Exploring Human Services

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Contents

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1. Introduction to Human Services

The History of Social Work in the United States

Activity:

Video: Legacies of Social Change https://vimeo.com/104132906

The inception of the social work profession in the United States can be traced back to the late 1800's beginning with charity work performed by local churches and communities seeing to meet the needs of the poor. Some of the earliest social work interventions were designed to meet basic human needs of populations and placed great value in providing support, assistance, and resources to families and communities in an attempt to alleviate suffering (Nsonwu, Casey, Cook & Armendariz, 2013). The profession now known as social work ultimately began as a result of a practice originally known as "helping" others to improve the well being of individuals, families, and communities. Throughout the years the social work profession played vital roles in the facilitation of social changes aimed at diminishing inequalities among various populations. Through the practice of "helping," social workers were able to address many social problems that plagued vulnerable populations through facilitating, advocating, and influencing individuals, communities, politicians, and law makers (Langer & Leitz, 2014).

Throughout the progressive movement era, many social workers emerged and were identified as key players known to have advanced the profession. These individuals came to be known as *pioneers* of the social work profession as their careers were devoted to improving the well being of individuals, families, and communities. In an effort to help conceptualize the social work profession, we will look closer at the origin of the social practice, as well as discuss a few pioneers and their contributions to the social work profession (Hansan, 2013).

In the early 20th century, Robert Hunter's book *Poverty* was published. Hunter's book placed a spotlight on America's poor and challenged society's long held belief that poverty signified moral failure (Hansan, 2013). Hunter's book demonstrated a critical need to implement specific social measures in order to prevent the destruction of the working class population on the verge of poverty. Hunter additionally identified conditions known to breed poverty calling into question the need but also the tolerance for these unjust conditions particularly by a professed Christian population (Hunter, 1904).

Another known pioneer of the social work profession is Mary Richmond. Throughout her career, Richmond searched for answers surrounding the reasons and causes of poverty while also examining the interactions between individuals and their environments. Richmond believed that interventions and treatment approaches needed to be focused on the person within their environment. As a result of this belief, Richmond developed the circle diagram as a way to help her clients identify sources of power available to them within their own environment. One of Richmond's biggest contributions to the social work profession was her book *Social Diagnosis* which was published in 1917. Richmond's book focused on the practice of casework with individuals and was the first book to identify a systematic and methodological way to document and diagnose clients (*Social Welfare History Project*, 2011).

Jane Addams is another well-known pioneer to the social work profession. Addams, along with Ellen Gates Starr, founded Hull-House in 1889. Hull-House was a successful settlement house located in an area of Chicago that was largely populated by immigrants. Residents of Hull-House were provided with multiple services which included daycare and kindergarten facilities for the children of the residents. Throughout her career Addams' continued to contribute to the

social work profession by advocating for the rights and well-being of women and children on several important issues, one of those issues being the implementation of child labor laws (Hansan, 2010).

Jane Hoey's career as a social worker began in 1916 when she was appointed as the Assistant Secretary of the Board of Child Welfare in New York City. Throughout the course of her career she would work in multiple social welfare agencies: serving as the Director of Field Service for the Atlanta Division of the American Red Cross, the Secretary of the Bronx Committee of the New York TB and Health Association, the Director of the Welfare Council of New York City, and ultimately as the Director of the Bureau of Public Assistance. Hoey is best known for her role in the enactment of the Social Security Public Assistance Act which became law in 1935. Following the law's enactment, Hoey became the Director of the Bureau of Public Assistance within the Social Security Administration and was responsible for organizing and implementing the distribution of the public welfare provisions (*Social Welfare History Project*, 2011).

Additional Reading Material

Mary Richmond's *Social Diagnosis*

https://archive.org/details/socialdiagnosis00richiala

Robert Hunter's *Poverty*

https://archive.org/details/povertypoor00huntuoft

Social Work: What is it?

For over a century the answer to this question has been not only varied but also debated among members of the general public as well as in the professional social work community. The definition of "social work" may not be as clear as one may think when attempting to understand the meaning of social work. Embedded within these definitions of "social work" are common themes which can help to conceptualize social work. Although there are many varying definitions used to describe social work, what matters the most is the purpose of social work and what guides and directs social work practice. According to the Council on Social Work Education (CSWE), the purpose of the social work profession is to "promote human and community well-being"; which can be achieved through promoting social and economic justice and preventing conditions that limit human rights for all people.

Even after defining social work and identifying the purpose of the social work profession, there continues to be some misalignment among the profession with the overall mission of social work. This is not surprising considering the increasingly diverse populations being served by the profession. What is becoming increasing clear as the diversity of client systems continues to expand, is the critical importance of professional competence in order to meet the unique needs of individuals as well as emerging social issues. In an effort to better prepare new social workers to respond to these new challenges and social issues, the CSWE adopted a competency-based education framework, Educational Policy and Accreditation Standards, which gives students the opportunity to demonstrate and integrate social work knowledge and skills in various practice settings. More than ever social work requires a broad knowledge base in order to effectively meet the needs of others but also to help clients find hope in the process. Finding hope is essential to the social work practice as hope helps to empower diverse populations facing unique challenges (Clark & Hoffler, 2014).

The feelings associated with a sense of hope are considered to be fundamental to the social work practice. Hope is essential to social work as it allows those facing challenges to believe in a positive outcome and hope can play a major role in how the challenges/circumstances are viewed. A sense of hope is as essential to clients as it is for social workers who are helping clients. Social workers struggling to feel hope may communicate this verbally and non-verbally in their

approach with their clients, ultimately impacting the effectiveness of the intervention. This is one of several reasons individuals wishing to pursue a career in social work should explore their personal values, overall worldview, beliefs, abilities, skills, and priorities as well as personal and career goals. This type of exploration is essential to determining whether or not a career in the social work field will be a good fit. In addition, individuals should also consider the demands, stressors, and challenges common to the social work practice giving serious consideration to whether helping the most vulnerable populations will negatively impact their own physical and/or mental health and overall quality of life (Sheafor, Horejsi, & Horejsi, 2000).

Additional Activities:

When in Doubt, Give Hope. (Speech starts at 2:20)

Allison Brunner a newly graduated MSW talks about her anxieties and doubts that recent graduates feel with their professional responsibility to hold hope for their clients. She describes her own doubts as a social worker, relates those to her personal moments of doubt and shares how she drew from those experiences to help her client. Using our experiences to benefit our clients rather than ourselves, is what we call "professional use of self." And as Carl Rogers demonstrated many years ago, bringing our genuine self to the clinical relationship is one of the most important things we can do to help our clients.

