely informs clients about how you will protect their privacy and records—and also the exceptions to these practices (i.e. child abuse, threats of violence, etc). I would encourage all clinicians to obtain copies of this from a colleague who is HIPAA-compliant and read this over to understand more about what is involved. Or do an Internet "Google" search for "Notice of Privacy Practices" and you will turn up hundreds of NPP's.

Q: Colleagues have said that since all billing will eventually be conducted electronically, I should comply with HIPAA now even though my practice is "paper-only". Is this good advice?

A: Following this advice will certainly not cause any harm. However, for some clinicians who never submit claims directly to insurers, this day may never come. And, for the remainder, you will have ample notice if and when insurers decide to require electronic billing. HIPAA compliance is not particularly complicated and your HIPAA-compliant colleagues will have lots of available materials you can borrow when that time comes. It is important to understand that there is a huge HIPAA industry attempting to capitalize on anxiety and panic. While some are charging as much as $2000 for training now, HIPAA workbooks will be available within months for $20.

Q: Is it true that Medicare will only accept electronic claims after October 2003?

A: Only partly true. The regulations also state that all practices with fewer than 10 providers have to be granted a waiver from this regulation (and thus can continue to submit paper claims). As soon as GWSCSW learns about the waiver process, we will inform members how to obtain this.

Q: I have heard that providers can be fined $25,000 for HIPAA violations. Is this true?

A: Yes, this is true.

Q: I missed the training, but want to obtain materials that will enable me to be HIPAA-compliant.

A: In the past few weeks, the New York Clinical Society has posted a complete HIPAA manual (in Adobe format) with forms on its web site. Hillel Bobek, the author of this, is extremely thorough. Although I haven't read this carefully, it seems to be a first-rate job. All the forms can be downloaded in MS-Word format for adaptation.

The GWSCSW got a group discount on the HIPAA Help materials developed by Ed Zuckerman, but is not selling any more of these manuals. You can purchase them individually for $70 including shipping by going to the web site at www.hipaahelp.info or by calling 1-800-801-5415 (and he is also selling a CD with the forms alone, but without the context and explanation of the manual for $15). It is worth noting that our workshop revealed some problems with this manual (none of the materials I've seen are perfect). The Clinical Social Work Federation (www.cswf.org) also sells HIPAA materials. And NASW has very useful information (including forms/documents) on its web site (www.naswdc.org) without charge for NASW members.

Q: Which product has the "best" forms?

A: Very little of the text of the HIPAA documents/forms is dictated by government regulations. Especially with the *Notice of Privacy Practices,* HIPAA encourages providers to describe their actual privacy practices in their own language. I'd encourage all to adapt materials from other sources to your own practice needs, keeping in mind state law and ethical standards. (On the following page, I've included wording that I developed for my NPP that others have found useful and that addresses issues not found in other material I've seen.)

If you would like any documents reviewed for compliance with HIPAA regulations and state law, you can contact Paul Newhouse, Esq., the attorney who provides our Society's prepaid legal plan. If you contact him soon at 410-296-1517 or email at *paul.newhouse@towsonlaw.com,* he will allow you to join the prepaid legal plan, which enables you to have legal consultation at a very reasonable rate. He was a very helpful consultant at our Society's HIPAA training.

Q: What is a good reference tool for updated HIPAA information?

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Notice of Privacy Practices: Possible Adaptations

Joel Kanter

Below is my personal adaptation of a key section of the NPP; this will make sense to you if you have other NPP's in front of you for review. Others have found this language useful. Feel free to copy it or adapt it as you see fit.

Permissible Uses and Disclosures without Your Written Authorization

Except in the specific instances mentioned below, I do not release identifying health information (called "protected health information" or PHI) about you without your specific written authorization. The exceptions to this policy are as follows:

1. Treatment: Except in extreme situations as explained in Section 4, if I need to communicate with others about your treatment, I will obtain your written permission to do so. However, if treatment involves family therapy or consultation, I may communicate with such family members that we agree should be involved.

2. Payment: If you wish to seek reimbursement for my services through your insurance carrier, I will have to disclose health information to them about you and your treatment. If this is required, I will have you sign a claims form, which allows me to share medical information with your insurer.

If your coverage does not involve "managed care", these disclosures are usually limited to your demographic information, diagnosis, type and dates of treatment, and the fees charged. However, if your health plan involves a "managed care" components (such as Magellan, ValueOptions, Cigna, or United Behavioral Health), then I may be asked to provide more detailed information about your symptoms, current functioning, treatment plan, and response to treatment. In any such situation, I will, at your request, discuss what information I am sharing with your insurer and, at your request, allow you to review this information before I submit it. If you then request that this information not be shared with your insurer, treatment will proceed on a self-pay basis. (You should carefully review any forms from your insurer that might authorize them to share your health information with third parties.)

3. Health Care Operations: At times, I will have to contact you regarding your treatment, scheduling of appointments, billing and other matters. It is your responsibility to inform me which methods you prefer to maintain your privacy. For example, if you do not want to be contacted at work, please inform me of this fact. Or, if you do not want me to leave my name on a family voicemail, let me know about your concerns. I attempt to conduct these communications with a respect for your privacy, but you will need to inform me of special concerns you have regarding such matters.

Also, I do share information about my clients with professional colleagues for the purposes of facilitating your treatment, fostering my own professional development, or helping to train other colleagues. In my opinion, such activities are required to provide high-quality treatment, develop my professional skills and enhance the knowledge base of our profession. For example, I may seek advice or consultation on treatment alternatives or specific client problems. Or, even after treatment ends, I may discuss a client or family in a professional meeting in order to improve my own skills or to train other staff. In doing so, I use pseudonyms to conceal client identity and, of course, do not share addresses, birth dates or any other such information that would be identifying. As such, such non-identifying disclosures are not formally considered "protected" information, but I do want to inform you about these.

Section 4 would include material on each NPP that details such exceptions as child abuse, violence, subpoenas, etc. ❖

Disclaimer: The HIPAA information contained in this Newsletter is provided as a service to members for educational and information purposes only and does not constitute legal advice. No claims, promises, or guarantees can be made about the accuracy, completeness, or adequacy of the information contained in this Newsletter. Laws and court interpretations change frequently. Legal advice must be tailored to the specific facts and circumstances of a particular situation. Transmission of the information is not intended to create, and receipt does not constitute, a lawyer-client relationship between the GWSCSW, or the author(s) and you. Nothing reported herein should be used as a substitute for the advice of competent legal counsel.

HIPAA *continued from previous page*

A: Visit the Department of Health and Human Services web site (*www.hhs.gov*). Click on "questions" in the upper right hand corner of the web page to get to the HHS Q&A web page. Then under the "categories" tab, click on "Privacy/HIPAA". Enter whatever subcategory or search term you like for clearly written Q&A.

Please don't expect the GWSCSW to serve as an ongoing HIPAA reference source. However, if you post questions regarding HIPAA on the GWSCSW listserv, you may obtain responses from other members. ❖

One-Day Genetic Study of Schizophrenia at NIMH

Karen Bartholomew

Schizophrenia is a complex, heterogeneous disease of the brain involving combinations of genetic and environmental factors. It often presents itself differently with each individual who has schizophrenia. It is a disease of the brain that we cannot predict or prevent...not yet.

Thanks to the scientific and technological advances related to the Human Genome Project, we are learning more about the human brain by understanding genes and how they might affect the development of the brain. At the National Institute of Mental Health (NIMH) in Bethesda, MD, researchers are studying the impact that genes have in families where one member has a diagnosis of schizophrenia. NIMH researchers are interested in comparing the genotypes and test results of the family member with schizophrenia to the genotype and test results of their siblings or healthy volunteers. Using elaborate mathematical methods, researchers will analyze various aspects of brain function that may be influenced by the genes. At this point in time, these analyses are used only for research purposes; no individual genetic results can be given.

Qualified volunteers can come to NIMH for one day and participate in a clinical interview and donate a sample of blood for genetic analysis. Other procedures involve a series of neuropsychological tests of cognition such as memory, attention, and perception as well as non-radioactive brain scans that include a clinical MRI (Magnetic Resonance Imaging) and a fMRI (Functional Magnetic Resonance Imaging.) Brothers and sisters can participate in these procedures with their sibling who has schizophrenia. Parents are invited to give a sample blood and share information about their family history. All information is confidential.

To qualify for this study, individuals must be between the ages of 18 and 55, have a diagnosis of schizophrenia or schizoaffective disorder (depressed type) and be willing and able to consent voluntarily to research. They must be in good physical health, and be free of significant drug or alcohol abuse.

Volunteer participation in these tests gives the scientists the much-needed data to better understand the brain and schizophrenia. It is our hope that this understanding will help researchers to develop better types of treatment for schizophrenia and, perhaps one day, the means to predict and prevent this devastating illness in ways not possible today.

This outpatient genetic research does not require any change in medication and there is no required overnight stay. NIMH can assist with transportation. Lunch is served, compensation provided, and every effort is made to make the visit to our clinical center as pleasant an experience as possible.

If you are interested in learning more about the NIMH One-Day Genetic Study, call Karen Bartholomew, LCSW-C, at 301-496-4304 or toll free at 1-888-674-6464 at the National Institute of Mental Health of the National Instititutes of Health, Department of Health & Human Services. ❖

Central Concepts Program: A Good Beginning

Ruth Neubauer

The Central Concepts Program is completing its fifth year with a very lively class of seven advanced-degree students. An outgrowth of the former Washington School of Psychiatry "Psychodynamics" Program, this is a one-year, non-certificate program in which the basic concepts underlying psychoanalysis and psychodynamic psychotherapy are taught. Patients for the students usually come from the Meyer Treatment Center, and low fee supervision is provided.

The course begins with illustrations and discussion of the process of long-term psychotherapy: the therapeutic frame, professional boundaries, the initial interview, the unconscious, repetition, ways of listening, manifest and latent content, and transference and countertransference. The emphasis is on the need to establish the frame/guidelines/expectations of the therapy in order that transference can be understood and interpreted.

