Greater Washington Society for Clinical Social Work

Education ♦ Advocacy ♦ Community

June 2008

news & views

GWSCSW Annual Meeting and Dinner

Friday, June 13
6:30 PM

at the home of Janet Dante
5207 Hampden Lane
Bethesda, Maryland

Friends • Wine • Potluck Dinner
Fabulous Door Prizes!

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www.gwscsw.org

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Challenge to the Privacy Privilege in DC

Margot Aronson

> *On May 6, 2008, bill 17-247 was voted into law by the District of Columbia Council. In essence: at the request of a DC child protection investigator, all Mandated Reporters are required to immediately provide copies of all relevant records of a child who is the subject of an investigation of child abuse or any other at-risk child residing in the household—that is, records bearing directly on the allegations of child abuse or neglect being investigated.*

Like so many social workers in clinical practice, I began as an investigator for Child Protective Services. The work was difficult, complex, and stressful. Out in the field I learned more about human nature, human pathology, family systems, and societal pressures than I ever could have imagined during graduate school. Assessing situations, intervening at the core of the crisis, determining whether a child would be safe… it was an impossible mix: hugely challenging and amazingly rewarding. And it provided extraordinary preparation for me in the years of work that followed as a therapist for highly troubled teens and their families.

All this is to say that, like other social workers in clinical practice, I have immense respect for child protective service workers—particularly when a department is flooded with reports, as now in the District of Columbia, where the number of calls to the Child and Family Services Agency (CFSA) has multiplied six-fold in the aftermath of the Jacks case.

So when in mid-March I heard about a bill before the DC Council that would expand the investigative range of CFSA workers, I wanted to learn more.

17-247 – A Bill on the Fast Track to Passage

Bill 17-247 (Child Abuse and Neglect Investigation Record Access Amendment Act of 2008) had originated in Councilman Tommy Wells's Committee on Human Services; it was now scheduled for First Reading before the Council on April 1, with the final vote scheduled for May 6. Although there had been a hearing in the fall, none of the mental health organizations presented testimony; somehow the bill had glided in under everyone's radar screen. (In fact, apparently the Council passed an earlier version of this bill, as an "emergency" measure, in 2006; unbeknownst to the mental health community, the measures have been law for quite a while.)

Wells's legislative staff promptly emailed me the final committee report with a copy of the "Mark Up" version of the bill. What I read was disturbing.

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Greater Washington Society for Clinical Social Work, Inc.
PO Box 3235, Oakton VA 22124
202-537- 0007

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GWSCSW NEWS & VIEWS
Editors: Jennifer Kogan & Maya Godofsky
Margot Aronson, Alicia George,
Erin Gilbert, Jonah Green, Shoba Nayar, Susan Post,
Connie Ridgway, Mary Lee Stein,
Ann Wroth, Kim Yamas

News & Views is published four times a year: March, June, September and December. The deadline to submit articles and advertising is the 20th two months prior to publication.

Articles and letters expressing the personal views of members on issues affecting the social work profession are welcome and will be published at the discretion of the editorial board.

Signed articles reflect the views of the authors; Society endorsement is not intended.

For advertising rates see page 27
Email ads to gwscsw@gmail.com

The next issue will be published
September 2008 and the deadline is July 20.

Email articles to koganblackwell@verizon.net

President's Message

Susan Post

Spring seems to be the busiest time of the year for the GWSCSW—I'm having a hard time keeping up! There are an array of continuing education classes and workshops, including our first-ever theater and dinner outing as well as programs in both Virginia and Maryland to discuss ethical issues raised in HBO's "In Treatment." These are exciting avenues for shared learning and for having some fun together. Joel Kanter has put together an energetic committee which is revitalizing our programs, and I know they have even more expansive plans in development for the coming year, including local CE lunches.

Thanks to Diana Seasonwein, we may finally have a 501(c)3 educational foundation next year. Diana, who also implemented the prepaid legal plan, managed to find an attorney who is doing the legal work for us this spring pro bono. The society will enter a whole new phase of development when this new status is finalized. It's an exciting time in our 33-year history.

It is also a period of frenzied legislative activity. What we would do without Margot Aronson I don't know. I don't think any of us has a clue how much time (and skill) she devotes to managing the bills and regulations that come at us from all three of our jurisdictions. Ethical issues have been under siege everywhere—from regs in Virginia related to "dual relationships" after termination, to an effort in Maryland to criminalize failure to report suspicion of abuse (we got it withdrawn), to the bill in DC which would require therapists to submit records related to investigations of child abuse or neglect. Margot has given us a pro-active voice in every case, has often mobilized our membership and other groups to action, and has given us all a first-class education in advocacy.

We held another appreciation brunch to celebrate our growing number of volunteers within the society, each of whom contributes something unique and important to the organization. It's also the time of year when we recruit new volunteers for all sorts of jobs both present and future. Nominations chair Tricia Braun is hard at work putting together a roster of candidates for next year's executive committee. And we're planning the annual June dinner meeting, where I hope to see many of you.

Several of our officers will be finishing their terms this spring. Ted Billings, who fortunately will remain as chair of the continuing education committee, has been managing our treasury and budget, and has done a remarkable job of juggling two major roles for the past year. Barbara Thaler has served with wit and enthusiasm as our secretary, and we will miss her sage voice on the executive committee. Beth Altman, a valued director-at-large for the past two years, will continue to devote herself to the Society as chair of the referral panel committee.

Not all the news in the Society is business related. I know that many of you have exciting changes taking place in your lives: babies and grandchildren being born, new homes, children graduating from high school and college, your own graduations from advanced clinical programs. Wouldn't it be great to know how many births we had in our organizational family

this past year? Why doesn't each new parent send an email to our newsletter editors, Jen Kogan and Maya Godofsky (herself part of this cohort) and we can get a count and cheer you all on?

It has been a thoroughly delightful and challenging experience serving as president of the Society this past year. I have gotten to know many wonderful people, have learned a lot about the operations of volunteer organizations, and have honed the skill of begging. So I look back with amusement to when I agreed to be a vice president two years ago, stating vehemently at the time, "OK, but you need to know I will NEVER serve as president."

Today I heard a piece on the radio entitled "Just so you know…." So here are some of mine:

"I hope we continue to bring more young people into active leadership positions, babies or not."

"I'm sorry I wasn't more gracious as a speaker at events—it's not what I'm good at. I will try harder in the future."

"I'm glad I took the job!"

Wishing everyone a wonderful summer… ❖

Treasurer's Report

Ted Billings

This is my last report as treasurer of the Society, and I want to thank several people who made it much easier for me to do my job. Janet Dante, my predecessor, has been a great source of information and support and was very generous with her time. Susan Post and Diana Seasonwein, the two presidents during my term, have been tremendously helpful. Jan Sklennik, who does the administrative work for the Society has been a joy work with. Thanks to all of you for making this experience rewarding. Getting to know each of you has been a delight.

The Society's financial health is strong. Membership dues continue to be the bulk of our income, while publishing the newsletter, office administration and advocacy comprise the bulk of our expenses. Our financial situation has benefited greatly from the change in the structure of the dues the Society pays to CSWA. Previously, dues were between ten and twenty thousand, last year they were three thousand, and this year they were one thousand. I believe we will once again end the year with a modest surplus. ❖

Making a Difference with Give an Hour

An interview with founder and President, Barbara V. Romberg

Nancy Markoe

Barbara V. Romberg

Psychologist Barbara V. Romberg, PhD is the founder and president of Give an Hour, a national, non-profit organization of mental health providers who volunteer one hour of therapy a week to veterans and their families. Give an Hour has 1,200 volunteers in 43 states and currently focuses on the mental health needs of military veterans of Iraq and Afghanistan. The organization is based in the Washington metropolitan area.

News & Views: Dr. Romberg, tell us about Give an Hour. What is the mission?

I created the organization in September 2005 to respond to acute and chronic conditions among veterans. According to recent reports, as many as thirty percent of returning vets suffer from symptoms of post-traumatic stress disorder and both DoD and the VA hospitals are having a difficult time responding to these huge numbers.

Give an Hour provides individual, couples and family counseling to adults and children for a variety of conditions and issues including depression, substance abuse, PTSD, traumatic brain injury, sexual health and intimacy concerns, and grieving and loss.

