NEWSLETTER

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC. SPRING 1994 • VOL. XXV, NO. 1

Society President Testifies About Managed Care Abuses

Joint Public Hearings by NYS Assembly

Capital District Chapter Member Also Appears

In joint public hearings held in January by the NYS Assembly, Society President Helen Hinckley Krackow testified in Albany before the Committees on Insurance and Health. According to the Assembly's notice, the purpose of these hearings: "To examine current health insurance and provider claims practices and HMO medical payments practices to highlight problem areas for consumers and identify specific legislative, administrative or regulatory remedies." Its Background section stated: "Complaints from consumers about problems with health insurance claims and HMO medical payment practices have grown in volume and complexity during recent years and are among the most difficult to resolve." Following is her testimony.

My name is Helen Hinckley Krackow and I am a certified social worker in private practice in New York City. I reside in the same city. I am testifying here today as President of the NY State Society for Clinical Social Work. I have brought along copies of the NYSSCSW Platform on Managed Care that I would like to pass out to the panel.

I am gratified that the Committees on Insurance and Health of the New York State Assembly are examining current health insurance and provider claims practices and HMO medical payment practices to highlight problem areas for consumers. Specific legislative, administrative and regulatory remedies are sorely needed. Many thanks are due to Assemblymen Grannis and Gottfried and the committee members for holding these hearings at this time.

The New York State Society for Clinical Social Work is an association of clinical social workers that sets professional, educational, and ethical standards and is devoted to the development of expertise in the practice of clincal social work. Clinical social work practice is the professional application of social work theory and methods to the diagnosis, treatment and prevention of bio-psycho-social dysfunction, disability or impairment, including emotional and mental disorders and developmental disabilities. Our members treat the mentally ill with outpatient psychotherapy in both private practice and agency settings. We have seen radical changes in mental health service delivery in the last few years with the growth of managed care, HMOs and the utilization review industry. As a Society we have made every effort to learn about, and stay abreast of the changing insurance climate, understanding the need for cost containment and

continued on page 7

New President Begins 2-Year Term

Former Met President Brings Skills and Ideas for Society

Helen Hinckley Krackow, CSW, BCD, has been planning to run for Society president for many years. She has a definite plan and looks forward to her 2-year term, which began January 1, 1994. Her 4 years as president of the Met chapter, the largest in the Society, prepared her for this office, she believes—yet the challenge is broader as she now heads 12 chapters statewide rather than one. Additional preparation came through her 1-year stint as president-elect, alongside outgoing president David G. Phillips, DSW.

Improve Professional Life

A major goal during her time in office is to improve the professional lives of clinical social workers:

- To secure social workers in the field of mental health delivery

continued on page 6

EXECUTIVE REPORT

Building Coalitions: Strength in Numbers

Society Joins Forces to Achieve Major Goals

In these first few weeks of my term, the focus of the Society is to join forces and build coalitions with other mental health professionals to fight for the survival of the profession. Our members are working on regulation of the managed care and utilization review industry, studying proposals for national mental health care delivery and continuing its efforts toward clinical social work licensing—directly with legislators and also with the aid of various coalitions. This degree of joint effort has always existed at the national level with our national advocates but has not occurred at the state level since we worked for the vendorship bill and parity in insurance reimbursement.

There are several coalitions in New York State that our membership should be aware of which are working to protect clinician-determined mental health treatment. The Coalition for Mental Health Professionals and Consumers in the Long Island and Metropolitan New York areas provides a beacon that resonates with similar coalitions in Albany and Western New York as well as Syracuse. These coalitions draw their membership from clinical social workers, psychologists, psychiatrists, and psychiatric nurses and consumers. They provide monthly task lists that suggest manageable work by concerned members to protect mental health treatment and inform legislators and the public about the impact of managed care on treatment. These coalitions are a valuable resource and are important groups to support.

In January of this year at a New York-New Jersey area meeting of the National Committee on Psychoanalysis, several of us met to report on our mutual efforts regarding regulation of managed care and activities regarding national health insurance. Those who attended realized that several of the organizations to which we belonged were duplicating efforts such as hiring counsel and developing similar plans and work agendas. Attending this meeting were members of the New York and New Jersey Societies, The Coalition for Mental Health Professionals and Consumers, the managed care chair of the Council of Psychoanalytic Psychotherapists, and a representative of the Psychoanalytic Consortium that includes the American Psychoanalytic Association, Division 39, of the American Psychological Association, The American Academy of Psychoanalysis, and the National Committee on Psychoanalysis of our National Federation. Within the room were several graduates of psychoanalytic institutes who have great concern about the impact of managed care and national health insurance on treatment. Believing that there is strength in numbers, we felt that we should reach out to as many professional societies, coalitions and institutes as possible. This consortium should include practitioners in other modalities of treatment as well as psychoanalysis.

There has been a second and third meeting of this coalition of organizations, loosely called "The Friday Night Group." In addition to the groups mentioned above, we also have representation from the NYS Psychological Association, NASW, Manhattan Psychological Association and numerous institute boards and professional societies. Coordination of efforts has been discussed around legislative action: collecting vignettes regarding the impact of managed care and utilization review. Other efforts will focus on public relations and consumer education about mental health treatment and developing training for members as to how to approach legislators. Working together, the group believes its efforts will prove effective.

The other coalition of great importance to us is that with the New York City chapter of NASW, with whom we have been working on the clinical licensing bill. It looks as if we have a consensus on the current draft. I would like to urge those of you who are members of the state organization of NASW to let that state board know that you support the clinical social work licensing bill. We would urge members to write to the NASW state board, asking them to support the current draft.

