Approved: 2-15-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 10, 1993 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Senator Marge Petty
Bruce Sneed, Radon Measurement and Diagnostics
Jim Yonally, Kansas Dental Hygienists Association
State Representative Forrest Swall
Gigi Felix, Executive Director, Kansas Chapter of the National Association of Social Workers
Liane Davis, Associate Dean for Academic Programs of the University of Kansas School of Social Welfare
Chip Wheelen, Kansas Psychiatric Society
Lawrence T. Buening, Jr., Executive Director, Kansas Board of Healing Art
Hal Boyts, President, Kansas Society for Clinical Social Work

Others attending: See attached list

The Chair called for Committee bill introductions.

Senator Marge Petty requested introduction of a bill that would establish health and safety programs for state employees under the Department of Administration. Senator Ramirez made a motion the Committee introduce the bill, seconded by Senator Walker. No discussion followed. The motion carried.

Bruce Sneed, Radon Measurement and Diagnostics, requested introduction of a bill that would establish a certification process for people who perform the duties of radon testing or mitigation. Senator Walker made a motion the Committee introduce the bill, seconded by Senator Papay. No discussion followed. The motion carried.

Jim Yonally, KDHA, requested introduction of a bill dealing with dental hygienists, similar to a bill vetoed by the Governor last year. Senator Langworthy made a motion the Committee introduce the bill, seconded by Senator Hardenburger. No discussion followed. The motion carried.

The Chair opened hearing on **SB 120** - Social workers definition.

State Representative Forrest Swall appeared in support of **SB 120** and stated the issue of qualifications and the right of social workers to diagnose as part of the scope of social work practice comes to the attention of the legislature because of a recent ruling by the Attorney General that indicated the function of diagnosis is not clearly spelled out in the current social work licensing law. (Attachment 1)

Gigi Felix, K-NASW, expressed her support of **SB 120** and distributed copies of a balloon of the bill that added language clarifying the supervision of the licensed master social worker. (Attachment 2) Staff suggested the conferee might want to include hospitals and psychiatric hospitals in the proposed amendment on page 2 of the bill.

Liane Davis, Associate Dean, University of Kansas School of Social Welfare, appeared in support of **SB 120**

and outlined the educational preparation social workers receive that prepares them to diagnose mental disorders. (Attachment 3)

Chip Wheelen, representing the Kansas Psychiatric Society, expressed his opposition to **SB 120** stating his organization does not disagree with the purpose behind the bill, however, they do object to the wording of the bill. Mr. Wheelen recommended a substitute version of **SB 120** which accomplishes the goals set out by the Kansas Chapter of NASW, but does so in a manner that is appropriate and explicit. The proposed bill would require the Behavioral Sciences Regulatory Board to create a special designation of licensed specialist clinical social workers for those social workers who have achieved advanced training and education sufficient to qualify them as diagnosticians in the mental health field. This substitute bill would specifically authorize LSCSWs to diagnose psychological disorders and socially dysfunctional conditions but would prohibit them from diagnosing mental illnesses. Mr. Wheelen stated the language is modeled after the advanced registered nurse practitioner law contained in the Nurse Practice Act and is consistent with the existing provisions of KSA 65-6308 which allows the Board to certify social workers who have achieved at least two years supervised clinical experience in order to be certified as a specialist and thus practice independently. (Attachment 4) In answer to a member's question, Mr. Wheelen stated his recommended language is consistent with current practice among social workers and would not broaden or narrow the scope of practice. Workers' compensation and the use by various mental health professionals of the Diagnostic and Statistical Manual published by the American Psychiatric Association as a reference document were discussed. In regard to licensing and regulation, it was pointed out a wide range of medical specialties are currently under one statute.

Larry Buening, Jr., Board of Healing Arts, appeared before the Committee and expressed concern regarding **SB 120.** The first concern relates to the changes made by the new language set forth on page one, lines 42-43 and page two, lines 1-3 of the bill, which would allow licensed specialist clinical social workers or licensed master social workers to make diagnosis of mental conditions classified in the current version of "The Diagnostic and Statistical Manual of Mental Disorders." The other concerns relate to a licensed master social worker who may make a diagnosis when working under the supervision of a qualified mental health professional, as well as language dealing with psychological testing. Mr. Buening stated the proposed amendment makes no provision for the referral to an appropriate physician licensed to practice medicine and surgery in order to make a medical diagnosis required because of current physical disorders or conditions which may be potentially relevant to the understanding of the management of the case. (Attachment 5)

Further testimony in support of **SB 120** was provided by Hal Boyts, President, Kansas Society for Clinical Social Work, as well as written testimony in support of the bill submitted from the following: Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.; Steve Proctor, LSCSW; Carl Myers, LSCSW, Washburn University; Emily Holman, President, Kansas Chapter, NASW; and David C. Rodeheffer, Kansas Psychological Association in opposition to the bill. (Attachments 6, 7, 8, 9, 10 and 11)

The Chair appointed a subcommittee on **SB 120** to further study the bill consisting of Senators Praeger, Langworthy and Walker.

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for February 11, 1993t.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-10-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Carl S. Myers	1812 CREST DR Topeka	Washburn Univ.
Cheryl H. Kinderknecht, ACSW	BSRB → 900 Jackson	Behav. Sc. Reg. Bd.
Camille [illegible]	Judicial Center	AG
Edith Mott	315 [illegible]	Silver Legislator
Sandra Strand	Lawrence	KINH
Senator Marge Petty	Topeka	Legislator
Paul M. Klotz	Topeka	Assoc of CMHCs Ks. Inc
Bruce Snead	MANHATTAN	KSU
Lee Cannon	P.O. BOX 22 Garnett, KS 66032	KINH
Bev McGill	6917 Caener Shawnee KS 66216	KINH
Denah Dykes	3107 SE Downing - Topeka	SW Student - WU
Dee [illegible]	3005 SW Randolph, Apt A Topeka	SW Student - WU
Patricia Morgan	2012 SW High Topeka	SW Student - WU
[illegible]	3430 Indiana	SW Student WU
Shana Schwetz	2126 SW 36 St.	(social work) SW Student WU
Barbara Heng	1036 N Prospect Liberal KS 67901	KINH
Frances L. Fracker	1831 Barker Lawrence, Ks. 66044	KINH
Herbert C. Lewis	1548 S. 37th St. Kansas City, KS. 66106	KINH
Stephen E. Albright	P.O. Box 1602 LAWRENCE, KS 66044	RMD INC.
James R. Shay	5029 Georgia Avenue Kansas City KS. 66104	KINH
Gladys A. Shay	5029 Georgia Ave. Kansas City Ks. 66104	KINH
Vivian Reynoso	6541 SE 53rd St Tecumseh, Ks 66542	KINH
Laura Boggan	Topeka KS	Sen. Karr's Intern

Cont'd

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 2-10-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Sue Selk	Sup	K-NASW
Emily Holman	~~Sup~~ Overland Park	K-NASW
Sherry Clayton	Topeka	K-NASW

SOCIAL WORK LICENSING

Statement Regarding SB 120

Presented by Representative Forrest L. Swall

February 10, 1993

SB 120 addresses the issue of the qualifications and the right of social workers to diagnose as part of the scope of social work practice.

This issue comes to the attention of the legislature because of a recent ruling by the Attorney General which indicated that the function of diagnosis is not clearly spelled out in the current social work licensing law.

Social workers have always engaged in diagnosis whether in mental health work, public social services, and any and all other fields and areas of work. Knowledge and skills in diagnosis has long been a part of the professional training of social workers. Other conferees will speak to this in more detail.

There are several thousand social workers engaged in practice in a wide range of service in Kansas. The agency that might be most affected should the correction proposed in SB 120 is mental health. Social workers have distinguished themselves in the field of mental health. Their service is especially significant given the important emphasis on making further transitions from the mental hospitals to community programs.

SB does nothing to change the current practice. It simply brings the law into compliance with current practice. It is a correction that will not impact negatively on the state or any of the other helping professions. SB 120 will in essence remove any legal impediments to continued social work practice in Kansas.

I recommend the committee's favorable action on this bill.

Senate PHSW
Attachment #1
2-10-93

Session of 1993

SENATE BILL No. 120

By Committee on Public Health and Welfare

1-28

AN ACT concerning social work; relating to qualifications and responsibilities of social workers; amending K.S.A. 65-6302 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-6302 is hereby amended to read as follows: 65-6302. As used in this act, unless the context clearly requires otherwise, the following words and phrases shall have the meaning ascribed to them in this section:

(a) "Board" means the behavioral sciences regulatory board created by K.S.A. 74-7501, *and amendments thereto.*

(b) "Social work practice" means the professional activity of helping individuals, groups or communities enhance or restore their capacity for physical, social and economic functioning and the professional application of social work values, principles and techniques in areas such as psychotherapy, social service administration, social planning, social work consultation and social work research to one or more of the following ends: Helping people obtain tangible services; counseling with individuals, families and groups; helping communities or groups provide or improve social and health services; and participating in relevant social action. The practice of social work requires knowledge of human development and behavior; of social, economic and cultural institutions and forces; and of the interaction of all these factors. Social work practice includes the teaching of practicum courses in social work.

(c) "Psychotherapy" means the use of psychological and social methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation to acquire greater human realization of psychosocial potential and adaptation; to modify internal and external conditions which affect individuals, groups or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Forms of psychotherapy include but are not restricted to individual psychotherapy, conjoint marital therapy, family therapy and group psychotherapy. *Psychotherapy includes diagnosis of the mental conditions classified in the most current version of The Diagnostic and Statistical*

Senate Public Health & Welfare
Attachment 2
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Manual of Mental Disorders by a licensed specialist clinical social worker, or a licensed master social worker under the supervision of ~~*a qualified mental health professional. If psychological testing is required to complete a diagnosis, referral will be made to a qualified, licensed psychologist.*~~

Sec. 2. K.S.A. 65-6302 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

----a Licensed Specialist Clinical Social Worker, a licensed psychologist, a licensed physician, a licensed Community Mental Health Center, or a state facility authorized to provide psychotherapeutic services.