One other aspect of our program is that we offer our service recipients the opportunity to give back—to pay it forward, so to speak. Service personnel are very proud, they have expertise in a variety of areas, and they are willing and able to help others. We offer opportunities for recipients to help others, and we think it's a very important part of our mission.

Do mental health professionals require additional training to volunteer?

No, we make training opportunities available to our volunteers who are interested, but additional training is not required. Many of our visitors are family members dealing with anxiety or relationship issues, for example and the mental health providers do not need to be trauma experts in order to help them. We try to make it really easy for professionals to give what they have to offer.

How many people are involved as volunteers and clients?

We are approaching 1,200 providers in 43 states. Some states like New York, California, Washington State, Texas and metropolitan Washington, DC area have a hundred or more providers. Alaska has just one. We are working to recruit in all areas, especially those places where the need is greatest. Our volunteers include social workers, psychologists, psychiatrists, marriage and family therapists and other professionals. There are others such as massage therapists who have a lot to offer, but our organization focuses on licensed mental health providers.

There is a huge need—more than 1.7 million military personnel have been deployed since September 11th. The service members return with physical injuries and psychological symptoms and their families suffer too. We know so much more now than we did after Vietnam, but we're still seeing a repeat of the affects of war on military personnel and their families.

How do you recruit the providers?

We recruit through the media—we just ran a full-page ad in *Time* magazine and the response has been tremendous. The ad and the space were donated and we are very grateful for the publicity. Providers and potential clients are very excited about the work that Give an Hour does, and we are focusing on spreading the word to those who may not be aware of what we do. Our organization is featured in newspapers and on radio and we try to recruit providers through mental health organizations in communities where we have unmet needs.

What opportunities are available for Give an Hour volunteers?

Give an Hour is named for the most basic way that a mental health practitioner can help—offer one hour each week of therapy at no charge doing what the practitioner does best without leaving her office. This

is the simplest way for people to give back. But many are interested in helping out in other ways as well. For example, an artist in Ohio created a beautiful memorial for a military unit that lost many soldiers. The life size images of the fallen will be opened first to soldiers in the unit and families. Give an Hour arranged for mental health providers to be at the event to counsel survivors and families should the need arise. There are a number of different ways that people can be involved.

How did you decide to start Give an Hour and how did you go about it?

My father was a WW II Navy vet who served in battle in the Pacific. When I was a child, he would sometimes recall that time to talk about war buddies and funny stories. Although he never talked about the difficult times—it just wasn't something people talked about then—I could sense the intensity about his experience.

Later, I grew up in the shadow of Vietnam. My older brother had a number, but wasn't drafted because he was in college. But his friends were drafted and fought and came back and were never the same. Some didn't come back at all. Several years ago, I was with my older daughter when we saw a homeless Vietnam veteran on the street. My daughter asked me, "How could we let this happen?" The question came together at a time in my life when I was ready to take action. I knew I had to do something; Give an Hour was my way of giving back.

It's been an interesting path from the initial idea to this point. Things came together rather quickly. In the summer of 2005 I read *Non-Profits for Dummies* and by September we were incorporated. Then we became a 501(c) 3 and assembled a board. And now, just a few years later, we have providers in 43 states.

How do mental health providers get involved with Give an Hour?

We hope your members will go to our website (www.giveanhour.org) and find out more about the organization and the people we help. Our volunteers choose from many different ways to help—everything from providing therapy, to lobbying on the Hill, to making a donation or helping out at events.

The system is very user-friendly. Providers can register and get their license verified. They are able to indicate exactly how they want to be involved and the kind of work they specialize in. Then they are matched up with service members. Providers determine their own schedule and can help in the way that works for them—in their own offices. We try to make the volunteer system simple and convenient.

We also try to be attentive to our volunteers' evolving needs and to the experience of being a volunteer. The organization offers training and networking—and of course a tremendous amount of satisfaction. Recent trainings for volunteers have included combat stress and online links to televised lectures on pertinent topics. We're also sensitive to create a culture where volunteering is as healthy and positive for our providers as it is for the recipients. Luckily, our volunteers tell us we've succeeded.

A volunteer of ours was interviewed about her experience with Give an Hour. The interviewer asked the volunteer why she joined us. Her answer was very simple. She said, "How could I *not* join? They ask so little." ❖

Nancy Markoe, LCSW-C, LICSW has a private practice in northwest DC and Bethesda, MD.

Towards a More Therapeutic Divorce: Addressing Separation's Legal Side

Jonah Green

Sarah was a talented therapist who approached her work with children from a family systems perspective. She was working with William, a seven-year old with mood and behavior problems, along with his two parents, Fred and Charlotte. During the intake the parents denied having problems in their relationship, but during subsequent family sessions they seemed very much at odds. Sarah held a meeting with Fred and Charlotte alone to discuss their differences, and in the session the couple revealed that Charlotte had just told Fred that she had met someone else and wanted a divorce. After attending to both partner's feelings and making sure that Charlotte was firm in her decision, Sarah began regular meetings with the couple to assist them with the emotional and physical tasks necessary to disengage and begin building a "two-home family". Following one such session, Fred wrote Sarah an email saying that, on the advice of his attorney, he would no longer attend therapy with Charlotte. Sarah continued to hold sessions with William and each parent and she encouraged Fred and Charlotte to cooperate with each other. At the same time, again following his attorney's advice, Fred continued to stay in the house in an effort to obtain an advantage in their battle over custody and financial issues. The parents began to argue loudly and frequently in front of William, and the boy grew ever more moody and oppositional.

Due to a variety of cultural and economic circumstances, the divorce rate nearly tripled in the United States from the 1960s through the 1980s. While researchers such as Judith Wallerstein and E.M. Hetherington have differed in their assessment of the overall impact of divorce on families, all studies have concluded that orderly and low-conflict divorces result in better outcomes for family members. Clinicians have developed a number of techniques to help divorcing families minimize conflict and move through the divorce process in a structured manner.

The powerful emotions and complicated tasks inherent in separation and divorce often result in chaos and disorganization (Ahrons, 1994; Emery, 2004). Direct guidance to the spouses about how to proceed with the separation can provide a necessary order. It helps to inform parents that the separation process should begin as soon as one partner is sure that he or she wants a divorce. It is best if parents inform the children about a separation before it takes place. They should present a common "story" about the cause of the break-up that minimizes blame on any family members, and they need to assure the children that they will continue to work together and support each other. Parents should also provide children with details about how their lives will change. It is usually best if the parent who was less involved in the children's day to day lives then moves out of the residence, and that he or she lives as close as is feasible.

It is important to work closely with divorcing spouses in setting up an initial parenting plan that will take place immediately upon the separation. The plan should include a specific schedule and precise tasks for each parent. Clinicians should offer explicit guidance during these sessions on how the spouses can communicate effectively, and continually steer discussions towards how to best meet their children's needs. Including children at strategic points in these discussions can clarify their concerns and facilitate more effective agreements. (Isaacs Et. Al., 2000) Specific advice to parents concerning the content of effective parenting plans can move the process along; one helpful guideline is that children usually adjust best if their schedules, activities, and levels of contact with each parent after the separation approximate what existed when the parents were together.

Families benefit when clinicians encourage parents to reach agreements on issues of child support, property settlement, alimony, legal and physical custody, and visitation as expeditiously as possible following the separation. Clinicians need to give the message that the settlement process is **not** about obtaining justice, but rather about generating a fair agreement that maximizes each family member's emotional and financial well being. A suggestion that the spouses go through an Alternative Dispute Resolution (ADR) process, which can lead to legally binding settlements, can be an excellent intervention. One such process is *mediation,* wherein a third party assists the divorcing spouses in negotiating to a consensus. In a newer process called *collaborative divorce*, spouses work with attorneys, mediators and other professionals to nego-

tiate a settlement. Most ADR procedures are less costly than litigated divorces, and not as likely to lead to legal battles following settlements. These processes can also reinforce the improved communication among the divorcing spouses that therapists have begun facilitating.