Retrieved from: http://www.socialworkpodcast.com/GraduationSpeech2009.mp3

Bachelors of Social Work (BSW) versus Masters of Social Work (MSW)

According to the Bureau of Labor Statistics, the minimum pre-requisite needed to gain employment in the social work profession is a Bachelor's Degree in Social Work (BSW). However, those with specific career goals may be required to obtain a higher level of education. Therefore, some may wish to pursue a Master's Degree in Social Work (MSW).

Social workers may serve in all of these different roles in varying degrees at any time in their career.

There are some similarities between the two degrees which include the expectation that both BSW and MSW students complete supervised field placements within a social service type agency. The requirements related to the length of placement, expected tasks, and/or hours may vary based on degree. Common social service agency placements for both BSW and MSW students include places such as hospitals, schools, or mental health or substance abuse clinics. In addition to this requirement, both BSW and MSW graduates must be granted a license in the state they wish to practice. Licensure for an MSW requires a minimum of 2 years of supervised clinical experience following graduation and a passing score on the Association of Social Work Boards (ASWB) licensing examination.

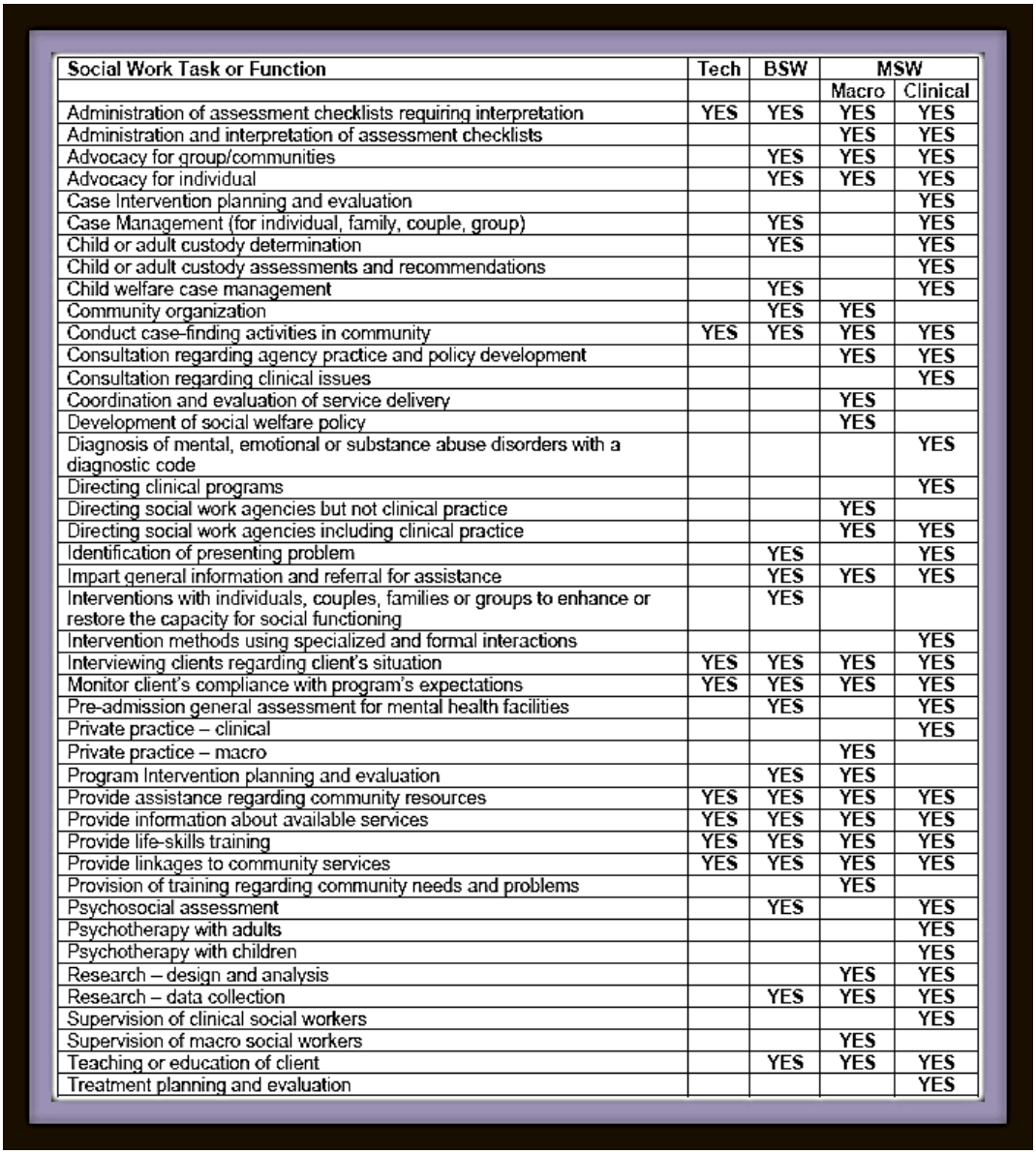
There are several key differences between BSW and MSW degrees. One of the first differences is the pre-requisite for entrance into the programs. Typically the only requirement needed to enter into an accredited BSW program at a college or university is that the candidate has declared social work as their major. This differs from an MSW program as MSW candidates apply for entrance into the program after already having obtained a Bachelor's Degree in which the graduate has likely earned credits in coursework areas related to psychology and sociology.

Another difference is the coursework required based on the desired degree. The Council on Social Work Education (CSWE), which accredits U.S. social work programs, designates BSW undergraduate programs teach students about diverse populations, human behavior, social welfare policy, and ethics in social work. Additionally, students are required to complete a supervised field placement at a social service agency. Baccalaureate social workers have the ability to obtain specialty certification in certain areas through their state chapter of the National Association of Social Workers

(NASW), which offers specialty certification available in child, youth and family social work, gerontology, casework, and hospice, and palliative care. Master's degree programs focus on developing clinical assessment and management skills and prepare students for work in a more targeted areas depending on the student's interest.

The other important differences between the two degrees involves the type of employment each degree holder is eligible for and the earning potential based on the degree. MSW graduates typically earn a significantly higher salaries than BSW graduates. Individuals with a BSW degree tend to be employed in entry level jobs as caseworkers and are expected to provide direct services to clients through assessing, coordinating, and referring to area resources. The Michigan Board of Social Workers outlines the scope of practice/expected duties for social workers based on education and designated practice area (see chart below).

