NEWSLETTER

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC. SUMMER 1993 • VOL. XXIV, NO. 2

ANNUAL MEETING REPORT

Managed Care: Speakers Stress Requirements of Process

Joining the Ranks, Meeting the Needs

By Anne L. Cunynghame, MPH, ACSW, CAC, BCD

On May 8th, the State Society's conference on "Negotiating the Maze of Managed Care" featured two keynote speakers who represent different but complementary perspectives. Elizabeth Neuwirth, MS, Corporate Vice President for Operations Policy and Staff Development – Preferred Health Care, and formerly a psychoanalyst, discussed "What Does Managed Care Want From Us? A Psychotherapist's Guide to Survival." The second keynoter, Maurie C. Cullen, MSW, BCD, a Californian and leading marketing consultant and lecturer on managed care, addressed "A Provider's View of Managed Care: Positive Business Strategies for Clinical Social Work Practice."

The Employer Pays—and Makes the Rules

Ms. Neuwirth stressed medical necessity, the cornerstone of managed care, and elucidated four elements required for establishing medical necessity:

1. There must be an assessment and a diagnosis. The recommended treatment must be adequate as to quality, thoroughness and appropriateness, and must be essential, that is, at the right level, not too little, not too much.
2. The care must conform to U.S. standards of practice; the provider must be licensed (or otherwise credentialed).
3. The care must be at the most cost-effective level.
4. The treatment should be expected to result in improved functioning and lead to termination.

Utilization review is also vital to the managed care process. Provider and managed care representative assess the patient's condition to determine the appropriate intensity of treatment. To be effective in this exchange, the provider must think in terms of function and dysfunction. What is the patient's difficulty? Is it a sexual problem? An eating disorder? Substance abuse? Disabling depression? Panic attacks? Once the problem is identified, the patient's

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25th Annual Meeting—1993

The 25th Anniversary Annual Meeting of the State Society took place May 8th at the Marriott Marquis Hotel in Manhattan. The large turnout of more than 200 testified to the crucial importance of the topic to clinical social workers. The day-long event addressed "Negotiating the Maze of Managed Care" and was sponsored by the Society's education committee at the direction of Diane Heller Kaminsky.

The morning session included an introduction and welcome by the education chair and by President David G. Phillips, DSW, who introduced special guests and committee chairs. Committee reports and presentations to successful Diplomate candidates as well as special recognition of Mitzi Mirkin, executive secretary, preceded the two keynote speakers. After-lunch workshops covered a variety of topics surrounding the issue off managed care as it impacts on clinical practice. Reviews of several workshops appear in this issue.

Court Upholds Value of Forensic Expertise by Clinical Social Workers

By Betty Gewirtz, CSW, BCD

The status of clinical social work as a distinct specialty within the social work profession and the role of clinical social workers as providers of forensic mental health services were affirmed on June 16, 1993 in a decision by Judge Budd Goodman of the New York State Supreme Court in *Matter of the Application of the Director of the Assigned Counsel Plan.* Under New York State law, judges are required to determine *reasonable compensation* for expert services rendered to indigent defendants and to direct payment to those experts. New York City recommended a rate of compensation for psychiatrists of $125 per hour, for psychologists of $90 per hour and for certified social workers of $45 per hour. When Judge Goodman approved an hourly rate of $100

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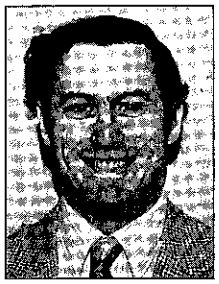
Clinical Documentation and Recordkeeping

By Hillel Bodek, MSW, CSW, BCD



The first part of this series discussed the legal requirement for clinical recordkeeping, the seven key purposes of clinical documentation and the nine elements of good clinical documentation. This second and concluding article addresses the essential components of an initial assessment, the key ingredients of a good progress note and the role of clinical documentation in assuring quality clinical social work services.