An orderly legal divorce process can dovetail well with a clinician's effort to assist the family with reorganizing into a "two-home family", (Dozier, 2005) tied together by the children. The core of clinical work following a separation consists of sessions with the divorcing spouses that promote "co-parenting", wherein the parents communicate clearly and effectively about the children's needs, and each supports the other's parenting efforts. A positive co-parenting relationship helps both parents remain involved in children's lives, keeps kids out of parental conflict, and facilitates consistent routines, rules, and schedules. Sessions with children, sibling groups, and individual parents along with children can also serve to strengthen the structure of the divorcing family.

Shepherding a family through the painful and complicated process of separation and divorce is challenging under the best of circumstances. Obstacles such as personality disorders, substance abuse, mental illness, divisiveness among the extended family or domestic violence can further complicate efforts. In addition, the advice of attorneys can provide a formidable obstacle in the path of therapist's efforts. In the above vignette, the counsel of Fred's lawyers undermined Sarah's otherwise skillful interventions. Sarah might have been more successful if she had advised the spouses to negotiate through an ADR. In his book *Working With Divorcing Spouses* (2006), the mediator Sam Margulies maintains that the focus of attorneys on conflict undermines the cooperation necessary for healthy divorces, and that clinicians should make specific efforts to steer parents away from litigated divorces and towards ADR procedures.

An interface with the legal system is part of any divorce process. Property, custody, and financial arrangements need to be settled, and courts need to approve the agreements. In certain cases people need to pursue litigation in order to protect both their and their children's interests against unreasonable ex-partners. Even when spouses mediate, lawyers can play constructive roles by reviewing settlements before final signatures. But too often the legal process itself generates needless strife and trauma. If clinicians steer divorcing spouses away from destructive legal advice and towards ADR procedures, they will be better able to assist families in moving through the divorce process, and families will be better positioned to heal and rebuild. ❖

Resources:

The Collaborative Divorce Association, Inc., www.collaborativedivorcemd.com

The National Family Resiliency Center, www.divorceabc.com

Northern Virginia Mediation Services, www.nvms.us

Jonah Green, LICSW, LCSW-C practices therapy for children, families, and individual adults in Kensington, MD.

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From Therapist to Mother: Integration of the Self

Janna Perry

When I left full time employment to have a baby, I expected to undergo a huge life change in my new role as a parent, and I worried about losing my clinical skills. Though the adjustment was immense, I have found that my clinical training has enhanced my parenting abilities. Now, as I am launching a part-time private practice, I am finding that my experience as a parent is enriching my abilities.

My daughter reminds me that the work of being fully present with another is challenging and takes constant practice. In our society that expects tangible and immediate results, it is easy to get distracted by the next task. Yet, what my child needs most is for me to be as attuned as I can be with her, so that I can provide the holding and containment she needs to grow. When I can be fully present for her, I discover the real joy of connection. The same is true for me in my role as a therapist.

My clinical training included a rich depth of psychodynamic theory and technique, but also emphasized it is okay not to know; that we as therapists don t have to be, and can t be, the experts. With my baby, there may be empathic ruptures and repairs, but she, like my clients in therapy, will keep teaching me what I need to know. I have learned to trust that she will tell me when she is hungry, tired, or needs to be held. As a parent as well as a therapist, I find that I rarely "know" exactly what to do next, but have instead had to rely on my awareness to guide my next move.

Although reflecting on theory and observing ourselves is essential, at times it can distract from being in the present. The overuse of theory or our observing ego can make us distant, overly self-conscious, and preoccupied with an agenda. Winnicott s notion that there is no such thing as a baby resonates with me as I notice the ways in which my daughter and I are not separate. When I allow myself to be fully present with my daughter, the separation between us becomes less distinct, promoting our mutual receptivity to unconscious communication, and enhancing our connection .

My daughter communicates constantly with me through her body, voice, and through the feelings that I experience. Likewise, in therapy, many levels of communication occur simultaneously. Therapists practice the art of listening on many levels at once. In order to thrive as a therapist as well as a mother, it is essential to have other people who provide support, holding, and containment.

As I prepare to start seeing therapy clients again, the presence of my daughter in my life gives me a renewed focus. I marvel at how my daughter is fully in her body, in her senses, and in the present. As a therapist I have become more interested in how we as adults can reconnect with our own sensory awareness, intuition, and vitality. My daughter has enhanced my understanding of how emotions move in the body but can get buried deep below layers of defenses. Becoming a mother has moved some defenses aside, and made me face some of the core anxieties of death and loss that underlie many of our individual and collective neuroses.

When I notice certain ways that I regress in order to bond with my baby it makes me think more about that dynamic in therapy. Likewise, it has been fascinating to see how my baby often regresses slightly before she learns a new skill. In my work with clients I will now be even more aware that growth is not linear, and often, just when things appear to be falling apart, an important shift can happen.

The other night, I was rocking my daughter to sleep and reading a book that describes how putting words to feelings literally integrates the functioning of the brain hemispheres *(Parenting From the Inside Out,* Siegel and Hartzell). Though it focuses on how parents can help children develop these skills to form a coherent narrative, I thought about how we do this as therapists. We help others to integrate, and to live with integrity. Connecting my roles as a mother and as a therapist has helped me start to integrate my own experiences.

Finally, this new role has shown me the value of community in our personal and professional development. I am grateful for a community such as this clinical society, which provides space for me to share some of these thoughts. I ve been very aware lately of the need for such networks to support the various domains of our lives. We are fortunate as clinical social workers to have a profession that enriches and is enriched by all our life experiences. ❖

Janna Perry, LICSW, LCSW-C has a part-time practice in Greenbelt, Maryland.

OUT & ABOUT

This column shares news about members' professional accomplishments—our publications, speaking engagements, seminars, workshops, graduations—as well as our volunteer projects and special interests or hobbies. Here is what some of us have been up to…

Katrina Boverman, who sings with the Archdiocese Mass Choir (a group of eighty people from different parishes all over the DC area), was honored that she and her choir were one of the choirs selected to sing for the Papal Mass held last April 17.

Tybe Diamond was recently interviewed by Pamela Brewer for her radio program on group psychotherapy. Tybe also presented a workshop on aging for the American Group Psychotherapy conference. In addition she is teaching a course on transference, countertransference, and intersubjectivity in couples therapy for the Institute of Contemporary Psychotherapy and Psychoanalysis.

Sheila Rowny and Naomi Greenwood presented a three-hour workshop, titled *Enhancing Your Sexual IQ,* to the Maryland Psychological Association last March 28.

Rob Scuka conducted a two-day intensive training in Relationship Enhancement Therapy for Couples and Families at Seoul National University at the invitation of the Korean Association of Family Therapy. 130 professionals, ranging from university professors in social welfare to practicing clinical professionals and graduate students, attended the training. ❖

Send your information for Out & About to newsletter co-editor Jen Kogan at koganblackwell@verizon.net.

Reviews are in…
GWSCSW Sponsored Theater Party is a Hit

Society members attended the April 13 performance of Arthur Miller's *The Price* at Theater J at the DC Jewish Community Center. The play was an intense portrayal of the family dynamics between two sons and their father. The cast included Robert Prosky as the father along with his two biological sons. There was plenty of time for socializing and dinners at Skewers, a nearby restaurant. A wonderful time was had by all. Photo by Beth Altman

Volunteer Appreciation Brunch Touts Dedicated Members

A number of dedicated Clinical Society volunteers attended a delicious Volunteer Appreciation Brunch on April 27 at Maggiano's in NW DC. Susan Post made an eloquent speech thanking the all of the attendees, and especially noted Margot Aronson, who has done an outstanding job as the chair of the Legislative and Advocacy committee. ❖

ADVOCACY & LEGISLATION

■ MARYLAND

Alice Neily Mutch

Two years ago the Legislative Council—the coalition of the Maryland and Greater Washington Societies—embarked on a campaign to increase legislators' awareness of and appreciation for the profession of clinical social work by soliciting feedback from them on issues of importance to clinical social workers. This effort has resulted in a greater understanding of the profession and paved the way for further interest from the legislators.

Increasingly clinical social workers are identified as a significant component of the mental health system. The Legislative Council has been involved in the work of the Reimbursement Task Force, authorized in the 2007 session, and recently the Special Committee on Drug and Alcohol asked for your input on what gaps exist in substance abuse treatment in the State, and for your recommendations for remedy.