As daunting as the problems are that plague the practice of mental health treatment, I believe that there is opportunity in adversity. We need to find support in the mental health community when our interests and concerns overlap. Let's share the best of what we have to offer and use it to secure our profession by working together.

Helen Hinckley Krackow, CSW, BCD
President

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CSWs Gain Entry as Providers and Pursue Additional Inclusion

By John A. Chiaramonte, CSW, BCD
Vendorship Chair

NATIONAL

In response to members' complaints of nonreimbursement, the significant efforts of Sharon Kern-Taub (Met chair) have resulted in alteration of coverage. The National Writer's Union and the Neighborhood Cleaner's Trust Fund have agreed to include clinical social workers in their policies effective immediately. Gary Unruh, marketing director of the National Institute for Clinical Social Work Advancement (NICSWA), assisted with a state-by-state key to determine the highest social work level in each state to be accepted as reimbursable by these associations. Additionally, responding to a member's complaint, this committee was able to obtain reimbursement from a large corporation for a non-licensed clinical social worker as an independent provider. These efforts emphasize that licensing New York State CSWs is essential so that we can serve the numerous self-insured companies that reimburse only licensed social workers.

Self-insured companies with which this committee are negotiating include AT&T, Merrill Lynch, Hertz, Motorola, Sony, U.S. Life. Once again, the situation becomes more complex: all 50 states have differing titles and/or criteria for registration, certification, or licensure of CSWs. NICSWA has been working intensively with these and other companies, assisting them in deciphering clinical social work interstate regulatory discrepancies and inconsistencies.

The Federation's counsel informs us that if and when a national health plan passes that includes recommended basic benefits covering CSWs, this legislation will supersede the present loopholes of all states for social work reimbursement. The result will mandate self-insured companies and states without parity laws (17) to accept clinical social workers as reimbursable providers.

MEDICARE

For clinical social workers to receive maximum Medicare reimbursement (100%), they must register to become a participant in the Medicare program. Doing so begins the 5-year countdown from new provider (80% reimbursement) to 100%. One does not have to have Medicare patients, only to be registered with Medicare. Having a BC/BS number only makes you an eligible Medicare provider, not a registered participant. To become a registered participant, members should call the Medicare provider registry (212-476-1576) and request to be activated as a Medicare provider, then call 914-243-7682 and request a provider agreement to sign.

LOCAL

Subsequent to our meeting with local union 1199 of the National Health and Hospitals Corporation in Feburary 1993, they have decided to increase their outpatient mental health fees effective July 1, 1994 from $17 to $25 per session for clincial social workers. Psychologists have been increased from $35 to $48, psychiatrists from $55 to $75. These fees are reimbursed 50% by the plan and 50% by the patient. We understand that a task force of local 1199 social work delegates will be meeting in the near future to look critically at the amounts and disproportionate reimbursement format.

> ***The majority of complaints received by this committee are concerned with members' inability to gain access to closed managed care panels.***

The majority of complaints received by this committee are concerned with members' inability to gain access to closed managed care panels. The committee will be working with our legislative and managed care committees in an effort to address the inequities and problems related to managed mental health care. A brief description of problems from members around managed health care issues should be sent to your chapter's vendorship committee chair so that we can categorize these and forward them to the Society's legislative committee to assist in lobbying for regulatory legislation. Members can do this anonymously. Legislators want to know of the problems of managed care from both providers and consumers alike. Call and/or write especially to Senators Daniel P. Moynihan and Alphonse D'Amato and, for New York State, Senators Michael Tully Jr. and Nicholas Spano and Assemblymen Richard Gottfried, Pete Grannis, and Steven Sanders. Members should also join the Coalition of Mental Health Professionals and Consumers (516) 424-5232 in their efforts to protect both providers and patients. [See testimony by Society president, page 1]

The vendorship committee continues to serve the membership by promoting the use of clinical social work services through assisting members with problems of reimbursement, provider exclusion, etc. Members may contact their chapter vendorship chairs for help with these issues.

COMMENT

Have you begun to feel that our profession is under attack? In the last month this committee received notice from Value Behavioral Health Inc. that clinical social work fees are being set at $67/session and that the new GHI managed care plan is setting CSW fees at $60/session. While Vendorship has been flooded with outraged phone calls, both GHI and VBH have not. One GHI representative expressed surprise at the lack of uproar following their fee announcement. What can we do?

If no one joined these panels, then of course they would have to reassess their rates and entice providers to join. However, everyone believes that there will always be enough social workers who will join. As we see it, the only reasonable way to go is to join these panels and to put pressure simultaneously on our representative organizations (NFSCSW and NASW) to address our outrage, head-to-head.

According to "Psychotherapy Finance," 1993, the national mean clinical social work fee is $75 and, according to the 1993 National CHAMPUS Survey, mean fees for psychology and psychiatry are $90 and $103, respectively. It's interesting and perturbing to note that while Value Behavioral Health Inc. offers psychiatrists $104/session ($1 above the national mean of $103), and psychologists $89 ($1 below the national mean of $90), they offer social workers $67 ($8 below the national mean of $75). When asked about this, a representative of VBH stated that various states and locales have differing fee schedules. They refused to forward their national fee schedules and were unable to state how these fee amounts were arrived at. Presidents of both NASW and NFSCSW were subsequently consulted and expressed interest in taking action to address the VBH disproportionate fee schedule for social workers. Recently the advancement division of the Federation agreed to select

continued on page 10

Frontiers of Psychodynamic Theory: Implications for Therapeutic Interventions

Joint Conference Features Speakers, Workshops

By Julie Kipp, CSW

The Eisner and Lubin Auditorium of the Loeb Student Center of New York University held a capacity crowd on Saturday morning, November 20, 1993. Clinical social workers and other clinicians were gathered for the conference, "Frontiers of Psychodynamic Theory: Implications for Therapeutic Interventions," a first-time joint presentation of the New York State Society for Clinical Social Work and the New York University School of Social Work PhD program. Two lively keynote presentations by Eda G. Goldstein, DSW, and Jeffrey Seinfeld, PhD, were given in the morning, followed by an array of afternoon workshops.