NASW
National Association of Social Workers KANSAS CHAPTER

TESTIMONY IN SUPPORT OF SB120, AMENDED

SENATE PUBLIC HEALTH AND WELFARE

Good Morning Senator Praeger and members of the Senate Public Health and Welfare Committee. I am Gigi Felix, a licensed master level social worker in the state of Kansas. I am the executive director of the Kansas Chapter of the National Association of Social Workers (K-NASW) and am here this morning to SUPPORT the amended version of SB120. This legislation amends the social work practice act KSA 65-6302. Our intention today, as it has been from the beginning is only to clear up a legal technicality that was discovered last year by the Attorney General's office. This bill will clarify that by clearly giving social workers the legal right to diagnose as part of our psychotherapeutic work. We seek neither to expand nor limit the current scope of social work practice in the state of Kansas.

The legislation you have before you today has been amended to reflect several difficulties we saw in the version introduced. We have been working with a wide range of interested parties in developing this legislation, and are trying to work out whatever difficulties others may see. We are still trying to avoid turf battles, and inter-disciplinary squabbles. This version is an attempt to quell the fears and answer the questions others have raised.

Why we request the amendment:

1) The original version sited the QMHP (Qualified Mental Health

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Professional) as having the right to supervise a LMSW in clinical work. When we checked, the LMSW IS a QMHP. The current wording would have meant that MSWs would be supervising MSWs; obviously, this does not make sense. The QMHP also adds further confusion within the statute, which is what we are trying to clarify. We therefore deleted the QMHP language, and inserted the professionals who can supervise the LMSW.

2) The original version limited the psychological testing to ONLY licensed psychologists (PhDs). In the real world, this will not work. The Registered Master Level Psychologist (RMLP) also does psychological testing in the Community Mental Health Centers. To eliminate the testing by the RMLP would cause great hardship on the CMHCs, and carry a significant fiscal note for the state.

The Kansas Psychological Association (KPA), the Department of Social and Rehabilitation Services (SRS), and the CMHCs agree with this amendment.

Social Workers have been successfully and competently working in mental health settings since the time of Freud. Social work literature has a long history of publishing in the mental health diagnostic field. In 1917 Mary Richards published Social Diagnosis based on early casework techniques and diagnostic methods. This diagnostic work followed the evolution of the field: in the 1920s Freudian psychology provided the underlying theory and increased knowledge base, in the 1930s it expanded to include the living environment of the client. We continue to expand and refine our techniques and education to keep abreast of new issues. All licensed social workers

in the state of Kansas must complete 60 hours of continuing education every 2 years for license renewal.

Concern has also been raised about our use of the DSM for diagnosing mental conditions. It should be noted that in the current version of the DSM that:

1> a social worker was, and is, an editor of the Manual
2> social workers were part of the field testing of the statistical findings through using the Manual; and,
3> social workers have been using the Manual, as have the psychiatrists, MDs, and psychologists since its inception.

Another concern has arisen that the DSM is a medical diagnostic tool. This is simply not true. You will hear testimony today which cites the DSM that it has been developed for use by all mental health professionals. I will discuss this a bit more in a moment. There is also a movement to delineate the differences between "mental illness" and "mental disorder." The DSM defines a "mental illness" as:

> *"Mental Illness: see Mental Disorder..." A mental disorder is defined: "... an illness with psychologic or behavioral manifestation and/or impairment due to social, psychologic, genetic, physical, chemical, or biologic disturbance. The disorder is not limited to relations between the*

person and society. The illness is characterized by symptoms and/or impaired functioning"

I challenge anyone to define the differences between the statutory language. We hope to at least ease the confusion.

Social Work has also been challenged on our competence to do this work, and the field experience we have. I checked with the KU School of Social Welfare, was told that there were 1,320 hours in the field practicum for MSWs - that is over and above the field work of the BSW and includes supervision in both the field through the field supervisor, and in their practice classes. According to the licensure requirements for an LSCSW, (see attachment A) a social worker must submit a certified transcript of their MSW education, subject to approval by the board, 4,000 hours of clinical practice in addition to a minimum of 100 hours of direct supervision (see attachment B) before they qualify to apply for the LSCSW license. In addition, they must provide 3 letters of reference to ensure that they are worthy of the public trust. It is only then, that they earn the right to sit for the clinical test, which includes a wide range of questions, including ones on diagnosing mental conditions, and if they pass the test, they are licensed at the advanced level.

To further support our stand, I have attached several documents which show other "authorities" which support us... the Kansas Legislature, the Kansas Insurance Department, and the DSM itself:

1> *In the DSM III-R's introduction, on page xviii (see attachment C) it states:*

"... The impact of the DSM has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility..." (emphasis added)

I bring this to your attention to show that the volume is designed for use by ALL mental health professionals.

I'd also like to point out at this juncture that the DSM clearly refers the mental health professional to MDs for any physical testing, medication prescription or monitoring, and to psychologists for psychological testing. Social work does NOT want to do any of these things. We believe that a strong referral network for clients is imperative for our successful practice.

2> *For the next point, I need to take you on a short paper trail hike through Attachments D and E. Attachment D is a bulletin dated July 8,1986 from the Kansas Insurance Department which states on page 2, #9:*

"LSCSWs are considered to be eligible providers for the

(mental health) benefits mandated by HB2737..." (explanation added). This legislation became KSA 40-2,105.

This statute lists the insurance mandates of Kansas which include LSCSW social workers. Obviously the legislature and the insurance department of Kansas believe we are qualified to provide these services, and show their intent to allow us to do so.

3> *Staying with KSA 40-2,105... if you'd turn to sub-section b, (still in Attachment E), you will see that*

"nervous and mental conditions... means disorders specified in the diagnostic and statistical manual of mental disorders (DSM)..."

This last citation shows the precedent of the DSM in statute. These two documents together show that the legislature, and the insurance department again believe social workers are competent and qualified to work with the DSM as a diagnostic tool.

Social work is well integrated into both the private and public sectors of our state. In the state system, social workers are employed in the Community Mental Health Centers, the state hospitals and institutions, the youth centers, in both the community residences and institutions for the

developmentally disabled, in the correctional facilities and their subcontractors. SRS has prepared a fiscal note showing how the replacement of social workers in just the SRS system would impact the state which I will gladly share with you. The Community Mental Health Center Association tells me that the cost of replacing social workers with MDs and/or PhDs in that system alone would carry a state fiscal note of approximately $14 million. If this happened, it would be a true waste of the scarce resources our state has. Social workers currently serve the citizens of Kansas competently and successfully. To now deny that seems ludicrous.

In addition to working in the public sector of our state, we also are well integrated in the community system of services. In the community we work in the hospitals, schools, private psychiatric facilities, as well as in private practice. Our work in the therapeutic field goes back to the time of Freud, and we have been practicing in Kansas since our licensure was enacted in 1974.

I would also like to state that this legislation and the amendment, have been carefully and delicately crafted with feedback and advice from several interested parties - in fact if any interested party was not part of this process, I would be surprised. My thanks to the State Department of Social and Rehabilitation Services, the Association of Community Mental Health Centers, and the Kansas Society of Clinical Social Workers, for their support; and my thanks to the Kansas Medical Society and the Kansas Psychological Association for working on this issue with me. Most of the

questions and concerns are reflected in the amendment, though not all. The amendment that I have introduced today is the result of carefully weighing all suggestions and maintaining the balance of neither adding to, nor diminishing the scope of practice for social workers in the state of Kansas. The amendments we have seen drafted by other groups, which will probably come before you today, recommend the addition of unnecessary and confusing language (such as "social dysfunction") to the law. In our opinion, these would further cloud the issues and confuse the statute.

I thank you for your time this morning to present this issue, and I'd be glad to stand for any questions.

Attachments: *A: KAR 102-2-12 (LSCSW licensure requirements)*

B: KAR102-2-8 (Definition of Supervision)

C: DSM Introduction page xviii

D: Kansas Insurance Department bulletin 7/8/86

E: KSA 40-2,105

IMPORTANT FACTS: RE SB120

1. *This legislation is ONLY intended to clarify a point of law in our statute which the Attorney General's office discovered.*

2. *Amendment: the clarify the QMHP term:*
   - *MSWs are QMHPs so they would be supervising MSWs*
   - *language muddles the statute, opposite our intent*

3. *Competence:*
   - *a> 60 hours of continuing education every license cycle*
   - *b> 1,320 hours of supervised field practicum for the MSW*
   - *c> 4,000 hours of practice AFTER the MSW*
   - *d> 100 hours of supervision by an LSCSW during post graduate practice*
   - *e> 3 letters of reference*
   - *f> certified transcript of the MSW program*

4. *DSM was developed and written for all mental health practitioners.*

5. *Legislative and Insurance department's intent to allow social workers to practice psychotherapy.*

6. *The fiscal note to the state is $14+ million to replace social workers in the community mental health centers alone.*

This legislation has been developed with every interested party I could think of in the process. I developed this network so everyone would have advance notice that we were opening up the statute for clarification, and to ensure we would not hurt, or infringe on anyone's professional turf, and not hurt the private and public providers. The cooperation I received was incredible and I thank all who assisted me. The legislation is carefully and thoughtfully crafted to ensure that current social work practice is neither expanded nor limited by the legislation, that we will be able to continue doing exactly what we are currently doing, with legal clarity.

who fails the examination shall s[illegible] the fee required by K.A.R. 10[illegible]-3 for each subsequent examination which the applicant attempts to pass. (Authorized by K.S.A. 74-7507; implementing K.S.A. 75-5351; 75-5354; effective, T-85-36, Dec. 19, 1984; effective May 1, 1985; amended, T-86-39, Dec. 11, 1985; amended May 1, 1986.)