It is this kind of experience, demonstrating your interest in and willingness to participate in the legislators' efforts, which will convince legislators to become advocates for your issues in the future.

Legislation Concerning Practice & BSWE Issues

SB 243 / HB 965: These child abuse and neglect bills would have added to the list of mandated reporters, and, on the Senate side, created criminal penalties for failure to report. The Legislative Council took the lead in opposing this bill; the medical societies joined in. We argued that criminalization would ultimately lead to defensive reporting, noting that the threat of loss of one's professional license should be sufficient deterrence. We also recommended that the respective licensing boards take a look at the reporting process is and address the perception that there is under-reporting of abuse by social workers.

This very emotional bill died in the House, but will probably be re-introduced and pass the Senate next year. Member contact with Senators would be useful during this Interim.

SB 84: The State Board of Social Work Examiners (BSWE) will be increased in number by one licensed social worker who is primarily engaged in social work education at an accredited social work program, nominated from a list of names submitted by the deans and directors of the Maryland social work education programs. The BSWE will now consist of 12 members; at least four must be licensed certified social workers-clinical.

HB 811 / SB 764: In the long run, this bill, the outgrowth of an acrimonious debate between factions of dentistry, may have significant ramifications for the BSWE. It creates a Task Force on the Discipline of Health Care Professionals and Improved Patient Care, tasked with making recommendations to the Legislature by December 2008 regarding practices and procedures to enhance the fair, consistent, and speedy resolution of reports concerning substandard, illegal, or unethical practices by health care professionals.

HB 730: This Health Occupations bill would have created an exemption from any oversight by the state for any delivery of any health care treatments or advice except for traditional physician acts. Arguments for the bill centered on the right to choose one's own form of health care; proponents asserted that any opposition was based on money and turf. The bill died in the House, under the weight of arguments centered on the lack of protection of the patient, lack of oversight protections, confusion of the public on what constitutes qualified providers, the undermining of the current health provider licensing system and the lack of authority to discipline those who provide unsafe services.

Legislation Concerning Reimbursement Practices and Obstacles

An important focus of the Legislative Council during this session has been to promote opportunities for third party reimbursement and to weaken barriers to reimbursement. Through the office of our lobbying firm, Capital Consultants, information is available to members who seek (1) clarification of the reimbursement and practice law or regulations, (2) guidance for accessing new reimbursement opportunities, and (3) resources for challenging barriers to adequate reimbursement. Recognized as an interested party in the deliberations of the Task Force on Reimbursement, the Legislative Council has been gathering data on the concerns of clinical social workers across the State.

The following are reimbursement bills which were introduced to remedy problems that currently exist between carriers and health providers:

HB 709 / SB 469: This bill would have prohibited carriers from denying reimbursement for any service, procedure, or report for which a special services, procedures, or reports code exists in the current procedural and terminology (CPT) code book, as adopted by the American Medical Association. This bill received an unfavorable report in the Senate and was heard only once in the House. *(Could this be the route to getting marital and family therapies covered by insurers?)*

HB 815: This bill requires insurance carriers to give a provider, on request, a written copy of a schedule of applicable fees for up to fifty of the most common services billed by a health care practitioner in that specialty, plus, if applicable, a description of the coding guidelines used by the carrier to increase or reduce the practitioner's level of reimbursement and/or provide a bonus or other incentive–based compensation to the practitioner.

HB1161 / SB 719: Fierce debate about this bill resulted in regulations on provider network adequacy being published by the Maryland Insurance Commission on April 11, 2008, for public comment. The bill sought to require carriers to include adequate numbers of licensed providers in its panels to increase access to services in all areas of the state.

HB 1219: Known as the "Cram-down Bill," this measure restricts insurers from requiring that providers, as a condition of participating on a panel, provide services in other panels which reimburse at a lower rate. It also requires carriers to disclose all schedules of applicable fees for up to the 20 most common services billed. A provider may terminate participation on a provider panel by notifying the carrier at least 90 days before the date of termination; for at least 90 days after the date of the notice of termination, the provider must continue to furnish health care services to an enrollee of the carrier. This was a Herculean bill which has great impact upon certain providers who have affiliated with United Health Care and others.

HB 594 / SB 595: This bill was hotly contested, and resulted in a detailed compromise. What is at issue is reimbursement for services provided after application to a panel but before acceptance or non-acceptance by that panel (which, as we know, could be months later. Anyone with questions about this should contact Capital Consultants for specific, which go on for pages.

HB 1468: The effort to eliminate tiered co-payments for outpatient mental health (eg, first five visits at 80%, next 20 at 65%, etc.) resulted in establishment of a Study; members will have an opportunity for input on this issue.

The reimbursement bills were a hotbed of activity in the legislature. They have been the source of endless hours of debate between ALL of the licensed health care providers and the insurance industry. Resolution was difficult; some bills resulted in amendments which were accepted as compromises, others were tabled until next session.

Other legislation relating to clinical social work - in the areas of taxes for designated treatment services, authority for emergency volunteer practitioners to practice, PTSD, Community Services reimbursement rates for mental health providers, treatment services for returning veterans, and involuntary commitment - these will be studied this Interim. Again, members will have the opportunity for input as individuals and/or through the Legislative Council.

Much of our advocacy work takes place during the Interim, before the next session begins. Here are the most important tasks:

- Continue to pursue data from the 7,000 clinical social workers in order to make your case before the Reimbursement Task Force;
- Participate in the various Interim Studies throughout this summer and fall (particularly the study group on elimination of Tiered Co-payments);
- Pursue activities related to the Social Worker Board's exploration of child abuse reporting; and
- Pursue issues addressed through the Task Force on the Discipline of Health Care Professionals and Improved Patient Care.

This has been a very successful year; we look forward to increased recognition in legislative circles of the value of clinical social workers' input. ❖

Named by the Daily Record as one of the "100 Top Women for 2006", Alice Neily Mutch of Capital Consultants of Maryland is a lobbyist for the coalition of Maryland and Greater Washington Clinical Social Work Societies.

■ VIRGINIA

Christopher J. Spanos

Legislators convening on January 9, 2008 for the 60-day regular session 2008 General Assembly session faced two realities as they tackled a number of potentially contentious issues: a budget shortfall and a number of new faces, including a Democratic majority in the Senate. Now, having run over their regular scheduled adjournment, they have had a special session to deal with a state-wide capital bond issue and, after a brief recess, they will return on April 23 for what is commonly referred to as a VETO session. There may be an additional session to deal with transportation, as well.

None of the legislation of this session directly affected the practice of clinical social work. However, state lawmakers unanimously approved a series of legislative reforms to the way Virginia identifies, monitors, and treats the mentally ill.

Addressing gaps in the mental health system

Passage of the mental health reform bills—a legislative priority for Kaine and lawmakers from both parties—is seen in many corners as a landmark. These measures now head to Governor Timothy M. Kaine for his signature.

The legislation, largely contained in House Bill 499 (2008) and Senate Bill 246 (2008), attempts to address a number of gaps in the system exposed last April when a mentally ill student went on a shooting rampage at Virginia Tech. Among the reforms:

- New procedures for ordering, delivering and monitoring outpatient psychiatric treatment
- Increased patient oversight by community services boards
- An expansion of how long someone can be held in emergency custody for evaluation
- Spelled-out rules on what evidence can be used during the involuntary commitment process
- Required training for community service board screeners and examiners appointed by the court
- Greater disclosure of mental-health records to authorities considering treatment and commitment of an individual

Before leaving Richmond, lawmakers appropriated $41.7 million which the Department of Mental Health, Mental Retardation and Substance Abuse Services will divvy up among localities across the state. The budget is to include the following:

- Outpatient clinicians and therapists at community services boards (CSBs): $4.5 million
- Outpatient children's mental health clinicians: $5.8 million
- Emergency services at CSBs: 15 million
- CSB case management: $8.8 million
- CSB accountability: $600,000
- Jail diversion and crisis intervention training: $6.6 million
- Expansion of licensing staff: $400,000

Reforms spark anxiety among mental health advocates

A key part of public-funded mental health treatment in Virginia is provided by 40 local CSBs which also serve the mentally retarded and those addicted to drugs and alcohol. The CSBs have been short-staffed for years, mental health advocates say.

