

 **POSITION PAPER**

*BEHAVIORAL HEALTH CARE AND LICENSED CLINICAL SOCIAL WORKERS*

October, 2020

INTRODUCTION

Our country is facing a behavioral health\* crisis. The COVID-19 pandemic, coupled with the economic straits of closing down businesses, has left our society wracked with untold suffering. Physical and emotional isolation required for public health safety - distancing from one another, covering our faces, and very restricted physical contact - as well as the concomitant loss of jobs, loss of salaries, loss of homes, childcare, extended family contact, and in some cases necessary medical attention - has left us bereft of our basic human need for attachment. Since the COVID-19 crisis first appeared in the US, mental health and addiction disorders have risen from one in five to almost one in two (<https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>).

Licensed Clinical Social Workers (LCSWs) are deeply concerned about the exponentially increasing need for behavioral health services and the barriers to obtaining help. As clinicians working across a wide range of settings, LCSWs see firsthand the mental anguish resulting in pervasive anxiety, increased panic attacks, major depression, anger, fear, substance abuse, and spikes in family violence as well as suicidal thoughts, suicide attempts, and completed suicides. It feels overwhelming to many, a kind of societal trauma.

At the same time, there is another more insidious societal trauma which has been going on far longer than the pandemic. Social Determinants of Health (SDOH) are factors that affect mental health through added layers of deprivation, resulting in significant access and treatment disparities and untold suffering. SDOH problems can affect anyone, but systemic racism exacerbates them. As a function of systemic racism and its justification of inequitable

\* “Behavioral health” and “mental health” are used interchangeably in this paper.

distribution of resources, residents in so called “minority” neighborhoods have disproportionately more mental health problems exacerbated by lack of jobs, housing, food security, transportation, and lack of medical facilities. Black, Indigenous Americans and other People of Color experience individual bias in the form of misdiagnoses of depression as laziness, anxiety as incompetence, and other forms of bigotry that interfere with even being able to acknowledge the emotional pain they are suffering.

LCSWs believe that mental health treatment cannot be successful without attention to SDOH factors and the prejudices that lead to inadequate basic needs. An all-out effort to eliminate racism and establish an organized system of services, programs, and institutions is needed. Basic needs for shelter, food, and health care must be met. Children should have access to quality education, the elderly deserve decent health care, families need food and shelter. Individuals with handicapping conditions have the right to the specialized services they need.

Shelter and wraparound treatment can help keep those with mental illness from being sent to jails and prisons. Targeted social service programs needed to divert individuals experiencing crisis from their paths into the streets, hospitals, jails, and the foster care service systems.

LCSWs have rightly been called the backbone of behavioral health programs in this country, providing as they do, the bulk of behavioral health services in the United States. They are highly trained, qualified and licensed clinicians who, in addition to providing mental health diagnosis and treatment, work with varied populations in many governmental agencies, health care facilities such as hospitals, nursing homes, community mental health centers and non-profit agencies, as well as in independent private practice. LCSWs also have a long history of working with the disenfranchised and the poor as well as other socioeconomic groups in Child Welfare, Child and Adult Protective Services, Bureau of Adoption agencies, Departments of Aging, and Mobile Mental Health Teams. They help address the disadvantaged, vulnerable, and traumatized populations and are uniquely suited to understanding the behavioral health and SDOH factors that affect people’s lives. LCSWs are also on staff in VA facilities, hospice programs, hospitals, and universities where they work to train students, interns, and residents in individual, family, and group psychotherapy.

This paper is an attempt to use the expertise of LCSWs to make recommendations as to how our fragmented and broken mental health system can be repaired.

AREAS OF CHANGE – RECOMMENDATIONS

The Clinical Social Work Association (CSWA) offers the following recommendations about the areas that need to be changed in order to understand and provide services for Mental Health and Substance Use conditions across systems.

ENDING RACIAL DISPARITIES AND SYSTEMIC RACISM

One of the main barriers to adequate mental health and substance use treatment is the systemic racism that exists throughout our country. Black Americans suffer from a higher level of mental health problems as a result (SAMHSA, 2018). Black women over 30 in the United States are at an increased risk of death during pregnancy and birth because “weathering”, i.e., becoming worn out by long exposure to the noxious racist atmosphere, is so damaging (NY Times, April, 2018). Social Determinants of Health (SDOH), rooted in more than a century of racist “red-lining”, have typically limited access to economic improvement in communities of color, effectively cutting off access to better housing and educational opportunities.