Throughout the year, different faculty continue to explore the conceptual underpinnings of dynamic therapy by delving more deeply into transference, countertransference, the middle phase of therapy, and issues of termination. In addition, weekly supervision with the teaching faculty helps to integrate class time and the practicum segment of experiential learning, both with the patient and through discussions with the supervisor.

This is a program for new graduates as well as for more experienced clinicians who wish to take the opportunity to learn these invaluable concepts in a small group setting. For more information about the Central Concepts Program, call 202-237-2700. ❖

GWSCSW Presidential Profiles: Vesta Downer

Tricia Braun

This is the first in a series of interviews with past presidents of the Greater Washington Society for Clinical Social Work. Part of our identity is from all those individuals who came before us who committed themselves to the vision of what it means to be a clinical social worker. It has been through their leadership—their inspiration, their challenging us to stretch personally, professionally and into the community, to do what is right according to the values our profession is founded upon, and their dedication—that has propelled us through the changing times. May we continue their commitment to impeccable standards of practice, advocacy for the health and well being of our clients, and the goodwill towards one another.

Eloise Agger (1975–1977) and Louisa Schwartz (1977–1978), both now deceased, were the first two presidents of our Society. Vesta Downer was the third, serving from 1978 to 1979. In the early days, Ms. Downer recalls about 20 clinicians coming together with a focus on lobbying the Virginia and Maryland legislatures. Their goals were to gain coverage by insurance companies, work towards achieving professional status of being able to diagnose and treat mental health conditions, promote good clinical standards and improve the working conditions for social workers. In those days, she had the reputation as being a "political agitator." In the 1990s she and Laura Hamilton were known as the "dynamic duo" around Richmond. She served eight years on the Virginia Board of Social Work.

Ms. Downer was born in Nova Scotia, but early on moved to Connecticut where she grew up. At age 12 she read a book about Jane Addams of Hull House and thought, "That's what I want to do." She earned a bachelor's degree in psychology from the University of Vermont and worked for a few years for Connecticut public assistance before receiving her MSS (Master of Social Science) from Smith College. After graduating she worked for Psychiatric Institute in Baltimore in the Child Guidance Section. Going home for Easter on the train, she ran into an old Connecticut acquaintance, whom she soon married and then moved to Falls Church.

Ms. Downer worked for six years, and then stayed home for 14 years raising her two daughters. She did local volunteer work and became chairperson of the Falls Church Democratic Committee in the 1960s. The family moved to Manila for four years, then to Bangkok for one year. There she conducted intake evaluations for the Special Action Office for Drug Abuse Prevention and the 5th Division Army Hospital. At that time, American and foreign families were experiencing difficulties with their children as drugs were so readily available on the streets. She says sixth graders on heroin were common.

Upon returning to the States in 1973, Ms. Downer began working for "The Crossroads", a Fairfax County drug abuse program. She says many people use alcohol for escape, and clinicians easily overlook its abuse. In 1977, she began running 10Ks in the Washington RunHers. The day she was interviewed she had completed a 2½ mile run, which she does several times a week. Health and fitness are priorities for her. In 1980, she began working at the Woodburn Mental Health Center, in the roles of clinician, team leader and supervisor. Through the years she has supervised social work students from Catholic, Smith, Howard and Virginia Commonwealth universities. She remains in contact with many of these who are now social workers. When mentoring students, Ms. Downer believes that it is important to show them respect and to hold the expectation that they can do the work. Teaching and supervising has been the most rewarding part of her career. Since 1985, she has been involved with EMILY's List, a fundraising organization that promotes pro-choice Democratic women candidates for state and national office.

In 1994, Ms. Downer left Woodburn to focus on "doing whatever she wants," including Earthwatch trips to Argentina and Costa Rica, and walking trips in the UK and Portugal. In 1995, she traveled to China for the women's meetings and took two trips to Turkey. She has had a life-long interest in writing, attending *Flight of the Mind* writing workshops, and has written essays, short stories, and poems. Her "backyard wildlife habitat" is both a hobby and a sanctuary. She was a charter member of the National Museum of Women in the Arts.

Ms. Downer has witnessed many changes in the field of social work. She has done some private practice, but has felt more devoted to public service. She says she has always been more concerned with the macro, rather than the micro. She believes change must be focused on improving basic conditions, e.g., food, adequate housing, and medical care, rather than treating a person to adapt to inferior conditions. It concerns her that there are schools in the District that are falling apart—that sanitary conditions are so bad, children wait until they get home to go to the bathroom or wear coats all day in winter because there is no heat in the schools.

Ms. Downer says she would like to see the Society and social workers "light some fires underneath the legislatures." She believes that the characteristics of a good social worker include: empathy, good common sense,

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CSWF

Clinical Social Work Federation

Richard Yanes

■ ***The fight for funding***

Almost halfway through this fiscal year, the Congress finally adopted appropriation bills, an action left over from last year, and passed a budget for the operation of the government. No sooner was this done, then the President presented Congress with his budget for the next fiscal year.

In early action on the new budget, the House adopted the President's recommendation for tax cuts and was then forced to reduce the budgets for health spending. The Senate reduced the President's recommendation for tax cuts by about half resulting in less of a reduction for health spending, but both houses are now projecting cuts below FY03. Some estimates go as high as a loss of more than $1.4 billion for health services alone.

■ ***Mental health parity***

Both the Senate and the House saw the reintroduction of mental health parity bills this month. S. 486 by Senator Domenici (R-NM) was introduced with 54 Senate cosponsors. The House bill, H.R. 953 by Representative Patrick Kennedy (D-RI), was also introduced with 201 cosponsors. Both bills are titled the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, after the long-time Senate champion of mental health issues, Paul Wellstone, who was killed last year in a plane crash. With the support demonstrated by the number of cosponsors on each of the bills many people are hopeful that this will be the year we see the passage of this landmark legislation.

■ ***Medicare Modernization***

We also saw the reintroduction of the Medicare Mental Health Modernization Act in both houses. H.R.1340 is authored by Representative Fortney (Pete) Stark (D-CA) with 15 House cosponsors. Representative Stark has authored and consistently been supportive of this legislation over the years. The Senate bill, S. 646, is authored by Senator Jon Corzine (D-NJ) and has seven Senate cosponsors.

There have been no major adjustments to the Medicare program since its inception in 1965. The above bills would end co-pay discrimination by reducing current outpatient co-payments from 50% to 20%, equalizing these co-payments with regular health benefits; elimi-

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NASW

National Association of Social Workers

Tommy Wells, Executive Director of the Consortium for Child Welfare, is the only social worker in the District of Columbia who holds an elected position. A long-time DC resident and member of the DC Board of Education, Mr. Wells will be featured at this year's Annual Meeting of the NASW-DC Metro Chapter. He will be speaking about the ways in which his social work experience and education prepared him to function effectively as a Board Member. The luncheon meeting will be held at the Women's National Democratic Club on New Hampshire Avenue, on June 6. For more information or to make reservations call NASW-DC Metro Chapter at 202-336-8395. ❖

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COP

Committee on Psychoanalysis

Audrey Thayer Walker

■ *Sarah Pillsbury New COP Chair*

Sarah Pillsbury will lead the local National Membership Committee on Psychoanalysis in Clinical Social Work (NMCOP*) chapter as DC/Baltimore Area Chair. Dr. Pillsbury is an experienced clinical social work psychotherapist who is presently in full-time private practice and teaches at the Washington School of Psychiatry. She is a founding member of the Institute for Contemporary Psychotherapy and Psychoanalysis and is on the Board of The Clinical Social Work Institute.

Dr. Pillsbury received her doctorate from The Catholic University of America where her dissertation focused on the experience of the individual within the couple dyad. She is presently developing several papers for future publication and is a member of the New Directions Program, Washington Psychoanalytic Institute.

■ *Tarpley Long Dinner Meeting*

Tarpley Long's thoughtful integrative paper, "Psychotherapy and Acting: Capturing the Moment Before Speaking," focused on the interaction between the actor and her "role", the psychoanalyst and her client: the process of mutual enlightenment. Ms. Long's presentation skills so captivated her audience that what is, in truth, a sophisticated and challenging paper, was assimilated with ease—and on a Friday evening over dinner and a full house! What a delightful evening with such a fine teacher/actor/clinical social worker/psychoanalyst!

■ *GWSCSW/NMCOP Study Groups*

Study groups develop strong professional bonds and support increasingly sophisticated professional identity. Presently, GWSCSW/NMCOP has two ongoing study groups with an additional one proposed for Northern Virginia. Ms. Drake leads the newest Study Group. The initial topic is "Sado/Masochism: Management of Transference-Countertransference in the Clinical Hour." Although fully subscribed, Ms. Drake may consider adding a person or two. If you are interested, call her as soon as possible at 301-320-5659.

The original study group completes its fourth year, is peer led, and focuses on the integration of recent infant research findings with clinical theory and practice. This past year the group has utilized Beatrice Beebe's and Frank Lachman's recent book, *Infant Research and Adult Treatment: Co-Constructing Interactions*. Membership for this group is presently closed.

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CSWI

The Clinical Social Work Institute

Carolyn Gruber

On Friday, May 16, The Clinical Social Work Institute celebrated the completion of its fourth year of doctoral education with the 5th Annual Spring Reception and Awards Presentation. The Spring Reception took place at St. Columba's Episcopal Church, located at 4201 Albemarle Street, NW, Washington, DC. Ms. Fran Thomas, LICSW, and Council Member Phil Mendelson were honored.