Left to right: David G. Phillips, DSW, president of NYS Society; Eda G. Goldstein, DSW; Jeffrey Seinfeld, PhD; George Frank, DSW, professor and coordinator, PhD Program, NYU School of Social Work.

Dr. Goldstein, professor and chair of Social Work Practice Curriculum Area, NYU School of Social Work, preceded her presentation, "A Self Psychological Perspective," with a salute to the packed auditorium. She was pleased to see that despite "the ravages of managed care, the social work community is alive and well." She went on to give a clear explanation of the principles of self psychology, developed by Heinz Kohut. With narcissistic patients, he found that empathy, rather than neutrality, proved effective. Resistance and rage were seen as understandable responses to frustration. Interpretation was used in a climate of empathy. Countertransference was seen as the cause of lapses of empathy.

Self psychology focuses on the selfobject needs of the infant—mirroring, idealization and twinship. The development of a cohesive self depends on the (at least partial) fulfillment of these needs, normally achieved in relationship with a dependable selfobject. Through what has been termed "optimal frustration," but which Dr. Goldstein prefers to call "optimal responsiveness," the growing self increasingly takes over selfobject functions, although one never totally outgrows one's need for selfobjects.

Self psychological treatment emphasizes "experience-near empathy" and the development of the selfobject transferences. Through this approach, the patient may be able to overcome his rage at past traumas and fear of being hurt again, and then may be able to experience needing, and having selective needs met. Dr. Goldstein observed that the "field has been more concerned with the harm of giving too much, rather than the disastrous consequences of giving too little."

We have been more concerned with the harm of giving too much, rather than the disastrous consequences of giving too little.

The second keynote presentation was by Dr. Jeffrey Seinfeld, associate professor, NYU School of Social Work, on "An Object Relations Perspective." Dr. Seinfeld focused on the contributions of the British independent school to current theories of treatment. Object relations theory is rooted in Freud's observation that the depressed, self-denigrating patient is really attacking the internalized bad object. Dr. Seinfeld pointed out that W.R.D. Fairbairn was trained in the ministry, and preferred to think of the problems and treatment of the bad object in the terminology of the medieval concept of possession by a demon, for which the treatment might have been burning at the stake. ("At least it was short-term!" as one colleague observed.) According to Fairbairn, in the internalized object world of the dependent child, it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil.

Object relations treatment focuses on the gradual separation from the bad object, a complicated proposition, since the bad object has been exciting as well as rejecting. It is important to respect the patient's tie to the bad object, while allowing the patient to cure the bad object in the therapist by reenacting the traumatic relationship with a therapeutic outcome.

Both of these theories share the conviction that it is feasible to treat regressed, "unanalyzable" patients, and emphasize the defensive nature of primitive behaviors. The self psychological approach recognizes the patient's excessive grandiosity and provocative behaviors as means of fending off realization of searing traumas to the self.

Both of these theories share the conviction that it is feasible to treat "unanalyzable" patients.

Object relations theory attributes the patient's tenacious hold on the bad object to the human necessity of being in relationship, even if bad, rather than not being in relationship at all. Dr. Seinfeld pointed out that a social work perspective is useful with these more regressed patients, whose disturbed inner worlds have resulted

continued on page 10

BOOKS

Freud and Hypnosis: The Interaction of Psychodynamics and Hypnosis

Dr. Milton Kline, EdD

Matrix House Ltd.
New York, NY, 1958
189 pages

Reviewed by
William Ballen, CSW

In *Freud and Hypnosis*, the author has brought together Freud's major writings on hypnosis in an effort to clarify both his conception of hypnosis and his motivations for abandoning it. Kline begins with numerous examples of how Freud's use of hypnosis was linked historically to the pre-psychoanalytic period of his work. Since Freud had not yet discovered the importance of tranference, resistance and working through in the context of a sound therapeutic alliance, his use of hypnosis was not informed by psychoanalytic theory as he later understood it. Freud's structural theory (id, ego, superego) and the still later contributions of ego psychological, object-relational, self-psychological and relational constructs, inform hypnotic technique far beyond Freud's limited suggestive-cathartic-abreactive applications.

Freud's use of hypnosis was not informed by psychoanalytic theory as he later understood it.

Freud's technique for hypnosis was limited to simple authoritarian commands such as "sleep" which he usually carried out with his finger held before the patient's eyes, or his hand on the forehead. He learned what hypnosis he knew in Paris from Charcot and Bernheim whose hypnosis demonstrations Freud found rather spellbinding and charismatic. So much so that he was the first to translate Bernheim's *New Studies in Hypnotism* into German. From these early role models, Freud developed the belief that "the hypnotic state" (as though there is just one) was simply a state of heightened suggestibility. He admittedly became frustrated with the number of patients that he could hypnotize with authoritarian techniques. Early on he wrote, "I gave up the suggestion technique, and with it hypnosis, so early in my practice because I despaired of making suggestion powerful and enduring enough to effect permanent cures." The antiquated notion that ideas could be forcefully implanted in a patient's brain without resistance came to a screeching halt.

Dr. Kline informs us of additional reasons for Freud's discard of hypnosis. On one occasion a female patient, upon awaking from hypnosis, threw her arms around Dr. Freud's neck. Freud (who did have a sense of humor) wrote, "I was modest enough to not attribute the event to my own personal attraction, and I . . . felt that I had now grasped the nature of the mysterious element that was at work behind hypnotism. In order to exclude it . . . it was necessary to abandon hypnosis."