Indigenous people and other persons of color face similarly grim outcomes. The current tensions between law enforcement and persons of color, especially Black Americans, create an ongoing source of trauma.

Acceptance of racism as an embedded quality in our nations institutions, policies and practices, stands in the way of opportunities for advancement for African Americans that would be unquestionably available to White Americans. However, while there is surely a need in our country for White Americans to be educated about White privilege and racial bias, the immediate need is for broad systemic change to deal with longstanding inequities.

*CSWA believes that until systemic racism is addressed, interrupted and ended, there can be no real cure for the social ills of our country. Systemic racism negatively affects the mental health of all our citizens. Clinical Social Workers see this as an urgent need.*

LIMITED HOUSING OPTIONS

Many studies have shown that one of the most important criteria for good mental health is stable housing. Finding stable housing often presents a major hurdle for individuals with mental/behavioral health and substance use disorders. So-called “affordable housing units” are often swept off the table in favor of greater profits toward the end of negotiations between developers and a city’s housing authority, and the years-long waiting lists for rent control apartments are legendary. Sadly, with extremely limited resources and few options, these individuals move frequently from a temporary housing unit to the streets, then to either jail or a hospital setting, in an endless dysfunctional process. Here are three problems that make finding housing difficult for those with mental/behavioral health and substance use disorders:

1. One of the first hurdles in renting or buying a home is the completion of a housing application requiring a criminal history *background check*. This can prove problematic even if charges were dismissed. Additionally, a history of a few late rent or mortgage payments can be disqualifying. Surely allowing more flexible criteria for occupancy could make affordable assisted living units and apartments/duplexes more accessible.
2. Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) recipients have *monthly benefits* that are inadequate to meet food, housing and medical needs. Current benefits must be reevaluated to cover the basic needs of SSI/SSDI recipient.
3. Attention should also be paid to the multiple issues keeping housing *opportunities out of reach for (Black, Indigenous, and People of Color) BIPOC individuals* because of decades of underinvestment in communities redlined by the federal housing authority in the 1930s. While on the one hand, obtaining and maintaining housing is a struggle for those with mental health conditions, the many barriers to gaining improved housing causes significant mental stress for minorities.

*CSWA sees the need for housing as urgent for the mentally ill. Also, CSWA believes that programs need to be established to follow persons with behavioral health/substance use difficulties as they move in and out of institutional settings.*

END REIMBURSEMENT DISPARITY FOR LICENSED CLINICAL SOCIAL WORKERS (LCSWs)

LCSWs are highly trained mental health clinicians providing mental/behavioral health services in diagnosing and treating persons with Substance Use and Behavioral Health disorders. As noted earlier, LCSWs provide the majority of behavioral health services in hospitals, geriatric facilities, schools, VA facilities, private practice, and community mental health centers in the United States.

The Centers for Medicare and Medicaid Services (CMS) determines reimbursement rates for clinical services of psychiatrists, psychologists and clinical social workers, based on specific services. Until 2018, these rates were tiered, with psychologists earning 25% less than psychiatrists for exactly comparable psychotherapy services, and clinical social workers 25% less than that. Psychologists were then paid at rates equal to psychiatrists for psychotherapy services.

* 1. Reimbursement Disparity – LCSWs object to lower reimbursement than other mental health providers for the same specific behavioral health services, i.e., mental health diagnosis and psychotherapy. That issue was remedied for psychologists, who now are at the same rate as psychiatrists for the exact same service. It is time for clinical social work to be recognized as providing service of equal quality and equal reimbursement as other Medicare mental health providers.
	2. Medicare and Medicaid – LCSWs have been stalwart supporters of Medicare, Medicaid, and other government programs serving many vulnerable populations. Failure to respect the profession with equal pay is a serious disincentive to joining the Medicare and Medicaid panels.