MSW graduates are often employed in clinical settings such as a hospital or a private practice setting and also in various administrative positions. MSW graduates can obtain either a Macro or Clinical license. The scope of practice differs depending on the type of MSW license. According to the National Association of Social Workers (NASW), a licensed Master Social Worker with macro designation can expect to be involved in administration, management, and supervision of human service organizations and perform functions that seek to improve the overall population's quality of life through a policy/administrative perspective. These tasks range from collaboration, coordination, mediation, and consultation within organizations and/or communities, community organizing and development, research and evaluation, and advocacy/social justice work through involvement in the legislative process. A licensed Master Social Worker with a clinical designation (micro) typically work directly with individuals, families, and/or groups in an effort to improve the client's overall quality of life. Social workers can expect to perform the following tasks/functions: advocating for care, protecting the vulnerable, providing psychotherapy as defined as "assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other biopsychosocial problems."



Social Work Task or Function	Tech	BSW	MSW	
			Macro	Clinical
Administration of assessment checklists requiring interpretation	YES	YES	YES	YES
Administration and interpretation of assessment checklists			YES	YES
Advocacy for group/communities		YES	YES	YES
Advocacy for individual		YES	YES	YES
Case Intervention planning and evaluation				YES
Case Management (for individual, family, couple, group)		YES		YES
Child or adult custody determination		YES		YES
Child or adult custody assessments and recommendations				YES
Child welfare case management		YES		YES
Community organization		YES	YES	
Conduct case-finding activities in community	YES	YES	YES	YES
Consultation regarding agency practice and policy development			YES	YES
Consultation regarding clinical issues				YES
Coordination and evaluation of service delivery			YES	
Development of social welfare policy			YES	
Diagnosis of mental, emotional or substance abuse disorders with a diagnostic code				YES
Directing clinical programs				YES
Directing social work agencies but not clinical practice			YES	
Directing social work agencies including clinical practice			YES	YES
Identification of presenting problem		YES		YES
Impart general information and referral for assistance		YES	YES	YES
Interventions with individuals, couples, families or groups to enhance or restore the capacity for social functioning		YES		
Intervention methods using specialized and formal interactions				YES
Interviewing clients regarding client's situation	YES	YES	YES	YES
Monitor client's compliance with program's expectations	YES	YES	YES	YES
Pre-admission general assessment for mental health facilities		YES		YES
Private practice – clinical				YES
Private practice – macro			YES	
Program Intervention planning and evaluation		YES	YES	
Provide assistance regarding community resources	YES	YES	YES	YES
Provide information about available services	YES	YES	YES	YES
Provide life-skills training	YES	YES	YES	YES
Provide linkages to community services	YES	YES	YES	YES
Provision of training regarding community needs and problems			YES	
Psychosocial assessment		YES		YES
Psychotherapy with adults				YES
Psychotherapy with children				YES
Research – design and analysis			YES	YES
Research – data collection		YES	YES	YES
Supervision of clinical social workers				YES
Supervision of macro social workers			YES	
Teaching or education of client		YES	YES	YES
Treatment planning and evaluation				YES

Social Work Scope of Practice, created by the Michigan Department of Licensing and Regulatory Affairs (LARA)

For a pdf of this chart, please see: http://www.michigan.gov/documents/mdch/mdch_sw_swgridforscopeofpractice_216194_7.pdf

What is a client? What's in a name?

It is important that the social work profession accurately define and describe the relationship that exists between those who receive services and those who provide services (social workers). Over the years many terms have been used to describe the service-recipient relationship. Many of these terms have been scrutinized as failing to accurately describe the relationship that exists between the social worker and the service recipient. McLaughlin (2008) identified four terms commonly used to describe the social worker-service user relationship as patients, consumers, and service users. It is important to explore the language used to conceptualize this relationship because the social work profession seeks to empower the most disadvantaged and vulnerable of the population the language we use matters.

Client is the most widely used term used to describe the social work relationship.

The meaning and implications of the term "client" have been questioned as it gives the impression that the social worker is in a position of power over the client. In this instance a client would be viewed as someone who needs help but does not have the ability to help themselves, due to some deficiency either a lack of skills or ability, and therefore requires the knowledge of a social worker (McLaughlin, 2008).

The term "consumer" has been used to describe the relationship of those who use services the state offers. The meaning and implications of using the term "consumer" suggests that those receiving services has options and choices and the social worker is acting as a manager or a monitor of services and/or resources (McLaughlin, 2008).

The term "service user" has also been used in various social work settings. However "service user" may not be appropriate for use in all types of social work practice. For example social workers working in the arena of children's protective services are mandated to respond to child abuse and neglect based on agency and state law. In this situation the service user would most likely object to the social worker's response, therefore the service user would not be officially involved in the decision making process. Over the years social workers have been given a major role in the assessment of needs and risks over client groups and this role is often associated with a policing or surveillance role. In this way the relationship that exists between the client and social worker may get confusing and ambiguous (McLaughlin, 2008).

Common Roles of Social Workers

Over the course of their career, a social worker at any one time may perform multiple roles to varying degrees. The difficulty for many social workers is that over time the roles that involve direct case work have lessened; often social workers will find themselves in a position that involves little client involvement. One of the most difficult situations social workers will experience in their careers is the conflict they face while fulfilling some of the following roles often expected of a social worker at one time.

Broker

A social worker acting as a broker assists and links people with services or resources. In this role social workers assess the needs of the individual while also taking into account the client's overall capacity and motivation to use available resources. Once the needs are assessed and potential services identified, the broker assists the client in choosing the most appropriate service option. The social worker as a broker role is also concerned with the quality, quantity, and accessibility of services. This role is expected to be up-to-date on current services and programs available, as well as familiar with the process for accessing those resources and programs (Zastrow, 2016).

Case Manager

A social worker acting as a case manager identifies the needs as well as the barriers of their clients. Occasionally case managers may also provide direct service to their clients. Case managers often engage with clients who require multiple services from a variety of agencies and work with the client to develop goals and implement interventions based on the identified goals. Social workers acting as case managers remain actively engaged with clients throughout the process by identifying and coordinating services, monitoring identified services and providing support when necessary, and finally providing follow-ups to ensure services are being utilized (Zastrow, 2016).

Advocate

A social worker as an advocate seeks to protect client's rights and ensure access and utilization of services they are entitled to receive. Social workers may perform advocacy work by advocating for a single client or by representing groups of clients with a common problem or identified need. Social workers may advocate with other organizations/ providers and encourage their clients to advocate for themselves in order to address a need or obtain a service. Advocacy is an integral and fundamental role in the social work profession as it is necessary to promote overall wellbeing. The National Association of Social Workers (NASW) (2015) "has specified social workers' responsibility to the community and broader society since its adoption in 1960, and in 1996, strengthened its call to require *all* social workers

to "engage in social and political action" to "expand choice and opportunity" and "equity and social justice for all people" (p. 27). Social workers acting in this capacity may advocate in varying capacities but often times may find themselves in a position of educating the public in order to garner support to seek changes in laws that are harming and impacting the wellbeing of clients. Social workers acting as advocates should always consider whether they are acting and advocating in a way that maximizes client self-determination (Zastrow, 2016).