It is now generally accepted that there is heightened transference/countertransference configuration in the hypnotic relationship.

Again, since this incident precedes Freud's momentous discovery of transference and countertransference, he lacked the conceptual tools necessary for understanding this phenomenon. It is now generally accepted that there is heightened transference/countertransference configuration in the hypnotic relationship. For Freud, however, there was still no way of understanding his patient's behavior or his own discomfort with it. It remained "mysterious". The mysterious evolved, in his thinking, into hypnosis as an eroticized condition—in other words, it was the patient's condition—and not yet a relational process.

Space limitations preclude exploring other theoretical attempts by Freud to explain hypnotic phenomena. One of them, however, is his equating hypnosis with the state of being in love.

Dr. Kline quotes Freud: "From being in love to hypnosis is evidently only a short step. The respects in which the two agree are obvious. There is the same humble subjection, the same compliance, the same absence of criticism toward the hypnotist just as toward the love object." Dr. Kline observes that "the above description may hold for a variety of transference relationships but can hardly serve as a generalization for the hypnotic state or the hypnotic relationship. . . .Many subjects will be critical of the hypnotist's actions and suggestions. Thus, in states of hypnosis involving light or medium trances (which are most common in hypno-analytic psychotherapy), there is no humble subjection, no enforced compliance, but rather a basis for increased psychologic productivity. Overt behavior remains at the ego discretion of the subject."

The scientific investigation of hypnosis has advanced considerably since Freud's time; there is prodigious and stimulating literature; clinical and experimental research in hypnosis has long disproved Freud's flawed understanding of it. And yet, perhaps due to Freud's towering and unrivaled position in the history of psychoanalysis, most analytically trained therapists of today know as little about hypnosis as Freud did in 1895. Is this what Freud the scientist wanted? It is doubtful, for it was to his credit that he never claimed any expertise or objective understanding of hypnosis. In fact, writing toward the end of his life, he said ". . . and perhaps someday it will be necessary to alloy the copper . . . of suggestion to the pure gold of analysis."

Within the last 20 years, formulations regarding the use of hypnosis in psychoanalytic treatment have been informed by ego psychological, object-relational, self-psychological and relational concepts. Hypnoanalysis like psychoanalysis is no longer simply archaeological but is architectural. The contained perceptual and sensory alterations that are possible in hypnosis are being utilized to tailor hypnotic interventions differentially across the maturational continum of psychic structuralization. Within the last 10 years, there has been a greater emphasis on the hypnoanalyst's use of self in the treatment of less than neurotic character structures. Hypnotic technique, informed and guided by psychoanalytic developmental psychology, provides a more focused and concentrated "holding environment" and a deeper internalization of symbiotic self-object experiences that further development and resolve conflict. Training in clinical hypnosis fortifies the analytically-oriented therapist with methods for either augmenting or circumventing direct interpretation.

Freud and Hypnosis is not a new book, but it may be new to many people in the field. The serious reader will be led to re-examine hypnosis as a valuable mechanism

continued on page 7

Public Relations Committee Gains Momentum

Report by Sheila Peck, CSW
Public Relations Chair

We have had considerable response to the committee's call for membership, and we are growing! Here, some details.

We've received a number of copies of letters-to-the-editor both published and unpublished. These will serve both as a central file and a reference source and will provide a better sense of what our members, as clinical social workers, are saying to the media. Please send along any you may have. We will index it and distribute the index.

In February *Good Housekeeping* magazine published "The 327 Best Mental Health Experts." They specifically excluded social workers. In response to my letter, I spoke with Donna Behen, medical editor. Social workers were excluded, she said, because a) the list is intended as a referral source for people in crisis, and they generally seek help at the doctoral level, from which referrals are then made to us (secondary) therapists, and b) there are too many of us.

She was surprised to learn that most of our referrals come from former patients, colleagues and managed care companies. She was truly amazed to learn that managed care refers by zip code, not credential. She seemed willing to learn and actually apologized.

Whatever we can do to keep the name of the Society in the media is useful. Let us know of events that can be publicized. Even if it is not published, the editor will become familiar with our name. If a picture goes with the release, so much the better. Include the names of local publications. We will be sending letters to outlets that routinely omit the mention of clinical social work from relevant articles or programs.

We would welcome input for a flyer for clinicians to have in their offices that explains clinical social work to consumers.

Any and all feedback and suggestions are welcome. *(516) 899-2688* □

NEW PRESIDENT *(continued)*

- To raise the consciousness of the public so that it regards social workers in the same way as it thinks of psychiatrists and psychologists—equals in mental health care.

One way to accomplish this is to expand public relations efforts: to make concerted efforts to get the Society's name into public awareness through the media, simultaneously monitoring media coverage to ensure that social workers are included in coverage of issues concerning mental health care delivery. [See public relations report, page 6.]

Helen believes in the development of clinical practice committees and that they will serve the Society's members. As therapy becomes more specialized, such committees are important to members and can serve to expand the scope of help offered to consumers. Just as important, these groups can enhance the practice of clinicians who specialize in a specific area of treatment, e.g., substance abuse or marital counseling. Increasingly, corporations are concerned with an employee whose personal problems undermine performance in the workplace. Skilled clinicians in these areas will be selected to work with such employees (albeit for short-term therapy).

Helen feels strongly about recruiting new members; this issue has been frequently mentioned in the past and continuing efforts to increase membership is a priority. With the issue of licensing so important to CSWs, the broadening of membership takes on additional importance.