102-2-10. Licenses. (a) Each applicant who meets the standards for licensing shall receive a license appropriate for display.

(b) If a license is revoked, the licensee shall be informed of the board's action by certified mail, and the licensee shall return the license to the board within 30 days.

(c) If a licensee fails to renew the license, the licensee shall be informed in writing that the licensee is required to return the license to the board within 30 days. (Authorized by K.S.A. 74-7507, as amended by L. 1986, Ch. 299, Sec. 42; implementing K.S.A. 75-5351, 75-5357; effective, T-85-36, Dec. 19, 1984; effective May 1, 1985; amended May 1, 1987.)

102-2-11. Renewal. (a) Each licensed social worker shall renew the license by submitting a renewal form to the executive secretary together with the renewal fee prescribed in K.A.R. 102-2-3.

(b) At or prior to the time of the renewal, each licensed social worker shall submit evidence of satisfactory completion of 60 hours of continuing education as defined in K.A.R. 102-2-4a and 102-2-5.

(c) Each individual who holds a social work license but who fails to renew the license on or before the date of expiration, and who thereafter applies for renewal of the license, shall certify to the board in writing that the individual has not practiced in Kansas as a social worker or held forth as performing the services of a social worker after expiration of the license. If the board has evidence that the individual continued to practice in Kansas as a social worker or that the individual held himself or herself out to the public as a social worker after the expiration date of the license, the individual may be requested to appear before the board. The individual's eligibility for renewal of the license shall be determined by the board. (Authorized by K.S.A. 74-7507, as amended by L. 1986, Ch. 299, Sec. 42; implementing K.S.A. 75-5358, as amended by L. 1986, Ch. 340, Sec. 4; and K.S.A. 75-5359; effective, T-85-36, Dec. 19, 1984; effective May 1, 1985; amended, T-86-39, Dec. 11, 1985; amended May 1, 1986; effective May 1, 1987.)

KA- 102-2-12 (ATT A)

102-2-12. Licensed specialist clinical social work licensure requirement. (a) In order for an applicant to qualify for licensure at the specialist clinical social work level, the following requirements shall be met:

(1) completion of two years or ~~4,000 hours~~ of post-graduate, supervised, clinical experience with a minimum of 4,000 hours of service. The supervision shall be provided by a licensed specialist clinical social worker, or one eligible for licensure at that level if supervision occurred in a state other than Kansas;

(2) participation in a minimum of a one one-hour supervisory session per week ~~or~~ with a minimum ~~total~~ of 100 hours in supervisory sessions over the two-year period; and

(3) successful completion of an examination approved by the board for this level of licensure.

(b) Documentation attesting to the applicant's completion of the supervised clinical social work experience shall be submitted to the board at the time of application and shall include a statement by the supervisor that the overall objectives of clinical social work supervision have been met. The documentation shall include:

(1) a supervisory contract ~~which~~ that has been developed between the supervisor and the applicant. The contract shall consist of specific

(A-1)

~~objectives;~~ goals and objectives, the means to attain the goals, and a description of the manner in which the goals relate to the overall objectives. Under extenuating circumstances, ~~the board may waive~~ the supervisory contract; may be waived by the board;

(2) a summary of the types of clients and situations dealt with at the supervisory sessions;

(3) a written explanation of the relationship of the goals and objectives of supervision to the supervisory session; and

(4) the length of time spent in the supervisory sessions over the two-year period.

(c) Out-of-state applicants who received supervision in a state other than Kansas shall also submit documentation from their supervisors attesting to the supervisor's eligibility to provide supervision. An out-of-state supervisor shall be considered eligible to provide supervision if the supervisor has met the requirements contained in K.A.R. 102-2-12(a).

(d) Out-of-state applicants who cannot provide the documentation required by subsection (b) of this regulation shall be supervised in Kansas for a minimum of 10 hours in order for the Kansas supervisor to ensure that requirements have been met.

(e) Social work consultation shall not meet the supervision requirements. (Authorized by K.S.A. 1989 Supp. 74-7507; ~~as amended by L. 1986, Ch. 299, Sec. 42~~; implementing K.S.A. ~~75-5351~~ 1989 Supp. 65-6306, and K.S.A. ~~75-5353~~ 1989 Supp. 65-6308, ~~as amended by L. 1986, Ch. 340, Sec. 2~~; effective, T-85-36, Dec. 19, 1984; effective May 1, 1985; amended May 1, 1987; amended February 25, 1991.)

thorized to practice social work;

(30) soliciting the clients of colleagues or assuming professional responsibility for clients of another agency or colleague without appropriate communication with that agency or colleague;

(31) making claims of professional superiority which cannot be substantiated by the social worker;

(32) guaranteeing that satisfaction or a cure will result from the performance of professional services;

(33) claiming or using any secret or special method of treatment or techniques which the social worker refuses to divulge to the board;

(34) continuing or ~~order~~ ordering tests, treatment, or use of treatment facilities not warranted by the condition of the client;

(35) failing to maintain the confidences shared by colleagues in the course of professional relationships and transactions with those colleagues;

(36) taking credit for work not personally performed whether by giving inaccurate information or failing to ~~give~~ disclose accurate information;

(37) if engaged in research, failing to:

(A) consider carefully the possible consequences for human beings participating in the research~~;~~;

(B) ~~failing to~~ protect each participant from unwarranted physical and mental harm~~;~~;

(C) ~~failing to~~ ascertain that the consent of the participant is voluntary and informed~~;~~; and

(D) ~~failing to~~ treat information obtained as confidential;

(38) knowingly reporting distorted, erroneous, or misleading information;

(39) ~~when termination or interruption of service of the client is anticipated,~~ failing to notify the client promptly when termination or interruption of service of the client is anticipated, and failing to seek continuation of service in relation to the client's needs and preferences;

(40) abandoning or neglecting a client under and in need of immediate professional care without making reasonable arrangements for continuation of that care~~, or~~;

(41) abandoning an agency, organization, institution, or a group practice without reasonable notice and under circumstances which seriously impair the delivery of professional care to clients;

~~(41)~~ (42) failing to terminate the social work relationship when it is apparent that the ~~service~~ relationship no longer serves the client's needs;

~~(42)~~ (43) failing to maintain a record for each client which accurately reflects the ~~client~~ client's contact with the social worker. Unless otherwise provided by law, all client records shall be retained for at least two years after the date of termination of the contact or contacts;

~~(43)~~ (44) failing to exercise appropriate supervision over ~~persons who are~~ anyone authorized to practice only under the supervision of a social worker;

~~(44)~~ (45) practicing social work in an incompetent manner; or

~~(45)~~ (46) practicing social work after expiration of ~~his or her~~ the social worker's license. (Authorized by and implementing K.S.A. ~~1986 Supp. 75-5356~~ 1989 Supp. 65-6311 and K.S.A. 1989 Supp. 74-7507~~, as amended by L. 1987, Ch. 315, Sec. 17~~; effective May 1, 1982; amended, T-85-36, Dec. 19, 1984; amended May 1, 1985; amended, T-86-39, Dec. 11, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended February 25, 1991.)

102-2-8. Supervision. (a) Licensed social workers.

(1) Social workers having less than the specialty social work license shall not engage in private, independent practice.

(2) Any person who provides clinical social work services as a self-employed person, member of a partnership, member of a professional

KAR 102-2-8 (ATT B)

poration, or a member of a group practice and who is not licensed as a specialist clinical social worker shall be supervised by a licensed specialist clinical social worker.

(3) Social work consultation shall not meet the supervision requirements for the social work service provider.

(4) A minimum of one hour of supervision shall be provided per 40 hours of service delivery.

(5) ~~The--supervisor~~ No social worker shall ~~not be~~ supervise under a ~~supervisory--agreement--with~~ license that is limited or restricted by the board. This provision may be waived by the board upon application for review by the proposed supervisor.

(b) Non-licensed social work service providers.

(1) Social work consultation shall not meet the supervision requirements for the non-licensed social work service provider.

(2) Social workers utilizing non-licensed individuals in the delivery of social services shall specifically delineate the non-licensed individual's duties and provide a level of supervision which is consistent with the training and ability of the ~~supervisee.~~ non-licensed social work service provider.

(3) A written agreement shall be developed between the supervisor and the employer of the ~~social-service---designee,~~ non-licensed social work service provider, consisting of specific ~~goals/objectives,~~ goals and objectives, the means to attain the goals, and the manner in which the goals relate to the overall objective for supervision of the ~~social-service designee.~~ non-licensed social work service provider. Documentation of the written agreement shall include:

(A) a copy of the written agreement;

(B) a summary of the types of clients and situations dealt with at the supervisory session;

(C) a written explanation of the relationship of the goals and objectives of supervision to the supervisory session; and

(D) the length of time spent in the supervisory session.

(4) A minimum of one hour of supervision shall be provided per 40 hours of service delivery. No less than four hours of supervision per month shall be provided.

(5) ~~The--supervisor~~ No social worker shall ~~not be~~ supervise under a ~~supervisory--agreement--with~~ license that is limited or restricted by action of the board. This provision may be waived by the board upon application for review by the proposed supervisor. (Authorized by and implementing K.S.A. 1989 Supp. 74-7507; ~~as amended by L. 1986, Ch. 299, Sec. 42;~~ effective, T-85-36, Dec. 19, 1984; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended February 25, 1991.)