Educator

Social workers acting as a teacher or educator often help in times of crisis for many clients. In this role social workers help clients develop insight into their behaviors through providing education aimed at helping clients learn skills to handle difficult situations and identify alternative life choices. In this role social workers aim to increase their client's knowledge of various skills some of which include: budgeting, parenting, effective communication, and/or violence prevention (Zastrow, 2016).

Counselor

A social worker acting as a counselor helps clients express their needs, clarify their problems, explore resolution strategies, and applies intervention strategies to develop and expand the capacities of clients to deal with their problems more effectively. A key function of this role is to empower people by affirming their personal strengths and their capacities to deal with their problems more effectively (Zastrow, 2016).

Risk Assessor

Social workers acting as risk assessors have been given a major role in the assessment of needs and risks over a variety of client groups. Assessment is a primary role for social workers and often times is what dictates the services and resources identified as needs for clients. Often time's social workers acting in this role find themselves in precarious situations as the relationship between the client and social worker may be conflicting, especially when working in the mental health field. While working as a risk assessor in the mental health field the social worker may experience conflict between encouraging client self-determination and addressing safety risks.

Mediator

It is common that social workers act as mediators and negotiators as conflict is the root of many areas of social work. Social workers acting in these roles are required to take a neutral stance in order to find compromises between divided parties. In this role social workers seek to empower the parties to arrive and their own solutions in order to reconcile differences and reach a mutually satisfying agreement (Stoesen, 2006).

Researcher

A social worker in the role of researcher or program evaluator uses their practice experience to inform future research. The social worker is aware of current research and able to integrate their knowledge with the current research. Social workers acting in this capacity are able to utilize the knowledge they have obtained through gathering and examining the research to inform their practice interventions (Grinnell & Unrau, 2010).

Group Leader

Social workers who play the role of group leader or facilitator can do so with groups of people gathering for purposes including; task groups, psychoeducational groups, counseling groups, and psychotherapy groups. Task groups are like the name infers task oriented and social workers facilitate that process by understanding group dynamics. Psychoeducational groups are led by social workers who focus on developing members' cognitive, affective, and behavioral skills in an area group members are deficient through integrating and providing factual information to participants. Social workers who facilitate counseling groups help participants resolve problems in various areas that can include: personal, social, educational, or career concerns. In psychotherapy groups social worker address psychological and interpersonal problems that are negatively impacting member's lives (Corey, Corey, & Corey, 2014).

Additional Suggested Readings

Kerson, T. S., & McCoyd, J. (2013). In response to need: An analysis of social work roles over time. *Social work*, 58(4), 333-343. doi: 10.1093/sw/swt035

Gibelman, Margaret (1999). The search for identity: defining social work – past, present, future. *Social Work*, 44(4), 298-310. doi: 10.1093/sw/44.4.298

Characteristics and Skills of Effective Social Workers

Much like the definition of the term "social work," the characteristics and skills required to become an effective social worker are also hard to define and require versatility in this complex and constantly changing environment. Competent and effective social workers are expected to have knowledge in varying intervention strategies and skills in order to enhance functioning and empower others. Effective social workers also must be willing to consider the needs of those being served when designing interventions seeking to enhance the wellbeing of others. In doing so many social workers may adopt specific roles or a combination of roles in order to effectively and efficiently meet the identified need(s). Some common elements and skills have been identified as effective across micro and macro practice settings. It is important to remember that when we are discussing effective social workers it is not just about *what* they do, it is also about *how* they do it (Sheafor, Horejsi & Horejsi, 2000).

Self-Awareness

One of the most important skills necessary for becoming a competent and effective social worker is self-awareness. Self-awareness starts with getting to know yourself and requires clarifying one's own values and assumptions. Every day we are learning and changing as a result of our experiences, therefore self-awareness is a lifelong process that cannot be acquired through education and readings alone. This process requires understanding of past experiences and reflecting on the impacts of those experiences in relation to your world view and view of yourself. People who practice self-awareness can recognize, understand, and regulate their emotions. Self-awareness allows individuals to maximize their strengths by acknowledging their weaknesses. By recognizing areas of both strength and weakness, self-aware people can take proactive steps to manage their weakness and avoid setbacks (Sheafor, Horejsi & Horejsi, 2000).

Competence

Competence is essential in the social work world as there are numerous treatment approaches and intervention strategies available for clients. That being said, it is impossible for a social worker to be competent in every intervention strategy or treatment option. Social workers are expected to be knowledgeable in areas and intervention strategies they will be utilizing with their clients. According to Sheafor, Horejsi, and Horejsi (2000), generalist practice social workers need to be prepared to treat a diverse population of clients, which requires knowledge in a variety of assessment and intervention techniques.

Effective social workers can identify personal values, political beliefs and assumptions but also are willing to develop knowledge of other cultures through formal education and interaction. Professional development allows social workers to develop skills that will enable them to implement successful interventions. Cultural competence is also an area that should be considered when determining effectiveness. All social workers should continually seek cultural knowledge; through education and direct interaction. Culture is an area that is constantly changing and social workers should be prepared to engage in life-long learning in order to seek competence.

Empathy

One of the most critical elements is the relationship between the social worker and the client. Specifically whether or not the client feels the social worker is genuine, supportive and empathetic towards them. A sense of empathy from the social worker increases the chances of building a therapeutic relationship with the client. Because of this, ability to

empathize is essential for social workers. Dr. Brown (2013) suggests that empathy is the best way to ease someone's pain and suffering and is the skill that fuels connections. Empathy is a choice that requires individuals to acknowledge their own vulnerabilities which is often why the ability to empathize is considered a difficult skill to develop.

Critical thinking

The ability to critically think is crucial to the social work profession. Social workers use critical thinking skills on a daily basis to problem solve issues. Critical thinking skills include the ability to ask thoughtful and appropriate questions aimed at empowering others to find their own solutions. It is by applying critical thinking skills that social workers are able to make accurate observations, evaluate client abilities/limitation and/or agencies abilities/limitations. Critical thinking skills can also help social workers generate possible solutions and identify appropriate interventions to implement based of their critical evaluation of the issues and known barriers. Critical thinking skills also aid in the social worker's ability to examine and evaluate the effectiveness of the interventions (Sheafor, Horejsi & Horejsi, 2000).