*CSWA believes that the unfair disparity of the reimbursement rates for LCSWs compared to other Medicare behavioral health clinicians must be changed to provide equal pay for equal work. Inadequate compensation contributes to the shortage of behavioral health providers, including LCSWs.*

THE “VALUE” OF MENTAL HEALTH TREATMENT

There are over 300 diagnoses in the Fifth Edition of the Diagnostic and Statistical Manual (the DSM-5) currently used to identify mental health/behavioral health conditions. LCSWs are qualified to diagnose all 300 and treat the majority of conditions through psychotherapy, authorized by their state licenses.

Surely there is no question that severe and persistent mental illnesses will take more time to treat than acute conditions. Yet the reporting system that Medicare has developed to measure provider output and establish incentive pay places all 300 conditions - whether chronic or acute - into one category for review. A similar conceptual error was evident in last year’s Medicare Treatment Reviews, which drew necessarily faulty conclusions based on generalizations about the need for frequency of psychotherapy, the length of sessions, and the overall period a treatment lasts, *without regard* to the conditions treated.

While treatment review systems could have value, to be valid, they must make a distinction between whether severe and persistent mental illnesses or acute conditions are being treated.

* Treatment Needs – The treatment needs of behavioral health patients should be based on the LCSW’s biopsychosocial evaluation. Comparisons of treatment of all behavioral health patients, regardless of what diagnosis is being treated and the severity of the disorder, is not just unscientific. This process leads to another disincentive for LCSWs to provide Medicare mental health services.

*CSWA supports treatment measures and reviews that are not based on comparing one LCSW’s practice to everyone else’s and that makes distinctions between the acute or chronic nature of a given mental health disorder.*

ENFORCEMENT FOR PARITY LAW

The passage of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) established the requirement that insurance carriers cover mental and behavioral health care at a rate consistent with coverage of physical health care. However, no enforcement mechanism was built into the rules, and over the years, insurers have implemented numerous ploys to successfully bypass the requirement, including:

1. Medical Necessity - restricting treatment to a specific number of sessions without regard for a clinician’s assessment of the severity and/or chronicity of the client’s illness. Medical necessity restrictions are especially problematic because they tend to be applied to chronic mental and behavioral health conditions which require more than the 10 to 20 sessions many insurers want to cover. To alleviate acute symptoms is not equivalent to treating a condition, and often it is our most vulnerable clients who are harmed by this discriminatory treatment.
2. Rejecting Standards of Care – in 2019, a California appeals judge, (*Wit vs United Behavioral Health*) found United Health Care insurer to base treatment decisions on the minimizing cost rather than on generally accepted standards of care. This landmark case must be codified with Congressional legislation to stop the widespread practice by insurers of putting profits over patient care.
3. Network Adequacy – another complication involving parity relates to the not-uncommon failure of insurers to provide network adequacy for their plans, that is, ensuring enough in-network providers within 30 miles to provide services. Enrollees regularly call everyone listed on their insurance plan’s network to be told they are not taking new patients, have retired, or are no longer in the plan. A client should not be forced to pay more for an out-of-network provider, currently the case for mental/behavioral health treatment, because there are no in-network providers available.

*CSWA strongly supports MHPAEA enforcement of coverage for in-network and out-of-network LCSWs and the right of LCSWs to make qualitative treatment decisions in the best interest of the patient, as MHPAEA intended.*

END RESTRICTIONS TO TREATMENT IN SKILLED NURSING FACILITIES

Fear, anxiety, and loneliness exacerbated by pandemic conditions have increased seniors’ already high need for mental and behavioral health services. LCSWs are a major support for this vulnerable population and the loss of their services in 1997 created a huge hole for those living in Skilled Nursing Facilities (SNFs), as follows:

1. Lack of Psychotherapy Services – Based on a misunderstanding of the differences between casework services and mental/behavioral health services, the law prohibits LCSW reimbursement in Skilled Nursing Facilities (SNFs) unless the LCSW is an employee at the SNF. This restriction severely limits access to crucial diagnosis and treatment for this vulnerable population.
2. Telemental Health and Audio-Only Mental Health Treatment – these delivery systems had not been an option for homebound seniors living in SNFs until the COVID-19 pandemic. Ironically, pandemic conditions led to the temporary waiving of telemental health and audio-only treatment restrictions, a silver lining in a dark time. Clinicians are able to deliver treatment to an otherwise isolated population. Unless telemental health and audio-only behavioral health delivery systems are implemented permanently, access to care for the elderly will again be denied and the elderly will suffer.