(B-1)

102-2-9. Examinations. (a) Each applicant for licensure by the board shall take an examination approved by the board. The pass criterion score shall be:

(1) One standard deviation below the national norm for those applicants who take the examination offered by Educational Testing Service or Professional Examination Testing Service; and

(2) at the criterion reference cut-off score for those applicants who take the Assessment Systems, Inc., examinations. Each applicant shall be notified of the results in writing.

(b) The usual and customary examination shall be a written examination. Special arrangements shall be made for applicants with a physical handicap or handicaps when requested by the applicant.

(c) Waiver of examination. The written examination requirement may be waived for any applicant, other than an applicant for reinstatement of a revoked or suspended license, if the applicant successfully passed the written portion of an examination deemed by the board to be substantially equivalent to that used in Kansas at a level equal to or greater than the criterion pass score.

(d) Each applicant for licen-

DSM-I
ATT C

THE IMPACT OF DSM-III

The impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility. Recent major textbooks of psychiatry and other textbooks that discuss psychopathology have either made extensive reference to DSM-III or largely adopted its terminology and concepts. In the seven years since the publication of DSM-III, over two thousand articles that directly address some aspect of it have appeared in the scientific literature. In some of these articles, the results of research studies using the DSM-III diagnostic criteria to select samples have been reported; in others, the reliability or validity of DSM-III-defined disorders has been critically examined.

DSM-III was intended primarily for use in the United States, but it has had considerable influence internationally. As a result, the entire manual, or the Quick Reference to the Diagnostic Criteria ("Mini-D"), has been translated into Chinese, Danish, Dutch, Finnish, French, German, Greek, Italian, Japanese, Norwegian, Portuguese, Spanish, and Swedish. Many of the basic features of DSM-III, such as the inclusion of specified diagnostic criteria, have been adopted for inclusion in the mental disorders chapter of ICD-10.

HISTORICAL BACKGROUND OF THE DSMs

DSM-I. The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term *reaction* throughout the classification reflected the influence of Adolf Meyer's psychobiologic view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

DSM-II. In the development of the second edition, a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases*, for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and ICD-8 went into effect in 1968. The DSM-II classification did not use the term *reaction*, and except for the use of the term *neuroses*, used diagnostic terms that, by and large, did not imply a particular theoretical framework for understanding the nonorganic mental disorders.

DSM-III. In 1974 the American Psychiatric Association appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January 1979. By the time this new Task Force was constituted, the mental disorders section of ICD-9, which included its own glossary, was nearly completed.

Although representatives of the American Psychiatric Association had worked closely with the World Health Organization on the development of ICD-9, there was concern that the ICD-9 classification and glossary would not be suitable for use in the

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THE PROCESS

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KANSAS INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division Fax 296-2283

STATE OF KANSAS

FLETCHER BELL
Commissioner

See Page 2 as related to Social workers

Bulletin 1986-10 (Addendum)

TO: All Companies Authorized to Transact Accident and Health Insurance in the State of Kansas

FROM: Fletcher Bell
Commissioner of Insurance

SUBJECT: Enactment of House Bill No. 2737 (1986)
Addendum to Bulletin 1986-10 dated June 6, 1986

DATE: July 8, 1986

* This bill mandates minimum mental health benefits for insurance policies

There have been several questions about various areas of compliance with House Bill No. 2737 since the issuance of Bulletin 1986-10. The following items are intended for clarification:

1. We wish to clarify the types of contracts which are subject to the requirements of this bill. All individual and group contracts of hospital, medical and/or surgical expense coverage must include the mandated benefits for nervous or mental conditions, alcoholism and drug abuse. Such coverage includes, but is not limited to, a basic hospital expense policy, a basic medical - surgical expense policy, a basic major medical expense policy, etc. Contracts which provide solely indemnity benefits, such as hospital indemnity or nursing home coverage as well as disability income, accident only, specified disease or Medicare Supplement coverage are not subject to the requirements of this bill.

2. The conditions specified in House Bill No. 2737 may be subject to the normal underwriting review given to any condition upon application or renewal for the policy or contract involved.

3. The pre-existing definitions, limitations, and exclusions of a contract may apply to the conditions specified in House Bill No. 2737 in the same manner they apply to any other condition.

4. In-patient benefits for treatment of nervous or mental conditions, alcoholism or drug abuse must be provided at the same level they are provided for a medical condition. For example, if there are no copayments applicable to a medical in-patient claim no copayments may be applied to claims for the conditions specified in House Bill No. 2737.

5. Item d in House Bill No. 2737 excludes only benefits for the assessment required by a diversion agreement or court order to attend an alcohol or drug safety action program. Court ordered treatment of alcoholism or drug abuse cannot be excluded.

2-17

Page 2 Bulletin 1986- CA&Ins. continued

6. The minimum payment amounts specified in House Bill No. 2737 apply only to out-patient benefits.

7. Contract definitions of the conditions specified in House Bill No. 2737 may be no less favorable, and in no way more limiting than in the law.

8. If rates for the contract or policy involved are subject to review by this department, and a rate adjustment is made in response to the inclusion of these benefits, it must be filed with this department. Rates must be accompanied by an actuarial memorandum which explains the method of determining the rates and which certifies they comply with applicable laws and regulations and that benefits are reasonable in relation to premiums charged.

9. Licensed Specialist Clinical Social Workers are considered to be eligible providers for the benefits mandated by House Bill No. 2737 unless the policyholder has refused social worker coverage in writing, pursuant to K.S.A. 40-2,114.

10. The benefits mandated by House Bill No. 2737 must be added to all existing individual and group expense based contracts, including those cases in which a given policy or form is no longer being issued in Kansas.

We hope this clarification is of assistance to you. If you have any questions, please let us know.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:jbah
4908mt

H.B. No 2737 is the mental Health Mandate law
K.S.A 40,2,105 attached

2-18

all existing individual and group expense based contracts, including those cases in which a given policy or form is no longer being issued in Kansas.

AT. E

We hope this clarification is of assistance to you. If you have any questions, please let us know.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:jbah
4908mt

H.B. No 2737 is the Mental Health Mandate law K.S.A 40,2,105 attached

license.

History: L. 1973, ch. 195, § 1; July 1.

40-2,102. Insurance coverage for newly born children; notification of birth. All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage relate back to the moment of birth.

History: L. 1974, ch. 189, § 1; July 1.

40-2,105. Insurance coverage for services rendered in treatment of alcoholism, drug abuse or nervous or mental conditions; applicability or nonapplicability of section. (a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy

notwithstanding any provision of an individual or group policy or contract of health and accident insurance, delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly licensed psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly licensed psychologist.

History: L. 1974, ch. 189, § 1; L. 1986, ch. 299, § 7; June 1.

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(E-1)

nder such group policy, except as provided n subsection (d), which shall be limited to ot less than 30 days per year when such erson is confined for treatment of alcohol- sm, drug abuse or nervous or mental con- ditions in a medical care facility licensed nder the provisions of K.S.A. 65-429 and mendments thereto, a treatment facility for lcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a reatment facility for drug abusers licensed nder the provisions of K.S.A. 65-4605 and amendments thereto, a community mental ealth center or clinic licensed under the provisions of K.S.A. 75-3307b and amend- ments thereto or a psychiatric hospital li- censed under the provisions of K.S.A. 75- 3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indem- nity, except as provided in subsection (d), of the costs of treatment of such person for alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such per- son's lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psy- chologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "nervous or mental conditions" means dis- orders specified in the diagnostic and sta- tistical manual of mental disorders, third edition, (DSM-III, 1980) of the American psychiatric association but shall not include conditions not attributable to a mental dis- order that are a focus of attention or treat- ment (DSM-III, V Codes).

(c) The provisions of this section shall be applicable to health maintenance orga- nizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

(d) There shall be no coverage under the provisions of this section for any assess- ment against any person required by a di- version agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.

(e) The provisions of this section shall not apply to any medicare supplement poli- cy of insurance, as defined by the commis- sioner of insurance by rule and regulation.

History: L. 1977, ch. 161, § 1; L. 1978, ch. 166, § 1; L. 1986, ch. 299, § 8; L. 1986, ch. 174, § 1; July 1.

CASE ANNOTATIONS

1. Group insurance policy "made" where master policy delivered; issuance of certificates to individuals not controlling. Simms v. Metropolitan Life Ins. Co., 9 K.A.2d 640, 642, 644, 685 P.2d 321 (1984).

40-2,106. Definitions. For the pur- poses of this act: (1) "Independent insur- ance agent" means any licensed agent rep- resenting an insurance company on an independent contractor basis and not as an employee. This term shall include only those agents not obligated by contract to place insurance accounts with any insur- ance company or group of companies.

(2) "Insurance company" means any property or casualty insurance company ad- mitted to the state of Kansas, except the term shall not include any company which requires membership in the company, as contained in the articles of incorporation or bylaws of such company, as a prerequisite to insuring that member.

(3) "Commissioner" means the commis- sioner of insurance.

History: L. 1977, ch. 163, § 1; L. 1982, ch. 199, § 1; July 1.

40-2,107. Minimum notice require- ments for cancellation of insurance agency contract by insurance company. (a) Insur- ance companies may contract with inde- pendent insurance agents as to binding au- thority, policy services, adjusting services, commissions and other subjects of interest between agent and company. Such con- tracts which have been effective for more than one year shall not be terminated or amended by the company except by mutual agreement or unless 180 days' prior notice has been tendered to the agent, except that this shall not apply to terminations for fraud, material misrepresentation or failure to pay such agent's account less the agent's com- mission and any disputed items within 10 days after written demand by the company. During such notice period all contractual conditions existing prior to such notice shall continue.

(b) Any independent insurance agent whose contract with an insurance company has been terminated under the provisions of subsection (a) shall have until the policy renewal date, but not more than one year, to

place the busine minated contrac company.