Work With New Therapists

During Helen's tenure, the Met chapter grew in number, in skills and in service; she plans the same for the Society. For example, a mentoring program began, whereby practicing clinicians worked with graduates just beginning in their professions; this can be an effective program for the Society. Enhancing this effort, she will work to reactivate the Society's supervisory panel. Current economic conditions make it difficult for many beginning therapists to attend institutes for postgraduate training. The skills and experience of members can serve to help these new professionals.

Helen states that she "encourages all members to become involved through their own special interests." She has been traveling and speaking at chapters around the state. A major issue for all clinicians now and for some time to come is managed care [see testimony on this topic, page 1]. To become effective advocates for themselves, clinicians must grow in number and become organized for added clout as managed care invades the practice of health care of all types.

Push for Licensing

Concomitant with these clinical and practical issues, a major push for licensing must continue "for clinical and educational purposes as well as for public and communications goals." As a practical matter, with uniform standards established, corporations as well as managed care companies will receive a clear picture of precisely what professional CSWs are capable of, can provide, and are licensed by the state to deliver. As the largest Society within the National Federation, New York must continue its leadership position on a state level while playing a strong role in Federation's national advocacy efforts.

All efforts must include members in the less populated regions of the state. The Society serves as a resource, the organization that best represents professional CSWs statewide. An ongoing effort that will gain new momentum is to increase educational and leadership opportunities in these areas and to enlist the talents of these members in the overall goals. Helen emphasizes that workers "can empower themselves—to lobby effectively, to organize themselves and to speak for themselves."

Together with the stepped-up public relations program and the growing specialized areas of treatment, the emerging professional can "educate legislators as to the real picture of mental health care delivery," notes Helen—that social workers provide more than 65 percent of the mental health care within the state. And, coming full circle, members are encouraged to explore their own interests as opportunities widen.

The Society continues to grow, now numbering some 2200; it is in an especially good position to recruit additional members. Now more than ever clinicians need the strength of a professional organization to fight for mutual goals.

As a professional organization, Helen stresses, the Society must serve its members by "encouraging growth in all the areas that have to do with practice," to fight for the professional recognition of its members as qualified clinicians, and to "create a climate in which to practice." □

Groups Dealing With Managed Care

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Coalition for Mental Health Professionals and Consumers
P.O. Box 438
Commack, NY 11725-0438
(516) 424-5232

Western New York
Interdisciplinary Managed Care Coalition
- Laura Salwen 716-838-2440
- Carol Creighton 716-834-0191

SOCIETY PRESIDENT *(continued)*

for accountability in a climate of economic crisis. The irony is that there is no crisis in cost for outpatient mental health services. Outpatient psychotherapy accounts for only 4 to 5% of total health care costs, with cost increases in line with the Consumer Price Index. Outpatient care is not contributing to health care cost increases.

> ***The irony is that there is no crisis in cost for outpatient mental health services.***

Our members, report that health insurance practices and HMO medical payment practices are causing great difficulty for patients. Even when our interactions with case managers are cooperative, payments do not come for authorized treatments. My Society has come to the point of feeling that legislative regulation of the managed care and freestanding utilization review industry is needed . . . [my] testimony will be aimed at the difficulties that need to be regulated and not to the strengths or advantages of the managed care and utilization review industry when it functions properly.

At the outset I feel it is important to say that consumers who are suffering from mental illness are often handicapped by aspects of their disease in ways that those suffering from physical illness are not. Physically ill people usually do not suffer from humiliation, embarrassment or need to keep the details of their illness private. Shame is often often involved in cases of abuse, incest, rape, substance abuse, perversions, etc. [Society generally] and our patients themselves feel unforgiving of their differences. Intrusive, rigid, or insensitive utilization review that does not take specific pathology or patient needs into account can prevent treatment. One patient of mine terminated treatment rather than submit to a managed care company's insistence on psychological testing. She felt that testing was proof that she was crazy. It was difficult enough for her to speak to me, let alone be tested by a stranger. Patients with paranoid pathology cannot tolerate thinking that intimate details of their treatment are needed to justify coverage. People in sensitive jobs—either political office or high level jobs often [do not] use their insurance because of fear of exposure. Mental health benefits that have been available over the years have been underutilized because people use them as a last resort. It is much less shameful to self-medicate with alcohol or drugs . . . than to seek mental health treatment. Therefore, outpatient care is not contributing to health care cost increases.

Our members report that claims are most often denied because managed care (MC) companies lose outpatient treatment reports and then claim that reporting is not timely; decide treatment is medically unneccessary; or terminate treatment when patients object to going on medication or [attending] an AA group. As the large companies buy out smaller companies, they become more disorganized and impersonal. One MC company [referred] a woman for evaluation for treatment. . . . The company was using an electronic data report form. No certification was made because the computer could not read the black ink on the evaluation form. The evaluation was resubmitted. The data was not picked up a second time. No amount of telephone contact brought results. Finally the company sent a letter stating that reports had been submitted in an untimely fashion. The evaluator felt she could not abandon the patient and saw her for many unpaid sessions. Many months later the matter was straightened out but had caused additional stress to both the client and the therapist at a time when the patient was trying to escape from an abusive personal life. It has been our understanding that MC practices could not be regulated under current insurance law in New York because they are not insurance companies but rather fund managing companies. We support legislation to expedite claims processing.