Ms. Thomas received the Elma Kahn Wolf Award. This award honors social work practitioners who have demonstrated outstanding leadership and have made significant and sustained contributions to mental health and social welfare. Ms. Thomas fits the bill and more so. She received her MSW from the University of North Carolina in 1963, is a former President of the Greater Washington Society for Clinical Social Work, and is the person most instrumental in establishing licensure for social workers in the District of Columbia. Her skills in utilizing necessary community and political supports, in organizing and coordinating strategic planning processes, brought a victory and legitimacy to social workers that benefits us as practitioners and serves the best interests of our clients as well. We are grateful, still, for Fran's vision, wisdom, leadership and hard work.

Mr. Mendelson was the recipient of the Annual Clinical Social Work Institute Leadership Award. This award is given to individuals who have demonstrated outstanding leadership and service through their contributions to the health and well being of the citizens of the District of Columbia. Mr. Mendelson, a Council Member at Large, was honored for his commitment to fair housing, public safety and public health, and for his sensitivity to the needs of the District's most vulnerable residents. He is originally from Cleveland, Ohio where his family was extremely active in public service (his mother was a chapter president of the League of Women Voters and a crusader for nursing home reform). He came to Washington, DC, in 1970 to obtain a BA in political science from the American University and then remained, getting involved in public service activities. Beginning in 1989, Mr. Mendelson began serving as a legislative aide at the DC City Council and was first elected as a council member in 1998. Of almost equal importance to all of the above is the fact that Mr. Mendelson is married to a clinical social worker. ❖

CSWF, *continued from page 14*

nate the lifetime cap for inpatient mental health visits which does not exist for regular health benefits; correct the skilled nursing facility billing problems for clinical social workers by allowing them to once again bill Medicare directly for services provided to residents; and, more.

While Medicare is long overdue for an update, the Federation and many mental health care organizations are concerned that the Administration and Congressional Republicans will only address the Program through their stated priorities, prescription drugs and privatization. With the parties so divided on their approach to this program the passage of acceptable legislation will prove to be a difficult fight.

■ *Patient's Bill Of Rights*

In early February, Representative Charles Norwood (R-GA) introduced his legislation in the House, H.R. 597, with no cosponsors. Senator Edward Kennedy (D-MA), who has provided leadership on this issue in the Congress for years, has not yet introduced his legislation. While it is expected that he will again author the bill in the Senate, there is, as yet, no date set for its introduction.

You may recall that Senator Kennedy amended the language of last session's bill into an appropriations measure and then lost the battle to keep the language in the bill to the House Republican leadership in a Conference Committee. While last session's legislation had 200 cosponsors in the House and 40 in the Senate, the concern is that this legislation will be caught-up in the fight over tort reform. Tort reform, a high priority for the Administration and Congressional Republicans, limits the ability of harmed consumers to file lawsuits and recover damages. Many mental health organizations worry that the fight to pass a Patient's Bill of Rights will be tougher in this Congress than it was in the last.

■ *HIPAA And The Privacy Rule*

Legislation. Before finalizing the HIPAA Privacy Regulations, the Administration changed the provisions requiring the individual's consent to access and use protected health information (PHI) to what is referred to as "regulatory permission". That is, managed care companies, HMOs, et al, now have permission through the regulation to access and use PHI without requiring the individual's consent. Representatives Markey (D-MA), Waxman (D-CA), and Dingell (D-MI) are strongly opposed to this approach and introduced legislation just prior to Congress' adjournment last year to reverse this situation and restore the individual's right to control the use of PHI through consent. We are working to have the legislation reintroduced in this Congress.

HIPAA Materials And Training. As many of you are aware, the Federation completed its 13-state Training Program on the HIPAA regulations. Response from the Trainings has been uniformly positive. Upon completion of the project, the Federation will have provided information directly to more than 700 individual practitioners.

For information on how to purchase the Manual or the CD visit the Federation website at www.cswf.org. Materials are still available.

■ *The Freedom Commission on Mental Health*

The Freedom Commission on Mental Health was established by Executive Order to undertake a one-year study of the system of delivery of mental health care in the United States. The Commission held hearings throughout the country and received testimony from a variety of national and local mental health care and service organizations including the Federation. As its one-year period draws to a close, the Commission is in the process of preparing its final report. It is anticipated that the report will contain a variety of specific recommendations upon which the Congress and various regulatory agencies will be able to act.

In its October interim report, the Commission called the existing mental health system "... an inefficient maze of private, federal, state and local government programs with scattered responsibility for services that frustrates both people with mental illness and providers of care...." The Report went on to identify barriers to quality care and recovery, fragmentation and gaps in care for children and adults, as well as cite encouragements that rewarded dependency through a mix of inadequate rehabilitation and disincentives to work. Perhaps its most critical comments were reserved for the failure to make mental health a national priority.

For more information you can visit the Commission's web site at *www.mentalhealthcommission.gov.* ❖

Richard Yanes is Executive Director of the Clinical Social Work Federation. He can be reached at cswfed@hotmail.com.

Please report change of address/phone/office to the GWSCSW office:

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COP, *continued from page 15*

If you are interested in belonging to a study group in Northern Virginia, please contact Sarah Pillsbury at 202-332-9473.

■ *NMCOP National Conference*

March 11- 14, 2004 are the dates of the NMCOP national conference, "Psychoanalysis: Changing in a Changing World: Impact on Theory and Practice." The conference will be held in New York City. Several of our members have submitted papers. Others have volunteered as readers. This outstanding scholarly theory and practice oriented conference is a place to learn, share, and grow. So, do attend, participate, "refuel" and network with clinical social workers from all over the United States.

■ *David Phillips Former NMCOP President*

In May, David Phillips, former NMCOP president, visited the GWSCSW for its Ethics Workshop titled "I Want to Hold Your Hand: Ethical Dilemmas in the Therapy Room." Dr. Phillips was responsible for writing the Clinical Social Work Federation Ethical Standards. He also was a major figure in the Psychoanalytic Consortium, which developed training standards in psychoanalysis for psychoanalytic institutes. As the NMCOP representative, he assured that clinical social workers maintain equal status with psychologists and psychiatrists. He is one of our social work intellectual gentle giants. His sensitive persistence of steel combined with his mental acuity make things happen.

■ *Changing of the Chairs*

I am honored and privileged to have served as COP area chair for the past six years. My professional heart warms as I think of interactions with so many of you: interesting, remarkable, varied social work professionals. Growth and change occur within the context of meaningful relationships. I am a stronger social work professional because of my involvement with you and COP. I hope you have also benefited. This grass roots organization, NMCOP, is vibrant, lively - non-bureaucratic: a breath of fresh air. With sadness, but also a satisfied professional heart, I pass on the chair to Sarah Pillsbury. She is fortunate, as are we. COP will certainly have my active support and participation. My best and warmest wishes for the years ahead.

■ *Membership Information*

All GWSCSW members are eligible to join our local COP Chapter. For information, call Sarah Pillsbury at 202-332-9473. ❖

The National Membership Committee on Psychoanalysis in Clinical Social Work is affiliated with the Clinical Social Work Federation.

Questions with Answers

GWSCSW FAQs

I thought I was going to get 3 CEUs when I attended both The Pavilion and the wonderful talk by Tarpley Long, but I only got one! What gives?

It was hard to tell who earned 1 and who earned 3 when we were handing the CEUs out at Chef Geoff's. If you should have gotten 3 CEUs, call the office at 202-537-0007 and we'll send you the certificate.

What's happening with the GWSCSW Mentor program? Is GWSCSW still looking for mentors and mentees?

The Mentor program is on temporary hold. If you are interested, let us know (202-537-0007); we'll need a little help giving it a jump start, and then it will be running again.

I have a friend who tried to get a membership application and couldn't get through to anyone. Is GWSCSW trying to be exclusive or something?

No, no, no! Somehow, no matter how we try, some things fall through the cracks...and we're trying hard to figure out where the cracks are. Meanwhile, though, have your friend try the office (202-537-0007) or call the membership chair, Charles Rahn, at 301-493-6841. ❖

Pursuing Truth, Justice and Righteousness: A Call To Action

JWI's First International Conference on Domestic Abuse in the Jewish Community

July 20–22

Join hundreds of social workers, domestic violence professionals, activists, educators, and clergy on July 20–22, 2003 for Jewish Women International's First International Conference on Domestic Abuse in the Jewish Community.

Visit our conference website *(www.jwicalltoaction.org)* for program and speaker updates and sponsorship opportunities.

For more information or copies of the conference brochure, call JWI at 1.800.343.2823

15.5 contact hours(CEUs) pending with NASW.

■ GWSCSW Directory Update / Change of Address, Office Info, Email, etc.

In addition to your name, please enter only information that has CHANGED since the last directory.

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Home Address _____

City/State/Zip _____

Home (_____) _____

Home Office (_____) _____

Fax (_____) _____

E-Mail _____

Remove Office: located at _____

Add Office:
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City/State/Zip _____

Office (_____) _____

Other: _____

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Downer, *continued from page 13*

respect for the individual and the ability to maintain boundaries. It is important to know that the client is a separate person, needing to find answers and making his or her own decisions. She strongly believes it is important to be a full person, "to have a life." In counseling, she was forever asking, "what are you doing for yourself?" Her advice from the vantage point of a life fully lived, "There are a lot of things to do. Go out there and enjoy them." Ms. Downer has two daughters now living in Massachusetts and Connecticut and two grandsons. She may be reached at *vdowner@erols.com.* ❖

Using the Listserv Archives

Joel Kanter

The GWSCSW Listserv is an active "group" with more than half our Society's members participating. All participants can access the listserv archives dating back four years and read all postings until the current date. This is particularly helpful if you want to check a posting you saw several weeks ago, but had deleted (i.e. an announcement of a therapy group for battered women, or someone looking for office space). Simply go to *www.yahoogroups.com* and register with Yahoo (upper left hand corner of web page). Make sure you indicate you do NOT want any commercial email. Once you have access to the yahoogroups web page, you can also adjust your participation on the listserv so you won't get email when you go away on vacation. When you return, you can review any emails in the interim on the archives and reset your account for "normal" email delivery.