History: L. 1 ch. 199, § 2; L.

40-2,108. S by commissione promulgate such are necessary to this act. Violatio tions of the unfai 40-2407 and 40 apply if the com renewal or polic preserve insura protect policyho

History: L. 1

40-2,109. M caps; rate discr forcement. (a) N charge unfair policy fees or rat any policy or co annuity or policy erage for a perso cant therefor has icap unless the ra provide, is based ples or is relate anticipated expe pany shall unfair ments of dividen under a policy, conditions of suc because the own has a mental or the difference is principles or is r ably anticipated

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(c) Enforceme section shall be 24 of chapter 40 notated, and acts supplemental the

History: L. 19 ch. 133, § 1; July

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TESTIMONY ON BEHALF OF SENATE BILL NO. 120

I am speaking today in my role as Associate Dean for Academic Programs of the University of Kansas School of Social Welfare. I have been asked by the Executive Director of KNASW, the social work professional organization, to speak to the educational preparation that social workers receive that prepares them to diagnose mental disorders. As I understand it, what is currently under consideration by this committee is an amendment to the social work licensing law that specifically permits social workers to diagnose mental conditions as classified in the most recent Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as DSM IIIR.

As you will hear repeatedly throughout this hearing, there is no substantive basis for distinguishing among mental illness, psychological disorders, and mental conditions nor, as far as I know, has anyone offered a clear definition of these terms. Indeed the American Psychiatric Association has chosen to use yet a fourth term, mental disorder, in its **attempt** to classify psychological disorders. I highlight the word **attempt** because the Diagnostic and Statistical Manual of Mental Disorders is an evolving manual. We are presently using a revision of the DSM III and a fourth edition has been in process for at least the past five years, if not longer. As stated in the Diagnostic and Statistical Manual itself "there is no satisfactory definition that specifies precise boundaries for the concept "mental disorder. " Needing to set some boundaries, the authors have included in this manual, clinically significant behavioral or psychological syndromes that are typically associated with painful symptoms or psychological distress. What that means to the layperson is that this manual is an attempt to give names to patterns of behaviors that cause people psychological distress. Included are such things as alcohol abuse, major depression, and schizophrenia, as well as a cluster of disorders known as adjustment disorders that represent maladaptive reactions to psychosocial stressors (such things as divorce, chronic illness, etc.)

While the DSM is a product of the American Psychiatric Association, and while the overwhelming majority of its developers were psychiatrists, social workers (as well as psychologists) participated in its development and in the subsequent training of those who use it.

Now let me tell you how we prepare our students to be competent to carry out the task of diagnosis. Since all schools of social work are accredited by the Council on Social Work Education, I can speak not only to how we prepare our students at KU, but I can speak to how social workers who graduate from other schools across the country are prepared as well.

Master's level social work education provides for two years of full-time study. After the first or foundation year, all students must demonstrate proficiency and competence in five professional areas: Human Behavior and the Social Environment, Social Work Practice, Research, Social Welfare Policy, and the Field Practicum. To do this, they either take five specialized courses in each of these areas that span the academic year (as we do at KU and as is done in most of the schools across the country) or the material is integrated in another fashion. It is specifically in the human behavior, practice, and practicum courses that social workers, during their first year in the program, develop the basic competency to be able to reliably use the DSM. In the human behavior sequence, students obtain knowledge of the biological, psychological, and social determinants of human behavior across the life span. They learn about normal as well as abnormal manifestations of behavior. This knowledge is then put to use in their social work practice courses and in their practicum where they demonstrate

Senate PR & C
attachment 11-3
2-10-93

competence in performing assessments of clients and use these assessments to develop and then implement interventions appropriate to restore persons to healthy and adequate functioning. Students are in the field practicum sites for a total of 600 hours during their first year. These sites are varied and include mental health centers, inpatient psychiatric hospitals, schools, and residential centers for persons with physical and mental disabilities. It is in their field practica, that students, working under close supervision, demonstrate the ability to make diagnoses, when these are appropriate. This ability is further reinforced in the classroom which builds on and enhances their practicum experiences.

In the second year of their master's programs, the overwhelming majority of social work students across the country specialize in clinical social work practice. In this second year, students take additional course work to further refine their ability to conduct psychosocial assessments and develop and implement appropriate interventions. Students do an additional 720 hours of field practicum, specializing more directly in clinical psychotherapy for individuals and families.

Since one of the primary purposes of the DSM is to provide a common language for all clinicians (psychiatrists, psychologists, and social workers) to communicate about and treat the disorders for which they have professional responsibility, the developers of the manual paid special attention to assuring that mental health professionals with diverse degrees, diverse theoretical orientations, and diverse experience, could all understand and use it in a reliable fashion. As a result, DSM III takes what they refer to as a descriptive approach to mental disorders. What that means is that it provides as comprehensive a description as possible of the specific clinical features of each disorder. Furthermore, these clinical features are described at the lowest order of inference possible. What that means is that, whenever possible, easily identified behavioral characteristics or symptoms are used.

The symptoms are not very difficult to recognize. For example, to make a diagnosis of what we generally think of as major depression, the clinician must identify:

A. A dysphoric mood or loss of interest or pleasure in all or almost all usual activities....

And

B. At least four of the following which must have been present nearly every day for at least two weeks:

1. poor appetite or significant weight loss or increased appetite or significant weight gain

2. insomnia or hypersomnia

3. loss of energy....etc.

The clinician must then rule out the presence of some other specific disorders whose manifestations are also clearly explicated.

I have spent this time describing the DSM III because it is important that you understand that it has been developed to be a common language for all mental health professionals.

As a result of the education received in the foundation year, all social workers should be able to competently use DSM III to make appropriate diagnoses, especially under the guidance of the appropriate mental health professionals as specified in the legislation. Further, once they have graduated from the program, had the requisite two years of supervision, and passed the examination for specialized practice as a clinical social worker (an examination which includes questions on diagnosis), they should be capable of competently and independently using DSM III.

Social workers are frequently in the front-line, seeing persons in mental health clinics, in hospitals, in schools who experience a variety of what are considered mental disorders. Social work education prepares social work practitioners to diagnose the broad range of such disorders. Social work education also prepares social work practitioners to recognize when referrals to other mental health providers are necessary, to effectively link clients with other mental health providers, and to work collaboratively with them. Thus, making a diagnosis is not the end of our work with clients, but is the beginning of a collaborative process with the client and often with other mental health providers.

Testimony presented by:

Liane V. Davis, Ph.D., LSCSW
Associate Professor
and
Associate Dean for Academic Programs
University of Kansas School of Social Welfare
February 10, 1993

Kansas Psychiatric Society

a district branch of the American Psychiatric Association

623 S.W. 10th St. - Topeka, Kansas 66612-1615
(913) 232-5985 or (913) 235-3619

February 10, 1993

TO: Senate Public Health and Welfare Committee

FROM: Chip Wheelen
KPS Lobbyist

SUBJECT: Senate Bill 120 as Introduced

Thank you for the opportunity to express our opposition to SB 120 in its current form. It is our understanding that the impetus for this legislation arises because of two Attorney General opinions which conclude that a social worker may not direct the activities of a registered masters level psychologist at a community mental health center because the social worker laws do not authorize a licensed social worker to diagnose psychological disorders. It is noteworthy that when the first of these two Attorney General opinions was rendered in 1987, it also concluded that physicians could not oversee the activities of RMLPs because the Healing Arts Act did not authorize physicians to diagnose psychological disorders although they could diagnose and treat mental illnesses. We responded by requesting the 1988 Legislature to amend the Healing Arts Act in a fashion that simply authorizes physicians to diagnose and treat psychological disorders as well as mental illnesses. A similar solution is all that is needed to address the concerns of the social worker profession.

In contrast, the Kansas Chapter of the NASW has approached this matter in a completely different fashion. The bill before you now is unacceptable for the following reasons. First, it erroneously redefines "psychotherapy" in a fashion that would include diagnosis of all disorders listed in a "diagnostic and statistical manual." This is blatantly erroneous in that psychotherapy is not a diagnostic technique. It is, however, a treatment modality often employed subsequent to a diagnosis. Furthermore, we are extremely concerned that a publication referred to as "Diagnostic and Statistical Manual" is presumably the publication by the American Psychiatric Association which is used by various mental health professionals as a reference document. The DSM with which we are acquainted includes within its many definitions of mental disorders organically based mental illnesses that require a medical diagnosis in order to conclusively determine the correctness of the diagnosis.

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Attachment #4
2-10-93

In other words, SB 120 as introduced is clinically incorrect and authorizes licensed social workers to engage in the practice of medicine and surgery. This authority would not be restricted to specialist clinical social workers who have obtained advanced training and expertise, but would apply to all social workers licensed to engage in social work practice in the State of Kansas. If anyone tells you that SB 120 does nothing more than statutorily codify current practice in the field of social work, please be advised that you have been misinformed.

We do, however, recognize the valuable skills of specialist clinical social workers who are integral members of the mental health team. Therefore, we respectfully recommend that your Committee substitute another version of SB 120 which accomplishes the goals set out by the Kansas Chapter of NASW, but does so in a manner that is appropriate and explicit. Attached to this statement is a draft bill which is consistent with both the social work laws and other laws defining the scope of practice of a respective licensed professional. This bill would require the Behavioral Sciences Regulatory Board to create a special designation of licensed specialist clinical social worker (LSCSW) for those social workers who have achieved advanced training and education sufficient to qualify them as diagnosticians in the mental health field. This substitute would specifically authorize LSCSWs to diagnose psychological disorders and socially dysfunctional conditions but would prohibit them from diagnosing mental illnesses. This language is modeled after the advanced registered nurse practitioner law contained in the Nurse Practice Act, and it is consistent with the existing provisions of K.S.A. 65-6308 which allow the Board to certify social workers who have achieved at least two years supervised clinical experience in order to be certified as a specialist and thus practice independently.

