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**SOCIAL WORKERS' SERVICES UNDER FEDERAL
EMPLOYEES' HEALTH BENEFITS PROGRAM**

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THE KANSAS STATE UNIVERSITY

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HEARING

BEFORE THE

**SUBCOMMITTEE ON
MENT AND EMPLOYEE BENEFITS**

OF THE

**COMMITTEE ON
OFFICE AND CIVIL SERVICE**

HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

SECOND SESSION

ON

H.R. 11544

**A BILL PROVIDING FOR DIRECT ACCESS TO SOCIAL WORKERS'
SERVICES UNDER THE FEDERAL EMPLOYEES' HEALTH
BENEFITS PROGRAM**

FEBRUARY 6, 1974

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SOCIAL WORKERS' SERVICES UNDER FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

WEDNESDAY, FEBRUARY 6, 1974

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS,
Washington, D.C.

The subcommittee met at 10:13 a.m. in room 340, Cannon House Office Building, Hon. Jerome R. Waldie (chairman) presiding.

Mr. WALDIE. The subcommittee will come to order.

Today the subcommittee will hear testimony on H.R. 11544. The provisions of this bill would amend the Federal employees' health benefits provisions to allow participants under the health benefits program to have direct access to the services of licensed and or certified clinical social workers without the necessity of supervision or referral by a physician. It is my understanding that Aetna Life & Casualty has currently taken under consideration recommendations that subscribers to its Federal employee plan be entitled to receive reimbursement for such services as social workers may provide under the scope of the plan's coverage without the necessity of a physician's referral.

The subcommittee has over the years investigated the inefficiencies of the Federal employee health benefits program in order to assure that employees receive quality care at reasonable and fair cost. Additionally, our inquiries have revealed certain deficiencies in the delivery of health care services.

If, under the Federal employee plan, mental health provisions are to be developed in a way that will provide greatest access at least cost, then we must make sure that Federal employee plan subscribers have direct access to all competent mental health practitioners. Social workers are highly trained professionals who are, as the most numerous and widely accessible mental health practitioners, the backbone of our mental health care delivery system. Where clinical social workers are licensed and/or certified by statute as providers of mental health services, there can be no reason to prohibit participants under the Federal employee plan from having "direct access" to their services, in the opinion of the chairman of the subcommittee.

The first witnesses we will call are Mr. Arnold Levin and Mr. Wright Williamson, representatives of the National Association of Social Workers.

Mr. Levin and Mr. Williamson, please come forward.

Gentlemen, you may proceed as you desire.

Mr. LEVIN. Thank you, Congressman Waldie.

Mr. WILLIAMSON. I beg the indulgence of the committee, Congressman, because I have run afoul of the secretarial problem and shall have a written statement to the committee later, if I may.

Mr. WALDIE. That will be fine.

Mr. WILLIAMSON. Thank you.

STATEMENT OF ARNOLD LEVIN, PRESIDENT, ILLINOIS SOCIETY FOR CLINICAL SOCIAL WORK, REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS AND THE ILLINOIS SOCIETY FOR CLINICAL SOCIAL WORK

Mr. LEVIN. Mr. Congressman, my name is Arnold M. Levin. I am a clinical social worker in private practice in Chicago and Homewood, Ill. I am president of the Illinois Society for Clinical Social Work and a member of the National Association of Social Workers.

I am here representing both the Illinois Society for Clinical Social Work and the National Association of Social Workers. I am here to offer testimony in support of H.R. 11544.

I have decided to offer a brief case example to illustrate a number of the reasons why I support this resolution. The situation simply put is as follows: an elected official of the State of Illinois sought my professional help to offer psychotherapy to his teenage child. I agreed to offer my services. The elected official and his family are covered under the State of Illinois employee health benefit program for psychotherapeutic services.

His claim for reimbursement for the payment of fees to me was disallowed because clinical social workers were not or are not, covered specifically under this plan as reimbursable vendors. The official decided to continue his child in treatment with me, but he has had to bear the burden of the fee himself.

Like most other elected officials, he is not independently wealthy and, like most of the others, he has, indeed, made considerable financial sacrifices in order to continue to serve the people of Illinois. While my fees are relatively modest, specifically \$30 a visit, the teenager, in my judgment needed to be seen at least twice a week, initially, so that the expense was \$60 a week or \$240 a month. Treatment was necessary for about 1 year with decreasing frequency of visits. But the overall cost came to almost \$2,000.

In addition, the child, for various reasons, needed to be placed in a private school where the tuition was in excess of \$3,000 a year. Clearly, the combined expense was a heavy one. Indeed, the father had to ask my forbearance to wait to be paid for an indefinite period of time.

Some of the issues illustrated by this particular case are the following: First, all of us, no matter what our station in life, are part of the population at risk who may at some time require some form of psychotherapy for ourselves or our families. The cost to the individual and his family for such services are considerable.

In the United States we have depended on the insurance method to pool the risk of such an expense.

Second, a quite respectable member of the community was deprived of his vested rights in an existing insurance scheme for which he had paid.

Third, his right to choose freely the particular professional person and service he deemed best for his own family had been usurped. It was as though the wisdom of the insurance carrier were substituted for his own individual wisdom.

Fourth, a member of a well-established profession was discriminated against by the insurance carrier. And fifth, an increased financial burden was placed upon a family already burdened.

Had the elected official been a Federal employee or Federal official he might have found the cost of my services reimbursable provided that (1) a physician had referred to me; (2) that the physician continued to supervise me; and (3) that the physician see the teenager in question initially and at least once every 90 days. The elected official's personal judgment would not have been considered sufficient to permit him to choose me as the appropriate person to help him and his family. The choice would have been taken away from him.

In addition, the official, his family, and particularly the teenager, would have been subjected to the discomfort of having to be seen by one or more people in addition to myself at a time when the family was acutely upset, uncomfortable, and sensitive. The family's privacy would have had to be intruded upon at just the point when feelings were at their rawest. Had the family lived in one of the more rural sections of the State of Illinois, or in a rural community elsewhere in the United States, most likely they could not have found a professionally trained psychiatrist to make the appropriate evaluation and referral.

But, assuming they had been able to, the cost to the family would have been increased as well as the cost to the provider.

Mr. WALDIE. May I interrupt you just a moment?

Mr. LEVIN. Yes, sir.

Mr. WALDIE. Does it require a psychiatrist to refer or just a doctor of medicine?

Mr. LEVIN. No; as I understand it, Congressman Waldie, the requirement is for a doctor of medicine. I was—and as a matter of fact, I regard that as an even more serious problem.

Mr. WALDIE. I do, too, and that's why I thought I should mention that, because if it were a psychiatrist, there might even be some reason for that. A doctor of medicine referring seems to be totally nonsensical, burdensome, and costly.

Mr. LEVIN. I could not agree with you more and I thank you for interjecting that. I was being kind.

Mr. WALDIE. Well, we don't have to be kind in this room. We can be up front.

Mr. LEVIN. All right.

Costs tend to spiral under the currently administered program. Finally, an autonomous, well-trained, long-experienced professional would have been forced to behave as though he were not an autonomous, well-trained, long-experienced professional, who would have had to seek a pro forma referral and supervisory arrangement.

H.R. 11544, if enacted, would go a long way toward eliminating some of the disadvantages I have illustrated above. It would provide freedom of choice for the consumer. It would recognize the realities of professional practice of psychotherapy. It would minimize the hu-

miliating aspects for the consumer of the currently administered program. And it would likely cut costs to the program.

We have available statistical studies from the Department of Health, Education, and Welfare and other sources which we respectfully request your permission to attach and submit to the subcommittee, for your committee's consideration.

Mr. WALDIE. Thank you.