Standards for reviewers need to be set by an independent state-regulated board of professionals. Consumers who are suffering from mental illness need to be assured that people who have similar degrees of experience as their providers and an understanding of the ethical principles of the profession are evaluating their treatment plans. To justify treatment, providers are asked to provide intimate details of patients' personal lives such as early hospitalizations, cult activities, homosexuality, etc. Reviewers often refer to the patients by name rather than use the code number. This is particularly difficult Upstate where the managed care reviewer and the patient may live in the same general area. Reviewers are often judgmental. One of our practitioners was referred a depressed woman of 41. She was depressed because she could not conceive a child. The reviewer would only certify 8 sessions "because a woman of her age was too old to be worried about having a child." Often reviewers do not understand the complexity of the cases they are evaluating. One of our members was able to help an alcoholic stop drinking. Without alcohol to manage his fears of his own aggression, the patient had to struggle with allowing himself to be assertive. Rather than allowing him to have psychotherapy or work through his conflict, the reviewer insisted that all this patient needed was a 3-session assertiveness training group. The patient returned to drinking in 4 months. Recently we had a citizen freeze to death because he was refused lithium to medicate his manic depression.

An independent review board that could take anonymous complaints would be helpful to one of our members who resides in an area Upstate where there are only 6 social workers on the panel of a particular MC company. This company has not reimbursed more than 3 sessions in a year of approved treatment. They apologize profusely every time she makes contact but the check is not in the mail. She is afraid to report the firm to the State Insurance Department because this company is making a major bid in her area for a large state contract. She is afraid she will not work, as the town is a one-industry town.

> ***Standards for reviewers need to be set by an independent state-regulated board of professionals.***

A disturbing trend has come to light regarding a particular MC company that is based in Minnesota but has an office in Manhattan. Several of our Upstate members report that when the corporation began offering this MC company as an alternative to an indemnity plan, the providers were told to terminate their treatment in 4 sessions. In one case the

continued on page 10

BOOKS *(continued)*

of human psychology. As Kline so aptly states, "The present-day utilization of hypnosis in psychotherapy is in no way going back to the hypnosis of Freud's period. It is, rather, the moving ahead toward a frame of reference within which, as envisioned by Freud, we view the complications and disorders of human behavior as aspects of a general psychology of mental functioning rather than an isolated area of psychopathology." As a work that thoughtfully examines Freud's thinking about hypnosis in light of the scientific evidence available at that time, this book endures as a classic.

William Ballen, CSW, *is chair of the Society's clinical hypnosis committee. He is a specialist and consultant in hypnotherapy and is in private practice in Long Beach.*

Additional Testimony from Capital District Addresses Current Policy

My name is Betsy Owens and I'm a Certified Social Worker in private practice at the Center for Human Growth in Albany, New York. I reside in Albany. I am here today to represent the New York State Society for Clinical Social Work and the Capital District Social Workers in Private Practice.

Thank you to Assemblymen Grannis and Gottfried and the esteemed committee members for the opportunity to present our views. Mental health service delivery has changed dramatically with the inception of managed care, HMOs and utilization review. This will be my primary focus but I will also reference indemnity practices.

Claims practices: The more paperwork . . . to be generated the greater the likelihood of error. When large numbers of personnel are responsible for certifying care, data processing errors are rampant. In addition, we suspect that delays in processing may be one way to obscure a grim financial picture for the carrier. Cash reserves are increased and interest accrues as claims go unpaid. One IPA recently cited computer problems for the last year and I continue to be unreimbursed for sessions which I performed last June. In years past I have observed a slowing of reimbursement towards the end of the calendar year. Many consumers are damaged by these practices whereby they may unwittingly sign on with a plan that appears to be viable but has practices which impede the treatment for which they have paid. Many providers are refusing to continue in those plans, which reduces client choice.

Our concern is that the medical dollar will continue to be eroded by management inefficiencies and misrepresentation of the advertised benefits.

We fully support legislation which would expedite claims processing. These mandates should also apply to reimbursement related to government agencies, e.g., crime victims, Medicare; we have found that reimbursement is even more problematic under these plans than with the private insurers.

Ranking of health insurance companies: We have found that this is one of the most powerful tools in resolving problems with the insurance carriers. However, most consumers are not aware of this ranking and the impact this ranking has on the financial status of the company. Most consumers are fortunate if they have even cursory references to this ranking in their local newspaper.

There is no question that insurers should be required to report on the claims denied rankings. However, I would suggest that this process be brought a step further:

Market forces appear to be the most powerful incentives for carrier accountability. Our concern is that the medical dollar will continue to be eroded by management inefficiencies and misrepresentation of the advertised benefits.

We would like to propose a process that would reward the best and most responsive plans. Consumers should be informed at the time they sign on with a plan exactly what the track record of that particular company has been, a variation on a "Consumer Report" type of analysis.

The format could include for each carrier the record from the last 5 years including

1. rating as per the Best Report, or comparable index
2. number of claims denied/pending
3. NYS complaints data summary
4. a figure representing the percent of administrative personnel of the entire budget and/or salaries and administrative expenses of the total budget
5. an indicator of the number of diagnoses approved with this plan
6. an analysis of the cost per unit of services

The information could be generated by the carrier's own computer system and monitored by the insurance department. It should be required information provided to consumers at the time they sign on. Carriers who have been able to deliver a high degree of cost effective services would be rewarded by an increase in interest in their plan.

The data regarding the cost efficiency of managed care has not been analyzed in a manner that allows consumers to make adequate decisions regarding the purchase of their plans. My understanding is that, in NYS, the IPAs have not been determined to be more cost efficient than the traditional indemnity plans. The freestanding HMOs have been determined to be more cost efficient . . . primarily because they insure a healthier consumer. My question is this: if . . . IPAs restrict the number of services provided, yet they cost the same as the traditional indemnity plans, is the dollar which would have been previously used for services in the indemnity plans now being used for administration of the IPA or HMO? We need to have mechanisms for the analysis of this data which should be made known to consumers when they sign on with the plan.