Postings cover a range of topics, including requests for referrals, announcements regarding office space or therapy groups, HIPAA and managed care news, updates on clinical matters, conference announcements and Society activities.

To join the listserv, just send a brief email with your name to *gwscsw@juno.com.* ❖

Family Picnic with Legislators

The Maryland Legislative Council of Social Workers is planning something new for this summer. The Council, which is made up of GWSCSW, Maryland SCSW, NASW-Metro DC, NASW-Maryland, and Social Work Administrators Group, will be sponsoring an afternoon picnic fundraiser—with a jazz band and barbecue—in the pavilion of one of the Baltimore area parks. Maryland legislators will be invited, to provide an opportunity for them to meet with social workers in an informal setting and learn more about social workers' issues. Look for more information by flyer on this summertime event. ❖

Out & About

Tricia Braun

This column, highlighting activities you are involved in outside the Society, is meant to aid you in identifying professional resources and enhancing networking opportunities. For each newsletter I will be soliciting your input on workshops you will be conducting, papers you will be presenting, articles you are writing for academic and popular publications, research you are conducting, or special volunteer projects you are involved with. So... here is what's happening:

Maryland Governor Erlich has appointed **Jewell Golden** to the State Board of Social Work Examiners on Licensing. Ms. Golden's four-year term begins July 1. The Senate Executive Nominations Committee interviewed her, and, along with the Maryland Senate, acted favorably on her appointment. Ms. Golden also presented a workshop on "An Overview of Social Work Licensure" for NASW-Maryland Chapter in May, in Catonsville.

News item from Bulgaria: **Joel Kanter** presented a workshop on "Clinical Case Management with Mentally Ill Patients" at the Bulgarian Institute of Human Relations in Sofia, Bulgaria, in April. This institute, affiliated with the New Bulgarian University, offers Masters Degrees in Clinical Social Work, Family Therapy and School Counseling. The Clinical Social Work Program is the only course of its kind in Eastern Europe and has received considerable technical support from Smith College. Professionals are struggling to adapt clinical social work concepts to a developing nation emerging from over 40 years of Communist rule. The Society donated the book, *Adult Attachment,* which the Institute requested for a new research project.

The Clinical Social Work Institute presented **Frances Thomas** with the Elma Kahn Wolf Award at its Annual Spring Reception on May 16. This award honors social workers for their outstanding leadership and their contributions to mental health and social welfare. Ms. Thomas is a former President of the Greater Washington Society for Clinical Social Work. ❖

Legislative News

■ VIRGINIA

Chris Spanos

The 2003 session of the Virginia General Assembly adjourned on Saturday, February 22, 2003. The General Assembly held a so-called VETO session on April 2, 2003. The Assembly passed several legislative items of interest to the Clinical Society that were signed into law by the Governor. These include insurance legislation, practice and professional issues, mental health legislation, public mental health and substance abuse issues and Medicaid policy and reimbursement. In addition, there are two bills that were considered by the General Assembly, but failed to become law, that are of interest to the Clinical Society.

Insurance Legislation

Children Health Insurance – FAMIS (SB 1218, HB 2287). Legislation to make it easier for children to enroll in FAMIS, the health insurance program for children in working poor families, has been signed by the Governor. It establishes a program incorporating both Medicaid and the Family Access to Medical Insurance Security (FAMIS) Plan in order to provide coordinated services to children. The Medicaid portion is named FAMIS Plus. The bill codifies practice by requiring the use of a single application to determine eligibility for both Medicaid coverage for children and FAMIS. Coverage for the mental health services currently provided for children enrolled in Medicaid is extended to individuals eligible for FAMIS. The bill reduces the waiting period from six to four months between the time a child was covered by private health insurance to when eligibility for FAMIS can be established. The cost-sharing requirements are amended to clarify that the annual aggregate cost-sharing for all eligible children in a family (living between 100 percent and at or below 150 percent of the federal poverty level) and will not exceed 2.5 percent of the family's gross income and will be limited to nominal co-payments. The nominal co-payments for all eligible children in a family will not be less than those in effect on January 1, 2003.

Health Maintenance Organizations (SB 1195). This legislation permits a health maintenance organization to offer to its subscribers deductibles, co-payments, and cost-sharing provisions provided they comply with applicable state law.

Health Insurers – Payment of Claims (HB 2803). This law requires health insurers to report the actual amount paid for each claim for the preceding two years, less discounts, deductibles and services not covered, when requested by the policyholder.

Practice and Professional Issues

Unemployment Compensation – Exclusion for Independent LCSWs (HB 2484). This legislation provides for a statutory definition of classifying when a licensed clinical service provider qualifies as an independent contractor. Services performed by a licensed clinical social worker, licensed psychologist, licensed professional counselor or licensed psychiatrist do not constitute "employment", for purposes of unemployment compensation, if the individual providing the services (i) operates under a contract specifying that he is free from control or direction over the performance of the services, (ii) is licensed to perform independent clinical services, (iii) is compensated solely from fees charged for the services that he performs, and (iv) has a valid business license issued by the locality where he performs the services.

Tax Credit for LCSWs (HB 1764). This legislation adds professional counselors, clinical social workers, clinical psychologists, and marriage and family therapists to the list of health professionals eligible for a tax credit for donated services provided at a nonprofit clinic where such services are provided at no charge or on a sliding fee.

Patient Records (SB 769, HB 1870). This law specifies what must be done with patient records when a health care practitioner closes, sells or relocates his or her practice. It requires practitioners who are relocating a professional practice to notify the patient at his last known address and by newspaper publication of such relocation. Present law requires this notice in the case of a sale of a practice. The notice must also disclose the charges, if any, that will be billed by the practitioner for providing the patient copies of his records.

Health Regulatory Board Investigations (SB 920). This measure specifies how complaints are to be received and handled by the health professional licensing boards. It requires the executive officer and the chief of staff of every hospital or other health care institution to report to the Board of Medicine within 30 days the knowledge of any health impairment that may render a health professional a danger to himself, the public or his patients; any unethical, fraudulent or unprofessional conduct; any disciplinary action taken by the hospital or other health care institution; and any voluntary resignation from the staff. The hospitals and other health care institutions must make such reports within 30 days, except

that reports concerning the commitment or admission of a health professional as a patient shall continue to be made within 5 days of when the chief administrative officer learns of the commitment or admission. Any person who fails to make a required report will be subject to a civil penalty not to exceed $25,000, as assessed by the Director of the Department of Health Professions, and to denial of licensure or certification unless the penalty has been paid.

Mental Health Legislation

Civil Commitment Procedures (HB 2698). This legislation requires the Judicial Council to appoint a committee on civil commitment procedures to establish statewide policies and guidelines that identify the party or parties responsible for the safety and security of individuals who are the subject of or who participate in involuntary detention and admission activities in order to assist the courts and other participating parties in the uniform and effective operation of the Commonwealth's civil commitment statutes.

Perinatal Depression (HB 2310). This law requires each licensed nurse midwife and hospital providing maternity care to make available to each patient and relevant family members information on postpartum blues and perinatal depression (formerly called postpartum depression) prior to discharge. This information will be discussed with the maternity patient.

Patient Records, Health Insurance Portability and Accountability Act (HB 2463). This measure revises the patient records law to bring it into conformity with the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). This measure deals specifically with the legal provisions related to subpoenas for records.

Public Mental Health and Substance Abuse Issues

Mental Health Restructuring (HB 1400). The General Assembly reported a budget bill with language dealing with restructuring the state public mental health facility system. It is the intent that the Governor and the Department of Mental Health, Mental Retardation, and Substance Abuse Services continue working to restructure the mental health, mental retardation, and substance abuse system. Restructuring shall include collaboration with communities and other stakeholders to develop community reinvestment plans for addressing the care needs of individuals discharged or diverted from state facility care.

Medicaid Policy and Reimbursement

We have been successful in seeing no reduction in Virginia's Medicaid rate structure for reimbursement to licensed clinical social workers and other mental health providers. We have had to put off our efforts to seek an increase in Medicaid rates of reimbursement for mental health services due to the Commonwealth's fiscal situation.

Legislation Not Signed into Law

Access to Services (HB 1499). This bill would have required parental notification for a variety of health care services for which a minor now can consent to as an adult. Since mental health and substance abuse treatment are two of these services, many professionals had expressed concerns that this bill would create a barrier to care for adolescents who were afraid their parents would find out about their problems. The Senate Education and Health Committee voted to kill the bill by a vote of 10 – 5. Therefore, this bill will not become law. Del. Lingamfelter (R-Woodbridge) who introduced the bill indicates that he plans to work with the opponents before the 2004 session, address some of their concerns, and re-introduce legislation to require parental notification for health care services.

Mental Health Courts (SB 1098). This bill to create pilot mental health courts failed to reach passage by the Assembly. ❖

■ MARYLAND

Stephen C. Buckingham

Last fall, the Maryland Legislative Council of Social Workers (MD-LCSW) recognized that the state's fiscal problems were paramount in the public policy debates in Annapolis. For this reason, the Council set as its top priority "The State Budget: Assuring Adequate Funding for Vital Programs." Without pitting important programs against each other for scarce resources, the Council focused its energies on educating lawmakers on the worth and value of various programs that address critical needs for Maryland residents.

Social workers and their clients provided important testimony to budget committees on the importance of existing programs, urging against funding cuts and limitations on eligibility. In addition, the MD-LCSW argued forcefully against trying to make up for revenue shortfalls by expanding gambling in Maryland through slot machines at horse race tracks. Instead, the Council advocated raising revenues through modest tax increases and eliminating tax loopholes that currently allow corporations to avoid payment of their fair share of taxes. To a large degree, this fit well with the position of House Speaker Michael Busch, and was reflected in the budget and tax measures that ultimately passed. Unfortunately,

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Governor Ehrlich vowed to veto the corporate tax bill, thereby creating a $135 million hole in the budget. Should this veto occur, additional cuts will be made to the budgets of state agencies, resulting in reductions in services and/or employee layoffs. The Governor has until the end of May to make this decision.