Mr. LEVIN. These data illustrate that social workers, well trained and experienced, provide the vast bulk of psychotherapeutic services throughout the United States. These data further reveal that the substantial number of such social workers are better distributed geographically, particularly in rural areas, than are professionals in the fields of psychiatry and psychology.

These data suggest that the way the Federal employees health insurance program is currently administered works to the disadvantage of all Americans, including elected Government officials, particularly discriminating against those who happen to live in areas not well supplied with clinically trained social workers.

Further data suggest that availability of psychotherapeutic services tends to reduce the total overall medical insurance costs through reducing utilization of medical facilities by high medical users.

We understand there is concern that without medical supervision service by social workers would be offered unnecessarily and for longer periods of time than necessary. We know of no evidence to support this argument. Indeed, clinical social workers have been in the forefront of research and practice efforts to reduce the length of time required for treatment and to find less expensive ways of offering psychotherapeutic services.

I have cited only one piece of writing in the literature. There are many others.

In relation to the case example I have given, one might ask why the elected official decided to seek me out especially. Certainly it was not because I am somehow unique, since there are many clinical social workers like me. It was not because there were no other professionals available. Rather, the father was referred to me through a trusted friend. Being in the peculiarly exposed and sensitive position within which elected officials find themselves, he wanted someone he could trust. He trusted the judgment of his own friend most of all, as would any one of us.

The resolution under consideration would alter the administration of the Federal employees health insurance program in such a way as to provide those covered with such freedom to choose.

My own credentials are in good order. I am a member of the Academy of Certified Social Workers. I am certified in the State of Illinois. I am licensed as a clinical social worker in California. I am a graduate of the University of Chicago, School of Social Service Administration. I am a graduate of the Chicago Institute for Psychoanalysis and hold certificate therefrom.

I have taught medical students and nurses at Mount Sinai Hospital, Chicago Medical School.

I laugh at myself as I am reading this, but I have a point in doing so.

I am a lecturer at the University of Chicago Graduate School. I am chairman of the Citizens Grant Review Committee of the Illinois

Department of Mental Health. I was the chairman of the technical advisory committee of the Juvenile Protective Association in Chicago. I have been a consultant to the Illinois Youth Commission and to the Scholarship and Guidance Association in Illinois.

I am a past president of the Psychoanalytic Child Care Association of Chicago. For many years I was the executive director of the Family Service and Mental Health Center of South Cook County. I have been exposed on the direct line of fire for almost 25 years. My credentials are in order, yet unless the bill you are considering is passed, before I can serve someone under the Federal employees health insurance program, I must be supervised and certified once again by a member of a profession other than my own.

Clearly, I think H.R. 11544 ought to be passed.

Thank you.

Mr. WALDIE. Well, I can't let you stop there. Why were you laughing?

Mr. LEVIN. Well, it sounded like I was selling myself on the open market there a bit, as I read it out loud.

Mr. WALDIE. I see. Impressive credentials, and I think the point you are making is strongly made by a recitation of your experience.

I think probably the only question that I would want to pursue somewhat is the conclusion you have drawn from studies that are apparently in existence that show there would not be an overutilization of these services, were they to be covered. I am curious as to the studies that come up with that conclusion. Could you describe them a bit? Where has such service been available so that we could determine whether it would be abused in terms of utilization?

Mr. LEVIN. Well, in the studies that I am aware of, I have—I think I have cited them somewhere in here—I apologize for not finding these things as quickly as I would like to.

The Health Insurance Association of America, I believe, is the publisher of a regular series of studies. Among the studies that they distributed within the last 2 or 3 years, were studies of the Kaiser-Permanente plan in California and the health insurance plan of New York.

In both of those plans, mental health services are included and social work services are part of the mental health component of their plans.

Mr. WALDIE. Are they required to be supervised by a medical doctor?

Mr. LEVIN. In relation to the Kaiser-Permanente and HIP, I cannot answer the question. The plan where I can specifically answer the question is the Downriver guidance clinic near Detroit, Mich., where there is a contractual arrangement with the Blue Cross-Blue Shield, and I think the United Auto Workers with this particular authorization that requires no medical referral and no medical supervision, where the program has gone on at least 2 to 3 years and where utilization, overutilization has not, indeed, been a problem at all and we can have—

Mr. WALDIE. I think that would be helpful to the committee and if you could provide, if not the study for our records, which probably would be the best source, a reference to it and a summary on that point, because as I understand the carrier's position, and this is the

position that is adopted in toto by the Civil Service Commission, their fear is that there would be overutilization without supervision. And I don't know on what they base their fear, except an intuitive belief that might occur.

I gather there has been no opportunity, other than the Kaiser you are talking about, to really test that theory, and apparently your statistics tested and find it wanting in terms of validity. It would be helpful to have that as part of the record.

Mr. LEVIN. With your permission I will try to be in direct contact with the director of that service, and as quickly as I can, have that material in your hands.

[The information follows:]

I have been in telephone contact with Mr. Judson Stone, Director of Six Area Coalition Mental Health Center (former Director of the Downriver Guidance Clinic, which was the contracting agency with Blue Cross-Blue Shield of Michigan for the program discussed), 2075 Fort Street, Lincoln Park, Michigan 48146. The Downriver Guidance Clinic contracted with Blue Cross through the United Auto Workers Union to offer out-patient mental health services. No medical referral nor supervision is required. The contract called for a cost ceiling of \$400 per person covered per year for out-patient coverage. Coverage was renewable as of January 1 of each year. Actual utilization of costs came to \$210 per individual actually served within the out-patient mental health service. Service is offered by clinical social workers. A peer review system was developed and still exists.

Mr. Stone further reported that in verbal discussion with representatives of Blue Cross that the clinical social work program contains costs more effectively than any of the other mental health programs covered by Blue Cross in Michigan.

Mr. LEVIN. I was going to say that in a related area, namely: in relation to the use of psychologists' services, CNA, which is an acronym for Continental Assurance Co.—it is a major holding and insurance company—had covered psychologists' services and in a report informally to a psychologist friend of mine, CNA indicated that in their experience there was no evidence of overutilization once that program was introduced.

There are couple of other examples, but at the moment perhaps that will suffice.

Mr. WALDIE. Are licensing and certification laws that are presently in existence in the States, adequate in your view, to guarantee the professional standards that we ought to expect in this field?

Mr. LEVIN. At the moment I would have to answer the question negatively. Only a few States do have adequate licensing laws at the moment. However, the national association of social workers, through its development of the academy of certified social work, has been developing standards for competence.

I happen to have been a member of the Certification of Competence Committee for a number of years, so I am very intimately involved in that standard study issue, and at the moment I would have to say that that was probably the best measure available to us.

There is a second process that the professional associations have undertaken, and that is: we have established in certain cities, review committees to evaluate our peers in relation to their competence to practice what they say they are going to practice. But we are working towards licensing in a number of States at the moment.

Mr. WALDIE. Would that deficiency in any way hamper the implementation of this bill?

Mr. LEVIN. I think it would be easy—at the moment I think it would be something of a hinderance, but I think it is relatively an easy one to work with in that it is easy, relatively easy to establish who, indeed, meets the standards that are set, that are called standards for admission to the academy for certified social workers—

Mr. WALDIE. Do you have a copy of the bill before you?

Mr. LEVIN. Yes, I have one.

Mr. WALDIE. Okay. Take a look at "Standards" set forth in the bill.

Mr. LEVIN. Yes.

Mr. WALDIE. That's from lines 6 through 9 or through 10.

Mr. LEVIN. Yes.

Mr. WALDIE. Does that standard meet the standards you are talking about?

Mr. LEVIN. In that it—it does and it does not. The standard as set in the bill, as described in lines 7 and 8, namely; "A Master's Degree in Social Work and two or more years of supervised experience in a clinical or hospital setting," I would feel that I would want something that would specify a little bit more about the specific clinical experience.