The Society's definition of clinical social work states, in pertinent part, that "clinical social work practice methods and approaches include . . . differential diagnostic assessment and treatment planning . . . implementation of appropriate assessment-based treatment plans, including brief and long-term psychotherapy with individuals, couples, families and groups, habilitation, crisis intervention, hypnosis, biofeedback, patient education and client-centered advocacy . . . ." Professional practice standards require that clinical social work treatment be based on a proper differential diagnostic assessment and be implemented in a planned manner with identified goals, methods, time frames and criteria to measure its efficacy and appropriateness.

Elements of an Initial Assessment

An initial differential diagnostic assessment, which may be abbreviated or elongated depending on the circumstances of a particular case, provides the basis for the development and implementation of the treatment plan. As with any other area of clinical practice, lack of a proper clinical assessment is likely to result in less than optimal and perhaps even inadequate or inappropriate treatment. Thus, the failure to conduct an appropriate differential diagnostic assessment is a serious deviation from the standard of care owed by a clinical social worker to a patient. The conduct and documentation of a proper initial assessment includes:

A. **identification of the referral source(s),** gathering information about the background and reasons for the referral and assessing the patient's response to and expectations with regard to the referral;

B. **defining the presenting problem(s),** both in the patient's own words, as well as in terms of the clinician's perception of the presenting problem(s);

C. **detailing the history and clinical course of presenting problem(s),** and the details of services and treatment the patient has sought or received to deal with that problem;

D. **gathering relevant history** (family, medical and psychiatric, history of substance abuse, educational/occupational, interpersonal relationships, etc.) and material from the patient and from collateral sources, in appropriate detail, by topic, identifying the sources of such historical information;

E. **describing the clinician's observations of the patient(s),** interview data, mental status examination and material received from collateral sources;

F. **detailing prior clinical services,** the background and reasons therefor, the results of such services and the reason(s) for termination of those services;

G. **making a differential assessment: a bio-psycho-social diagnosis,** 1) in functional as well as diagnostic terms, 2) distinguishing between observations, hard data and opinions, 3) supporting generalizations and conclusions, and 4) determining the degree of confidence in the assessment;

H. **developing an initial differential treatment/service plan** with identified goals, methods to be used, time frames and standards to measure treatment progress in functional terms, with a rationale for prioritizing of treatment goals and for the choice from among various treatment alternatives and strategies;

I. **assessment of prognosis with supporting rationale;** and

J. **describing the patient's response to the assessment** and to the proposed treatment plan and, if the patient agrees to proceed with that plan, obtaining informed consent for implementation of that plan.

Elements of a Progress Note

Ongoing clinical social work services should be documented, keeping in mind the seven key purposes of clinical documentation and nine elements of good clinical documentation set forth in Part 1. Depending on the evolving circumstances of each case, certain purposes of documentation will be more important than others at various points in treatment. For instance, if a patient's mental status deteriorates and he or she becomes threatening, the purpose of carefully documenting the clinician's professional response and clinical decision-making and the purpose of risk management/malpractice protection will predominate. In a case in which a patient who has significant medical, family and mental health problems is being served by several different professionals, documentation geared toward the purpose of coordination of professional efforts will predominate. A proper progress note which need not be particularly extensive—in most cases merely several sentences—should include:

1. the date of the contact
2. description of the type of contact (i.e., in person, telephone)
3. indication of who initiated the contact (i.e., regularly scheduled session, phone call by patient's family, inquiry from another clinician/service provider)
4. statement of where the contact took place (i.e., office; or if at home, the address; if by phone, the phone number called)
5. indication of who was involved in the contact (i.e., patient, family, other clinician, family friend)
6. a description of the themes of the contact
7. details of any new significant history obtained
8. details and description of relevant problems newly identified and/or significant new events
9. description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances
10. statement of what was accomplished in the session
11. statement of what was not accomplished in the session that requires follow-up
12. details of obstacles noted to progress in treatment, if any, and a plan to address these, and
13. description of a plan for further care, changes in treatment plan/goals and reasoning to support these, particularly in response to crisis situations or

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Managed Care: Advocate vs. Adversary

By Mark Dworkin, CSW, BCD
Chair, Managed Care Committee

The business [yes, business] of health care and mental health care delivery continues to change. Sadly, many Society members feel rudely awakened and are crying out for action. Action is already under way—but it is action to work with the managed care movement and with government.