The new legislation will, among other things, require CSB workers to spend more time monitoring patients ordered to receive mandatory outpatient treatment, and to attend all commitment hearings held across the state. Those hearings have numbered about 30,000 in recent years and are likely to increase as a result of the loosening of legal criteria under which the state can hold or treat the mentally ill against their will.

Another concern is the lack of money for additional inpatient psychiatric beds. According to a study by the Treatment Advocacy Center, Virginia have a serious bed shortage and the lack of mental hospital space in the state that has led to backlogs of patients in hospital emergency rooms.

New mandates for repairing "decades of neglect"

The legislation will, among other things:

- Lower the threshold for involuntary commitment from "imminent danger" to "substantial likelihood" of causing harm to self or others
- Improve monitoring of people under outpatient commitment orders

- Allow emergency custody to be extended from four to six hours
- Authorize mental health providers to share information
- Require independent examiners and community services board representatives to attend commitment hearings
- Require that all people who receive court-ordered mental health treatment, inpatient and outpatient, be included in a database used to screen potential gun buyers

There is a strong feeling by advocates of mental health services that true reform in the mental health services system should seek to prevent before it must treat, and focuses on individuals and their paths to recovery instead of on their illnesses. Actions taken in the 2008 session are just a first step, and regular and substantial investments are needed to turn around the "decades of neglect" that passed before the Virginia Tech shootings brought mental health concerns to the legislature's attention.

The Virginia Commission on Mental Health Law Reform plans to evaluate the new laws, particularly those concerning commitment and mandatory outpatient treatment. Implementing the new laws will also require training, coordination, and oversight. ❖

Chris Spanos is Government and Public Affairs Counselor for the coalition formed by the Virginia Society for Clinical Social Work and Greater Washington Society for Clinical Social Work.

■ DISTRICT OF COLUMBIA

Margot Aronson

"Healthy DC" is Councilmember David Catania's new proposal to make the District's health insurance market fair and accessible, and it has the potential to provide welcome relief for the thousands of District citizens (something like 45,000) who are uninsured or forced to pay exorbitant market prices for minimal coverage. Created as a partnership of CareFirst BlueCross BlueShield with the District, the plan is supposed to have premiums based on income, not age or health conditions. We hope, then, that when the details have been fully vetted, that the District will have a health insurance coverage program guaranteeing affordable, quality health care for all D.C. residents.

The Greater Washington Society for Clinical Social Work has been active in community discussions of the District's health insurance crisis over the past several years. Our advocacy efforts have primarily been focused on ensuring the inclusion of mental health in whatever plan or plans were to be proposed. Over the next weeks at the Council hearings, we'll put emphasis on issues we think are particularly important for mental health coverage: no exclusions for pre-existing conditions, for example, and reasonable reimbursement rates to ensure an adequate provider network. We'll also weigh in on the importance of a transparent process with public comments, evaluation, and progress reports.

Dr Martin Luther King, Jr., once said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." The District is taking a major and exciting step to try to overcome inequities in health care coverage. Members are encouraged to become informed and involved; email Mary Lee Stein at mlsmsw@aol.com for more information. ❖

Margot Aronson, LICSW, GWSCSW vice president for legislation and advocacy, is currently in private practice in the District.

■ FEDERAL

Laura Groshong

H.R. 5447, the *Dorothy I Height and Whitney M. Young, Jr. Social Work Reinvestment Act,* sponsored by Rep. Edolphus Towns (D-NY), is a bill which would form a commission to study social work practice and report to Congress on where there may be ways to improve retention rates and meet the anticipated increase in the need for social workers in the coming years. A companion bill, S. 2858, sponsored by Sen. Barbara Mikulski (D-MD), has also been submitted. The bills represent an opportunity for the Clinical Social Work Association to partner with the National Association of Social Workers in support of the whole profession.

An opportunity to collaborate with NASW

CSWA president Kevin Host and I had the opportunity to meet with Dr. Elizabeth Clark, NASW executive director, in Seattle on April 22 and had a long frank and collegial discussion about our mutual interests. Dr. Clark indicated she agreed with our concerns about the lack of reference to clinical social work in the bill and that she intended to have a clinical social worker included in the proposed commission when the bills are 'reported' to Congress. She also indicated that NASW was very pleased to have the chance to work with CSWA and clinical social workers as an important subspecialty of social work. We all agreed that when prominent social work organizations can work together, there is a much better chance of success. President Host and I were convinced that Dr. Clark was sincere in espousing NASW's willingness to work with CSWA and acknowledge the interests of clinical social workers.

A Legislative Alert has been sent out to CSWA members and affiliated societies, including GWSCSW, to encourage Congress to pass these bills. Please remember that the Association is a separate organization from the Society and that you need to join each organization separately. Supporting both organizations is the only way to have advocacy for clinical social work interests at the national and jurisdictional/state levels. If you have not yet joined the Association, please consider doing so at www.clinicalsocialworkassociation.org today. ❖

Laura Groshong, LICSW, is Director for Government Relations for the Clinical Social Work Association

***Privacy Privilege** , continued from page 1*

On the positive side, 17-247 can be said to represent an effort to provide CFSA with immediate access to information; the measure dramatically expands the scope of the preliminary investigation. A CFSA investigator—who previously had access to the information only of the reporter of abuse/neglect—can, with this authority, go immediately to *any Mandated Reporter* who has contact with that child to ask for information regarding the allegation. (There are about 20 categories of Mandated Reporter, such as teacher, physician, and, of course, mental health professional.)

What was negative? *All* Mandated Reporters could be required to provide an investigator with copies of *all* records pertaining to the child who was the subject of an investigation, as well as *all* records of other children at risk in the household.

This posed two serious problems. First, and of critical importance to mental health professionals, was the betrayal of children's privacy rights. There is no doubt that disclosure of confidential psychotherapy records has a chilling effect on the therapeutic relationship, if not irreparable damage to the child and family.

Further, bypassing judicial review with regard to a child's privacy rights could set a very dangerous precedent, contrary to Code of Federal Regulations 42 CFR Part 2, Section 2.63 on Confidential Communications, to the intent of the Supreme Court decision in *Jaffee v Redman*, and to the District of Columbia Mental Health Information Act.

The second problem was that the task of reproducing *all* records, which would fall to the Mandated Reporters, could be daunting, never mind the overwhelming responsibility falling to the CFSA worker to try to secure, sort, interpret, and store them, while maintaining the strictest possible confidentiality protocols.

Advocacy on two fronts

Danille Drake, our representative on the DC Confidentiality Coalition, quickly alerted psychiatrist Barry Landau, Coalition Chair. We also partnered with Professor Matt Fraidin of the University of the District of Columbia School of Law, and all of us began alerting professional colleagues of our concerns. We made multiple calls and had meetings with Council legislative staffers. Emails flew.

By the time of the First Reading, the letter we hand-delivered to Council members had been signed by the presidents of GWSCSW and NASW-DC, the Washington Psychiatric Society, and the Baltimore-Washington Institute for Psychoanalysis; it requested an exemption for mental health professionals from the record disclosure provision of the bill. We were assured that such an exemption would be offered by Councilwoman Carol Schwartz and accepted as "friendly" by Councilman Wells.

A separate letter to the Council from Professor Fraidin opened with a strong endorsement of the mental health exemption and then urged that the record disclosure requirement for other [non-mental health] Mandated Reporters be limited to records bearing directly on the specific allegations. Since the mental health exemption letter had been signed by GWSCSW president Susan Post, I co-signed this letter as GWSCSW vice president.

First Reading: disappointment

Perhaps we should not have been surprised, but we were, and disappointed, too, when the proposed Schwartz amendment was *rejected*. It was particularly frustrating given Councilwoman Schwartz's statement on introducing her amendment that CFSA had been queried and was "on board."

The one bit of good news was that Councilman Wells accepted an amendment offered by Councilman Phil Mendelson to limit the records sought by CFSA to those "bearing directly on the allegations."

Grassroots action and coalition building

In the month between First Reading and the final vote, we were increasingly active. A grassroots campaign resulted in a flurry of calls and emails thanking Councilwoman Schwartz for her support and understanding, and urging Councilman Wells to reconsider exemption of mental health professionals. Members reached out to other societies and professions, and our coalition grew dramatically.