Eligibility: The benefits package is not always clear, particularly in mental health. Consumers are led to believe, as in the proposed Clinton legislation, that "x" number of sessions will be available in their plans. Those of us who are experienced in managed care are aware that this is misleading; these sessions are generally reviewed through a utilization review (UR) group and reviewers have been known to arbitrarily cut off the benefits before they reach the maximum number of sessions allowed. Several years ago we queried 75 providers with a certain plan and only 3 providers over a 7-year period had ever reached the maximum allowance with any client on this plan.

Usual and customary rates: It is not an easy or expedient process for a client to determine that a treatment is financially feasible. The usual and customary rate is not always accessible due to the insurer's citation of anti-trust violations and the client is not aware of the reimbursement schedule until the claim is processed. In addition, the rate frequently varies by county.

Some reviewers view their role as supervising therapists rather than regulation.

Additionally, the usual and customary rate is not always an accurate representation. One indemnity plan reimburses at its "usual and customary rate" of $16 per session for psychotherapy. This is misleading and the carrier should be denied the ability to advertise inaccurate information.

This rate information, as well as any claims paid/denied vouchers from the carrier should be written in terms which consumers can readily understand.

Utilization review: Several years ago the Capital District mental health providers documented over 100 instances of client harm through improper utilization review procedures. These reviews were done by non mental health nurses and clerks. With sufficient regulation and oversight, UR can be handled in ways which do not impair client health. The most effective UR is that

which is done via peer review, with experienced reviewers who are also active practitioners. The most skilled reviewers are still in the field and not doing these reviews full time.

Some reviewers view their role as supervising therapists rather than regulation. They may insist on treatment to which both the client and therapist object. Some . . . have gone so far as to insist that clients take psychotropic medication or enter groups when either course is aversive to them. The reviewers are not held accountable for treatment mandates dictated to therapists who are far more skilled than themselves.

Many reviewers insist on doing reviews at stultifying intervals, i.e., every fourth session. The research indicates that most clients complete treatment prior to the 10th session with or without reviews and, consequently, an unnecessary burden is placed on the provider. This adds additional costs to both the provider and the consumer to provide this extraneous documentation.

The literature is replete with studies indicating where managed care is most effectively used. Yet it continues to be done for all procedures. For instance, there never was a cost crisis in outpatient mental health. The cost savings are in avoiding substance abuse and adolescent hospitalizations and providing alternatives to inpatient residential treatment. Yet outpatient is monitored to the "nth" degree. I question why someone is being paid to tell me I can use the number of sessions I would have used anyway.

In addition, UR can impede treatment through administrative barriers. In the last 2 months, I experienced 1-month delays in getting two clients into treatment because of the inaccessibility of the phone reviewers. This is not acceptable for emergency care, suicidal clients or clients in crisis.

The definition of allowable services is sometimes used to the detriment of the insured and the benefit of the carrier. For instance . . . "medically necessary" and "acute conditions" are subjective terms. One client's sessions were denied because she was "chronically" suicidal instead of "acutely" suicidal. We question whether she would have been defined as chronically or acutely "dead" if the suicide had been carried out. One client jumped off a bridge after the therapy session. The trauma to the family and the therapist was increased when the payment was denied because the suicide was not "a mental health condition" with a disability in psycho-vocational functioning. I question why "death" is not considered an interference in psycho-vocational functioning and why suicide does not indicate a mental health condition.

It seems more likely that the reason is the client was not available to protest.

We fully support regulation of UR as defined in the Gottfried bill.

Adequacy of the number of providers in managed care programs: When provider panels have been limited, we have observed 2 effects:

1. A waiting list is created which limits client choice and use of the plan. Some have implied that this is the intent.
2. The limited panels pose a threat to those providers who make legitimate complaints to the plan. If they advocate for their clients they are asked to leave the plan. Consequently, we have panels where the threat of economic blackmail against the practitioner's livelihood forces them to go along and not advocate for improvements in the system.

Special illnesses: We have concerns about the following groups: there are those who require absolute privacy in their treatment, either because of personality characteristics or because of their own or their families' professional positions in the community. I have clients who desperately need inpatient treatment who cannot access this because they have a professional relationship with both the carrier and with the treatment providers The plans have refused to make special provisions for these clients.

Another area of concern is the trend towards paying only for acute mental health treatment. Many clients have a dire need for intensive psychotherapy and sign on with the plan when it is an implied benefit in their marketing brochures. It is with more frequency being denied. The exclusion of this benefit is not always cost-effective: when the underlying pathology is not resolved, it re-emerges with other symptomology.

Thank you for the opportunity to present these views. □

Elected and Re-elected Board Members

Elections in Fall 1993 resulted in the following members' election for 2-year terms:

1st Vice President	Marsha Wineburgh, MSW, BCD (Met)
Treasurer	David A. Ackerman, CSW, BCD (Suffolk)
Members-at-Large	Allen A. DuMont, CSW, BCD (Queens)
	Jacinta (Cindy) Marschke, CSW, PhD, BCD (Mid-Hudson)

MANAGED CARE

New Group Meets

Report by Susan Mellan, MA, CSW, BCD

Responding to the crisis induced by the intrusion of managed care, the New York-New Jersey area chair of the committee on psychoanalysis, Rick Alperin, DSW, organized a special meeting held on February 25th. The meeting was designed to share information with a broader network of professionals, both as individuals and as representatives of professional organizations and analytic institutes, and to find out what each is doing about the problems.