Clinicians must replace the adversarial relationship between provider groups and the managed care industry with a collaborative effort, working together with mutual understanding.

Managed care organizations want small panels of qualified providers to whom they can refer patients; this allows better management of their networks. From a business point of view this is logical and understandable. From a patient care viewpoint, however—especially from the perspective of the patient—he or she must have the freedom to choose the therapist with whom she or he feels comfortable. The Society understands the business point of view but disagrees and strongly advocates for freedom of choice for the patient.

In most cases managed care pushes for brief therapy. This too is understandable; there is a shrinking health care dollar and this industry sees itself as the watchdog—budgeting for crises and taking care of the seriously mentally ill. We, in our offices, know firsthand the suffering that people bring to therapists; implicit in this relationship is trust—that as clinicians we will use our best judgment in terms of treatment modality. Obviously some modalities take longer to implement than others. We see as our responsibility the need to explain to managed care why in each case we have chosen a certain modality based upon the individual need of the patient.

Each managed care company has its own way of conducting utilization review: length of stay, number of visits certified, during what period, etc. This diversity creates an intolerable burden for therapists. We strongly advocate for state-regulated uniform standards. Moreover, managed care contracts include "hold harmless" clauses to indemnify a company from risk. We see this as a shift in risk to the provider. This is unacceptable.

Finally, and sadly again, insurance pays for illness. Illness is defined as *time limited,* with specific procedures performed by an *expert* to *remediate the problem.* This means, it would appear, that insurance—with managed care as the enforcer—no longer pays for what we know as psychotherapy but rather for psychosocial rehabilitation, which is the remediation of symptoms due to Axix IV stressors (in the DSM III-R). Currently there is nothing we can do about this except present research proving that the longer term ego reconstructing therapies are the proper course of action for the specific problems presented to therapists.

Trying to tear down the managed care industry is a waste of valuable time and energy, Rather, the following offer the clearest strategies for moving forward:

- informing the consumer about choice and limits
- advocating for the patient
- having protection under the law to argue a point without the threat of dismissal from a panel
- working for freedom of choice of provider and modality
- establishment of uniform standards
- dialog with the business community.

In the late fall/early winter we will be holding "town meetings," locally and Upstate. These meetings will review the State Society's platform and ask for input on the direction members wish the Society to take. Members' opinions will be solicited on how to move mental health care delivery forward in today's climate. Interested participants may prepare position papers or present short addresses. Look for notification of date, time and place. Paid-up members only, please! □

DOCUMENTATION *(Continued)*

special/markedly changed circumstances.

Thought and reflection are requisites for producing an accurate initial assessment and an informative progress note. Having to prepare proper clinical documentation serves an important role of helping assure quality patient care by making clinicians think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work and weigh alternative approaches to the care of their patients. The capacity for professional self-reflection and self-appraisal of one's professional work is essential to a clinical social worker's professional development, to the maintenance of their professional skills and to their provision of high quality clinical services. Rather than viewing clinical documentation as a meaningless chore that consumes precious time, clinical social workers should view it in this light, as a form of self-supervision that is an essential element of their professional practice and of their provision of quality clinical services. □

Corrections

The following are corrections to the article, "Clinical Documentation and Recordkeeping," that appeared in the Spring 1993 issue. Editing to accommodate limited space resulted in the change in exact meaning. The corrections follow, as requested by the writer, Hillel Bodek, CSW.

The first sentence of the second paragraph should read:

The Rules of the Board of Regents defining unprofessional conduct define unprofessional conduct by a health care professional as including, "failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years." 8 NYCRR 29.2(a)(3).