We contacted social work ethics guru Frederic Reamer, PhD, who argued for "(1) careful screening of these requests to avoid gratuitous disclosures that could undermine client trust and (2) judicial oversight of such requests when disclosures seem to be warranted to protect a minor." He agreed that in bypassing judicial

continued on page 16

***Privacy Privilege** , continued from page 15*

review, 17-247 invites city social workers to violate their own ethical obligations in asking mental health professionals to violate theirs.

Rallying around our advocacy for mental health exemption, a coalition of anti-domestic violence advocates and legal services providers who work on behalf of DC children and families requested the Council to include substance abuse and domestic violence counselors as well. Insofar as possible, we coordinated our efforts for the good of all. When I alerted the American Civil Liberties Union of the National Capital Area to the issue, they promptly signed on with both coalitions!

As one school social worker said to me: "We work all day helping children! Tell me, how does anyone think that the wholesale undermining of child therapy will help children?"

May 5 and May 6: countdown and vote

Finally, we hand-delivered our letter with its hundred-plus signatures (see letter on the next page) and, after a meeting with Councilman Mendelson, spoke with the legislative staffers of five council members. They were supportive, but made it clear that ultimately the decision of Councilman Wells would carry the day… and his staff did not offer any hope.

You can watch it on the Internet—Google *DC Office of Cable Television 13*, click *on demand*, then find Week 1, May 6, 2:24 PM. Councilman Mendelson introduces the amendment, it is discussed, and ultimately it is withdrawn. A memo in opposition from CFSA is read. Councilman Wells notes that it has been appropriate for therapists to voice concerns about confidentiality, but that the child's safety takes priority.

What is so frustrating about 17-247

Implementation of 17-247 will have the unintended consequence of real harm to the very children that CFSA is trying to protect. The exemption we sought was not for the benefit of mental health professionals but for the clients and patients whose treatment, private space and autonomy we believe must be protected.

There is no need to betray the child's trust and his right to privileged communication in therapy, no need to open the door to potential misuse of confidential information. The great majority of abuse/neglect investigations quickly prove the allegations to be unfounded.

As Mandated Reporters, mental health professionals are *already required* to report suspected abuse, and even to write a detailed report if asked by the CFSA to do so. We let the families and children with whom we work know, right up front, that where a child's safety is concerned, we must and will report to CFSA. The information needed at the beginning of an investigation can come verbally, or even by written report, *as the law already provides*. Often, in fact, we make the report in the presence of the child, or help the child make the report; insofar as possible, that process is part of the therapy.

Disclosure of the child's confidential records is a betrayal of the child, who has come—often with great difficulty—to trust the safe environment of the therapy office. Happily, in those cases when treatment records are needed, the District has a process for judicial review as an investigation progresses; it is already in place and effective. Unhappily, this law bypasses that process.

Even so, we can celebrate…

With our perseverance, we gave the amendment the best possible chance for consideration and passage. And, thanks to our advocacy, a dangerously broad measure has been narrowed to focus on records that might be relevant and useful, and the judgment about what is relevant is in the hands of the Mandated Reporter.

To those of you who emailed or called, your grassroots efforts really made an impression; our meetings with staffers were possible only because you had Council members wanting to know more about the issue. In the long run, we've made Society and the views of clinical social workers known to the Council, which could be advantageous in the future.

In the next issue of *News & Views,* we'll look at the final wording of the law, and how clinical social workers can respond—ethically—to its requirements. ❖

Coalition to Protect the Privacy Rights of Children and Families

We the undersigned strongly urge the Council to exempt mental health professionals from the record disclosure requirements of Bill 17-247.

As written, the proposed Child Abuse and Neglect Investigation Record Access Amendment Act of 2008 (Bill 17-247) violates long-established principles of privacy of mental health records, unnecessarily invades the child's right to privileged communication, and opens the door to potential misuse of confidential information.

The requirement of disclosure of psychotherapy records at the onset of an investigation of child abuse or neglect -- without judicial review -- has disturbing implications:

- Disclosure of confidential records is known to have a profoundly chilling effect on the treatment relationship between child and psychotherapist. Damage to the family and child's trust in therapy may be irreparable, and bring an end to needed treatment for the child.
- The proposed amendment risks a repetition of the abuse trauma itself, because the private space of the child is once again invaded, leaving the child helpless and without a safe space.
- To bypass the judicial review with regard to a child's psychotherapy records would set a dangerous precedent which is contrary to the intent of the U.S. Supreme Court's decision in *Jaffee v Redmond* as well as the District of Columbia Mental Health Privacy Information Act.
- Compliance with the requirement to disclose psychotherapy records without judicial review would place mental health professionals in violation of the ethical codes and accepted standards of care required by each of the clinical mental health professions.

In fact, the measure is excessive with regard to the records of mental health

professionals. As mandated reporters, mental health professionals are already required to make reports of the nature and extent of suspected abuse or neglect of children. In the great majority of abuse/neglect investigations, allegations prove to be unfounded. District law already provides that, as an investigation progresses, the decision about specific treatment records or any other information needed by Child and Family Services Agency (CFSA) can be made at the discretion of a judge in the privacy of a closed courtroom. This process is already in place.

An amendment exempting mental health professionals from the record disclosure requirements of Bill 17-247 would prevent the unintended consequence of harming the very children that the bill means to protect. Psychotherapy records should not be sought at the outset of an investigation, nor should they be disclosed without judicial review.

ORGANIZATIONS
Greater Washington Society for Clinical Social Work
National Association of Social Workers DC-Metro Chapter
Washington Psychiatric Society
Child and Adolescent Psychiatric Society of Greater Washington
Baltimore-Washington Society for Psychoanalysis
Accreditation Council for Psychoanalytic Education
American Psychoanalytic Association
American Civil Liberties Union of the National Capital Area
Association for Psychoanalytic Thought
District of Columbia Psychological Association
In addition to the organizations,
115 social workers, psychiatrists, psychologists and others signed onto this letter.

CLINICIANS & MONEY

Nine Steps to Debt Reduction

by Peter Cole, ChFC, LCSW

Peter Cole

Credit cards are to personal finance what cigarettes are to your health. My wife smokes one cigarette a day at most. She goes days without any cigarettes at all. The five cigarettes she has per week hopefully are not excessively harmful. I, on the other hand, used to be a two-pack-a-day Camel Filters man. Now I do not smoke at all, because I know that I cannot smoke in moderation. The point is that if you can handle credit cards without carrying forward a balance, they are fine. However, if you are carrying thousands of dollars of credit card debt over time, you might want to seek help in getting the credit card monkey off your back.

As clinical social workers, we all know that behavior is a tough thing to change. You are also probably aware that ongoing credit card debt is bad for your financial health. Just in case you are in denial, however, here is some information to consider. According to CardWeb.com, in 2001 the average American carried a credit card balance of $8,400. If you carry an $8,400 balance that is charged interest at 20% per year, you are paying $1,680 annually in interest alone. That does not include the many expenses and late charges that are larded onto most credit cards.

Don't let yourself be seduced and then ripped off by the credit card industry. Let's say you are 40 years old and could invest that $1,680 into an IRA each year at a 6% annual return until you retire at age 65. At retirement, you would have over $102,000 in your IRA. When you carry credit card debt, not only are you paying out exorbitant fees, but you are paying in lost opportunities to invest in yourself for your retirement or other life goals.

Like the cigarette companies, the credit card companies are simply offering you the right as an American to exercise your freedom to choose. Fair enough. But also like the cigarette companies, they target young people and manipulate the consumer with sophisticated and misleading marketing. To put it bluntly, the credit card companies are not your friends. They make money by seducing consumers into overspending and then charging extremely high interest and fees.

Dr. Eric Hollander, a highly respected researcher at the Mt. Sinai School of Medicine in New York, is studying the question of whether to include compulsive shopping as an impulse disorder in the *Diagnostic and Statistical Manual of Mental Disorders*. In an interview with National Public Radio's "Talk of the Nation," Dr. Hollander stated that many people think of compulsive shopping as a trivial problem, in that we relate it to the normal pleasure we all find in making a purchase. These behaviors are frequently hidden from family and friends and can cause individuals and families significant distress. One difficulty is that some people who have this condition have spent down the financial resources with which they might otherwise seek out psychotherapy.