We do not disagree with the purpose behind SB 120. We do, however, object strenuously to the wording of the bill. Therefore, we offer to you a much improved substitute for your consideration and hopefully recommendation for passage. Thank you for considering our position on this important quality of care issue.

CW/cb

New section to be supplemental to Article 63 of Chapter 65

(a) On and after January 1, 1994, no licensed social worker shall announce or represent to the public that such person is a specialist clinical social worker or use the acronym LSCSW or SCSW unless such licensed social worker has complied with requirements established by the board and holds a valid certificate of qualification as a specialist clinical social worker in accordance with the provisions of this section.

(b) The board shall establish standards and requirements for any licensed social worker who desires to obtain a certificate of qualification as a specialist clinical social worker. Such standards and requirements shall include, but not be limited to, standards and requirements relating to the education and training of specialist clinical social workers. Such standards shall require at a minimum that the licensed social worker successfully complete at least two years of supervised clinical training beyond the normal training requirements to become a licensed social worker. The board may give such examinations as it deems necessary to determine the qualifications of applicants.

(c) The board shall adopt rules and regulations applicable to specialist clinical social workers which:

(1) Establish education, training and qualifications necessary for certification as a specialist clinical social worker at a level adequate to assure the competent performance by specialist clinical social workers of those functions which specialist clinical social workers are authorized to perform.

(2) Define the expanded scope of practice which specialist clinical social workers are authorized to perform beyond the scope of practice of a licensed social worker. The board shall adopt a definition of expanded scope of practice under this subsection which authorizes a specialist clinical social worker to diagnose psychological disorders and socially dysfunctional conditions, but such definition shall not authorize a specialist clinical social worker to diagnose mental illnesses. The definition of expanded scope of practice adopted by the board under this subsection shall be consistent with the education, training and qualifications required to obtain a certificate of qualification as a specialist clinical social worker which protects the public from persons performing functions as a specialist clinical social worker for which they lack adequate education, training and qualifications.

(d) This act shall take effect and be in force from and after its publication in the statute book.

KANSAS BOARD OF HEALING ARTS

JOAN FINNEY
Governor

LAWRENCE T. BUENING, JR.
Executive Director

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(913) 296-7413
FAX # (913) 296-0852

M E M O R A N D U M

TO: Senate Public Health & Welfare Committee

FROM: Lawrence T. Buening, Jr.
Executive Director

RE: Senate Bill 120

DATE: February 10, 1993

Thank you for the opportunity to appear before you and to express concerns, on behalf of the State Board of Healing Arts, regarding the proposed amendments to K.S.A. 65-6302 as set forth in Senate Bill 120. While the Board has not met and taken a position as a whole on the proposed amendments to SB 120 since its introduction, after consultation with the President and other members of the Board, I have been authorized to express, on behalf of the Board, concerns regarding the proposed amendments submitted by this bill.

The first concerns relate to the changes made by the new language set forth in page one, lines 42-43 and page two, lines 1-3 of the bill. This sentence would allow licensed specialist clinical social workers or licensed master social workers under the supervision of a "qualified mental health professional" to make diagnoses of mental conditions classified in the current version of

Senate PH&W
Attachment #5
2-10-93

The Diagnostic and Statistical Manual of Mental Disorders (currently DSM-III-R). In the introduction to DSM-III-R the following is stated at the introduction page XXV:

> **"Multiaxial Evaluation System.** DSM-III-R has a multiaxial system for evaluation to ensure that certain information that may be of value in planning treatment and predicting outcome for each person is recorded on <u>each</u> of five axes. Axes I and II comprise the mental disorders; Axes III, physical disorders and conditions; and Axes IV and V, severity of psychosocial stressors and global assessment of functioning, respectfully. In its entirety, the multiaxial system provides a biopsychosocial approach to assessment." (emphasis added)

It is the Board's understanding of the proposed amendment that it would allow either a licensed specialist clinical social worker <u>or</u> a licensed master social worker under the supervision of a qualified mental health professional to make a diagnosis of mental conditions classified in DSM-III-R. If this understanding is correct, the Board questions the qualifications and competency of those individuals to make such diagnosis since the multiaxial evaluation required under DSM-III-R requires that any current <u>physical disorder or condition</u> also be considered in understanding and managing the case. Secondly, a concern is offered that a licensed master social worker may make a diagnosis when working under the supervision of a "qualified mental health professional". This term is defined in K.S.A. 59-2902(w) as follows:

> "(w)(1) 'Qualified Mental Health Professional' means 'a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist, respectfully, under a contract with a participating mental health center, or (2) a registered masters level psychologist or a licensed specialist social worker or licensed master social worker or a registered nurse who has a specialty in psychiatric nursing who is employed by a participating mental health center and who is acting under the direction of a physician'.

Depending upon the legislative intent and interpretation of the term "qualified mental health professional", the amendments offered by this sentence in SB 120 would enable the diagnosis of mental conditions without any involvement of individuals licensed to practice medicine and surgery in the state of Kansas. Furthermore, it would not allow for persons licensed to practice medicine and surgery and specializing in psychiatry who are in private practice to utilize licensed master social workers in their practice. This amendment would totally abrogate the longstanding concept adopted by the Legislature that the diagnosis of mental (not only psychological) conditions be under the management and control of physicians licensed to practice medicine and surgery. Such amendment is a radical departure from existing statutory law and common practice and the Board expresses a great deal of concern that such be accomplished without considerable deliberation by this Legislature.

Concerns are also raised regarding the sentence commencing at page two, line 3. The Board submits that more than "psychological testing" may be required in order to make a complete diagnosis. However, the proposed amendment makes no provision for the referral to an appropriate physician licensed to practice medicine and surgery in order to make a medical diagnosis required because of current physical disorders or conditions which may be potentially relevant to the understanding of the management of the case. Rather, this sentence specifies that if "psychological testing" is required to make a complete diagnosis the matter will be referred to a psychologist. The Board submits that there may be any number of medical conditions which would require the case to be referred to a person licensed to practice medicine and surgery.

In conclusion, while licensed specialist clinical social workers and licensed master social workers with supervision may be capable of making certain psychological diagnoses, the proposed amendments to K.S.A. 65-6302 as submitted in SB 120 go far beyond this concept and allow the "diagnosis" of "mental conditions" which should be limited to individuals licensed to practice medicine and surgery in the state of Kansas. Furthermore, the bill should provide that if <u>any</u> further testing is required to make a psychological diagnosis, such case may also be referred to persons licensed to practice medicine and surgery.

Thank you for the allowing the Board to submit these concerns. I would be happy to respond to any questions.

Statement Regarding SB120 To

KANSAS STATE SENATE HEALTH AND WELFARE COMMITTEE

February 10, 1993

By Hal Boyts, MSW, LSCSW

President, Kansas Society for Clinical Social Work

Madam Chairperson, members of the Committee: Thanks for the opportunity to say a few words in support of Senate Bill 120. My name is Hal Boyts and I am a clinical social worker at Prairie View, Newton, Kansas which is a not-for-profit mental health center. We provide outpatient and inpatient services for both mental illness and chemical dependency. As Director of the Wichita Division, I manage an interdisciplinary staff of 17 including six clinical social workers and five psychiatrists. This staff also provides medical management and shares responsibility for programming of the HCA Wesley Medical Center's psychiatric unit. As Director of Marketing, a good part of my time is spent negotiating contracts to provide mental health and chemical dependency services through a broad variety of preferred provider organizations, health maintenance organizations and insurance companies, as well as employer groups who wish to purchase services directly. I am also on the boards of the National Federation of Societies for Clinical Social Work and the National Institute for Clinical Social Work Advancement. During my 17 year tenure as a mental health center director in Kansas, I was involved in formulating the statute to license clinical social workers and participated in writing the first exam to license clinical social workers. I mention these activities as a means of sharing with you the perspective from which I approach the regulation of clinical social work.

The purpose of Senate Bill 120 is to clean up the ambiguities caused by using similar but different terms in the statutes licensing mental health professionals. These terms are "mental illness", "mental conditions" and "psychological disorders". Since these terms are used interchangeably in practice, the framers of the statutes probably gave no

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consideration to the possibility that one day the attorney general would consider them to be mutually exclusive.

The attorney general's office in Opinion 92-43 came to the conclusion that psychiatrists could diagnose mental illness, but not psychological disorders; that psychologists could diagnose psychological disorders, but not mental illness; and that clinical social workers could diagnose mental conditions, but not psychological disorders and mental illness. Since clinical social workers are licensed to do psychotherapy, as are psychiatrists and psychologists, and the first step in doing psychotherapy is to make a diagnosis, Senate Bill 120 attempts to restate in more consistent terms what clinical social workers are expected to diagnose as they provide psychotherapy.

The question has been raised as to whether this is a substantive change or just semantics. It is semantics. Clinical social workers are trained in graduate school to diagnose and are examined to do so after 4000 hours of postgraduate supervised practice in a clinical setting. I have not seen the current test but I know that the original exam specifically tested the applicant for their ability to assess symptoms and arrive at psychiatric diagnoses for the various categories of problems in the APA Diagnostic and Statistical Manual. Such diagnosing was going on for decades prior to legal regulation.

In my capacity as Director of Marketing at Prairie View, I have observed that in the dozens of contracts we have with payers to provide the full range of psychiatric and chemical dependency programs to their members, that all expect licensed clinical social workers to diagnose. I also do not recall any who require supervision of the LSCSW in order to do so.