Communication skills

Communication in the social work profession encompasses a wide-range of activities beyond the ability to communicate effectively with their clients and other professionals. Determining the best approach to utilize when communicating with clients and other professionals will require the use of critical thinking skills. Many social workers are often working in the role of helping others who are seeking to make changes. Therefore, effective social workers will use a combination of different strategies to help move clients towards change. Social workers with effective communication skills avoid directly telling other's what to do and rely heavily of their ability to communicate in order to empower clients to identify their own solutions. Developing and utilizing effective communication skills help clients establish trust and promotes rapport building between the social worker and the client which increases the chances of a successful intervention.

It is important to understand that effective communication skills go beyond one's ability to communicate verbally and includes the ability to communicate through written reports as well as non-verbally while displaying active listening skills. Effective non-verbal communication requires the social worker to portray and display an empathetic, non-judgmental attitude when listening and engaging with clients. Effective written communication skills include the ability to communicate concisely, professionally, and honestly in various written formats as there are multiple mediums in which a social worker must be able to communicate. Because of this, competency in using word processors, email systems, spreadsheets, databases and knowledge of grammar and spelling are an important communication skill. These tasks may seem simple and appear obvious, however may prove challenging. Over time communication skills can be learned with practice, regular reflection, and self-assessment (Sheafor, Horejsi & Horejsi, 2000).

Additional readings

D'Aprix, A. S., Dunlap, K. M., Abel, E., & Edwards, R. L. (2004). Goodness of fit: Career goals of MSW students and the aims of the social work profession in the United States. *Social Work Education*, *23*(3), 265-280. http://dx.doi.org/10.1080/0261547042000224029

Supplemental Activities

Brené Brown's TED Talk: *The Power of Vulnerability*

https://www.ted.com/talks/brene_brown_on_vulnerability

Brené Brown on Empathy (2:53)

https://youtu.be/1Evwgu369Jw

Challenges Ahead

Rothman and Mizrahi (2014) identified a need to rectify an imbalance that exists between micro and macro social work practice to not only strengthen the profession, but to overcome the multitude of problems facing society. Historically the social work profession has addressed the needs of the population with a dual approach, encompasses both macro and micro practice social workers to achieve social progress. This approach requires involvement from social workers at every level of practice to bring about social reform as well as meet the needs of individuals and families.

Currently, the American Academy of Social Work and Social Welfare (AASWSW) is pioneering an innovative approach to achieving social progress powered by science called "The Grand Challenges of Social Work." The AASWSW identifies 12 challenges and major social problems impacting today's society. Today's social workers will need to address and implement effective approaches known to improve individual and family wellbeing in order to begin strengthening the social fabric of America.

The 12 challenges are as follows:

The challenge to ensure healthy development for all youth: The AASWSW has identified the need to prevent behavioral health problems emerging in over six million young people yearly. Evidence has identified several effective prevention based approaches to address the severe mental, emotional, and behavior problems affecting today's youth.

The challenge to close the health gap: More than 60 million Americans have inadequate access to basic health care. Even more disturbing – the majority of people with inadequate access also experience discrimination and poverty. There is an extreme need to develop new strategies targeted at improving the health of our society.

The challenge to stop family violence: Assaults by parents, partners, and adult children are common American tragedies that often result in serious injury, including death. This type of violence impacts society through various arenas. Effective intervention strategies have been identified and if implemented could help break the cycle of violence for many families.

The challenge to advance long and productive lives: Through identifying and engaging individuals with healthy and productive activities, overall health and well-being can be improved.

The challenge to eradicate social isolation: Social workers can help with this challenge by educating the public about the impacts of social isolation as well as, promote effective ways to make social connections.

The challenge to end homelessness: Over 1.5 million American's experience homelessness at least one night a year. Homelessness affects health and well-being and often has lasting impacts on personal development. The challenge will be to implement and expand on proven approaches as well as, implement policies that promote affordable housing.

The challenge to create social responses to a changing environment: Climate change and urban development exacerbate the already existing social and environmental inequalities of marginalized communities. The challenge will be to develop improved social responses based on this knowledge as well as, helping those impacted by the changing environment through developing policies specific to helping those in need.

The challenge to harness technology for social good: A unique opportunity to access and target various populations and social problems exists because of advances to technology. The challenge will be for social workers to find ways to use technology to not only access knowledge, but to gain expertise for the advancement of the social work profession.

The challenge to promote "smart decarceration": With the United States having the world's largest percentage of its population behind bars this could prove to truly be a grand challenge. "Smart Decarceration" calls for a reduction in the

number of people imprisoned, as well as the willingness of a nation to embrace a new and proactive way of addressing safety.

The challenge to reduce extreme inequality: One out of every five children live in poverty, while the top 1% owns almost half of the wealth in the U.S. Poor health outcomes and decreased overall well-being have been documented results of living in poverty. Inequality can be reduced through increased access to education, wages, tax benefits, and/or home ownership. Social workers should seek to adopt policies that promote equality.

The challenge to build financial capability for all: Nearly half of all American households are financially insecure, which means they do not have adequate savings to meet their basic living expense for three months. By adopting policies that support security in retirement accounts as well as, access to financial services that provide for financial literacy there can be a significant reduction in the economic hardships faced by families.

The challenge to achieve equal opportunity and justice: Historic and current prejudice and injustice in the United States impacts several groups of people by impeding and excluding access to education and employment. In order to overcome this challenge social workers must embrace and appreciate diversity and begin shedding light onto unfair practices.

Additional Reading/ Activities

Bent-Goodley, T.B. (2017). Readying the profession for changing times. *Social Work*, 62(2), 101-103. doi: 10.1093/sw/swx014

Singer, J. B. (Producer). (2016, March 28). #103 – The Grand Challenges for Social Work: Interview with Dr. Richard P. Barth [Audio Podcast]. *Social Work Podcast*. Retrieved from http://www.socialworkpodcast.com/2016/03/grand-challenges.html

Activities for Chapter One

Activity #1

25 questions to help you get to know yourself

http://www.mistysansom.com/know-who-you-are-with-these-25-questions

- What does your ideal day look like?
- What did you want to be when you were younger?
- Who are you most inspired by? Why?
- Who would you love to meet? What would you ask?
- What habit would you most like to break? What habit would you most like to start?
- Think of a person you truly admire. What qualities do you like about that person?
- How do you like to relax?
- When was the last time you did something you were afraid of?
- What are you most proud of?
- What are you most afraid of?
- If life stopped today, what would you regret not doing?
- Who would you like to connect (or reconnect) with? Why?
- What qualities do you admire in others?