In my view, the credit card industry has taken advantage of many individuals who are susceptible to these kinds of impulse control problems as well as people without serious impulse control issues who are simply encouraged on a daily basis to use consumer credit without thinking. It is an unfortunate fact of life in modern America that there are many corporate interests who try daily to benefit from individual susceptibility to credit card spending. Getting off of the credit card habit is a little like quitting junk food: everywhere you turn, you are invited to spend impulsively, just as the innumerable junk food outlets you encounter daily invite you to eat impulsively and without thought.

When I was a smoker, I used think of my familiar Camel Filters as a kind of friend. Now I think of them as an adversary. I think this kind of cognitive reframing may be useful with regard to credit card use. In modern America, it is just about impossible not to use plastic. But if you think of consumer credit as your adversary rather than your friend, it will begin to put you in a more realistic frame of mind with regard to your spending. When you use plastic, it is best to have an arrangement where you are limited to the funds you have available. If you are using credit to get airline

miles, be sure to pay those balances off each month if you possibly can. It will be a lot cheaper for you to buy your tickets online and pay the balance in full than it will be to pay upwards of 20% on revolving credit and more on top of that in various fees.

If you have determined that you want to work on your credit card spending, here are some practical steps you can take.

1. Make a fearless and searching inventory of your credit card debt. Study your balances along with the interest and fees you are paying. If you find that that this step causes a great deal of anxiety, then you might want to get support from a trusted friend who will simply sit with you while you look carefully over your balances.
2. Resolve that you will only use your credit for emergencies. If you can't afford it, then don't buy it. Save money until you can pay for it in cash.
3. List the cards by the interest rates they charge, ranking them from lowest to highest.
4. If you have a credit card with an interest rate of, at most, 14%, move your balances to that card. If you do not have a card with a low interest rate but you have the credit standing to be issued a card with more favorable terms, go to CardWeb.com to compare credit card options. Get a card with a lower interest rate and transfer your high-interest card balances to that card.
5. Determine the maximum you can to afford to pay each month to reduce your card balances. Resolve to pay at least 2.5% of the balance each month. If you pay only the minimum, it will take a very long time, and a great deal in interest payments, to get to a zero balance. How much could you pay if you absolutely had to: $500, $750, $1,000?
6. When paying off credit card debt, pay off your cards with the highest interest rate first and work your way to the lower rate cards.
7. Many cards have low introductory fees. If you want to be aggressive, move your credit card balances to one of these cards, and pay aggressively for those first six months.
8. Refinancing your home usually offers a more favorable interest rate, so move the money into mortgage financing debt. But be careful not to run the credit card balances up again!
9. Hang in there! Carrying credit card debt is seductive and ultimately damaging financially. Do not give up. You can get the credit card monkey off your back, but it will not come easily.

Remember, the best time to start financial planning is ten years ago. The second best time is now. Good luck, and call or email me if you have any feedback or questions. ❖

Peter Cole, LCSW, is a Chartered Financial Consultant, director of Insight Financial Group, and Clinical Professor of Psychiatry at the University of California Davis School of Medicine. He is the author of Mastering The Financial Dimension of Your Practice: The Definitive Guide to Private Practice Development and Financial Planning (Brunner Routledge) and True Self, True Wealth (Simon & Schuster). Peter can be reached at (800) 426-1399 or www.trueselftruewealth.com.

COMMITTEE REPORTS

Continuing Education

Ted Billings
ted.billings@gmail.com

This spring, we have been busily planning the course offerings for our 2008-2009 series and hope to have a brochure out to you in the early summer. New committee member, Flora Ingenhousz circulated a survey on the listserv soliciting recommendations from members for course subjects, times and length. We were very pleased with the response, thank you, and used the information in developing our curriculum for next year.

We are going to try something new next year by organizing the courses around a central theme. Next year it will be "The Brain." The committee is actively recruiting instructors who will be able to link recent advances in neuroscience to clinical social work. We hope to have offerings on a variety of topics including basic brain function, neurofeedback in clinical practice, and how neuroscience informs psychodynamic, and family and systems theory.

We will also be offering basic courses our members need for licensure. Carolyn Gruber will teach a class on ethics and we hope to have several sections of supervision.

Please feel free to contact any of the members of the committee with comments or suggestions for our continuing education program.

Ethics

Judy Gallant
jg708@columbia.edu

Following are sites for Codes of Ethics that our members may use. You are only bound by the Codes of those organizations of which you are a member, or licensed. If there are other organizations you feel it would be helpful to add to this list of resources, please contact Judy Gallant.

NASW: www.socialworkers.org/pubs/code/code.asp

Clinical Social Work Association: www.cswf.org

American Board of Examiners in Clinical Social Work: www.abecsw.org/about-code-ethics.php

Maryland Board of Social Work Examiners, Code of Maryland Regulations (Title 19 COMAR 10.49 Chapters .01 to .08): www.dsd.state.md.us./comar/

Social workers licensed by DC and Virginia use the NASW Code of Ethics.

International Federation of Social Work: www.ifsw.org/en/p38000324.html

American Psychoanalytic Association: www.apsa.org/ABOUTAPSAA/ETHICSCODE/tabid/200/Default.aspx

Child Protective Services: A Guide for Caseworkers. Based on NASW Code of Ethics, applied specifically to child protective workers: www.childwelfare.gov/pubs/usermanuals/cps/cpsq.cfm

Karen Prince is the newest member of the Ethics Committee, and we wanted to introduce her in this report. Karen graduated from Syracuse University's School of Social Work in 1979. She has worked with children, adolescents, couples and families in a variety of settings, including Children's National Medical Center, The Center for Family Research at George Washington University Medical Center, and the Center for Adoption Support and Education. Karen has participated in extramural research studies, conducted workshops, and published on issues related to families with children facing chronic illnesses and physical disabilities. She is currently in private practice, where she specializes in couples and family therapy and treating children and adults with anxiety and depression.

Legislative & Advocacy

Margot Aronson
malevin@erols.com

As our newsletter deadline approaches, the committee is focused on preserving the privacy privilege for the children of DC. We lobbied the Council effectively to narrow the scope of DC Bill 17-247, but are still working to retain the long-standing protections afforded to psychotherapy records.

Thanks to you very responsive Society members, we can be proud of our highly effective grassroots call-in and email campaign focused on

those Council members specifically involved in decision-making on the bill. We've got their attention! We've also taken the lead in alerting other mental health and community organizations to the issue; met with Council legislative staff; coordinated with other groups to produce a sign-on letter, and made innumerable phone calls.

At the same time, we're busy participating in community discussions of "Healthy DC' – a joint DC and CareFirst health care insurance plan designed to cover DC's 45,000 uninsured. Our primary concern is that affordable quality mental health treatment be an intrinsic part of the plan.

Our most exciting news is that we've accepted an intern from Howard University for our Maryland coalition (the Legislative Council). Second year MSW student Novlett Lewis will start her internship in the Fall, but has, on her own, been spending time with our lobbyist, Alice Neily Mutch, learning her way around Annapolis and the Assembly.

Our efforts in Maryland and Virginia are described in the Legislative pages of this newsletter issue. We continue to depend upon a few committee members, and burnout is around the corner. In Maryland we are embarrassingly dependent upon the active participation of the Maryland Society, and we don't pull our weight in our own highly-important and influential Prince George's and Montgomery Counties. Two or three folks in each jurisdiction could make all the difference—and I guarantee that you'll find it interesting and fun. Call me at 202-966/7749 or email malevin@erols.com to learn more!

Membership

Melinda Salzman
salzmanmsw@starpower.net

Our annual Tea drew some forty members to Patricia Garcia Golding's beautiful home in DC. We were delighted by the response to our first ever Evite, designed by the tech savvy Gwen Pla. Susan Marks and Jane Morse supplied an array of tea treats and Janet Connors, Joan Fishbein, Meredith McEver, Gwen Pla, Sue Stevens and Melinda Salzman came early and stayed late to set up and clean up.

The introductions and discussion session highlighted both the work of Society committees and the broad range of individual interests and skills of our membership. The collective expertise of our Society was in evidence.