Up to that point that certainly applies and would be a standard that I could accept and I think that would be one that would protect the community, the public interest, which is something that is of high concern to us.

The issue of licensed and/or certified at the moment, would mean that a very substantial number of practitioners in States that do not have a licensing or registration law, would be discriminated against as the bill currently stands.

Mr. WALDIE. Should States have licensing and/or certification laws?

Mr. LEVIN. Yes.

Mr. WALDIE. Should we not then, enact legislation that would, in fact, encourage them in that direction?

Mr. LEVIN. I would tend to agree with that position.

Mr. WALDIE. Clearly, the bill, as drafted, because of the two standards, a general standard describing qualifications professionally and then an external standard requiring a State or Federal assessment by licensing or certification, has the result, of narrowly construing the class to which the bill has applications. Narrowly; thereby, defining also its impact, and politically making the probability of the bill's acceptance greater.

Do you find its definitions unduly restrictive?

Mr. LEVIN. No, I do not.

Mr. WALDIE. Let me introduce Mr. Moakley, a member of our committee, the Congressman from Massachusetts, and Joe, you may desire to say something. You may desire not to.

Mr. MOAKLEY. Well, I have read the bill, Mr. Chairman, and I am just here to listen to the testimony. I have had many social workers in my Boston office come in and talk to me in favor of the bill and I am just wanting to hear the other side of the coin.

Mr. WALDIE. I don't think you are going to hear it.

Mr. MOAKLEY. I don't think so.

Mr. LEVIN. You won't hear it from me.

Mr. WALDIE. Mr. Williamson?

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. Mr. Levin, thank you very much.

When Mr. Williamson has concluded, if you desire to participate in either his comments or our questions, feel free to do so.

STATEMENT OF WRIGHT WILLIAMSON, BETHESDA, MD., REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. WILLIAMSON. Thank you, sir.

My name is Wright Williamson and I have a professional private practice in Bethesda, Md., so I am well acquainted with the insurance programs that cover the vast majority of the Federal employees in this area.

I am here as a representative of the National Association of Social Workers and I am certainly here in support of H.R. 11544. This is my first time before your committee, but we have had representatives here so often I really feel we should offer committee members at least honorary membership.

This issue has been struggled with a long time before this committee, before the Civil Service Committee, and with the various insurance companies in the area.

I am a member of the academy of certified social workers, which is probably not very well known outside of the profession. Its requirements for membership state that a person shall have a master of social work degree from an accredited school of social work; that they shall have spent at least 2 years of supervised clinical experience in an acceptable setting, and also that they shall have passed a written examination. The examination is getting tighter every time it is given. My understanding is that the last time it was given, 17 percent failed to pass the examination and will have to try again.

There is something in the history of social work which I think has—

Mr. WALDIE. Excuse me. May I interrupt you a moment there?

Mr. WILLIAMSON. Yes.

Mr. WALDIE. As you described the qualifications, you were using closely the words of the bill in terms of the standards that are demanded in the bill; at least the first standard.

Mr. WILLIAMSON. Yes.

Mr. WALDIE. Except you weren't quite using those words, and I am curious as to whether we omitted words that ought to be included or whether there was a reason for the omission?

Should the bill define supervised experience? It would seem to me it should. Supervised experience is hardly a very meaningful description of what kind of supervision is demanded.

Mr. WILLIAMSON. I would agree that the addition of a requirement for supervision by an experienced social worker should strengthen the intent of the legislation.

Mr. WALDIE. I will keep the comment in mind, as to whether the bill should have a better definition in that regard, for those who are waiting to testify.

Then, the bill uses the word "in a clinical or hospital setting," and you used the modifying adjectives, "in an appropriate clinical setting." What did you mean by that change?

Mr. WILLIAMSON. Well, "clinical setting" gets a bit fuzzy. A person who wanted to argue that they met the standards could argue that, having worked in a welfare office and having been in face-to-face contact with people on a daily basis, and having to solve problems, represents a clinical setting. I think it is a highly debatable issue within the profession and one I would not try to get introduced with regard to this bill. I think I would prefer the narrower definition.

Mr. WALDIE. What is the narrower definition?

Mr. WILLIAMSON. Specifically clinical in terms of ongoing treatment over time.

Mr. WALDIE. In other words, you think "appropriate clinical" ought to be defined?

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. That may very well—

Mr. WILLIAMSON. That may be difficult and perhaps it would be easier to leave it in and let the profession define "clinical setting," as it is in the process of doing.

Mr. WALDIE. Well, I think those are points that we ought to solicit additional testimony upon.

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. Because they concern me as being too generously drafted in terms of standards and we ought to be seeking standards that have some meaning.

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. Mr. Moakley, did you want to comment there?

Mr. MOAKLEY. No.

Mr. WALDIE. OK. Please continue.

Mr. WILLIAMSON. The history of social workers has been founded generally in agencies and institutions. And I think this has led us away from having due regard and concern for our own standards as set by our own profession. We have allowed the publicly sanctioned agencies, such as family service agencies, Jewish Social Service, Catholic charities and agencies of this sort, to set the standards for the profession. And while I think we are late, we are very quickly coming to the point of establishing our own internal standards which will clearly differentiate who is qualified to provide what services.

Locally, the Washington Chapter of NASW has developed what we call the Clinical Peer Review and Standards Committee, and I have the honor of having been its first chairman. This committee is made up of nine professional social workers, all of whom are members of the Academy of Certified Social Workers, and all of whom have had extensive clinical experience themselves. The committee is set up to review questions brought by insurance companies with regard to fees, with regard to the length of time of a session and with regard to the duration and method of treatments used.

It reviews questions of ethical practice and other issues brought by patients themselves, or representatives of patients, meaning direct family members, other social workers and other health practitioners. We recommend to the insurance companies the finding in our cases and we have stated our willingness, though I am thankful we have not been called to do so as yet, to stand up in court and support our recommendation to the insurance company, should a company be sued for failure to reimburse on services that we did not feel were appropriate. We are willing to stand up and defend it.

We have taken a further step which I think will help to more clearly define those workers who are eligible to provide service in what kind of setting or on an independent basis. And this is through the development of a structure that's now being considered by the national organization of what has been called to date, the National Registry of Clinical Social Workers. This requires membership in the Academy of Certified Social Workers—

Mr. WALDIE. May I stop you just there?

Mr. WILLIAMSON. Yes.

Mr. WALDIE. Would you provide for the record some background on the Academy of Social Workers? Its history, how it has performed, what are the standards for membership, how long has it been in existence.

Mr. WILLIAMSON. May I do so in the written material I submit to you?

Mr. WALDIE. Yes.

[The information follows:]

In October 1960, the Delegate Assembly of the National Association of Social Workers authorized the establishment of the Academy of Certified Social Workers (ACSW). The initial requirements for membership eligibility were that a person have an M.S.W. degree from a recognized graduate school of social work, that he had worked for two years under the supervision of a member of ACSW, and that he had been a member of NASW for those two years.

Within the past three years, Academy membership has been placed on the stronger requirement of passage of a written examination. The supervision requirement has been altered so a person may receive supervision from someone other than an ACSW member. (There is a move to re-institute this requirement.) Beyond this, the Academy is working to develop specialty examinations in the several fields in which professionally trained social workers are active.

Mr. WALDIE. I gather that this is an important institution in your view, in terms of standards of the profession?

Mr. WILLIAMSON. Most certainly. Yes; the national association regards it as such. I think that the development of the National Registry of Clinical Social Workers is a step beyond, because it requires that a person be a member of the academy—these are suggested requirements and subject to amendment.