The third paragraph should read:

Clinical documentation and record-keeping are often viewed as a chore, yet another burden heaped upon health care professionals. However, clinical documentation and record-keeping serve several important purposes, most of which are equally applicable to agency as well as private practice settings. The seven key purposes of clinical documentation are:

The next to last paragraph should read:

Good clinical documentation 1) provides relevant information in appropriate detail, 2) is organized with appropriate headings and logical progression, 3) is thoughtful, reflecting the application of professional knowledge, skills and judgement in the treatment/services provided, 4) is appropriately concise, 5) serves the purposes of documentation (as outlined above) that are applicable to a given situation, 6) uses relevant direct quotes from the patient and other sources, 7) distinguishes clearly between facts, observations, hard data and opinions, 8) is internally consistent, and 9) is written in the present tense, as appropriate.

WORKSHOP

Practice Opportunities in a Managed Care Environment

By Donald S. Cornelius, CSW, BCD

Opportunity is hardly a word typically associated with managed care. The more common experience is the loss of autonomy in the conduct of our practices and limitations on our access to clients because of closed provider networks. Those clinicians currently working under the managed care umbrella are being challenged to treat serious problems in briefer encounters with clients and are burdened with administrative details. The threats to professional integrity and livelihood are real.

Yet to focus solely on these challenges may put clinical social work in a position of not preparing adequately for the decade ahead. Managed care as currently configured is not a permanent fixture. It is only part of the larger experiment in health care reform. This is an essential perspective in securing a place for social work in the evolving health care system.

No one knows at this juncture what reformed health care will look like. However, several common themes are now apparent. There will be universal access. Every citizen will be covered by some basic package of benefits. Mental healthcare, while likely to be restricted, will be part of the basic benefit. The disparity between private and public, Medicare and Medicaid, sponsored benefits will gradually disappear.

Reform should radically expand the potential client base for social work health care services.

Strategies to ensure cost effectiveness and efficiency will be real. The consumer will have incentives to access the level of care most appropriate to the level of the disorder. For example, problems in living and mental disorders amenable to talk therapy will not be referred to clinicians with medical credentials. Clinical social work has a firm presence in the field of mental health and the social worker will be seen as a cost effective provider of choice.

Utilization management and the triage of care will apply to all levels of health care services. Verification of need and establishment of medical necessity will be standard procedures. On the one hand this will likely limit the use of open-ended ego reconstructive psychotherapies as a covered benefit; at the same time, however, those suffering from mental disorders will be more likely to receive needed care. Social work stands to gain as more people are referred for mental health treatment.

The concept of health care is expanding beyond the narrow bounds of medical procedures and clinical interventions. There is a growing awareness of the biopsychosocial dynamic to the quality of a healthy life. Prevention, now largely neglected, will be given a greater share of resources.

For the field of social work, such an orientation is not new. The profession has a long history of practical and theoretical experience working with individuals and communities from the psychosocial perspective of care. The other health care professions are only beginning to develop this expertise. Social work has the opportunity to put its imprint on this more comprehensive notion of well-being.

Awareness of opportunity is one thing—taking advantage is another. The following comments are offered as suggestions for possible action.

- It is important to nurture your current practice. Reform is not likely to move as quickly as the rhetoric. There is time to think, plan and consider a response. Panic is not conducive to creativity.
- Develop a special expertise on the mental health continuum of care. The general practice of psychotherapy is not a specialty. Referrals will go to clinicians who have proven track records with specific problems or populations: eating disorders, behavioral medicine, reconstituted families, individuals newly discharged from the hospital, etc.
- Think programmatically. Care will need organization so that the consumer, both the client and the payer, will know what service will be offered, how long it might take to complete and how the service is to be evaluated. Providers will be asked to demonstrate through outcome their effectiveness in addressing the presenting problem.
- Network. While micro management of care is likely to decrease, paper work and administrative tasks will not. Practitioners may find it advantageous to form group practices for self-preservation, ensuring the needed support staff, computers and the electronic billing that will follow. Groups have more visibility in the marketplace and greater flexibility in establishing a niche on the continuum of care.
- Aggressively market the self-pay client. Last year consumers spent $13.6 billion on self-directed health care. The benefits of long term psychodynamically oriented therapies will have to be shown to the public. People will select this form of treatment and self-pay if they understand its value.
- Do not expect a great deal of relief from attempts to regulate managed care. The essential character of the industry will not be significantly altered. Use your energy and experience to build a practice that will validate the perspective of social work in setting the health care agenda. The field is open for imaginative ways of providing care; there are many opportunities to grasp.