Final Status of the Budget and Related Bills

The General Assembly passed three separate bills that affect the funding of state programs. These are:

Operating Budget (HB 40). The original operating budget for July 1, 2003 through June 30, 2004 filed by the Governor totaled $10.8 billion in General Funds, up 4.3% from last year, and cut 1,387 vacant positions while adding 431 new ones. Thirty of 54 agencies had reduced funding, and state employees did not get the 2% raise negotiated with Governor Glendening. The only programs that had significant increases in spending are aid to public schools (6.6%) and Medicaid (8%).

Budget Reconciliation & Financing Act (HB 935). This helps implement the FY04 budget by: (1) transferring various state special funds and non-budgeted funds to the general fund in fiscal 2003 and 2004; (2) making various changes to statutory funding requirements and revenue distribution provisions to allow for contingent reductions in the budget bill (HB40, 2003); (3) withdrawing several FY03 appropriations; and (4) increases several fees. The House decided against transferring to the General Fund the "excess fund balances" in four health occupation boards' special accounts, including $436,000 from the Board of Social Work Examiners. The Senate decided to make the transfers. The Conference Committee (final version) transferred half the funds ($218,000 from the BSWE). The bill also requires all health boards to obtain a tax "clearance" from the comptroller that an applicant has paid all taxes before issuing a license, effective 7/1/03.

Taxes and Revenues (HB 753). This bill reduces various vendor discounts for private firms that remit tax collections, imposes various tax compliance requirements, and raises new revenue. Specifically, it: (1) removes the exemption for HMOs to the 2% insurance premium tax; (2) partially closes the Delaware holding company loophole; (3) imposes a three-year tax surcharge of 10% on corporate income taxes; and (4) increases and expands corporate filing fees.

Under the general heading of budgetary issues, several sub-issues were identified, some involving legislation separate from the budget. The final disposition of each of these is reported below:

Issue: Adequate Funding for Child Welfare Caseload Reductions – hiring enough qualified professionals to reduce child welfare caseloads to meet the Child Welfare League of America standards.

HB 40 – Item N00G – DHR Child Welfare. This part of the budget includes the transfer of the remaining $8.2 million from the Joseph Fund in lieu of using General Funds, contingent on passing additional legislation (HB 935). The Governor's budget as submitted did not include adequate funding for caseload reductions, and the General Assembly is prohibited by the Constitution from adding funds to the budget. Legislative analysts reported that the progress DHR had made toward reducing caseloads for child welfare workers had been reversed by position abolitions and hiring freezes. The House and Senate cut $273,543 from funds to provide food stamps to legal immigrants, since federal funds will be available for this purpose beginning October 1. The final budget also prohibits more than a 1% increase in Temporary Cash Assistance payments in FY03.

Issue: Substance Abuse Treatment – expansion of capacity to provide treatment to substance abusers. The House Judiciary Committee voted down both bills.

HB 40- Item M00K – DHMH Alcohol and Drug Abuse Administration. The 7% increase in appropriations was largely due to the increase for Substance Abuse Treatment Outcomes Partnership (STOP) program required by statute. The House cut $5.59 million in funding from the $12 million proposed for the STOP program, which makes funding available to local jurisdictions (outside Baltimore City) that are able to provide a direct or in-kind match. Few counties can currently provide the funding match, and "growth in funding and treatment programs has, in many cases, exceeded the administration's capacity to expand."

HB 582 – Correctional Services – Substance Addiction Treatment. This bill would have required that an inmate who "(1) is currently incarcerated for a nonviolent crime or a substance addiction related parole violation; (2) has no prior convictions for a violent crime; and (3) has a verified substance addiction" be granted parole for purposes of participating in an appropriate substance addiction treatment program as long as there is space available in an appropriate treatment program. The Division of Correction would have been required to pay the cost of treatment, up to 50% of the cost of the inmates remaining sentence.

Issue: Patient Access to Mental Health Treatment – full funding of the public mental health system and the Medicaid system in order to avoid measures to limit eligibility and/or treatment benefits.

HB 40 – Item M00L – DHMH Mental Hygiene Administration. As introduced by the Governor, it included an

additional $30 million added to base expenditures per year for reimbursement of providers + $6 million for FY04 in anticipation of a 4.5% increase in people to be treated (Medicaid eligible). A deficiency appropriation of $30 million was also included to make up deficits for FY02 and FY03. Legislative analysts recommended cuts of $4 million through closing the RICA in Southern Maryland and $3 million in funding for core service agencies (CSAs). In the final budget, MHA is required to report back on statewide RTC capacity (rather than simply closing the RICA facility). The budget also took three-quarters of the proposed cut ($2.25 million) to CSAs and asked MHA to report back on how CSAs are organized/ structured. Language was adopted prohibiting MHA from increasing rates to providers unless specifically authorized by legislation. One million dollars cannot be spent until DHMH submits a plan to close one of the 3 state psychiatric hospitals while maintaining existing bed capacity.

HB 130/SB 91 - DHMH – Mental Health Services – Cost-of-Living Adjustment. This would have required that beginning in FY04, the fees paid by the Department of Health and Mental Hygiene to a community mental health service provider for providing mental health services to eligible individuals be adjusted annually by the rate of change in the consumer price index that may not exceed a 5% maximum rate. This bill failed in both houses without a vote by either the House Health & Government Operations Committee or the Senate Finance Committee. Since language in the budget prohibits DHMH from increasing provider rates without specific legislation, the Department cannot establish a COLA by regulation in the coming fiscal year.

HB 675/SB 209 – Maryland Medical Assistance Program – Reimbursement for Outpatient Mental Health Treatment – Dual Eligibility. This is for individuals eligible for both Medicare and Medicaid coverage and for which DHMH may obtain federal matching funds. It requires Medicaid to reimburse community- based programs & individual providers the entire amount of the Medicaid fee for outpatient mental health treatment, including any co-pay. It requires DHMH by August 1 to submit to the Governor and legislative committees a plan for reprioritizing existing grant funds to allow for the funding of the provisions of this Act. This was passed and sent to the Governor for signature or veto.

HB 360 – Mental Health – Early Childhood Mental Health Services – Pilot Program. It establishes a pilot program to provide mental health screening and consultation for children under 6 who are in early childhood programs or in licensed or registered child care facilities. The bill is contingent on available federal or other funding, including the continued receipt of funds from sources that funded the pilot program in Baltimore City and the Eastern Shore prior to July 1, 2003. This was signed into law by the Governor and is effective October 1.

HB 433 – Task Force on the Needs of Persons with Co-Occurring Mental Illness and Substance Abuse Disorders. It creates a Task Force to: "(1) identify and recommend creative ways to provide and deliver comprehensive, integrated, cost-effective services to the population with co-occurring mental illness and substance abuse disorders; (2) identify and recommend various methods of funding services through private and public sources; (3) make recommendations regarding both short-term and long-term residential services for people with co-occurring disorders, including recommendations on the number of units needed and a timeline for providing residential services; (4) make recommendations regarding how the Mental Hygiene Administration and Alcohol and Drug Abuse Administration may implement cross-training for mental health and addiction counselors; and (5) make recommendations regarding necessary legislation to implement the Task Force's recommendations." An interim report is due 12/1/04, a final report, 12/1/05. Providers on the panel include a psychiatrist, a nurse, a social worker, and a psychologist. This was passed and sent to the Governor for signature or veto.

HB 363/SB 676 – Maryland Medical Assistance Program – Maryland Pharmacy Access Hotline. This bill started as a prohibition against imposing preauthorization requirements on drugs to treat Medicaid recipients for mental illness. As passed, it requires DHMH to use existing resources to establish a toll free Maryland Pharmacy Access Hotline that: (1) operates during regular business hours; and (2) during non-business hours allows callers to leave a message" for program recipients who are "having problems getting necessary medicines." It requires the Department to develop a methodology to track the number and type of calls received by the hotline and to report quarterly to the Pharmacy and Therapeutics Committee on the number and type of calls received by the hotline. This was passed and sent to the Governor for signature or veto.

Issue: Mental Health Parity & Accountability – supporting measures to require private health insurers to provide adequate benefits (especially for mental health) to avoid dumping patients onto the public health system.

HB 25/SB 252 – Health Insurance – Task Force to Study Access to Mental Health Services. This establishes a Task Force to study and make recommendations by 12/31/04 regarding: "(1) Whether any changes should be made to the mental health parity requirements" of the law, "(2) The systemic barriers experienced by commercially-insured individuals when attempting to access community treatment; (3) How to ensure that com-

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mercially-insured individuals have access to medically-necessary mental health treatment; (4) The difference in mental health services coverage provided by the public mental health system, commercial health insurers, and commercial health maintenance organizations; (5) The structure and effectiveness of the public and private mental health care delivery system in the state; and (6) The impact on the cost of health care coverage in the state of any recommended changes to the coverage or delivery of mental health care services." This was passed and sent to the Governor for signature or veto.

HB 729 – Health Insurance – Behavioral Health Care Services. This requires carriers that provide behavioral health care services to complete and maintain a form developed by the Maryland Insurance Commissioner that contains specific information, including (1) total payments to a managed behavioral health care organization for the provision of behavioral health care services to members, (2) direct behavioral health care expenses [payments to care providers made by itself or a managed care contractor], and (3) "total expenses for quality assurance and utilization management activities and treatment plan reviews that are clinical in nature" [reported separately]. The bill clearly distinguishes between "direct behavioral health care expenses" and "behavioral health care administrative expenses". The carrier must make the completed form available to anyone upon request at a maximum $15 preparation fee plus actual postage and handling. This was passed and sent to the Governor for signature or veto.

Other important budgets include:

D14A: Office of Children, Youth, and Families. Legislative staff recommended eliminating all funding for the administration of Local Management Boards ($7.9 million) and to reallocate the Subcabinet Fund to other programs serving children and families. The Legislature cut $1 million, with a floor of $100,000, for administration in any jurisdiction.