The idea of a national registry has been approved in principle, but the details have not as yet been worked out.

We can submit a copy of the material that is available in its present form and it should be understood that it is submitted with the possibility of changes in the future.

Mr. WALDIE. May I ask you at this point: Is your suggestion that the standards set forth in this bill would be the standards required for registration in this national registry?

Mr. WILLIAMSON. I think that the standards required for registration are stronger than those set forth in the bill.

Mr. WALDIE. So that a person could still be qualified to deliver these services under the bill, though not a member of the registry?

Mr. WILLIAMSON. Yes, sir. Whether the insurance companies would agree to reimburse is another matter, because the registry is aimed principally at the insurance companies.

Mr. WALDIE. Well, if this bill passes it would not be our intention that the insurance companies would be able to make the sort of determination you suggested, then. That's the bag we are in now.

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. Insurance companies are making determinations as to whom they will reimburse, based upon their standards. We are seeking to set a standard here.

Mr. WILLIAMSON. Well, the insurance companies, of course, tell us these are the standards of the Civil Service Commission.

Mr. WALDIE. I know, but we are setting standards by statute.

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. And the only thing I want to make clear is: you are setting a higher standard for another purpose, perhaps, but I want to make it clear in your testimony that you are not suggesting your national registry, which I gather is a higher standard than the one set in the bill, shall be the standards that the insurance company will have reference to in terms of deciding who shall receive reimbursement?

Mr. WILLIAMSON. They would have reference to it, but I don't think they would be bound by it, certainly. There is no question of that. They would be bound by the legislation, I would assume.

Mr. WALDIE. I would assume, too. It is a ground that troubles me.

Mr. WILLIAMSON. All right.

Mr. WALDIE. Mr. Levin?

Mr. LEVIN. Congressman, it seems to me that your bill as presented here, the definition that includes "licensed and/or certified," while I would agree with the earlier suggestions that there be more specification of experience and what goes into the licensing and certification process, I think for my own point of view, Wright and gentlemen, I believe that that is a more appropriate way of establishing who shall be recognized as an appropriate vendor and who is not, and my reason for holding that opinion is that in the process of developing State licensing procedures, almost invariably, I think probably without exception, the State requires some form of examination procedure in addition to establishing a voucher, vouching for the training and training requirements. Usually an examination procedure is required.

There is more and more experience accumulating in the development of examination and I say this from my own experience on the certification of competence board, where a major task was to develop an examination. I had no idea how hard it was to test somebody. I had always thought it was in the eye of the test taker that difficulties would lie. That had been my only previous experience, but it is difficult.

However, there is a body of experience and knowledge developing, already developed and in the process of developing further, that I think will be available, State by State by State in the development of licensing procedures.

It seems to me that the involvement of the public, as is the case in the licensing arrangement, is important. I would not like to be in the position of supporting the physician for example, who says a profession should have total responsibility for policing or regulating itself. I believe there needs to be public involvement.

I agree with Mr. Williamson's statement that in the past social work as a profession has relied on the institutional structures like agencies, clinics, et cetera, to provide a structure for the setting of standards, the sanctioning of the practice, a control of quality, et cetera. We are now moving into a different phase or a different method of control and standard-setting, and it seems to me that that is a

good move, moving in the direction of licensing and certification with public involvement, and professional involvement. It is the way to go.

I didn't mean to make a speech.

Mr. WILLIAMSON. Gentlemen, I am certainly in agreement that licensing is far and away the stronger standard and I am in full support of it. I am concerned, however, with what happens in those States such as, I understand, Virginia which at this point has unofficially put a moratorium on licensing, that they have had so many bills presented that they have just decided, "Look, enough already. We are going to hold off."

The fact is that social workers are licensed in only four States. I don't know how many they are certified in. There has been a struggle, an ongoing struggle for years and I engaged in the early part of it in Massachusetts to get a bill through for social workers for registry or licensure status. I don't know what the status is now.

The fact is, while the bill might lend considerable impetus to social workers to draft licensing bills, to submit them, I don't know that it is going to do anything to encourage the legislatures of the individual States to pass the bills that were presented. And it was primarily out of our concern for the lack of a broad-based licensing structure that this plan for a national registry came about.

As licensing occurs, I would see the need for the registry plan to either shift direction or to be terminated entirely.

Mr. WALDIE. I understand.

Mr. WILLIAMSON. So we are really caught somewhat in the middle. We have a licensing bill before the legislature in Maryland now, but how it is going to go—it has been there several years running and, you know, it runs into trouble and we write a bill that we feel is one that would guarantee the best possible protection for the quality of service to the public, and it still runs into trouble of one kind or another because of various interest groups that can apply pressure.

Mr. WALDIE. I have often thought one of the problems in this field is a semantical problem that has developed because of the know-nothing attack on welfare that uses the social workers as part of the attack's focal point and therefore, to a large number of people, social worker is synonymous with the right wing attack on welfare programs.

Mr. WILLIAMSON. Yes, sir.

Mr. WALDIE. Overliberalism, all the nonsensical views that they possess of stereotypes and that nomenclature operates against what you are seeking by this bill and the ability to acquire the services you render because the services you render are stereotyped in the nomenclature of the social worker in too many people's minds.

Mr. LEVIN. Social work, I think, has been doubly blessed that, not only the right wing attack on welfare, but these days, left and right, I don't think, are too clear—

Mr. WALDIE. Yes.

Mr. LEVIN. But "Lefter" attacks on social work are also present for—in relation again to semantic problems where the social worker is regarded as an investigator—

Mr. WALDIE. Sure.

Mr. LEVIN. When in fact, I think we are something else.

Mr. WALDIE. Yes.

Mr. LEVIN. I know we are something else.

Mr. WALDIE. OK. I think I understand what you are talking about in terms of the National Registry and you are not suggesting it as a different standard than the bill. You are referring to it as an internal mechanism, I gather, of the profession, to raise the professional standards of the profession?

Mr. WILLIAMSON. Yes, precisely. It would require letters of reference; it would require that a person had had x number of years of supervised clinical experience. It would require that a person submit himself to an in-depth interview.

Mr. WALDIE. I presume, if this legislation passed, what it would certainly not only enable, but be a strong factor of encouraging insurance companies in those States where neither licensing or certification existed, to have recourse to the National Registry in terms of using this medical delivery system?

Mr. WILLIAMSON. Yes, sir. We are currently negotiating with some of the largest insurance companies in that direction. You mentioned in your comments, Aetna. Part of our discussion is around matters related to the registry.

Mr. WALDIE. Please continue.

Mr. WILLIAMSON. I think it only remains to say that as the registry program is developed it would be maintained locally and nationally as well, so that there would be ready reference material available to anyone interested in determining what social workers, by examination of his peers, has met the standards necessary to provide the services we feel are of the highest quality our profession can provide.

Mr. WALDIE. May I interrupt you for just a moment?

Mr. WILLIAMSON. That finishes my testimony.

Mr. WALDIE. Mr. Moakley?

Mr. MOAKLEY. Mr. Chairman, I have no questions. I have been brought up to date, as I say, prior to this, by many people from my area who have gone over the bill line by line and I am in favor of the concept and if you need any clarifying amendments, I will be in favor of that, but I am in favor of H.R. 11544 as written and if, as a result of the testimony elicited here this morning, you feel that there are any amendments needed to strengthen the bill, I would be in favor of those.

Mr. WALDIE. Thank you, Mr. Williamson and Mr. Levin. Do either of you have any additional comments you would like to make?

Mr. LEVIN. You have set my mind to thinking further about the language of the bill, I would not like to see the bill in any way weaken standards, but I do understand Mr. Williamson's point very well about the interim period, and perhaps there is some substitute that might be available as an interim step.

Mr. WALDIE. Yes.