Donald S. Cornelius CSW, BCD, is director of research and program development, Behavioral Counseling Associates of Long Island, P.C.

COMPATIBLE *(continued)*

Care and Psychoanalytically Oriented Psychotherapy: Professional Culture Clash and Transference," compared the conceptual base of psychoanalytically informed psychotherapy with that of managed care, concluding that they were rooted in incompatible systems—one in psychoanalysis and the other in business. Differences were emphasized between these cultures in the meaning of time, therapeutic goal and clinical role. Dr. Schechter presented case material to illustrate these differences in addition to the impact of managed care on transference.

Patsy Turrini, in "Internal and External Voices: Overcoming Fear, Sadism, and Providing Care," concentrated on clinical theory and those variables within the managed care review process that are incompatible with the practitioner's obligation to patients. She observed that many community mental health problems (e.g., child abuse, psychosomatic illnesses) cannot be adequately resolved through short-term therapy or medication. She believes that many of our patients' primitive fears such as stranger anxiety become intensified and their resolution is seriously hampered by the utilization review process; she notes that patients tend to project these fears onto the reviewer.

The general conclusion—by all panel members as well as many members of the audience—is that very basic incompatibilities exist between the managed care process and the clinical practice of psychoanalytic psychotherapy. In order to protect our patients and our profession, therefore, we must do everything possible to educate managed care companies, legislators and the general public as to our concerns. □

COURT UPHOLDS *(continued)*

for Hillel Bodek, CSW, BCD, the City asked Judge Goodman to reconsider his determination and to reduce this compensation to an hourly rate of $45.

In rejecting the City's request, Judge Goodman held that the City's recommended fees "obliterate New York State's statutory scheme which has established three levels of certified social worker [the CSW, the 'P' and the 'R' levels]" and "fail to distinguish between certified social workers in general and those who specialize in clinical social work in particular." He concluded that "[f]undamental fairness requires that reasonable compensation for an expert should recognize, in addition to other factors that relate to the actual expert services, the nature of the expert's knowledge, skills and expertise. Thus, it would be manifestly unjust to group all certified social workers together when making a determination of the hourly rate for *reasonable compensation* for a certified social worker." In his decision, the judge cited the Society's definition of clinical social work and recognized the Board Certified Diplomate (BCD) credential as the highest level of national certification of clinical social work competence.

Judge Goodman found that "the Social Work profession has established high standards for the practice of forensic clinical social work. . . . The Society conducts a two-year fellowship training program in forensic clinical social work for qualified clinical social workers, the only one of its kind in the country, to prepare them to apply properly their clinical social work skills in forensic settings[,]" and recognized the importance of "properly qualified certified social workers making available to the court system their unique and critically important talents in the service of the effective administration of justice."

In affirming his determination of a $100 per hour rate for Bodek, whom he noted is "well recognized, both in New York State and around the country, as the principal standard-setter and a respected leader in the field of forensic clinical social work," Judge Goodman stated that the hourly rates recommended by the City "manifestly fail to provide *reasonable compensation* to certified social workers as required [by law] and are fundamentally unfair to and constitute unwarranted discrimination against certified social workers as compared to other mental health professionals."

Over the past 2 years, the first group of Society members enrolled in the Forensic Clinical Social Work Fellowship Training Program developed and taught by Bodek. The 200-hour course included guest lecturers, discussion of numerous precedent-setting cases and required textbook reading; group members also performed forensic evaluation under supervision.