The process of diagnosis is a similar function for all three major disciplines as reflected in the fact that the standard code for billing diagnostic services is 90801 for clinical social workers, psychologists and psychiatrists alike. In contrast, a unique psychological procedure, such as psychological testing, is billed under Code 90830 which is not

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available to clinical social workers or psychiatrists. Other codes are available to psychiatrists for medical procedures, which are not available to either clinical social workers or psychologists.

It is important to note that the standard nomenclature for the diagnosis of mental disorders, as defined in the broadest sense, has always been the American Psychiatric Association's Diagnostic and Statistical Manual which is an interdisciplinary manual. If you understand the interdisciplinary approach to providing mental health services, you can understand why it is necessary to have just one diagnostic manual. While sponsored by the American Psychiatric Association, the authorship of the manual includes clinical social workers and clinical psychologists who also serve as trainers of all disciplines.

A question has also been raised as to whether the Diagnostic and Statistical Manual should be cited in defining conditions for which a clinical social worker can diagnose. Since the term "mental conditions" apparently does not do this, we simply need to find some way to cover "mental illness", "mental disorders", "emotional problems", "behavior disturbances", "substance abuse", "chemical addictions", and other pathological relationships and behaviors. We need a blanket definition to cover all the specific nuances within the broad realm of pathology related to thought, behavior and relationships. <u>While there certainly is mutually exclusivity in many procedures provided by the different disciplines, diagnosing and providing psychotherapy are functions that all disciplines do.</u>

Someone has raised the question about whether there are diagnoses in the Diagnostic and Statistical Manual which require the knowledge of physical medicine found only within the purview of a physician. The answer is obviously yes. The assessment processes of clinical social workers and clinical psychologists include medical histories so that these disciplines are trained to identify situations in which physicians need to be involved.

Also a question has been raised about making specific reference to the Diagnostic and Statistical Manual since it is a non-governmental publication subject to change. I don't

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know the answer. However if there is a problem, I would suggest that Senate Bill 120 make reference to whatever "Codification of emotional, mental and behavioral disorders and illnesses that is generally used by providers and payers in the mental health industry."

You may know that the state is now controlling Medicaid costs for psychiatric inpatient treatment by requiring a clinician to personally examine an individual before allowing hospitalization. Most of these examinations are done by licensed clinical social workers who obviously need to diagnose to complete this function.

In the final analysis, the question should be "How would the consumer be affected if clinical social workers could no longer legally diagnose mental illness, chemical dependency, etc." The main impact would be increased costs, delay in getting service, and in some cases, the inability to get services at all. Suddenly, a majority of the mental health providers could not treat until their prospective patient would have been seen by a psychiatrist. Although sometimes needed, a $135 psychiatric evaluation is usually not necessary. Furthermore, psychiatrists are frequently out of reach geographically or unavailable due to full schedules.

In summary, I recommend this Bill to you for the following reasons:

1. It is a housekeeping measure to keep in place the intent of the original social work licensing statute.
2. It reflects the prevailing practice within the industry.
3. It protects consumers by continuing to make services available and hold costs down.
4. The managed care part of the healthcare industry now requires it.

I will be happy to respond to questions.

HRB/js/SB120

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Association of Community
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Testimony on S.B. 120
SENATE PUBLIC HEALTH & WELFARE COMMITTEE
Honorable Sandy Praeger, Chair

By: Paul M. Klotz, Executive Director
February 10, 1993

Thank you for the opportunity to comment.

This Association strongly supports **S.B. 120**, as amended by NASW and put forward by their representative Ms. Gigi Felix. This amendment is the result of a carefully drawn compromise between various health care providers to put into law what has been done successfully in practice over the past 15 to 20 years.

The 30 licensed community mental health centers employ approximately 300 licensed social workers and heavily rely on their tried and tested expertise to provide quality services to over 83,000 Kansans seeking mental health services from the centers. These highly trained and professional social workers are essential to making the recently passed Mental Health Reform Program work as well as providing many of the other more traditional services that we have been rendering over the past 30 years.

If the Attorney General's Opinion is court tested and allowed to stand, the fiscal note to the 30 licensed centers would be approximately $14,250,000 to hire either licensed psychologists or physicians to take the place of these social workers. We would certainly be forced to approach the state for this additional money, at a time when the state is not able to pay for all the existing programs currently mandated.

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Our most recent salary survey (1991) gives the following average salaries, plus 15% added for fringe benefits for the following mental health professionals:

Physicians	$120,994
Licensed Psychologists	38,065
Licensed Social Workers	33,290

Even assuming that the state could find the additional $14.2 million in its already tight budget; the next major problem would be to find sufficient M.D.s and/or Licensed Psychologists willing to practice in our centers, particularly in rural areas and at salaries generally lower than the for-profit private sector. Also, given our experience and state hospital experience, there is no evidence to show that such a major transformation would produce a corresponding improvement in quality of service. We are in a position to judge quality of service, since we employ all of the above listed professionals and utilize them in specialized and general ways, depending on the particular needs of an individual client. Centers have found that both quality and cost effectiveness are well served by utilizing licensed social workers as providing in the amended **S.B. 120**.

Thank you!

Steve Proctor, L.S.C.S.W.

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Testimony Related to S.B. 120

Good morning members of the Senate Public Health and Welfare Committee and guests. My name is Steven Proctor, a Licensed Specialist Clinical Social Worker in private practice in Concordia, Kansas. Thankyou for allowing me to testify here today. I have recently been made aware that questions and concerns have been raised by interested parties regarding the qualifications of Licensed Master's Level Social Workers, (LMSWs), under supervision, and Licensed Specialist Clinical Social Workers, (LSCSWs), to diagnose the categories of disorders listed in the Diagnostic and Statistical Manual, Third Edition, Revised, known as the DSM III R. My testimony explicitly pertains to my professional qualifications however, since all LMSWs and LSCSWs are subject to the same standards for education and training and ethically and legally bound to practice only within the scope of their expertise, you may wish to interpret my testimony more implicitly as pertaining to all LMSWs and LSCSWs barring any formal constraints on their practice.

I received my Bachelor's Degree from an accredited Social Work program at the University of Iowa in 1979. I enrolled in the Master's program, clinical track, at the University Of Kansas in the Fall of 1987. The academic requirements included completion of 48 hours of course work over a two year period maintaining at minimum a "B" average. Courses directly related to the topic at hand were Human Behavior I and II, Clinical Practice I and II, Psychopathology, and Mental Health. Concurrently I successfully completed a Field Practicum at a Community Mental Health Center under the supervision of a LSCSW. This Practicum consisted of 16 hours per week the first semester followed by 24 hours per week the next three semesters, for a total of 1,320 contact hours. During formal supervision I was required to offer a rationale for clinical assessments complete with a diagnostic impression based on DSM III R classification.

Upon graduation with a Master's Degree in Social Work in May of 1989, I became employed at the Community Mental Health Center at which I did my Practicum. Shortly thereafter I received my license at the Master's level after passing a four hour examination offerred by the Behavioral Sciences Regulatory Board. This examination had numerous questions related to the DSM III R. From May of 1989 through May of 1991 my clinical

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work was supervised by a LSCSW at the Community Mental Health Center. The Diagnostic Evaluations, also known as Intake Evaluations, which I generated were reviewed and critiqued by my supervisor and again by the Center's Quality Assurance Team. After two years, 4,000 hours, of post graduate supervised work I passed the licensure examination for Specialist Clinical Social Worker, an exam replete with questions about mental conditions and the correct use of the DSM III R.

In November of 1991 I received my license as a Specialist Clinical Social Worker while employed on the Psychiatric Unit of a General Hospital. My duties included offerring psychotherapeutic services to both inpatients and outpatients, and yes, the diagnosis of mental conditions. More recently, in December of 1992, I entered in to private practice as an independent Clinical Social Worker with direct access to clients. To maintain my license I must abide by all regulations set forth by the Behavioral Sciences Regulatory Board and must obtain at least 60 hours of CEUs every two years.

Diagnosing mental conditions is more than the arbitrary application of labels to specific symptom clusters. It requires an indepth understanding of human behavior, patience and caring to gain a longtitudnal perspective of the pathological manifestations via social histories and collateral contacts, and the wisdom to see our clients as individuals having unique problems. I do not believe it is necessary to challenge the other established disciplines' qualifications to diagnose, rather in maintaining the status quo service delivery is enhanced by enabling clients to access quality mental health services in a timely and cost effective manner.

I am testifying with the hope that a change in statutory language will permit me to continue doing what I know I am qualified to do based on my education, training and experience. I am happy to address questions at this time. Thank you very much.

Respectfully submitted,

Steven Proctor LSCSW

TESTIMONY BEFORE THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE CONCERNING SB 120, AMENDED.

Senator Praeger and members of the Senate Public Health and Welfare Committee.

I am Carl Myers, a licensed specialist clinical social worker, and I am employed as an assistant professor in the undergraduate social work department at Washburn University. I have been a social work educator and clinical practitioner in the State of Kansas for the past sixteen years.

My comments today are as an individual clinical social work practitioner, and should not be construed as representing, in any way, the views of Washburn University.

I wish to speak in support of SB 120, as amended.

Perhaps it is not necessary to utilize this committee's time to elaborate at great length in what ways social work undergraduate and graduate school curricula provide the professional basis to make an assessment of the client system's presenting concerns as a basis for intervention.

Or, to explain the additional practice, supervision and written examination requirements in order to be licensed to practice independently at the LSCSW level.

I shouldn't think it necessary to explain in detail why diagnosis is an integral component of psychotherapy as practiced by clinical social workers, and all other providers of mental health services.

I believe the reasons for the addition of specific language are to make explicit what has long been fully accepted by the mental health community and third party payors.

It reinforces the current mechanisms whereby consumers have access to psychotherapy services under both public and private auspice.