*CSWA urges continuation beyond the pandemic of Medicare coverage of behavioral health services delivered independently by LCSWs in skilled nursing facilities, including telemental health and audio only service delivery.*

COVERAGE GAPS IN MEDICAID/CHIP

Medicaid and Children’s Health Insurance Programs (CHIP) enrollees have 33% more behavioral health/substance use needs as compared to the general population (NIMH, 2019). Enrollees lack access to mental/behavioral health assessment and treatment for the following reasons:

1. Individual State Providers – LCSWs are the largest group of behavioral health providers in the country, and In general are major providers of Medicaid and CHIP mental/behavioral health services. Since individual states determine who can provide Medicaid and CHIP services, some states permit only psychiatrists and/or psychologists to provide Medicaid/CHIP behavioral health services. This piecemeal approach leads to serious limitations in access to care treatment options for beneficiaries with significant needs.
2. Transportation Limitations – For the individual or family enrolled in Medicaid or CHIP, transportation to a health care provider’s office may be unavailable or too expensive. The temporary access to mental and behavioral health treatment through telemental health (including audio only care, which is critical where there is no broadband) has been, as mentioned, a silver lining during the pandemic, and should continue to be an option beyond the COVID -19 emergency.
3. Dual-eligibles – those beneficiaries who are both Medicare and Medicaid can often only access behavioral health services through telemental health or audio only services. Having these delivery systems available permanently would improve the mental health of individuals with severe disabilities.

*CSWA supports better funding of behavioral health services for Medicaid and CHIP enrollees with better access to LCSWs for Mental Health care by making telemental health and audio only services permanently available.*

INADEQUATE BEHAVIORAL HEALTH SERVICE FOR COLLEGE STUDENTS

Students in colleges, especially those between 18 to 24 years of age, are in dire need of increased behavioral health services. A major cause of death for students in higher education has been suicide for the past twenty (20) years (NIMH, 2019). Now, since the COVID-19 pandemic started, suicide is the number one cause of death for these college age students.

1. Mental Health Screening – CSWA strongly recommends that all colleges, universities and community colleges receiving federal funding should be required to have LCSWs provide behavioral health assessments, including screenings for trauma, depression, suicidality, and substance use. The increase in violent behavior on higher education campuses is a sign in many cases of behavioral health disorders. The more quiet suffering that takes place when students are depressed and withdrawn also requires behavioral health interventions. Suicidal thoughts, attempted suicides, and completed suicides on college campuses continue to be a major hurdle for the existing campus behavioral health delivery systems.
2. LCSWs On Campus – Student health centers should be encouraged to provide enrolled students with behavioral health services on campus delivered by LCSWs and other licensed behavioral health professionals.

*CSWA strongly supports more assessment by LCSWs of behavioral health conditions in students with access to treatment when behavioral health issues are identified.*

STIGMA ISSUES AROUND BEHAVIORAL HEALTH PROBLEMS IN MILITARY PERSONNEL

The behavioral wounds of military life can affect service members and veterans differently from civilians. Unlike civilians diagnosed with bipolar disorder, depression, or other causes of PTSD, military personnel think of themselves as sturdy and healthy, if not invulnerable. The military culture fosters this: the psychological injuries of military service – not just from combat – can carry stigma for the individual, who feels like a failure.

1. Psychoeducation – There is a need for psychoeducation for military leadership, service members, and veterans, about the way that preparing for combat, or being in a war, affects individuals. Even preparing for war can lead to PTSD, if the world is then permanently experienced as a dangerous place. The preparation needed to defend our country and have a strong military must be implemented in such a way that when not defending our country, members of our armed forces can live their civilian lives without being constantly in fear of danger.
2. LCSWs in the Military – One source of training might be LCSWs, the largest group of behavioral health providers working in VA facilities. LCSWs have specific understanding of military culture, PTSD, the impact on military families of combat trauma, disabling injuries, deployments and re-integration to the family and other challenges particular to military life.