D26A: Department of Aging. Legislative analysts recommended reducing funds earmarked for expansion of services under the Maryland Older Adults Medicaid Waiver by $1.25 million "to allow time for current backlogs to be reduced and services improved for current enrollees." With the cut, the program could still expand from the current 2,000 to 3,135 participants, but not to the proposed 4,135. The Legislature took part of the cut ($312,823), allowing expansion to 3,635 participants. It also capped the monthly subsidy for the Senior Assisted Living Group Home Subsidy Program at $550 (DOA was hoping to increase it from $500 to $600) and cut $758,500 from the program.

M00A: Board of Social Work Examiners. No cuts proposed.

M00M: Developmental Disabilities Administration – The full $11.2 million increase in Wage Initiative funding required by statute is included. Legislative staff proposed deleting this increase until the state can afford it, as well as $7 million for expansion of community services under the Waiting List Initiative. The Legislature took a 10% reduction in the funding for the Wage Initiative and a $3 million cut in the funding to expand community services. It also asked DHMH to report back on which one of the four state residential centers it will close in FY05. It also cut funding for grants to the Best Buddies program.

M00Q: Medicaid. Legislative staff recommended, "freezing MCHP enrollment, reducing payments to pharmacies, nursing homes, and managed care organizations, and increasing enrollee cost sharing" as potential cost saving options. A total of $60 million in cuts were proposed, including $15 million from MCHP, $11 million from managed care, $10.6 million from nursing home reimbursements, and $6 million from deleting expansion of the Waiver for Older Adults. The House made $40 million in cuts, including $10.9 million from MCHP by limiting new enrollment to children in families below 200% of the Federal Poverty Level (FPL) and requiring a family contribution (premium = 2% of income) from those above 185% FPL. It also cut $8 million from managed care and $10.6 million from nursing home reimbursements. The Senate restored $2 million of the House's $4 million cut in funding for MCO rates (8.2% increase for FY04), restored $780,000 for a rate increase for medical day care and home health care providers, cut $2 million from funding for prescription drugs, expecting additional rebates from manufacturers seeking inclusion of their products on the preferred list, cut $2 million for expansion of the Waiver for Older Adults program, and restricted MCHP eligibility to children with family incomes at or below 225% FPL [currently 300%], cutting $4.3 million from funding. The final budget adopted these Senate decisions and restored an additional $1.5 million in General Funds and $1.5 million in federal funds.

N00C: Dept. of Human Resources, Adult & Community Services. Total appropriation included a 6.2% increase over FY03 working appropriation. The Living at Home: Maryland Community Choices attendant care Medicaid waiver (Community Choices) is currently serving 426 people diverted from nursing homes, but applications are no longer being taken from the community. Applicants currently in nursing homes can still apply, and DHR estimates it can move 25 more people to the community in FY04, with Medicaid funding following the person from the institution to the community. The

House and Senate cut $1.624 million from the program due to DHR improperly accruing funds in 2002 and restricted funds for this program to that purpose alone. They also cut $500,000 from fatherhood and non-marital birth initiatives.

V00E: Dept. of Juvenile Justice (residential operations). The budget proposed by the Governor included a $3.5 million increase for enhancements, including mental health services, drug court, and management reforms. The Legislature cut $5.2 million, including $250,000 for mental health counseling, $250,000 for expansion of drug court, $763,472 to eliminate the break-the-cycle program, and $1.88 million due to delay in new programming at Victor Cullen. Language adopted by both chambers asks DJJ to report back on plans to develop a comprehensive, coordinated (wraparound) approach to services for youth.

Final Status of Other Priority Bills

In addition to budgetary matters, the MD-LCSW established a second tier of issues for advocacy during the 2003 session. Following is the status of significant bills that fall under these specific issue headings.

Issue: Child Abuse Reporting – supporting measures to encourage the reporting of suspected child abuse and holding accountable those who fail to report when required by law to do so.

SB 68 – Civil Actions – Child Sexual Abuse – Statute of Limitations. This extends the statute of limitations for civil child sexual abuse actions to 7 years from the date that the victim attains the age of majority. It does not apply retroactively to revive any application that was barred by the application of limitations before October 1, 2003. This was passed and sent to the Governor for signature or veto.

HB 588/SB 133 – Criminal Law – Child Abuse and Child Sexual Abuse – Increased Penalties. This redefines the existing child abuse statute to be "second degree child abuse" and creates a new offense of "first degree child abuse" involving a parent or other person with permanent or temporary care or custody or responsibility for the supervision of a minor who causes abuse resulting in death or "severe physical injury", which is defined as: "(i) brain injury or bleeding within the skull; (ii) starvation; or (iii) physical injury that: 1. Creates a substantial risk of death; or 2. Causes permanent or protracted serious: A. disfigurement; B. loss of the function of any bodily member or organ; or C. impairment of the function of any bodily member or organ." Penalties for first-degree child abuse are imprisonment not exceeding 25 years or 30 years if the violation results in death. Second-degree child abuse remains a 15-year sentence. This was signed into law by the Governor and is effective October 1.

HB 532 – Family Law – Central Registry – Exception. This prohibits a central registry maintained by the Department of Human Resources of information regarding child abuse or neglect investigations from including an individual's identity when an allegation or finding of neglect involves a child with a mental disorder or developmental disability who is released from a hospital or other facility, and the individual fails to take the child home due to a reasonable fear for the safety of the child or child's family. This was signed into law by the Governor and is effective October 1.

SB 195 – Family Law – Child Abuse and Neglect – Failure to Report – Penalty. This makes it a misdemeanor, subject to a $1,000 fine, for health practitioners, police

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officers, educators, and human service workers to fail to provide specified notice or make a report of suspected child abuse or neglect as required by law; and alters the time periods for making a report of suspected abuse or neglect to require an oral report within 24 hours and a written report within 48 hours. This was passed the Senate, but given an unfavorable report by the House Judiciary Committee.

HB 346/SB 249 – Family Law – Grounds for Absolute Divorce. This adds cruelty of treatment toward a child of the complaining party and excessively vicious conduct toward the child of a complaining party as grounds for an absolute divorce, and provides that recrimination is not a bar to obtaining a divorce on the grounds of: (1) insanity; (2) cruelty of treatment toward the complaining party or a child of the complaining party; or (3) excessively vicious conduct toward the complaining party or a child of the complaining party. This was passed and sent to the Governor for signature or veto.

HB 550 – Family Law – Reporting Out-of-State Child Abuse and Neglect. This requires that those required to report suspected child abuse or neglect to make a report involving a child living in Maryland, even if the alleged abuse occurred elsewhere. This was passed and sent to the Governor for signature or veto.

HB 480 – Task Force on Child Welfare System Accountability. This creates a Task Force to: "(1) determine a method for estimating the extent of child abuse and neglect in the state, including incidents that are not reported to authorities; (2) develop an agreed upon list of performance measures and qualitative assessments of individual cases that will help the state monitor the safety, permanency, emotional well-being, and educational development of children at each of the following steps within the child welfare system; (3) determine how the state can identify and initiate best practices in all aspects of child welfare with emphasis on: (i) outcome based care management; (ii) program accountability; and iii) measures of compliance with state and federal policies; (4) determine measurements of child outcomes to be conducted by an independent research facility, including longitudinal studies of represented families after child welfare service intervention is completed, in order to gather data for performance indicators; (5) study how data from [various specified] sources can be compiled and disseminated in order for the state to be able to monitor child safety, permanency, and well-being; (6) study methods for ensuring that evaluation data is used to improve child and family outcomes, as well as performance at all levels of child services agencies; (7) examine how funding mechanisms reinforce progress toward desired outcomes and possible changes in the child welfare funding system; and (8) study how the state can ensure access to all allowable federal funding to improve children's safety, permanency, and well-being." The Task Force's interim report is due 10/31/03 and a final report 12/1/04. The House Appropriations Committee added the study language the budget (HB 40) and the final budget includes it. Since this made passage of a separate bill unnecessary, the committee gave this bill an unfavorable report.

Issue: CareFirst Conversion to For-Profit Status – opposing the proposal that Maryland's Blue Cross Blue Shield health plan be converted and sold to a for-profit health insurance carrier, and requiring CareFirst to return to its nonprofit mission.

HB 1179/ SB 772 – Health Insurance – Nonprofit Health Service Plans – Reform. This bill alters provisions relating to the regulation of nonprofit health service plans [i.e. CareFirst Blue Cross Blue Shield]. It establishes that the mission of a nonprofit health service plan is to: "(1) provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan; (2) assist and support public and private health care initiatives for individuals without health insurance; and (3) promote the integration of a statewide health care system that meets the health care needs of all Maryland residents." It specifies that a nonprofit health service plans can satisfy its public service requirement by establishing that it has: "(1) increased access to, or the affordability of, one or more health care products or services by offering and selling health care products or services that are not required or provided for by law; (2) provided financial or in-kind support for public health programs; (3) employed underwriting standards in a manner that increases the availability of one or more health care services or products; [or] (4) employed pricing policies that enhance the affordability of health care services or products and result in a higher medical loss ratio than that established by a comparable for profit health insurer." Limits the compensation of directors and officers to $12,000 per year. It requires the replacement of all current Board members by December 1, 2003, and specifies the composition of the new 23-member Board. The bill establishes a Joint Nonprofit Health Plan Oversight Committee to examine and evaluate the ability of the nonprofit health service plans in the state that carry the Blue Cross Blue Shield trademark to meet specific goals. Lastly, it requires the Insurance Commissioner and the Attorney General to determine whether any conduct of CareFirst or its officers and directors violated the law in attempting to sell the plan to a for-profit interest. This was passed and sent to the Governor for signature or veto.

Issue: Standards for Issuing Petitions for Emergency Mental Health Evaluations – supporting a measure to

lower the standard from "imminent danger to self or others" to "likelihood of danger to self or other."