- What practical skills do you wish you had?
- Imagine you're in your 90s. What memories would you like to have? What stories do you want to tell?
- What is your favorite book/movie/song? Why?
- If you could make one change in the world, what would it be?
- What do you love to do for, or give to others (not an object – something from you personally)?
- What excites you?
- What do you wish you did more of?
- Pretend money is no object. What would you do?
- What area of your life, right now, makes you feel the best? Which area makes you feel the worst? Why?
- Let's jump forward a year. What would you like to have achieved in the past year?
- What piece of advice would you give to five year old you? Sixteen year old you? Twenty-one year old you? Right now?
- How do you want to be remembered in life?

Activity #2:

The Five Minute Personality Test

http://www.sagestrategies.biz/documents/FiveMinutePersonalityTestforclass.pdf

Activity #3:

Character Strengths Survey

https://www.viacharacter.org/www/Character-Strengths-Survey

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2. Social Work Practice Settings

SOCIAL WORK PRACTICE SETTING

Social Work practice begins with the purpose of the social worker. Understanding of the social work profession starts with an intense appreciation of the person in which the social worker serves (Sheafor & Horejsi, 2008). The social worker understands that humans are social beings, these social creature's growth and development need the guidance of nurturing and protection provided by others around them. It's this inter-connectedness and interdependence of people in the social environment that is the foundation of practice in social work as a profession. The environment a person lives in has a lot to do with how a social worker may apply knowledge and guidance. There are two distinct types of social work practice that are used according to the type of setting.

Direct Practice

Direct practice is when the social worker works directly with an individual, family, or group of people. The first direct meeting can occur in a variety of ways such as a crisis, voluntary, or involuntary. The first meeting is a critical point in establishing a good helping relationship. A social worker should prepare for any type of first contact, so that they may set up the best relationship possible with the client (Sheafor & Horejsi, 2008).

Advocacy Day

At the BSW level, direct practice is primarily done as a case worker. The case worker may met with the individual daily, weekly, or monthly depending on the type of work. For example, in short term crisis work, the person may have daily meetings. For adults with intellectual disabilities, a monthly check in may be more appropriate and required by the supervising agency. Direct practice is typically done as a worker at an agency, non- profit, or government setting. A direct case worker may be involved in many different areas of practice, including but not limited to working in adoption, Child Protective Services, in a group home for individuals with brain injuries, a shelter for abuse survivors, or with Community Mental Health. The caseworker may be involved in finding resources or providing support for the client. Meetings may take place at an agency or in the client's home.

At the MSW level, direct practice is usually done in the role of the therapist or counselor. Therapists generally see their clients on a weekly basis, although this time frame may vary. Therapists often work at the same agencies as BSW level caseworkers, but in a different role. While the BSW worker is involved with taking care of the many logistical issues a client may have (housing, food, etc.), the MSW worker is usually assisting the client with skill building, learning coping strategies, and focusing on their overall mental health treatment. Sessions may take place at an agency or in the client's home.

Indirect Practice

Indirect practice is generally when the social worker is involved in activities that consist with facilitating change through programs and policies. This type of practice is more of behind the scenes and is aimed to help prevent problems from developing. Also, the social worker may participate in this type of practice by advocating through agency administrators, legislators, or other powerful people to effect a change (Sheafor & Horejsi, 2008). You may also hear the term *Macro system practice*, which means systems larger than a small group or single person (Zastrow & Kirst-Ashman, 2010). Micro systems are continuously affected by the Macro systems. The two major Macro systems that impact individuals the most are communities and organizations.

Community is defined by Merriam-Webster a unified body of individuals: such as a state or common wealth; the people with common interests living in an area geographically. Community can also me the individuals are connected in other ways, such as an activity, job or an identifying ethnic trait (Zastrow & Kirst-Ashman, 2010). *Community Theory*, is a theoretical frame work adopted when working within a community. Community Theory consists of two components; the nature of the community such as perspectives which may include how it is defined. The second component is how social workers practice in the community (Zastrow & Kirst-Ashman, 2010).

An organization is defined by Merriam-Webster as an administrative and functional structure; this is a group of

individuals that come together to work towards a common goal (as cited in Zastrow & Kirst-Ashman, 2010). Each of the individuals involved in the organization preform specific duties.

Collaboration with agencies are a vital part of indirect practice. The social (Zastrow & Kirst-Ashman, 2010) worker can help facilitate change by reaching out to other agencies that can assist in meeting other needs of the client.

According to an article written by Johnson (1999), Indirect social practice has often referred to environmental intervention in the client's networks or social aspect. The belief was to help alleviate challenges in the client's surroundings. There are two elements associated with indirect practice. The first one is called concrete assistance, this is resources available to the client to help with basic needs. For example, food assistance programs are the most common resource needed for clients. The second element to indirect social work practice is sociopsychological intervention. Which is the adjustment of attitude or behavior of significant people with in the client's social environment (Johnson, 1999).

Human behavior occurs within a community, it is ever present and continuous. Individuals develop through the interactions with others. Behavior is ever dependent on others in the environment, as well as the individual client's behavior affecting those they interact making behavior interdependent (Zastrow & Kirst-Ashman, 2010). The term community can mean so many various things. As a social worker, one must figure out in what context the clients community affects them. What makes up that person's community? Do all the community members suffer the same common problems? Due to the broad nature of the meaning Community, we can break it down in three categories; A designated group of people; this group has something in common; and we know that because of a commonality the individuals in the community, they interact in some way or possibly will in the future (Zastrow & Kirst-Ashman, 2010).

Rural Environment

Rural Communities

Agreement among scholars have lead the social work profession to use a more generalist approach in small towns. The generalist approach allows the social worker to gain skills for working with individuals, families, small groups, organizations and communities. The rationale for this type of practice is solely based on the structural normality's in the majority of rural areas. These areas are usually characterized by a lack of formal resources which includes the

services of private social entities. The Social workers that serve in these areas often work in the public service. They are asked to perform in a range of problems that are presented by those they serve.

There is no set-definition of what defines a rural community, but as such can be understood as those non-metropolitan areas, including surrounding towns with a reduced population that have limited to no access to social services (Lohmann, 2012). It is important to note that despite the stereotype that all rural areas are the same, the reality is that all rural areas differ from one to the next based on socioeconomics, climate, surrounding culture, present ethnicities, and religious structures to name just a few. With this in mind, the rural social worker must be able to work positively within this communities, and take into consideration the differences that exist within them. These areas are usually characterized by a lack of formal resources which includes the services of private social entities. The Social workers that serve in these areas often work in the public service.