This latest court decision continues the gain in recognition for CSWs as forensic experts in state and federal courts. Bodek has been a strong influence in this area and has worked for changes in law regarding qualified CSWs. The new group of six who completed the training program will provide additional forensic expertise. □

Memories Invited

The Fall issue will commemorate the 25th anniversary of the Society's formation. Members are invited to share their recollections. Write a letter; submit a short piece. Deadline October 10.

Vendorship Highlights: Progress for CSWs

By John Chiaramonte, CSW, BCD
Chair, Vendorship Committee

United Airlines has modified its policy of reimbursing only those clinical social workers with the title LCSW. This is a major gain for clinical social work nationwide since there are currently only 22 states with the LCSW title. This change was the result of a grievance won by a group of pilots from New York and Connecticut who were being denied reimbursement for services provided by CSWs in their home states. The pilot grievance committee contacted the vendorship committee and in collaboration with NICSWA (National Institute for Clinical Social Work) provided the data on clinical social work essential for this grievance procedure. Effective immediately United Airlines reimbursement for clinical social work services will depend on the following criteria:

A. MSW
B. two years of postmasters clinical experience
C. state licensure or certification

Putnam/Northern Westchester BOCES has changed its policy to include "certified social workers as eligible providers for outpatient psychiatric care effective immediately. Benefits will be the same as those paid to other providers." This turnaround was achieved as a result of significant efforts by the vendorship committee, especially Anne Gordon, Westchester vendorship chair, and Gary Unruh representing NICSWA.

Local 1199—Hospital and Health Care Employees Union RWDSU/AFL-CIO

The vendorship committee and Staten Island chapter president Judith Weiss (former chapter vendorship chair and a current 1199 delegate) met with representatives of this union to discuss outpatient reimbursement for mental health services: $8.50 for social workers, $16.50 for psychologists, and $27.00 for psychiatrists. The meeting was most encouraging; we have agreed to meet further in a task force that will include several 1199 social work delegates. Earlier Local 1199 had been planning to develop its own PPO, which would have had an improved mental health package. The board of trustees, however, voted to drop this and maintain the status quo. We'll keep you informed.

United Parcel Service (UPS) has decided not to have anything further to do with the Society. It seems that our effort to assist them in developing an assessment panel has gone for naught. Unfortunately, it was our membership that undid us. UPS was flooded with members calling them, sending forms directly to UPS, etc. This is exactly what they didn't want. Hopefully we have learned a lesson by this experience that will serve us in the future. The good news is that UPS has chosen Preferred Health Care as its managed care company effective January 1994. PHC is one of the better managed care organizations and is quite supportive of social workers.

The vendorship committee continues its work of identifying and marketing the services of clinical social workers to self-insured, self-funded companies. Some of the companies we are presently working with include Arrow Electronics, Merrill Lynch, the International Brotherhood of Teamsters (Local 851), and Barnes and Noble (which requires MD referral). If you know of a corporation that does not include reimbursement for social work services or if you are having difficulty with reimbursement, empanelment, etc., please call your local vendorship chair and allow us to advocate and promote clinical social work on your behalf. □

WORKSHOP

The Psychological Effects of Managed Care on the Private Therapist

By David Grand, CSW, BCD

In recent years we have presented seminars regarding private practice development, both from a practical, how-to basis as well as from the view of the therapist's countertransference to practice as an inhibiter to practice development. This phenomenon we termed "practice resistance."

For the private clinician, the aim of scrutinizing practice resistance was to identify and overcome the internal barriers that derailed the pursuit of referral opportunities. These ideas, however, were conceptualized for application in the free market mental health delivery system which had predominated in our geographic region. The rapid, yet apparently relentless, intrusion process of managed care companies into our area has been eliminating piecemeal this free market.

The innovations in our presentations addressed the therapist's internal experiences touched on by being in practice; this self-exploration process is also highly relevant to understanding the onslaught of emotions evoked by managed care.

In this workshop we outlined the concepts developed around practice resistance, then examined in depth how these ideas allow us to understand how managed care emotionally effects our practices, our lives and our psyches.