HB 668/SB 273 – Mental Hygiene Administration – Emergency Evaluation – Standards and Content. This modifies the standards for emergency evaluations of individuals with mental disorders so that the individual's danger to self or another no longer needs to be "clear and imminent". Authorizes physicians, psychologists, clinical social workers, professional counselors and peace officers to base the petition for emergency evaluation on personal examination or observation OR on other pertinent information they obtain. This was passed and sent to the Governor for signature or veto.

Issue: Patient Access to Other Needed Services.

SB 732 – Maryland Health Care Commission – Hospice Care – Prohibition. This closes a loophole in the law that allows an out-of-state, for-profit company to purchase a former hospital-based hospice program authorized to serve the entire state and begin operating in areas of the state it had not previously served, thereby competing with local community-based nonprofit hospices. It provides that "a person who acquires or purchases a general hospice care program that was authorized to operate on a statewide basis prior to March 1, 2003, may only serve: (i) residents of any jurisdiction in which services were provided on or before December 1, 2001, and (ii) residents of other jurisdictions who are discharged, immediately prior to the delivery of hospice care services, from the health care facility that originally operated the general hospice care program." This was passed and sent to the Governor for signature or veto.

SB 477 – Small Business Health Insurance Affordability Act. This bill requires carriers to offer the Standard Health Benefit Plan to small employers (50 or fewer employees) in a format that clearly distinguishes it from other offerings of the carrier, indicates that it is the only plan required by state law, and specifies that all enhancements to the plan are not required by law. It lowers the maximum average cost of the SHBP from 12% to 10% of the average annual wage in the state, requiring the Maryland Health Care Commission to exclude or limit Plan benefits or expand cost sharing by customers to keep premiums below the cap. MHCC is required to conduct an analysis of the administrative cost of health plans in the small group market and prepare a report by 12/1/03. This was signed into law by the Governor and is effective July 1, 2003.

HB 143/SB 334 – Maryland Health Care Foundation – Maryland Medbank Program – Extension and Funding. This extends the termination date of the Maryland Medbank Program administered by the Maryland Health Care Foundation from 6/30/03 to 6/30/06 and authorizes Program funds to be used to distribute medication to enrollees in addition to purchasing medications. This was passed and sent to the Governor for signature or veto.

HB 950 – Maryland Pharmacy Assistance Program – Co-payment. This alters the co-payment for the Maryland Pharmacy Assistance Program to require a $2.50 co-payment for generic drugs or drugs on a preferred drug list and a $7.50 co-payment for brand name drugs not on a preferred drug list. It was passed and sent to the Governor for signature or veto.

HB 17 – Maryland Pharmacy Assistance Program – Eligibility. This alters the asset test and income limits for participation in the Maryland Pharmacy Assistance Program. Assets cannot exceed the level set for Medicare beneficiaries (currently 150% of the Maryland Medicaid standard). Income level is raised from $4,000 plus $500 for each family member to 116% of the Federal Poverty Level. It was passed and sent to the Governor for signature or veto.

HB 211/SB 450 – Short-Term Prescription Drug Subsidy Plan – Enrollment. It eliminates the limitation on enrollment in the Short-Term Prescription Drug Subsidy Plan currently at 30,000 individuals, requiring it to provide benefits to the maximum number of eligible individuals it can serve with the money in its fund. This was signed into law by the Governor and is effective April 8, 2003.

HB 726/SB 557 – Public-Private Partnership for Health Coverage for All Marylanders. Voted down in committee, these two bills would have expanded Medicaid eligibility to parents with household incomes at or below 100% FPL (increasing each year), uninsured individuals in the Maryland Pharmacy Assistance Program, individuals under 18 in the Maryland Children's Health Program.

Professional Affairs

HB 310/SB 268 – Department of Legislative Services – State Board of Social Work Examiners – Sunset Extension and Program Evaluation. This continues the existence of the State Board of Social Work Examiners in accordance with the provisions of the Maryland Program Evaluation Act (Sunset Law) by extending its termination date to July 1, 2014. It requires the Board and the Department of Health and Mental Hygiene to submit a report to legislative committees on or before October 1, on implementation of recommendations made by legislative staff in its sunset report. This was passed and sent to the Governor for signature or veto. ❖

COMMITTEE REPORTS

Annual Conference

Kimberly Satin Kubler

I'd like to take this opportunity to introduce this year's conference committee. We are Josephine Bulkley, Laura George, Jen Hackler, Kathleen Kenyon and myself. The committee is currently busy exploring options for speakers and conference space. As the details are finalized, information will be sent via the listserv, mail, and the September edition of the newsletter.

Continuing Education

Dolores Paulson

The Continuing Education Program experienced a banner year. The entire program was well received, but the ethics class caused a registration landslide. A total number of 193 participants registered for the courses and about half were non-members. Participants came from the distant areas of Roanoke, Harrisonburg, Lexington, Fredricksburg, Richmond, Hampton Roads, and Virginia Beach. Martha Chescheir graciously traveled from North Carolina to teach a section of "Clinical Practice in the Real World". Thank you for a most successful year!

The course offerings for 2003-2004 will be mailed to members in late June or early July.

Directory

Constance Hendrickson

In order to circumvent the tedious task of arranging the geographical breakdown of practice information for the Directory (as noted in our last newsletter), the membership application has been modified to request such information from the applicant. For Northern Virginia and the Maryland suburbs, zip codes match neighborhoods; thus the sort is easy. In the District, however, zip codes overlap from one neighborhood to the next. This requires the sort to be done manually, checking each address, map in hand. We hope that the change in the application process will make it easier during the yearly Directory update.

Ethics

Janet Dante

Our Ethics Conference on May 10, "I Want to Hold Your Hand: Ethical Dilemmas in the Therapy Room," was well attended despite terrible weather, with seventy pre-registrations and twenty walk-ins. Special recognition and thanks to the members of my committee: Marilyn Austen, Charles Rahn, Joyce Smith, and Jackie Urow, as well as to Margot Aronson for getting out the mailing. This conference was really a joint effort and wouldn't have happened without each person's contribution.

As the new Ethics Committee chairperson, I imagine discussing ethical issues in future issues of the Newsletter. If you have something you want to discuss, please email me at *janetdante2000@yahoo.com*. If the discussion leads to something that might be useful to other social workers, I will include it in the next newsletter.

Membership

Charles Rahn

The membership committee has received a number of inquiries about membership and a number of applications have been sent out to prospective members. Charles Rahn attended the "Celebrate Social Work Month" at the new Sunrise retirement community in McLean where he spoke to an audience of social workers about membership in the GWSCSW and, at that time, the upcoming Ethics Conference.

The membership committee will be contacting new members and encouraging them to attend our Annual Meeting on June 6. There they will be introduced and have the chance to learn more about the society first hand.

Newsletter

Cecilia McKay

The Newsletter Committee is working to create a historical file of the Society. If you or someone you know has any old issues of our Society's Newsletters and are willing to part with them, we would appreciate receiving them.

As always, volunteers for writing articles are welcomed. If you have recently written a paper or given a presentation and would like to share it with Society members, please email me at *ccmckaymsw@erols.com* or call at 301-802-4126.

Public Relations

Tricia Braun

The Public Relations Committee continues its support of the various committees of GWSCSW. It is working with the Membership Committee to encourage new members to attend the Annual Meeting in June and with the Referral Panel to explore ways of marketing this GWSCSW resource. The Committee is also in the midst of planning the Annual Meeting. I would encourage all of us to "advertise" the Society in our places of business, with colleagues who may not be members, and as part of our networking activ-

ities. All of us are involved in public relations. It is through maintaining a high profile in the community, promoting the value and contributions of our work, and identifying ourselves as clinical social workers that our public image is enhanced.

Referral Panel

Eileen Ivey

As the number of phone calls requesting referrals has decreased, the Referral Panel is looking at ways to advertise itself. If you have ideas about marketing our services, please call me at 301-652-1030. I am also looking for volunteers to help plan and implement such marketing strategies. ❖

Have you experienced conflict in clinical supervision?

PhD candidate wishes to conduct confidential interviews with MSWs who have experienced conflict in supervision.

If you might be interested in being part of this research project, call Elizabeth Thomas: 301-654-2888.

Book Review

Supervisory Relationships: Exploring the Human Element

by Tamara Kaiser

Reviewed by Constance Hendrickson

It was a special pleasure to have the opportunity to review *Supervisory Relationships: Exploring the Human Element* since I had the opportunity to meet the author, Tamara Kaiser, at one of the NMCOP meetings a few years ago in a study group on supervision.

Supervisory Relationships provides insight into the interpersonal dynamics that either impede or enhance effective supervision. Intended primarily as a supplement to other more comprehensive texts used in supervision training courses, it is clearly written, with each chapter providing illustrative examples of the points raised, a thorough summary, and a list of provocative questions to promote critical thinking. There is considerable material on cross-cultural issues, as well.

Ms. Kaiser's conceptual model has three elements of supervision: the goal of competent service to clients, the process of accountability, and the context of the supervisory relationship. This model recognizes that the immediate context of supervision takes place within the larger context of both the organization and other outside forces, such as funding sources, licensure bodies and the political environment.

The supervisory relationship involves interacting in a dynamic way to teach treatment skills. Ms. Kaiser cites a study that focused on supervisors' "support behaviors" (relationship skills) and "teach behaviors" (structuring skills). The researchers found that when both supervisors and supervisees exhibited effective "support behaviors", both individual clients and entire families increased their cooperative behavior. Other research cited supports the idea that there is a parallel or isomorphic relationship between supervisor and supervisee behaviors, as well as a connection between the behaviors and changes in client behaviors.

The last four chapters of the book cover three core elements of the supervisor-supervisee relationship: power and authority, shared meaning, and trust. Using stories and quotes gathered through numerous interviews with supervisors and supervisees, Ms. Kaiser offers an inside look at the complicated relational dynamics that operate between supervisor and supervisee.