Mr. WILLIAMSON. Well, as the bill is currently written, it would not affect the way I have to conduct my practice in Maryland a bit.

Mr. WALDIE. I see.

Mr. WILLIAMSON. That is, unless it is an impetus to the insurance companies to do business in a different way. We certainly are engaged in negotiating with them as hard as we possibly can.

Mr. WALDIE. Well, I would imagine—at least, I would hope that if we pass this bill and the insurance companies found that it would mean overutilization without any constructive results to the patient

were unwarranted, that that would open up a lot of doors in a lot of places, and nothing in the bill prohibits insurance companies from contracting for the delivery of such services in cases that do not have licensing and/or certification.

So, I don't think anything you have said is inconsistent with what you are doing. I just had a momentary qualm, though, not a large one, that the standards of the national registry may be a more concise standard than set forth in the bill, and though we set forth a standard in the bill, it may be that the companies will point to that as a profession's indication of what standards should be set and insist upon narrower standards even than those set forth in the bill.

Mr. WILLIAMSON. In those States where licensing exists, I can't imagine that it would be possible at all.

Mr. WALDIE. Do you think that licensing exists? Do you think that the recipient of either licensing or certification would be entitled to national registry treatment?

Mr. WILLIAMSON. I would feel confident that the person who is giving independent social worker services would have met all the standards that would have made him eligible for the registry.

Mr. WALDIE. Fine. Thank you very much, gentlemen.

Mr. LEVIN. Thank you.

Mr. WALDIE. Mr. William Jett, president of the Federation of Societies for Clinical Social Work, is our next witness.

STATEMENT OF WILLIAM JETT, PRESIDENT, FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

Mr. WALDIE. Mr. Jett? I understand you have no prepared statement you desire to present?

Mr. JETT. That is correct, sir.

Mr. WALDIE. Fine and dandy. You just proceed.

Mr. JETT. Mr. Chairman, members, I don't have a prepared statement to submit, but on behalf of the National Federation of Societies of Clinical Social Work, I will submit one later. Not being accustomed to appearing before these kinds of hearings, I wasn't aware that it was indicated. So—

Mr. WALDIE. No problem. We don't require that at all. We will accept it when you submit it. In fact if you had submitted one, I would have preferred to ignore it and just start testifying and answering questions.

Mr. JETT. OK. I will just try to respond, perhaps elaborate, on some of the comments that were made by Mr. Williamson and Mr. Levin.

I am a clinical social worker. I graduated from the University of Louisville with a master's degree in social work, 11 years ago. I have been in practice, both publicly and privately, since that time for a total of 11 years, in psychiatric settings, mental health clinics.

For the past 3 years, I have been in private practice in Lexington, Ky., by myself.

First of all, I would underscore the things that Mr. Levin said about his experiences through his case example. I would underscore that as being a typical occurrence. In the brief course of my 3 years in private practice, I have run into the same thing time and time again. Most of

my referrals, about 80 percent of them, come from physicians, pediatricians, internists, psychiatrists, and general practitioners.

These physicians, first of all, do not know about the provisions under the Federal Health Employees Benefit Act, which presently covers psychiatric social workers. It's somewhat redundant, but I would like to comment on this.

The way this bill is presently written—not 11544, but the other bill—it's a very unwieldy, burdensome process that one has to go through as a clinical social worker in order to qualify for reimbursement under this plan. It's equally difficult and even more embarrassing and burdensome for the client in question.

As you clarified the point here, the referral and the supervision, as under the current act, does not have to be made by a psychiatrist. This can be made by a pediatrician or even a proctologist, and I comment about the latter in something a light vein.

First of all, these physicians refer because they recognize a problem that is outside of their aegis or their skill. Pragmatically, I think they are too busy and disinclined generally to assume this referral and supervision kind of function. They also have to fill out the medical forms as the referring physician; they have to make evaluations. These have to be submitted periodically. Although they have to fill out the claim forms, they have to ask me for the diagnosis and so forth. It is just a very difficult process.

Then there is the question of how they are reimbursed for those services. Do they go to my billing statement? Do they charge the patient from their office, and so forth.

I have been rather fortunate. My practice has developed well in Lexington and I have been able to have a psychiatrist associated with my office. I provide him leeway to the office at no cost in exchange for the availability of his consultation services, precisely because of this dilemma and other situations pertaining to private insurance programs which require the same kind of medical supervision and referral as is required under the current Federal Health Employees Benefits Act.

Although this could be done through a physician, I feel that it is more appropriate—I have felt all along that if a case were going to be supervised that it should be supervised by a psychiatrist. That is why I have asked this gentleman to function with me in the manner that he has. It is working all right through him, but typically, when someone comes to me, rather than go back through that referring physician, pediatrician and so on, I refer the patient to the psychiatrist who evaluates him, and refers him to me. In that way we are legitimate in terms of qualifying under the present setup.

The psychiatrist then has the tie into the patient; in 90 days she can see the patient again, submit the report and so on.

It is expensive; it is difficult; it inhibits treatment sometimes in the initial phase when it is most crucial, because until you can legitimately get a physician to state and fill out the forms that they have referred somebody to you, the effect of their insurance coverage does not begin until that, in fact, is done. And sometimes this takes—well, it is delayed sometimes a couple of weeks and in the meantime, as Mr. Levin pointed out in the one case, the young boy that he was seeing required frequent consultations when initially seen.

In my experience most people do require immediate attention when they come to your office because they are usually in a critical type of state, sometimes two, sometimes five times a week. Once the emotional situation stabilizes, you can get them down to a weekly basis, a once every 2-week basis, and so on; so when you are perhaps in the most critical stage of the treatment you are most inhibited. It interferes with my ability to function as a clinician.

I don't really have to say this, but the very people we are asking to supervise our cases, the physicians, the proctologists, for example, are in no way skilled to do, and they will be the first ones to tell it; that they are in no way skilled to perform the task that the law requires of them. So, it is a formality; it is a routine, and I don't want to be impolite, but I think it is a farce, by and large.

In Kentucky, we are a very rural State as is wellknown, and we are also very conservative. We have three major urban areas which would not be considered major by most standards. Lexington has 150,000 people in it. That is one of them; that is one of our major urban areas. We have a very limited psychiatric availability in our state in the person of psychiatrists and psychologists.

I think there are less than 150 licensed psychologists in the entire State. I think there are in the neighborhood of some 200 psychiatrists located throughout the State.

This creates a particular problem in relation to mental health manpower and its availability in our States. Social workers far outnumber psychologists and psychiatrists combined. I think there are something like 2,400 social workers in our State, 800 of whom are masters degree level social workers. Many of our Federal installations are in areas where there is no available psychiatric or psychological consultations

For example, the Fort Knox Military Base, with its Civil Service Employees staff and the Bluegrass Army Depot, which is outside of Lexington by some 20 or 30 miles. It is very difficult for these people to get the kind of services freely that they need when they need them.

Social workers, more typically, are distributed on a more even basis geographically throughout the state and, in fact, are available. Some social workers that I know of have located themselves near these installations, in order to be available. To share something personally with you, I have considered opening an office near the Bluegrass Army Depot on a half-day-a-week basis in order to make it easier for the people that I see for services; to make it easier for them to have access to the office, because otherwise it means taking time off for the depot and traveling 30 to 60 miles by the time they get into the office and back. It takes a large part of the day, so with respect to manpower, I feel that the way the current bill is written—and again, not H.R. 11544—I feel that it is truly a drawback, both to the professional clinical social worker and to the person that might want to seek his services. If I could switch back just a moment to the medical referral basis—

Mr. WALDIE. Could you tell me when you referred to the current bill, what were you referring to?

Mr. JETT. The—not 11544.

Mr. WALDIE. You mean the existing law?