Workshop participants discussed their experiences and personal feelings as they encountered the managed care system. This sharing process enabled those present to see the commonality of their reactions and to feel less alone and unsupported in confronting the trauma evoked by these radical changes in our practices. Members identified with the concept that we are going through the various stages of mourning in response to the experience of loss of autonomy in our practices. Many of those present admitted that they experienced associations with the Holocaust, which were provoked by the seemingly lightning-quick takeover by managed care. The rapid negation of insurance benefits with its unanticipated shattering effect was seen as reminiscent of Kristalnacht. Negative profiling reminded others of the requirement to wear a yellow armband. An unexpected and highly poignant moment transpired when a participant shared that she had been in Germany during the Nazi era and that our discussion helped her to understand that discovering that most of the provider lists were closed to her now resonated of her childhood experience of having all doors to escape closed to her family.

Practitioners experience stages of mourning as they lose autonomy in managed care model.

Another potent association discussed in the workshop was that managed care reminds clinicians of messages from critical parents that they are selfish, can't be trusted and in general are inferior or worthless.

It is clear from these discussions that the practices and general attitudes of the managed care industry have powerful conscious and unconscious effects on our psyches as practitioners. It was also clear that we can benefit significantly by breaking out of our shock and denial in order to make informed decisions on how we can respond and adapt to these changes in our practices. □

MANAGED CARE *(continued)*

functionality is matched with the appropriate intensity of service. Ms. Neuwirth observed that many therapists show no regard for the severity of the illness when recommending treatment frequency. Psychoanalytic training, for example, follows a model of multiple visits weekly, regardless of real need.

Ms. Neuwirth's talk focused attention on a frequently overlooked fact—that it is the employer who makes the rules. The managed care company carries them out.

The Therapist as Businessperson

Ms. Cullen stressed the use of good business strategies in developing a successful managed care practice. The therapist must know each company's time frame. If treatment planning reports are not submitted on time, additional sessions will not be authorized and payment will be withheld. The recommendation for clinicians is to stay on top of the paperwork by tracking each patient. Another suggestion is to read managed care contracts carefully to avoid involvement with unacceptable policies or payment rates.

Social work professionals are actually ideally suited for managed care work, Ms. Cullen noted. Because of social work training, intake evaluations and assessment are second nature to social work clinicians. Further, social workers are collegial, a desirable trait for getting along. They are cost effective and perform quality work—social workers pay the lowest rates for malpractice insurance!

According to Ms. Cullen, employer groups have three concerns: accessibility, affordability, and accountability. They want services to be accessible to their employees and dependents; affordable treatment for cost containment; and they want providers to be accountable for offering treatment that is in the patient's best interest.

Medical necessity is the cornerstone of managed care.

Ms. Cullen suggested that those who want to work with the managed care process take training in brief, focused therapy and in chemical dependency. She noted that managed care companies often prefer to work with providers who have that expertise.

Addressing the criticism levelled at the managed care industry for presumed failure to maintain confidentiality, Ms. Cullen noted that the managed care process shows more concern for confidentiality, when compared to past practices in which an employee's claim papers went to the company's personnel director or even to the employee's manager.

The professional quality and thoroughness of the presentations made for quite an interesting morning. However, a good number of those present believed (correctly) that the program encouraged getting along with managed care and would have found it more valuable to hear also from someone opposed to managed care who could cite the objections and discuss possible options. □

A hungry lion prowling the jungle came upon two men sitting under a tree. One was reading a book while the other pecked away at a typewriter. The lion immediately pounced upon the man with the book and gobbled him up—for the king of beasts knew that readers digest, but writers cramp.

From Modern Maturity, August-September 1992.

ELDERLY *(continued)*

Diagnosis

- Social work psychotherapists who have a doctorate diagnosed clients *less* accurately.
- Social workers who hold positive attitudes toward the older person diagnosed clients *less* accurately.
- Social workers with more knowledge about aging diagnosed clients more accurately.