Regarding the issue of power, Ms. Kaiser addresses attitudes toward the power differential in supervision. She demonstrates that it is not a question of where on the continua of hierarchy/egalitarianism or dependency/autonomy one falls, but rather how the issue of power is addressed. The responsible use of authority in supervision involves a continual acknowledgement of its inherent existence in the relationship, a balance in which the supervisor is neither using power in an arbitrary way, nor abdicating power.

President of the Minnesota Clinical Social Work Society, Ms. Kaiser has effectively applied her background in social work, her concentration in marriage and family therapy, and her experience as a teacher of social work students to this thoughtful new book. I recommend *Supervisory Relationships: Exploring The Human Element* for supervision training courses. ❖

Reflections....

As the years and clients go by, our techniques and thinking constantly evolve (hopefully). We thought it would be an interesting and useful idea to share members' experiences in this regard. Our "Reflections" column does just that.

Walking, Talking, and Writing through the Transition

Ruth Neubauer and Karen Van Allen

Significant socio-cultural changes in the past thirty years have made it possible for women 50 and over to be the first generation to experience the years beyond retirement age as a continuation of productive times. Consequently, there are few role models, and as poet Adrienne Rich says, it is a "wildly unmothered" place for women.

Our work with individual clients and personal conversations confirms that this is indeed a "wildly unmothered" time. We have found, not surprisingly, that bringing women together with other women is a remedy for the absence of role models. Women are attracted to our groups because of a real or felt change: transitions such as the last child moving out or aging parents, changes in priorities such as loss of interest in one's profession, retirement or death of a loved one.

Every transition begins with an entrance story. Our group process allows each woman to bring her own "story"—to see it, deconstruct it and then reinvent one that carries her dreams and wishes. It is a time when all of a woman's life experience can come together to be used for a purpose that suits her and it is enormously important that she value the accumulated wisdom and knowledge she possesses.

For women, the sense of self is organized around the ability to make and maintain relationships, and a lost affiliation can mean both a loss of relationship and a loss of self. Because major transitions for women often involve changes in affiliative roles, women need support to honor the equal pressures that demand honest life choices.

Along with these changes, participants speak of the desire to get rid of clutter—things, meaningless tasks, distractions. And as women let go, they open up. As one participant decluttered her home, a long buried desire to drive across the country emerged. Freeing creative potential requires separating from outmoded identities and dated beliefs that no longer serve the self. Some of these losses achieve the level of sacrifice—forfeiting something important in the service of receiving something of even greater value. Grieving these losses creates space that makes it possible to discover "what next". Our intention is to try to keep this space open and to stay present to it.

The purest expression of the self emerges when the critical voices can be stilled, particularly when the inner voice must resist what one hears from society, family and friends. Reaching down, to the wise, intuitive, childlike center that harbors the imagination, provides ballast for this effort. In our work, we invite a descent to the imagination, and wondrous things emerge. We are no longer who we were, and we don't yet know who we may become, but each woman speaks of the desire to be connected in a deeper way to themselves, to others, and to their work. It is as if, at this time, the path with heart commands more for itself.

Our workshops and discussion groups have the same phases of joining, identifying issues, working through, not knowing, letting go, coming to new understanding, and beginning a creative process one would expect in a therapy group, although they are not therapy groups per se. Holding still while not knowing "what next" is what we are able to provide. For us, it is enormously rewarding to witness these groups coming together in the safe environment we work to create, so that each woman can proceed at her own pace, in her own style, on her own path.

We have chosen to work with women only to enable discussion to be as open as possible. We have consistently found that women are very happy and relieved to find similar themes. It is reassuring. Most of the time, these group members—strangers at the beginning—have continued to meet together after the workshops end. This alone speaks volumes.

One of our unique findings over the years has been the consistency of the questions raised by women over 50. No matter what the particular circumstance of life—married, divorced, single, partnered, widowed, children or no children, working or never worked—the questions involve looking for meaningfulness and purpose, doing something different, and fulfilling current or long-held dreams and wishes. These are questions of the self. They are not relational. They are about knowing there is limited time and wanting to use it in meaningful ways. ❖

Ruth Neubauer, MSW, and Karen Van Allen, MSW, have been facilitating discussion groups and weekend workshops for women over 50 since 1996 under the trademark name "Retirement" or WHAT NEXT. For further information, call either Ruth at 301-951-8630 or Karen at 240-893-2410 or e-mail: Retiremtwhatnext@aol.com

ADVERTISEMENTS

Advertisements, accompanied by full payment, must be received by the GWSCSW by the first of the month preceding publication. Material should be sent to GWSCSW Newsletter, 5028 Wisconsin Ave. NW, Suite 404, Washington DC 20016 or gwscsw@juno.com. For questions about advertising, call 202-537-0007.

Classified Ads: 75¢ per word
Minimum price $15 (20 words)

Display Ads: Full page 7½ x 9¼ $300
Quarter page 3½ x 4½.....$100
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Half page $175
Horizontal: 7½ wide x 4½ high
Vertical: 3½ wide x 9¼ high

Size of display ads indicated above is width by height. These are the only sizes that will be accepted. Electronic submission (EPS, PDF) preferred.

Publication does not in any way constitute endorsement or approval by GWSCSW which reserves the right to reject advertisements for any reason at any time.

OFFICE SPACE AVAILABLE

CLEVELAND PARK METRO: Attractive, bright, newly decorated office; part-time (some full days), flexible scheduling; reasonable rates. Call 202-363-4459.

CONNECTICUT AVE. & VAN NESS METRO: Attractive, windowed office in psychotherapy suite, 2 blocks from Metro. Kitchenette, waiting rm. Great location, secured building with workout room, morning coffee in lobby. Available Mondays, Fridays, Saturdays. Call Judy Mullan, MSW at 202-244-9242.

DUPONT CIRCLE SUBLET: Sunny, quiet office in landmark building with doorman, steps from metro. Two full days available in suite with three established therapists. Please contact Isabel at 202-362-7270 for further info.

FRIENDSHIP HEIGHTS: Beginning July 1, a great office in suite available Mondays, Thursdays, Fridays and Saturdays. Metro & parking. Call 202-244-8855 x 2. CPS: Amy Scott, Anne Burrows, Fred Boykin.

MCLEAN, VA: Office for sublet. Nice location. Separate waiting room. Parking. Available mornings before 10:00 A.M. and every afternoon/evening after 3:00 P.M. except Thursdays. Available Saturdays. Call 703-448-0696.

MCLEAN, VA: Windowed office in three-person psychotherapy suite in McLean Professional Park. P/T available immediately, F/T in August 2003. Please call Betty Wright 703-356-5313 or Donna Baughcum 703-821-1776.

NOVA/TYSONS AREA: Windowed walkout office—bright, beautiful. Convenient NOVA/ Tyson's area on Route 7, inside the Beltway. Prime location. Plenty of free parking. Call 703-790-0786.

ROCKVILLE/EXECUTIVE BLVD: Part-time office for rent with waiting room and kitchen. Handicap accessible and near public transportation. Call Helene 301-340-1598

POSITIONS

CLINICAL AND DEVELOPMENTAL PSYCHOLOGY PRACTICE in RESTON is looking for a VA licensed MH professional with experience working with children ages 2–5 and their families. Flexible work schedule, very interesting work. Opportunities for professional development. Please email Dr. Moshe Shtuhl at familycompass@aol.com with letter of interest and CV, or call 703-471-5517.

GROUPS

ADOLESCENT THERAPY GROUPS: Ongoing psychotherapy groups meeting evenings through summer in Rockville. Call Britt Rathbone, LCSW-C at 301-230-9490. www.rathboneand associates.com. Effective Quality Treatment.

HEALING FROM SEPARATION & DIVORCE GROUPS: Ongoing psychotherapy and support groups, meeting in Georgetown or Dupont Circle. Informational brochures available. Call Sarah Pillsbury, DSW, CGP (202) 332-9473; Psarah@aol.com.

SERVICES

NEED COMPUTER HELP? Computer giving you fits? Disk drive on the fritz? Avoid the headache and give us a ring. No job too big or small. We do house calls! Hodari McClain, LLC (202) 270-1101.

PROGRAMS AND EVENTS

SOCIAL WORK LICENSING: Prep Courses and Home Study Materials. For sample questions, schedule, and information call Jewell Elizabeth Golden, LCSW-C, LICSW, BCD, 301-762-9090.

LOST & FOUND

FOUND – Personal notebook at the May 10th Ethics Conference. If this might be yours, contact Janet Dante at *janetdante2000@yahoo.com* or by telephone at 301-428-0808

SUPPORT YOUR SOCIETY... JOIN A COMMITTEE!

UPCOMING EVENTS

Friday, June 6

GWSCSW Annual Meeting
Time: 7:00 A.M. – 9:00 P.M.
Location: St. Alban's Parish Guild Hall
Washington, DC
Info: Tricia Braun, 301-258-9444
clbraun@erols.com

Saturday, June 7

GWSCSW Collegial Support Group
(see box to right)

Sunday, July 20

Family Picnic w/Maryland Legislators
Info: To follow by flyer *(see page 19)*

Friday, August 1

Deadline for ads and articles for the September newsletter

Collegial Support Group Launched

In response to a notice in the March newsletter, members of the Society met informally on Saturday, April 5, in Margot Aronson's warm living room to discuss reactions to the Iraqi War. We had a very interesting and stimulating conversation about our many reactions, ranging from fear and anger to confusion. Many of us talked about how to help our clients process these chaotic events in light of their internal struggles. Everyone found the meeting to be quite helpful, as it allowed the airing of feelings in a non-politicized, safe environment. Although the fighting is over, at least for now, the issues posed by the current climate remain.

We invite the membership to attend our next meeting

Saturday, June 7
10:00 A.M.
at the home of Nancy Pines

For more information and to RSVP contact Adina Shapiro at 703-761-3939

Greater Washington Society for Clinical Social Work
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[redacted]