Mr. JETT. The existing law.

Mr. WALDIE. I see.

Mr. JETT. Most physicians do not know that when they refer—most physicians do not know that nonmedical therapists, psychologists, and clinical social workers, psychiatric social workers, as the bill states, are eligible for services under this act. And if they do know it, most of them are quite conscientious and they want to refer people to those that they feel are eligible vendors. What routinely happens is that they get referred to medical colleagues, I am not saying that this is deliberate; I am not saying that they wouldn't refer to clinical social workers and psychologists if they knew they were available, but the fact is: they do get referred to the medical community or to a favorite medical friend, when often this is not actually the best person of choice to refer a problem to. Many psychiatrists are disinclined to do anything of a marital counseling nature, for example, or family counseling—that type of thing.

So, in a way, that limits our availability and the choices that the recipient has, himself. That's just my personal thought.

In Kentucky at this time—we were talking about standards a few moments ago. We were talking about the States that had licensing laws in effect. I think there is something like 12 or 13 States that presently have licensing or certification or registration laws. I might have to be corrected on this point, but the most important thing is that most of the States throughout the country are in the process of submitting licensing laws at present. Kentucky is a case in point.

We currently have a bill before the Kentucky State Legislature that is designed to license professional clinical social workers. That particular specialty is written into the bill. The requirements for that person who is qualified to render independent or private practice is very much in line with the information that you have in your bill here. We did usurp some of it so that it would conform. We did usurp some of the qualifications so that our law would conform to the qualifications of this bill which we hope will get passed; so States are moving very rapidly in the direction of establishing laws to regulate their own professions; and this standard of requiring licensing or certification, I would like to speak very strongly in support of this.

Although that might create something of a hardship momentarily in some of our States that don't have licensing, I think what it will do, as I believe you suggested; I believe it will give a tremendous impetus to the States to seek a kind of legal sanctioning for professional social work practice that most of us in the field have long recognized as being very, very much necessary.

Concerning the question of a registry, I would like to comment very briefly about that.

The National Federation of Societies of Clinical Social Workers is also in the process of giving consideration to the establishment of a registry-like system, or peer review system, but we are taking a slow approach to that. We are considering it. We are inquiring with respect to some of the comments and suggestions that the private insurance industry has made to us, and we have been negotiating and talking to private carriers, to try to achieve there what we hope to achieve through 11544 here.

If and when they indicate that what is necessary and how it would be necessary and useful, we are prepared to respond and we are already laying the groundwork for it. We are prepared to proceed with such recommendations and establish a system that will try to insure

either, in addition to a State's licensing or certification law that would license the practitioner, or in the absence of it, adequate practice standards and controls for the clinical social worker.

I would like to make—just to conclude with a final thought or two about the language in H.R. 11544. Some consideration was being given earlier about the specifics of the language as it pertains to the experience that one wanted to consider in order to qualify one under this act; is that correct?

Mr. WALDIE. Yes.

Mr. JETT. My thought was: there in line 8, if the words in line 8, where it says, "More years of supervised experience in a mental health hospital or clinical setting"—I wonder if we put the insert after—

Mr. WALDIE. Wait a minute. It doesn't say after "mental health"—

Mr. JETT. That is what I am suggesting.

Mr. WALDIE. Oh, I see.

Mr. JETT. A question if that were included, would that not make it more specific?

Mr. WALDIE. Well, we will take that under consideration.

Mr. JETT. I don't know.

Mr. WALDIE. Yes, right.

Mr. JETT. Now, the other thought that I had regards line 8 again. Some question was being raised about the idea of "supervised experience." What constituted "supervised experience." Who was to supervise. This is just a thought that might be of some value. I wondered if we stick the word "eligible," under the provisions of this act, after the word—or to read thusly: "2 or more years of supervised experience by one eligible under this act."

The language isn't very articulate but the idea is there.

Mr. WALDIE. I understand what you are driving at and that is the kind of question I have. I don't know whether that language will suffice, but it is a good suggestion, and we will consider it.

Mr. JETT. If I could just make one more comment about this, I would like to conclude my up-front remarks.

Mr. WALDIE. Please.

Mr. JETT. We are talking about the clinical social worker here, but the word in line 7—lines 6 and line 7, we referred simply to "a social worker who has a master's degree and 2 or more years of experience," and then we go on to define clinical experience.

I wonder if it wouldn't, again, for consideration, if it might not tighten this up more so if we put the word "clinical social worker" in there. Then the title conforms to the experience we are requiring of the person.

Now, the thing that causes me a little concern about this not being in here, has to do with the comment that you made about the word "social work," the semantics being too synonymous with welfare and so on. "Social worker," to my way of thinking, is too generic.

If we are talking about clinical social workers here, I at least wanted to share the thought.

Mr. WALDIE. Well, I think that certainly touches one of the concerns that I personally felt as a layman, but I don't know how valid that is. I think that is right. I think "social worker" needs a more precise definition as to what we are dealing with in this act, because it is a considerably more professionally trained and skilled person than the term "social worker" necessarily connotes.

One may not be exclusive of the other, but one is not inclusive of the other and I presume that you could be a social worker without coming anywhere near the qualifications you are setting forth in this bill for reimbursement of services and somehow or other there ought to be, I would think, a title that reflects those different qualifications.

Mr. JETT. In line with this, if I could just share an interesting experience with you very briefly: I was speaking to a Parents Without Partners group about 2 months ago and there were about 75 people in the audience. After I concluded my talk I was given a very pleasant applause and then we went into a question period. And one lady asked me if I charged for my services as a private practitioner. I told her "yes." She said, "Well, what do you charge?" I told her it was between \$20 and \$30 a session. She gasped and I thought she was going to hyperventilate.

But the idea was that her impression of a social worker was an impression that I think a great many people have and, as Mr. Levin said earlier, we know who we are, but there are a great many people who don't know who we are, and I feel that it is consequential.

The law that's in effect now, specifies the word "psychiatric social worker," and even though I don't like the word "psychiatric," I think that is important because that limits who we are talking about and there is a generally understood idea within professional social work and interprofessional fields, psychology and psychiatry, of what a psychiatric social worker does.

I much prefer the word "clinical," because it is a little broader, but yet it does have parameters that are understandable and definable. It also kind of goes to the heart of this bill. It separates us from the psychiatrist, and what we are striving for here is an independent status as vendors. So many people for years and years have identified psychiatric social work with psychiatry and the social worker, in a sense, as being an extension of the psychiatrist.

So, my personal interest is delineating clinical social work as a profession, legitimately qualified and trained within its own right.

Now, that concludes my comments.

Mr. WALDIE. Thank you very much, Mr. Jett. We appreciate your testimony.

Our next witness is Mrs. Judith Kasser, president of the Pennsylvania Society for Clinical Social Work.

STATEMENT OF JUDITH KASSER, PRESIDENT, PENNSYLVANIA SOCIETY FOR CLINICAL SOCIAL WORK

Mrs. KASSER. Congressman Waldie, ladies and gentlemen: I am Judith Kasser, president of the Pennsylvania Society for Clinical Social Work, director of a family agency in Philadelphia, and senior instructor in psychiatry at Hahnemann Hospital.

I think the committee has already heard much that can be said about the amendment and about the more widely distributed accessibility of clinical social workers in offering mental health services than is the case with some of the other professionals. I would like to address myself to several other points that have come up.

We don't have licensing as yet in Pennsylvania, but I feel that the impact of a wording in a piece of national legislation that calls for licensing, would have an enormous effect on the States. I think licensing is very important in the public interest. It is moving across the country. There are problems with it but I think we need to hold the line in terms of standards and in terms of having the national legislation set some models for the rest of us to follow. And I think, as you suggested earlier that, indeed, this would be the case.