Incorporating this language assures that the present mental health service delivery system will continue to operate and evolve in an increasingly complex and rapidly changing health care financing environment.

As you are aware, the concerns about health care financing have to do with serious problems with access and efficiencies in the delivery of needed services.

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The immediate crisis is that too many people are finding themselves without access to needed services at all.

I concur with the position taken jointly by the Kansas Society for Clinical Social Work and Kansas NASW in terms of the need to specifically clarify the existing sanction and current practice of utilizing the classification system known as the DSM-III-R.

The issue of access to mental health services, and efficiencies in the delivery of mental health services becomes clear when you appreciate how information is transmitted between the health care reimbursement system, in its various forms, and the providers of services.

The basic language, universal in this complex referral-reimbursement system of various forms of public and private insurance companies, HMO's, EAP's, Medicare, and Medicade, is through the DSM III-R classification system.

The information exchanged to the insurance company regarding the nature and condition of the insured, as well as treatment provided, is expressed through digital coding standardized by the DSM-III-R. Paperless claims through computer modem is now commonplace.

In the real world of clinical practice, merely specifying the appropriate DSM III-R diagnostic term and code number is a very small part of an appropriate, comprehensive assessment of the antecedents and current dynamics of the problem, and the client system's resources and strengths which can be brought to bear on resolving the presenting problems, or symptoms.

But, in order for the client's health insurance to pay a percentage of the fee charged, the provider of service must specify a DSM-III code number.

If the lack of clarity in the statute about the explicit sanction of clinical social workers to express client conditions using the industry standard DSM-III-R codes led to excluding the consumers of mental health services now provided by the majority of mental health providers in the present service delivery system, the impact could be extremely disruptive to individual clients, private and public institutions, and would certainly aggravate the already serious problems with health care systems inaccessibility and inefficiency.

Carl S. Myers, LSCSW
Social Work Department
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Testimony for SB-120
Emily J. Holman, LMSW
President, Kansas Chapter-NASW

Good Morning. My name is Emily Holman. I am the President of the Board serving the Kansas Chapter of the National Association of Social Workers. I graduated from the University of Kansas with my Masters in social work in 1989, being licensed that same year. I have been the Unit Coordinator and social worker on an inpatient psychiatric unit for children for 3 years. I have received on-going supervision from an LSCSW since my date of hire.

I am here to lend further support for the amendment of the social work practice act 65-6302. We intend to make it clear, as a matter of statute, social workers have the right to diagnose as a part of our psychotherapeutic work.

With the reimbursement changes made by Medicaid in July of 1989 and the most recent Mental Health Reform legislation, the community is now strongly encouraged to meet the mental health needs of the public on an outpatient basis, where "wrap-around" services are utilized, such as, in-home family preservation, day treatment for the chronically mentally ill, partial hospital programs, etc. Social workers currently practice in all of these areas and are readily able to provide these services. For insurance companies the pendulum has swung to the other extreme and now an "average" inpatient stay for both Medicaid and insurance has been reduced from 30 days to as low as 4 to 6 days. Imagine the dilemma this has created for those clinicians, like myself, who must evaluate and assess a child, while

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complying with a shortened length of stay, and be confident in the recommendations we make.
For social workers to attempt to evaluate and diagnose a child without the DSM, or worse, to rely on the psychiatrist of our multidisciplinary team to do the diagnosing of the child, would clog and delay the system, at best, and to formulate a treatment plan without the DSM , would predictably cause hasty "labeling" that could effect the rest of the child's life.

Our hope, on the inpatient unit, is to be efficient, thorough, and specific as possible with our recommendations. Having to work under a short deadline, we need as many assessment tools and diagnostic instruments as are available. Because the DSM is the most researched, statistically supported, and the only standardized tool available, it is invaluable to all mental health professionals. Social workers are imminently qualified to use the DSM and are highly committed to their need to meet standards of licensure and practice of our profession. The piece of legislation before you aims to clarify this issue.

In the introduction of the DSM III-R, in reference to how it was formulated, it is stated : (p.xix)" The members of the Work Group were selected to ensure a broad representation of clinical and research perspectives...All of its members shared a comitment to the attainment in DSM-III-R of the same goals that guided the development of DSM III." Further a number of the goals specifically address the formulation of the DSM so it can be readily used in "varied clinical settings." Two goals focus on the need for universitality so the DSM is "acceptable to clinicians and researchers of varying theoretical orientations" while providing resource "for educating

health professionals." As stated by others here today, the DSM does not specify who can use it. As a matter of fact, it states it's goal is to be used in a variety of settings by all mental health professionals..

Some concern has arisen regarding who should be considered qualified to diagnose mental disorders versus mental illness versus psychological disorders. Here again, the DSM guides us through a definition of mental disorder that says "no definition adequately specifies precise boundaries for the concept of 'mental disorder.'" The DSM defines neither mental illness or psychological disorder.The DSM does define mental disorder, and makes references to "clinical behaviors, psychological syndromes, or patterns" all of which social workers are aware of, encounter, and diagnose in everyday practice (p.xxii).

Social workers practice in a vast array of professional arenas and we are a multifaceted discipline. In the mental health field, diagnosing is an integral part of our practice and while we are committed to providing outstanding care for our clients we are equally committed to assuring high standards of licensure, education, and practice as professionals. We do not want to create territorial disputes or any interdisciplinary distance. The issue is not whether social workers can diagnose mental illness, psychological disorders or mental disorders because as stated in past testimony, all these terms are equitable and appropriately interchangeable. Our goal is to make our statute clear: Social workers can diagnose.

The spirit of the DSM, as written, is not as a unidimensional tool, but to cut across disciplines, where the" guidelines for making diagnoses" are offered

"since it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators." The intent of the DSM is to provide an instrument available that is a standard for all mental health professionals. The intent of this legislation is neither to expand or limit our current scope of practice.

Thank you for you time and consideration, I would be glad to stand for any questions.

KANSAS PSYCHOLOGICAL ASSOCIATION

Testimony Before Senate Committee
on Public Health and Welfare

Senate Bill 120

February 10, 1993

I am Dr. David C. Rodeheffer, Ph.D. and am appearing today on behalf of the Kansas Psychological Association, as it's President. While we are appearing on the opponent side of the ledger today, our organization does not wish to be in the position of passing judgment on the qualifications of another profession outside the domain of psychology. Our only position is that any profession wishing to define a particular scope of practice be able to demonstrate adequate education and training to support that type of work. This is, we believe, in the best interests of the public who would be seeking services from such a profession. It is important to keep in mind that the consumer of mental health services may not be aware of quality treatment. They may be damaged not only by the provision of inadequate and harmful treatment, but may be damaged if the exact nature of their psychological problem is not correctly judged. Therefore it is of paramount importance that any profession granted diagnosis within its scope of practice by the legislature be adequately trained and prepared.

The profession of social work is asking that their scope of practice include diagnosis. They point out that they have had psychotherapy as their scope of practice and that diagnosis goes hand in hand with providing psychotherapy or treatment. What is important to keep in mind, however, is the scope of the diagnostic work that would be granted with these changes.

In referring to the Diagnostic and Statistical Manual as those conditions that they will be allowed to diagnose by law, they are covering a comprehensive range of diagnoses related to mental health. The conditions they are asking to be permitted to diagnose range from family and relationship problems; to adjustment reactions to crises and life stressors; to major psychotic conditions (including schizophrenia and manic-depression); to alcohol and drug addiction; to mental retardation; to some types of organic brain syndromes; to post traumatic stress disorders; to ingrained personality disorders; to dissociative disorders, including multiple personality; to anxiety related disorders; to a number of childhood disorders including attention deficit disorder, conduct disorder and pervasive developmental disorders including autism. The severity of symptoms and dysfunction within this array of disorders range all the way from relatively mild and transient mood and behavior changes to markedly significant changes in cognitive, intellectual, affective, interpersonal and adaptive functioning.

The process of making a diagnosis requires sensitive and at times difficult comparisons and contrasts between the plethora of symptoms and behaviors that a patient presents. It is not simply observing certain behaviors or listening to the description of symptoms by the patient. It entails, as well, knowing which questions to ask and which areas to explore in order to determine the nature of

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the problem. It is analogous to a person bringing their car into a mechanic, yet infinitely more complex. The owner may have some notion of what noises or problems the car is evidencing or have a general perception that the car just isn't running right; however, only when a mechanic, who is thoroughly trained and knowledgeable about not only the construction and workings of the car but also in the process of making diagnostic studies so that the right issues and the right questions are asked, will the exact source of the problem be pinpointed.

The process of diagnosis then, entails the decision making process whereby the presenting symptoms of a patient are skillfully and carefully clarified and explored against a backdrop of a thorough understanding of psychology such that the exact reason for the problems can be pinpointed and thus treated. Diagnosis not only entails an understanding of psychology and psychopathology but also thorough training in the decision making process by which one reaches conclusions about the patient's presenting symptoms and problems.

Because of the extensive range of diagnoses covered and because of the degree of knowledge and expertise needed to make these diagnoses, it is our position that certain basic educational and training experiences must be present as necessary, albeit not sufficient, requirements. We therefore feel that the following qualifications be considered statutorily:

> Those persons who are licensed under this act may diagnose mental conditions classified in the most current version of **The Diagnostic and Statistical Manual of Mental Disorders** if they have been certified by the Board to have completed:
>
> 1) At least 12 graduate credit hours of course work in the diagnosis of mental and emotional disorders including developmental, biological and abnormal basis of behavior; and
>
> 2) A practicum of at least 750 clock hours in a clinical setting which setting included diagnosis and treatment of mental disorders under the supervision of a practitioner licensed to diagnose.

I would like to thank the committee for the opportunity to appear on this issue. I would be glad to answer any questions now or at a later time.