As part of our outreach to students, Sue Stevens represented the Society at the annual Career Fair held at Catholic University for graduating social workers from Catholic and Howard. Sue, a veteran of this event, reports "It's always fun to learn about job opportunities for social workers and especially to let grads know about the many benefits of Society membership." Each year, the society sends gift certificates to local graduates which can be applied toward Society membership and activities.

The committee bids farewell to Joan Fishbein and Susan Marks, as they move on to other activities. Joan has been the friendly voice on the phone greeting many new members. Susan, who has served on the committee for several years, has stepped up in many capacities and most recently has been reaching out to students at VCU. We are grateful to both of them for their many contributions.

Mentor

Sheila Rowny
srowny@aol.com

On April 6 the Mentor Committee sponsored a panel discussion: "Getting Started in Private Practice". The four panelists, who generously donated their time on a Sunday afternoon, were Deborah Blessing, Jonah Green, Gloria Mog and Britt Rathbone. They shared their career experiences and offered valuable guidance to the 17 members of the GWSCSW who attended. This was the second time this workshop was offered, and based on the enthusiastic feedback of the participants we plan to organize another one in the future.

In other committee news, Betsy Carmichael has organized a peer support group of recent MSW graduates. This exciting new support group has already attracted 25 interested members. Please contact Betsy if you are interested in this group.

Last month on our listserv, Jewel Elizabeth Golden wrote eloquently of her experience as a mentor. Jewel has generously given permission to reprint her endorsement of serving as a mentor in this column. It is printed below:

"I'd like to make a pitch for mentoring. It is one of the activities I am engaged in where I can make a significant, and a very personal, contribution to our profession.

Yesterday, NASW-DC, at their Awards Luncheon, gave the Social Worker of the Year award to a young Social Worker, Susan Johnson who is involved in DC Mental Health and the DC Public Schools. She is a graduate of Howard. She

continued on page 22

Welcome New Members!

Full Members:

Karen Brandt

Eileen Dombo

Laurie Emmer-Martin

Mary Lee Esty

Sydney Frymire

Christine Jackson

Ana L. Pavia

Pam Thielmann

Daniel W. Wilson

Jennifer Wofford

Andrea Yudell

Graduate Members:

Melissa Beck

El-Kahina Hunt

Mary Jaquelin Simons

Lisa Wilson

Student Members:

Gretchen Fair

Amy Greenslit

Kathleen Nardella

Pamela Newman

Alicia Funes Nguyen

Ann Reilly

Elizabeth Draddy Vangaever

Carolina Villamil

Oksana Zadorojnaya

***Committee Reports**, from page 21*

is bright, creative, caring and a very hard worker.

And I am her Mentor. And I got to be a guest at the luncheon where she was honored. And I experienced the feeling of pride at what she has accomplished. And the wonderful feeling of passing on the quality experiences that were passed on to me."

Anyone who would like to volunteer to be a mentor for GWSCSW members, or anyone who would like to request a mentor, can download an application from the Mentor page of GWSCSW.org and mail it to Sheila Rowny.

Members who would like to participate on the committee can contact Sheila Rowny at 301.365.5823 or sheila@rowny.com.

Newsletter

Jen Kogan
koganblackwell@verizon.net

This newsletter issue is filled with samples of our membership's diverse interests and experience. Please continue to send us your news and views regarding special interests and practice areas. All viewpoints are welcome. The deadline for the September issue is July 20 .

Many thanks to Jonah Green for pitching in with editing this issue. His expertise was much appreciated. As always, a tip of the hat to Jan Sklennik for working her magic transforming individual articles into the newsletter as you read it. Thanks also to proofreaders, Kim Yamas and Alicia George, and to Beth Altman for taking photos for *News & Views!*

Programs

Joel Kanter
joel.kanter@gmail.com

The GWS Program Committee has been meeting regularly to plan an array of events for the Society. Chaired by Joel Kanter, Education Vice-President, membership includes Kate Rossier, Tish Reilly, Adele Redisch, Monica Glatt, Tina Levin and Jan Freeman. Recent events have included a brownbag lunch meeting at VCU School for Social Work on the HBO series, "In Treatment", a theater party to see the Arthur Miller play "The Price", and a dinner meeting with Gerald Schamess from Smith College as the presenter.

We are currently scheduling educational and social activities for the 2008-2009 year. These will include four informal brownbag lunch meetings in both Northern Virginia and Maryland/DC where GWS members will share practice ideas in a collegial setting. If you are interested in presenting at one of these meetings, or have other ideas for speakers or programs, please contact any of the members of the committee.

Referral Panel

Beth Altman
202-775-0041

The Referral Panel Committee is exploring different ways of increasing its visibility. Committee members are Mary Smith, Leslie Hunter, and Beth Altman. If you would like to join us, please call Beth Altman at 202-775-0041. ❖

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, PO Box 3235, Oakton VA 22124 or gwscsw@gmail.com. For questions about advertising, call 202-537-0007.

Classified Ads: 75¢ per word
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Horizontal: 7 wide x 4½ high
Vertical: 3⅜ 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 (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

ARLINGTON/ALEXANDRIA - At I-395, Shirlington. Full-time part-time offices in suite with other therapists. Furnished or unfurnished. Waiting room, kitchen, copier, fax. Other amenities: pool, tennis, exercise room and sauna. Convenient to DC, Maryland, Old Town, Pentagon, Crystal City. On Metro and DASH bus lines. Call Helen Reznick, PhD, at 703-379-9520 x2.

BETHESDA: Furnished, cozy office in suite to sublet Monday and Thursday mornings, all day/evenings Tuesday, Wednesday, Friday and Saturday. Minimum of four-hour blocks. Great location, walking distance to Bethesda Metro. Contact Marjorie Swett at 301-718-8075.

BETHESDA – Beautiful 657 sq/ft office in downtown Bethesda. Large windows, separate waiting room and access to kitchen. One office in two office suite. Other office occupied by full time practicing psychotherapist, separate waiting room. Small professional office building steps from shopping and restaurants. Ample parking. $1300 per month. 301-656-5776 or lmr6917@aol.com.

CHEVY CHASE DC – Sunny, large office at Connecticut & Nebraska Avenues with parking for clinician; plenty of street parking for clients. Kitchen, two bathrooms, spacious waiting room, full-time concierge. Many hours and days available. Call Deborah, 301-986-0099.

McLEAN – Part-time sublease.Spacious, sunny corner office, window walls, beautifully furnished, tastefully appointed. Shared waiting room. Landmark building, plentiful free parking, wheelchair accessible. 301-320-5659.

STERLING – Full time office available in Countryside for self-employed practitioner in well established practice. Call Mary Combemale, 703-404-1904.

TYSONS: Windowed ground floor office in suite of independent psychotherapy practices. Great Tysons location. Contact Bill McLaughlin at 703-448-8450.

WOODLEY PARK: Wonderful town house, steps away from Woodley park metro. Large sun-filled office in suite; available full or part time. parking space for therapist. email: rosaliem@aol.com

TRAINING

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.

GROUPS

ADOLESCENT THERAPY GROUPS: Ongoing psychotherapy groups for adolescents 11-22, meeting through summer. Offices in Bethesda and Rockville. Rathbone & Associates. 301-230-9490. www.rathone.info.

FREE PEER SUPPORT GROUPS: For children or adolescents who have experienced significant loss (death, divorce, other separation) in Silver Spring. Call RAINBOWS MD/DC Chapter at 301-495-0051.

■ 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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Other: _____

_____

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Fax to: 703-938-8389 or Mail to: GWSCSW, PO Box 3235, Oakton VA 22124 ■ Email info to: gwscsw@gmail.com

NEW MEMBERS!
THIS IS A GREAT OPPORTUNITY TO MEET AND NETWORK WITH GWSCSW MEMBERS. WE HOPE TO SEE YOU THERE!

GWSCSW Annual Meeting Party & Dinner

Friday, June 13 at 6:30 pm

Fabulous Food Potluck Dinner!

Choose one to bring:

Appetizer

Entrée

Side / Salad

Dessert

Wine and soft drinks will be provided

RSVP by June 6
gwscsw@gmail.com
202-537-0007
Let us know what you will be bringing!

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