*CSWA supports finding ways to overcome the systemic behavioral health problems that serving in the armed forces often creates in its members.*

COMORBID SUBSTANCE USE DISORDERS

The majority of patients with addictions also have mental health disorders (60 to 70%, SAMHSA, 2018). Unfortunately, substance use disorders and mental health disorders are often siloed and only one condition is addressed. LCSWs are qualified to assess both kinds of disorders and would be a major asset if involved in assessment.

1. LCSWs to Assess Comorbid Disorders – It is imperative that health care delivery systems that include assessment and treatment of both mental/behavioral health and substance use disorders at the same time be developed and implemented. Screenings for both disorders are needed to be done at the initial assessment of the patient.
2. Inpatient Treatment – LCSWs should be on staff of any substance use disorder facility to do diagnostic and psychosocial assessments upon admission, as well as provide ongoing psychotherapy. Behavioral health treatment of persons with substance use disorders should include a comprehensive assessment of each person and access to psychodynamic psychotherapy and psychotropic medications, with treatment provided by LCSWs and other qualified behavioral health professionals.

*CSWA supports the integration of evaluation and treatment of behavioral health disorders and substance use disorders as well as screenings by LCSWs.*

RESEARCH

 Increased funding is the key to more research related to behavioral health/substance use and the high comorbidity with physical illnesses. Almost all recent research shows that the combination of psychotropic medications and talking therapy (psychotherapy) is what makes for improvement in the functioning for patients with behavioral health conditions.

In the past few years, certain research touted as proof of the superiority of one or another treatment approach has been problematic. Studies of psychotherapy cannot be limited to quantitative studies measuring scores for before and after a number of sessions. Where qualitative research is excluded from consideration, the findings are suspect at best, and though one can claim a particular treatment is “evidence-based practice” (EBP) because the researchers collected evidence, that is not enough. The kind of evidence, the number of cases and length of time tracked, and the actual evidence itself must be considered and made clear. At times the findings are minimal, but the unfounded claim of EBP remains.

1. Evidence Based Practice must be able to document qualitative evidence of a treatments efficacy, and be measured over time to indicate long term effective change.
2. Attached please find research done in the past 10 to 15 years that documents the utility and effectiveness of psychotherapy.

*CSWA supports continued research by LCSWs into the complicated topic of which behavioral health treatments work best for specified behavioral health conditions.*

SUMMARY

Behavioral Health assessment and treatment in the United States is underfunded and unavailable to large numbers of our most vulnerable citizens. CSWA and Clinical Social Workers want to see the following changes made in order to help make behavioral health treatment as accessible and as important as care for physical health conditions.

1. Work to end the stigma of having behavioral health problems and seeking treatment for those issues with medical health care insurance, including Medicare, Medicaid and CHIP, providing coverage to receive treatment from qualified licensed behavioral health professionals
2. Reject racism as “endemic and ordinary” (Sule, 2020). Work to end systemic racism which disproportionately and negatively impacts Black, Indigenous Americans and other persons of color
3. Work to provide housing for all persons who lack long-term shelter that have behavioral health disorders and/or substance use disorders
4. Work to provide LCSW reimbursement for behavioral health services based on services delivered by CPT code, not by discipline
5. End unnecessary reports by LCSWs to insurers that are based on false comparisons of different behavioral health conditions
6. Allow LCSWs to practice independently providing behavioral health services in skilled nursing facilities
7. Implement and enforce mental health parity laws as defined in MHPAEA
8. Permanently provide coverage for telemental health and audio only services to be reimbursed at the same rates as CPT codes for in-person treatment
9. Increase funding for Medicaid and CHIP programs
10. Improve outreach/follow-up to military veterans with better access to behavioral health services
11. Increase behavioral health evaluation and treatment services for college students
12. Establish mandatory screenings for behavioral health and substance use for all elementary and secondary schools receiving federal funding
13. Increase attention to and assessment for comorbid behavioral health and substance use disorders for all ages and populations
14. Increase funding and research in behavioral health and substance use evaluation and treatment methods

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