Such limited resources in consideration include available locations, trained and licensed individuals, and monetary founds. Thus, as Lohmann (2011) describes, social workers must play multiple roles, from community organizers to caseworkers. As such, these roles are valued for their creativity in how treatment occurs, and how flexible the social worker is with switching between the individual and the community. Limited resources also mean that rural social workers often practice in isolation, without direct supervision and with difficulty accessing continuing educational materials. As such, it is important that these workers seek additional opportunities to expand their professional development and continue advocating for best practices.

Agreement among scholars have lead the social work profession to use a more generalist approach in small towns (Lohmann, 2012; Waltman, 2013). The generalist approach allows the social worker to gain skills for working with individuals, families, small groups, organizations, and communities. The rationale for generalist practice refers to the limited social resources available for rural communities that must be substituted by Social Workers. As such, the generalist approach is best used in rural settings, as it allows the social worker to take on multiple roles that the community needs.

One notable complication with rural communities is the potential of dual relationships between the Social Worker and their clientele. These relationships refer to the proximity of Social Workers living and working in the same environment, where clients may be neighbors or members of similar social groups. Pugh (2007) discusses that these situations present ethical problems, such as maintaining a professional appearance by avoiding invitations for conversations, but ultimately that the social workers role is defined by how they conduct themselves in the community. Additionally, Humble, Lewis, Scott, and Herzog (2013) describe the potential for professional fatigue when the social work is always “on duty”. Despite the additional transparency, rural social workers must balance their professional and private lives in order to work effectively in these areas.

Urban Environment

Urban Communities

In contrast to rural communities, urban communities are those settings involving metropolitan areas with an increase in population density, a decrease in general size, and an increase in access to social services for its population. The rise of industrialization has led to a migration from rural communities to urban ones, resulting in a population shift between the two areas where urban areas hold the majority of the population. This, in term, leads to an increase in problems, such as differences in socioeconomic status, an increase in migrant and immigrant populations, higher crime rates, and differences in health outcomes of residents.

Social workers in urban environments will find considerable job opportunities in both the public and the private sectors. Publicly, Social Workers may find jobs with Community Mental Health programs, alliances that work with veteran or homeless populations, and with educational settings to name a few. Privately, Social Workers may find opportunities for clinical care roles and job specialties, such as working with victims of sexual assault. What urban environments offer is the ability for the social work individual to focus on what area, while allowing referrals to other qualified individuals.

Unlike rural environments, urban environments allow for a range of continual educational options, including seminars at meeting halls or college campuses, specialized opportunities for trainings in issues such as a trauma, and the ability for social workers to gather in conferences. This, in turn, allows social workers to have outside supervision, as well as an increase in communication across the profession.

Despite the advantages urban environments offer in terms of networking and job opportunities, it is important to remember that there are setbacks. As mentioned, with an increase in population comes a rise in disparities between socioeconomic status. One of the larger issues faced by clients is the level of healthcare coverage that they can afford. This often entails poor healthcare outcomes, and a decrease in mental health care. Social Workers in these environments will often work with the economically disadvantaged, and must understand the cultural variations that exist in the area they work. Additionally, it is imperative that Social Workers understand the local resources available to their clients, such as transportation and food services, and be able to help their clients with these issues.

Social Work Job Opportunities

BSW- Bachelors of Social Work: this is considered an Undergraduate degree and is an employable degree once you gain your Limited License. If you choose not to move on to a Graduate degree you will need to take the state licensing exam to practice a career in what you have learned. Your employment at the BSW level will generally be related to casework. Many individuals work with just their BSW for their entire lives. If you enjoy casework, it is not necessary to obtain your MSW degree. There are many positions available for BSW level workers.

MSW- Masters of Social Work: this is considered a graduate degree and is employable with a Limited License. If you choose to stay with your MSW you can take the licensing exam in the state you are choosing to practice in and follow your state's guidelines for licensure and procure a clinical or macro licensure. After two years of practicing with your Limited License, you will be eligible for a full license. With this license you can practice independently without the supervision of a another fully licensed social worker.

Upon completion of your set professional education track, it is time to search for career opportunities. The search can be very overwhelming, even the thought of starting the process can be quite intimidating. Do not fear the search, with today's technology there are many ways one can look for career starting jobs. One of the most common is to strike out on the internet. There are many sites to type in key words for the type of job you are looking for. For example, www.indeed.com and www.monster.com are amongst the most popular when aiming to post a resume for a position. Another great way to find an opportunity is to search the webpages of agencies around the community in which you are searching. Agencies typically have a section for employment opportunities they have available. If you are searching for a position in your home states public sector, you can go to the state website and find out how to apply for those. Volunteering at an agency where you may be interested in employment is also another opportunity to learn about future job possibilities.

When you locate a position, it is time to apply. The application usually has two parts: the cover letter and the professional resume. The **cover letter** is a letter that pertains to the reason why you are interested in that position. In the letter, you explain why you are qualified for the position. It should be no more than a page in length, and carefully written with no spelling, grammar or punctuation errors. The cover letter along with the resume should indicate the application for a position. The letter is not the place to discuss salary, or reasons for leaving a past job. The cover letter should be written in a positive and cheerful fashion.

See figure one below.

The second aspect to the application process is the **professional resume.** The resume is more nonspecific than the cover letter and can be applied to several positions with minor updates. The organization consists of a summary of your professional credentials. The purpose is to showcase the applicant's abilities to the employer, in hope that he/she may consider the applicant for an interview. When creating a resumè there is no standard format, rather use a creative approach to gain the attention of the screening committee. Although you should avoid being adorable or cunning.

A resume should at least include the following information; other credentials may be added at the applicant's discretion:

Personal data. Include your name, street address, email address and phone number where you can be easily reached so you can discuss interview details.

Education. List the name of your degree(s), your major, the name of the colleges or universities you have attended and the graduation dates. Also list all the schools that you have attended (list in reverse order). Also denote any special classes or projects you were included in such as honors or special training you may have had.

Experience. List employment starting with your most current employer and jobs previous. Give the job title, name of agency, dates of employment and job duties. It is also helpful to employers for you to add any volunteer experience that has contributed to your skill base.

Activities and interests. Denote your professional interests as well as those that go beyond social work. This may include memberships in professional organizations, your participation in clubs, offices or special interests.

References. If the job opening is asking specifically for references they should be listed on the cover letter or on

a page after the resumè. The references you select to use, should be able to speak on your skills as they pertain to the position. Make sure to include the phone and email address of the people you have selected for references so that the employer can contact them.