So, I would support the idea that the amendment should state in rather specific and narrow terms, as Mr. Jett suggested, the description of the clinical social worker, as a professional licensed or certified by their respective States.

I think that licensing will, in a relatively short period of time, begin to gain momentum throughout the country.

I would also like to point out that family agencies, such as the one with which I am affiliated, exist and are offering autonomous mental health and counseling services all over the country to thousands of people and have been for their long history.

At the present time in my own agency there are several Federal employees in treatment. We can always get a physician to make the referral pro forma. This increases the bureaucratic entanglement and the cost; and there is resistance by the physician in being involved on this level. It is difficult for the patient; it disturbs the professional atmosphere and sometimes their confidence, but it is something that is being done across the country.

I would like to make myself available for any questions.

Mr. WALDIE. Well, I think probably we have covered most of the questions I was interested in, and you have generally concurred, I think, with those that preceded you.

At the present time do you offer privately your services?

Mrs. KASSER. Yes; I do.

Mr. WALDIE. And have you been reimbursed by any carriers for your services?

Mrs. KASSER. No.

Mr. WALDIE. Have any of the practitioners, to your knowledge, in Pennsylvania been reimbursed by carriers for similar services?

Mrs. KASSER. It's very erratic. The insurance companies offer decisions on a very erratic basis. Some people will be reimbursed, some people will not. Funny things happen as a result of this.

The vice president of our society is in the private practice group at the University of Pennsylvania and the Blue Cross people asked for her number. The chairman of the department, a physician and a board certified psychiatrist, just said, "Well, we haven't assigned her a number yet, because she is not reimbursable under the blues in Pennsylvania"——

Mr. WALDIE. I'm sorry. What do you mean by "numbers?"

Mrs. KASSER. Certificate number to make you eligible for reimbursement.

Mr. WALDIE. Oh, I see.

Mrs. KASSER. But she is accredited by her university, accepted by her peers, accepted by members of the other professions and offered as a private practitioner to people who come to the university.

Mr. WALDIE. And who has not given her a number?

Mrs. KASSER. Blue Cross-Blue Shield. They will not reimburse her. A great many things happen with the insurance. For example——

Mr. WALDIE. Let me stop you there a minute until I understand something.

Mrs. KASSER. Certainly.

Mr. WALDIE. Now, Blue Cross-Blue Shield does give certain social workers a number for reimbursement in Pennsylvania?

Mrs. KASSER. No.

Mr. WALDIE. Oh, they give none?

Mrs. KASSER. That is right.

Mr. WALDIE. Well, when you say "she has not been given a number," that would mean no one had been given a number?

Mrs. KASSER. That's right, and the issue that arises is that these things are done by administrative decisions, clerk decisions.

Mrs. WALDIE. What about Aetna?

Mrs. KASSER. Pardon me?

Mr. WALDIE. What about Aetna?

Mrs. KASSER. They have not reimbursed.

Mr. WALDIE. No carrier, to your knowledge, under the Federal employees program, or under any program, reimburses a social worker for clinical social work?

Mrs. KASSER. That is right.

Mr. WALDIE. In Pennsylvania?

Mrs. KASSER. In Pennsylvania.

Mr. WALDIE. So payment is solely and exclusively from the patient?

Mrs. KASSER. That's right.

Mr. WALDIE. Without any intermediary assisting?

Mrs. KASSER. That's right. This sometimes works to the detriment of the patient.

Mr. WALDIE. I would imagine it works to the detriment of the one paying the insurance all the time.

Mrs. KASSER. And they frequently can't go on with the therapist because of financial problems.

Mr. WALDIE. Well, surely.

Mrs. KASSER. And it restricts their freedom to choose.

Mr. WALDIE. Now, if you receive that patient on referral from a physician, you would be reimbursed?

Mrs. KASSER. That's right, presuming that the physician will sign the forms and go through the hassle.

Mr. WALDIE. Has that ever happened to you?

Mrs. KASSER. Yes.

Mr. WALDIE. You have been reimbursed when you received a referral from a physician?

Mrs. KASSER. Yes.

Mr. WALDIE. As a matter of interest to me, does it go that way? Does the physician refer the patient to you or does the patient come to you and you find a physician that will sign a referral?

Mrs. KASSER. It goes both ways but it very often goes——

Mr. WALDIE. Most often?

Mrs. KASSER. The patient will come to us and we find a physician we work with who will sign the referral.

Mr. WALDIE. On that point, Dr. Jett, or Mr. Jett, may I just ask you this question from the audience?

Does the psychiatrist for whom you provide office space sign the referral certificates for your patients?

Mr. JETT. It is kind of confusing. He signs the form with the diagnosis. Such forms require the signature of a physician, but I sign my own billing statement.

Mr. WALDIE. He does what?

Mr. JETT. He has to sign the diagnostic statement; the medical sheet that he fills out. I have reached the point—and this is part of the bulky part of it—in order to eliminate such confusion and have these applications come back from the insurance company a month later, I request that he write a brief statement, indicating that he has seen the patient; that he has evaluated him; that he referred it to me and that he is going to continue to supervise the case.

Mr. WALDIE. As a matter of actual fact, when the patient comes in, the patient comes into your office to see you; does he not?

Mr. JETT. Yes.

Mr. WALDIE. And you refer the patient to the psychiatrist who refers the patient back to you?

Mr. JETT. That's right. You see, it's much easier than trying to send him back to the physician's office.

Mr. WALDIE. It is a fairly good indication and I suspect happens quite often, of the artificiality of the requirement of medical supervision and therefore you are forced into these peculiar arrangements to comply with a standard that the carrier has established that really has no honest meaning to it.

Mr. JETT. That's right.

Mr. WALDIE. So, everybody has to play a little game at the cost to the carrier and to the patient and to every other insurer whose premium is based on that excessive cost, that extra cost that bought no service whatsoever, because you surely didn't buy anything from that psychiatrist, except a perfunctory report. You rendered the medical service that was delivered to that patient.

I am not asking for agreement to these concepts. I am suggesting that's the way it seems to me.

Mrs. KASSER. In mental health centers all over the country, social workers are delivering the services, 70 percent of the services, and the clinical director usually signs the forms. But it is, again, the kind of thing you are talking about where the forms are being signed.

Mr. WALDIE. Now, in your family agency center are the expenses of any of your patients reimbursed by the insurance companies?

Mrs. KASSER. No.

Mr. WALDIE. There is no physician in your agency who signs any forms?

Mrs. KASSER. That's right. We are an autonomous agency staffed only by social workers. We do not have a physician on our staff.

Mr. WALDIE. If you had one would you receive reimbursement for all your patients who are covered by insurance that has the provision requiring referral?

Mrs. KASSER. Yes. And we have discussed this and think that this would, you know, change the entire structure and philosophy of our agency.

Mr. WALDIE. From what to what?

Mrs. KASSER. From an autonomous one delivering services of a mental health nature to families, to one relating to the use of the physician as the supervisory person and offering our services in an ancillary kind of way under this physician's guidance. That is not the philosophy of the family agencies.

Mr. WALDIE. Another way of putting it: maybe you are not willing to engage in subterfuge that would permit your patients to have their expenses put up by the carriers?

Mrs. KASSER. We can't, since we are a public agency, but most of the people in the agency are also in private practice and have to engage in some of these very difficult maneuvers.

Mr. WALDIE. I am not condemning them for the fact that they are acting on behalf of their patients when they seek to get reimbursement but it is a shame the carriers haven't recognized that what they are superimposing on the system by the requirement is apparently not acceptable to the profession, and is an added burden without any commensurate benefit to the patient. If it had some benefit to the patient it would have some sense to it.

Well, Mrs. Kasser, I appreciate your testimony.