The first issue discussed concerned the potential of this newly organized group [see "President's Report" this issue] to act as a clearinghouse for information; this would reduce duplication of effort as well as the sense of isolation and helplessness practitioners face when confronted with abuses of managed care. Another issue was the need for legal/political activities such as lobbying. It was suggested that this group could act as a coordinating body to avoid the fragmentation that dilutes efforts to reach state legislators. On the national level, it would be helpful to coordinate the efforts of local groups with that of the National Membership Committee on Psychoanalysis, the Psychoanalytic Consortium and the National Federation.

Further, there is a need to educate the consumer. Research data is needed to support the argument for longer term treatment. It was suggested that participants collect vignettes for documentation so that those in government may see where the managed care system breaks down or fails altogther. In this effort a telephone network could be helpful.

The group agreed to reach out to involve all concerned organizations. □

SOCIETY PRESIDENT *(continued)*

provider was told that she was encouraging the patient's dependency. . . . [At the request of the MC company, the patient and family] traveled many miles into New York City for evaluation. It turned out that the orientation of this MC company was short-term cognitive. After evaluation they agreed the clinician needed to continue to treat her patient. However, they held up 9 months of payments and did not pay until the provider reported them to the NYS Insurance Department. They also suggested to the patient that she was too dependent on the therapist. This same company told another one of our members to terminate her case in 4 sessions as she was not on the panel. She asked to apply to the panel and was told that it was closed. When asked what would happen if the patient regressed, the provider was told that the patient could come into NYC for services. This is not only 40 miles away from the patient's residence, but the managed care company is now suggesting that the evaluators also provide the psychotherapeutic services. These actions step over the line of benefits management.

MC companies need to make it clear to purchasers that managed care is really regulated care. Clients do not understand when they elect a managed care plan that treatment they have been receiving under indemnity plans most likely will be terminated. They are told that their providers can join the panel. The providers apply and find that the panels are closed. Panels are repeatedly closed at this point. One of our members evaluated a patient who was being physically abused by the male members of her family. She wanted a female therapist. She was told that there were no female therapists in her area. There were six men on the panel and the patient must see one of them. The patient elected not to use her benefits. Another member who was black tried to get accepted to panels; she asked several companies if any of the panels included black providers. She was told repeatedly that the companies were under no obligation to divulge such information.

One of the fears of practitioners has been that, as the costs of . . . extensive reviewing mounted, the smaller managed care companies—who have provided good service to the insured—would fail and be bought up by . . . larger companies. . . . This seems to be the trend nationwide. Two rather large managed care companies, American PsychManagement and Preferred Health, have just been bought out in New York State by Value Behavioral Health. Social workers just received new contracts this week and have found that their fees for service have been reduced by VBH. Social workers provide 65% of the psychotherapy that is done nationally. The fees for psychiatrists and psychologists seem not to have been reduced. This has happened without warning and there is no recourse. In this case the adjustment of fees may not directly affect the consumer. However, it contributes to a sense of powerlessness to advocate for self and patient as these companies grow in size. There is currently no forum for arbitration.

We have been asked to be exquisitely accountable for the medical necessity of our work by companies that need to be required to be accountable to the public as well. The mental health of our population affects crime, work productivity, death rates, physical health, teenage pregnancy, school problems, etc. I believe that managed care companies should be accountable to New York State and that the books of these companes should be open to review. I think that ranking of health insurance companies by denial of claims rates and publication of the outcomes of challenges is an important tool in helping the consumer evaluate insurance plans. As providers are profiled, so should the track records of insurance companies and these should be published, [available to consumers.]

Time does not allow for full documentation of difficulties that our providers are having with such things as hold harmless clauses. Practitioners are left to take the responsibility for seriously ill patients when treatment is terminated.

In summary, the professional mental health community and the mentally ill of New York State need the legislature to pass [laws] regulating the insurance industry as it exists today in the form of managed care, HMOs and the utilization review companies. Providers who advocate for good treatment need to be protected. Consumers need to have reasonable freedom of choice. Review of treatment needs to be regulated so that it does not prevent consumers from obtaining the benefits they are promised and have paid for. □

FRONTIERS *(continued)*

in chaotic outer lives. The therapist may also have to play the role of educator as the patient strives to develop more healthy patterns of living.

In terms of treatment, these two approaches have much in common. With the self psychological approach, interpretation is secondary to empathy. Likewise in object relational treatment, interpreting is used to promote separation from the bad object, and holding is used to encourage internalization of the good object. Interpreting would however be ineffective and probably countertherapeutic until there is enough of an internalized good object to sustain the pain of separation from the bad object.

This first collaboration between the NYS Society and the NYU School of Social Work was a success in terms of the quality of the papers presented and the workshops available, as well as the great numbers of clinical social workers in attendance. Hopefully this indicates that a second collaboration will be forthcoming.

Julie Kipp, CSW, works with the Jewish Board of Family and Children's Services. She is in the NYU PhD program in social work.

CSWs GAIN ENTRY *(continued)*

a clinical social work representative to meet with VBH to address these concerns.

The unforunate trend seems clear—that managed care is reducing fees to all mental health providers and social workers, being at the low end of the scale, are feeling helpless and angry. Can anything be done to stop this systematic lowering of fees? The answer is not clear, but if we don't let our representative organizations know our feelings, they cannot represent us in any meaningful way. We need union representation so that a voice united can be heard and hopefully listened to. Contact your local and national leaders of Federation and NASW and let your feelings be known. □

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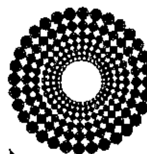

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PLACE: New York City

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124 East 28th Street, New York, NY 10016
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On Divorce Mediation

For a free directory of New York State mediators or for more information, write or call:

The New York State Council on Divorce Mediation
666 Old County Road/Suite 705
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800-894-2646

New York State Society for Clinical Social Work, Inc.
350 Fifth Avenue - Suite 3308
New York, N.Y. 10001

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