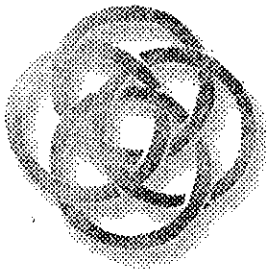
In addition to the influences of demographic variables to attitudes and the influences of these variables to knowledge, this study focused on how attitude and knowledge impacted on actual clinical decisions as presented in the vignettes. The vignettes presented six cases, 3 men and 3 women, with common mental health problems that appear in the general population. These included those related specifically to aging such as retirement and widowhood, as well as more general difficulties including sexual problems, intense anxiety or panic attacks and depression. Additional problems comprise certain personality disorders of more severe psychopathology, such as borderline personality disorder and the narcissistic personality disorder as described in the DSM-III (1986).

Previous studies indicated that the treatment offered the older client was usually different from that offered younger clients, and that the difference was found in a watering down or a lessening of treatment offered, such as crisis therapy or counseling (Knight, 1980).

This study indicates that treatment decisions of experienced clinicians were influenced by attitude toward and knowledge about aging. Social workers with positive attitudes and greater knowledge about the elderly do offer long-term or short-term dynamic psychotherapy more often than those clinicians with negative attitudes and less knowledge.

I hope that you will find these results of interest. As chair of the research committee I also hope that some members will be interested in joining this committee (whether you've done research or not) and help our Society find its place intellectually by contributing original research within our varied practices and to the clinical social work field. Thanks again, and if you are interested in the research committee please call: 212-362-8513.

Ellen Gussaroff, CSW, BCD, is supervisor/faculty, Postgraduate Center for Mental Health, Manhattan; adjunct associate professor of research, Fordham University; in private practice.



Integrative Therapy Institute

A Professional Education Program at the New York Open Center

The Integrative Therapy Institute offers in depth education to human service professionals who wish to incorporate psychospiritual, holistic perspectives in their work with people. The program's foundation is in the evolutionary depth psychologies of Roberto Assagioli and Carl Jung. Philosophically, Integrative Therapy views relationship as the ground of being. It approaches psychospiritual growth as transformation in the quality of relatedness — to self, to other, and to the larger community of life.

The Program: • Three year certificate program • Part-time program on weekends and one evening from October through June • Theory and application • Laboratory in Interactive Process • Supervision• Individualized Program Development.

Interested persons who are not enrolled in the Program may request to take individual courses upon request. Applications are accepted throughout the year.

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October 28, 1993	Scientific Lecture: Betsy Rubin, Ph.D., "Attachment and Self-Object Representation in Pre-Schoolers: Implications for Psychoanalysis"
November 10, 1993	Evening Open House for Training Programs
November 11, 1993	Scientific Lecture: Neil Altman, Ph.D., and Anni Bergman, Ph.D., Discussant, "Class and Caste: Bringing Social Class into the Psychoanalytic Domain"
December 9, 1993	Scientific Lecture: Eli Sagan, Ph.D., "The Psychoanalytic Theory of Morality: A Critique"
January 29, 1994	Training Day: A Day in the Life of an Analytic Candidate. A full day workshop for individuals interested in analytic training.
March 2, 1994	Evening Open House for Training Programs
March 12, 1994	"Gender Issues in the Supervisory Relationship" - A full-day conference featuring supervisory demonstrations by Lawrence Epstein, Ph.D., presented by the Training Program in the Supervision of the Psychoanalytic Process
April 20, 1994	Frantz Fanon, M.D., Memorial Lecture: Kathleen Pogue White, Ph.D. "Surviving Hating and Being Hated: Some Thoughts from the Psychoanalytic Perspective"
April 23, 1994	Training Day (see above)
May 4, 1994	Evening Open House for Family/Couples Program

The events mentioned above are open to all mental health professionals. For information on these events, or any of our training programs, please contact: **Registrar, Postgraduate Center for Mental Health, 124 East 28th Street, New York, NY 10016; (212) 576-4168.**

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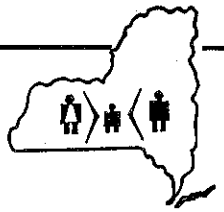

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