Mrs. KASSER. Thank you. Thank you for the opportunity.

Mr. WALDIE. Thank you.

Does anyone else have anything they want to present to the committee while we have a little bit of time left here?

If not—

Yes, Mr. Levin?

Mr. LEVIN. Congressman Waldie, it had occurred to me just now during the immediate past testimony that a question that you asked me earlier about the existence of data regarding overutilization or et cetera, might actually exist, although we have not been able to get it personally.

In the experience that CHAMPUS has had—and I am afraid again I cannot tell you what the acronym stands for, but servicemen and their dependents are covered under CHAMPUS for medical and health care. Under that system clinical social work services have been available for some years. Initially, when the program was first introduced, it required medical referral and supervision and some family service agencies made use of that program, unfortunately, I think in your words, by adopting certain subterfuge practices.

In later years, or after some time had passed, CHAMPUS, as I understand it, changed its policies so that clinical social work services have been offered without medical referral and without medical supervision.

We have not been able to get data from the appropriate governmental agency as to how that has worked out in terms of utilization. I don't know if the committee has the resource or the opportunity to get that data, but perhaps it can.

Mr. WALDIE. That is a good suggestion.

Mr. LEVIN. Thank you.

Mr. WALDIE. The committee is now adjourned.

[Whereupon, at 11:45 a.m. the committee was adjourned.]

[The statement which follows was received for inclusion in the record.]

STATEMENT OF THE NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

The National Federation of Societies for Clinical Social Work is pleased to have been permitted to comment on the need for House Bill 11544, a bill to allow Federal Employees direct access to the services of licensed clinical social workers.

The inclusion of the licensed clinical social worker as a direct provider of services under the Federal Employees Health Benefits Act can be justified on a number of grounds, which the Federation would like to lay before the Committee as concisely as possible

1. *Clinical Social Workers are competent independent providers of mental health services:* The training and certification of clinical social workers licensed or certified in the various states has been deemed sufficient by the states to permit them to practice independently, without the implied supervision and review of a physician which is currently imposed by the Health Benefits Program. To require physician referral is to deny the employee direct access to these licensed providers, as well as to escalate costs by requiring a second professional fee.

2. *There is no evidence to suggest that the inclusion of clinical social workers as primary providers will increase overall health care claims:* Appendix A bears directly on this frequent allegation of the insurance carriers. In the Permanente experience, broadening the mental health manpower pool appeared to bring about a drop in the use of medical services, and the overall utilization rate showed no increase.

3. *The mental health manpower pool is extremely limited, and geographically and ethnically skewed:* In 1970, a telephone survey of the three universities in California offering a doctorate in clinical psychology indicated that in that year only twelve doctorates were awarded in clinical psychology—to serve a population of some twenty-two million.

Surveys by other professional groups indicate that the Chicano and black population of California are poorly represented among the ranks of psychologists and psychiatrists, but may be better served when access is provided to the services of clinical social workers.

4. *Other carriers and disability plans have recognized the clinical social worker as a primary provider:* See Appendix B. In addition, CHAMPUS, (the Civilian Health and Medical Program of the Uniformed Services) has had a long and successful experience of use of the clinical social worker under this ambitious program.

5. *Direct access to the services of clinical social workers permits patients freedom of choice among qualified providers:* Where possible and feasible, beneficiaries under government supported programs should permit eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their Federal employment.

Since the public, and in many cases employees covered by other disability programs, may utilize the services of the clinical social worker without a referral process which may discourage use, to impose this requirement is to deny freedom of choice of the employee.

6. *To deny Federal Employees direct access to clinical social workers licensed for independent practice is to arbitrarily discriminate against this category of mental health providers:* Since the employee may obtain psychiatric care from a psychiatrist without additional medical referral, it is inequitable that such referral be required to render the same or similar services which the clinical social worker is licensed to provide.

7. *To require physician referral is to invite unnecessary cross referral:* Since the employee, more likely than not, finds his way to the clinical social worker for treatment without the required physical referral, the social worker must refer the employee to a physician, who, in turn, must refer the employee to the social worker, a burdensome and questionable practice.

In summary, clinical social workers are highly trained, competent mental health providers, capable of skillful and ethical professional practice without the need for medical referral and supervision as part of the provider contract.

APPENDIX A

PERMANENTE MEDICAL GROUP,
KAISER FOUNDATION MEDICAL CENTER,
San Francisco, Calif., June 10, 1968.

Dr. S. DON SCHULTZ,
Executive Officer, California State Psychological Association,
Palo Alto, Calif.

DEAR DR. SCHULTZ: In our research at Kaiser-Permanente we studied the question of whether psychotherapy will alter the pattern of medical care. The first of our studies found that psychotherapy patients initially were high "utilizers" of all our medical facilities, but after psychotherapy their utilization declined significantly and this decline remained in effect throughout a five year followup. On the other hand, the utilization of matched "control" group (not receiving psychotherapy) did not decline. The brief therapy and one-session-only psychotherapy groups had the largest decline in outpatient utilization, which helped to offset the cost of providing the psychotherapy. The decline in outpatient utilization of the long-term psychotherapy group was not enough to offset the combined psychological and medical treatments, which was greater than the cost of prior outpatient medical utilization alone. However, this group showed considerable decline in days of hospitalization, which initially had been very high, and this made the provision of psychotherapy financially feasible.

A further study attempted an early detection and referral of severe emotional problems in a population of almost eleven thousand patients. In spite of a concerted effort employing automated multitest screening and the cooperation of 32 physicians, it was found that attempts at early detection did not generate more psychiatric clinic patients than those generated through routine medical practice in our setting.

Our conclusions were (1) that if patients with emotional problems are not provided the alternative of psychotherapy, they have no recourse but to overly utilize existing medical facilities; and (2) the often expressed fear that the mere provision of psychotherapy will encourage abuse of that provision is not warranted. Should you wish additional details, these studies are published under mine and Dr. Follette's names in *Medical Care*, volumes V and VI, 1967 and 1968.

Sincerely,

NICHOLAS A. CUMMINGS,
Chief Psychologist.

APPENDIX B

REIMBURSEMENT OF INSURANCE CLINICAL SOCIAL WORKERS

1. Motion Picture Health & Welfare Fund (policy seems erratic). Los Angeles.
2. North American Aircraft Co., Los Angeles.
3. Sheet Metal Workers Union (some through Travelers Insurance considering inclusion of Clinical Social Workers in Contract should be contacted).
4. Federal Employees Indemnity—Agents, Blue Shield or Aetna Life Insurance, Hartford Conn.—policy seems erratic.
5. Southern California Edison Co., upon referral by physician.
6. Southern California Pipe Trades Trust Fund, Los Angeles—policy seems unclear. Generally L.S.W. disallowed, not in contract.
7. Kodak Processing Laboratories—Los Angeles.
8. Blue Shield through Champus Program (civilian employees of military).
9. Crown Life Insurance—Upon rec. of medical consultant, Los Angeles.
10. Metropolitan Life Insurance Co.—through San Francisco office.
11. Mobile Oil Co., Chas. R. Ferrario, Senior Claims Officer, San Francisco.
12. Government Indemnity Program through Blue Cross.
13. Screen Writers Guild—Los Angeles.
14. Provident Life Insurance.

15. Mass. Mutual Insurance Company (home office discontinued since California State Insurance Commission rule that C.S.W. were not covered by the Commission).

16. N.Y. Life Insurance Company.

17. Prudential Insurance.

18. Lockheed Group Plan, if recommended by medical.

19. Screen Actors Guild (some covered and some not).

20. Teamsters Union through Occidental Insurance—refuse L.C.S.W. since not written in contract.

21. Blue Cross—L.S. City School Teachers (subscribers only) recently disallowed.