Other information. You may want to add other information such as publications, travel experiences, and unique experiences that have impacted your skill level.

For examples of social work resumes, check out websites like http://resumezpras.tk/social-work-resume.html# or Google "social work resume example".

Upon a successful application process, you may hear back from the agency by receiving an invitation to interview. The interview typically will consist of a panel or committee of employees. The panel will ask you varied questions based on the type of position you are applying for, this may include scenarios of real possibilities on the field. To prepare for this interview, you will want to research the agency's mission and vision statements, the type of population they serve. You can achieve this knowledge by going to the agency's webpage, talking to employees, or stopping by the agency to pick up brochures on services. Finally, be prepared for inquiries about your personal and professional interests as well as your skills for specific job duties.

Licensure

Now that you are more familiar with the job processes let's move on to a vital part of working in the field, licensure. It is important to keep in mind that all states and countries are different with regulations regarding licensure for practice. The same goes for BSW and MSW criteria for licensure. The examples I am going to use is for the state of Michigan; these are the regulations that I am more familiar with, please make sure to review the laws in your area for licensure to practice.

The Michigan Board of Social Workers was created under Article 16 of Public Act 299 of 1980, as amended, the Occupational Code, to register social workers in Michigan. Public Act 11 of 2000 transferred the Board of Social Work, and its authority, to the Public Health Code, Public Act 368 of 1978, as amended.

Social Work is defined as the professional application of social work values, principles, and techniques to counseling or to helping an individual, family, group, or community to enhance or restore the capacity for social functioning and/or provide, obtain, or improve tangible social and health services.

The Public Health Code mandates certain responsibilities and duties for a health professional licensing board. Underlying all duties is the responsibility of the board to promote and protect the public's health, safety, and welfare. The Board implements this responsibility by ascertaining minimal entry level competency of health practitioners. The Board also has the obligation to take disciplinary action against licensees and registrants who have adversely affected the public's health, safety, and welfare. Chapter One also includes information on obtaining your license for social work practice.

Figure 1

John Doe, MSW Graduate

Street address city, State zip Phone and email address

Date Written

Agency Name

Agency address

To Whom It May Concern:

I am extremely excited and interested in the Prevention Coordinator position for CMH. My experience working with clients as well as extended education has equipped me with a multitude of professional skills.

Throughout my career I have demonstrated excellent interpersonal skills such as compassion and understanding. When I saw that CMH was accepting resumes for a Prevention Coordinator, I immediately knew it would be a good fit for me. I am highly interested in helping individuals succeed. I am socially perceptive and able to demonstrate a caring and compassionate approach to people's needs. I am also proficient at communicating with staff and clients, organizing and filing paper work as well as using multiple databases that will go along with the cases presented in this field. Not only do I have a great attitude, I am very detail orientated and I am also very motivated to do anything that is necessary to improve the clients' well-being. I would prove to be an exceptional asset to your staff, and most importantly to the Team.

My interest has recently been in developing my knowledge in Mental Health and Trauma, in which I can assist those in need. I have a yearning to empower people so that they can lead better lives. Due to my knowledge and experience with serving clients, I know that I have the talent and knowledge necessary to succeed and enhance the staff in your agency. Thank you for considering me; I welcome the opportunity to introduce myself to your agency in person to discuss this collaboration.

Sincerely,

John Doe

What is it like to be a social worker?

Life as a social worker is never boring. One of the wonderful things about social work is that there is such a wide variety of employment possibilities. If you do not enjoy one area of social work, there is probably another area that you will enjoy. There are jobs in casework, therapy, administration, supervision, advocacy, community work, education, and other areas. Over time, many social workers move between these positions as their interests and skills levels change.

To read more about what it may be like to be a social worker, read the interview with Professor Gladden below.

Interview

Interviewer: How lead you to become a social worker?

Dr. Gladden: When I was in my undergraduate program, I worked at Degage Ministries in Grand Rapids with homeless individuals. I didn't expect to love the work as much as I did! I decided social work wa the field I should be in and went straight into my MSW degree when I finished my BA.

I: What kinds of social work have you done?

Dr. G: I have done so many different kinds of work in the last 15 years! I started as a therapist for teens and adults who were survivors of domestic violence and sexual abuse. After that I worked with kids with autism, in therapeutic foster care, doing crisis work with adults and kids, and running a group home for adults with mental illness. One of my favorite positions was running and working on an Assertive Community Treatment

(ACT) team. The ACT program works in depth with adults with severe mental illness diagnoses such as schizophrenia and Bipolar I disorders. There are therapists, caseworkers, nurses, and psychiatrists all working as a team to keep the adult safely in the community instead of in the hospital or an institution. I founded and ran a non- profit organization to support refugees in the Grand Rapids community. I have also been a social work professor for 10 years now, working to train new social workers!

I: What is a typical day for you as a social worker?

Dr. G: There is no such thing as a typical day, which is one of the things I love about social work! I've had positions where clients came to me in the office, so that was somewhat consistent, although there were always surprises such as a crisis client coming in. When running the crisis lines and working with the refugees, I would often spend part of the day in the office and part of the day driving out to see clients. Now I spend some days teaching classes, others seeing clients, and some doing paperwork for part of the day while doing all the other activities.

I: What is your favorite thing about social work?

Dr. G: I love the feeling of making a difference in someone's life. There are many clients and students that you will work with that you have no idea what happened to them. Maybe they stopped coming in for therapy sessions without warning, or maybe the student graduates and you never even know if they are working in the social work field. But there are some that you do know about. I had a client who was a survivor of sexual abuse and sexual assault that I worked with for about a year and a half. At the end of our sessions, she wrote me a letter. In that letter, she said that I had saved her life. That may be overly dramatic, as I literally did not save her life, but that meant that to her, I made a difference. Those are the clients that keep you going.

I: What do you think makes social work unique?

Dr. G: I think social work's perspective of the person in the environment is key. Many professions look at one part of the individual, but social work looks at everything. We look at the client's mental status, where they live, where they work, what supports they have, what skills or strengths they have, and so much more! As social workers we need to know about more than just the person. We need to know community resources. We need to know about fields as varied as economics and neuroscience. And we need to have the ability to relate to the individual. Research has shown that it is not the method that we use that makes a difference, but the relationship. We need to be able to have those helping, supportive relationships with our clients. That is also what makes social work fun!

I: What advice would you give to new social workers or social work students?

Dr. G: Take care of yourself first. You need to know yourself, your beliefs, and what makes you feel safe and fuels your passions. Have outside interests and people to give you support. You can't be there for your clients unless you take care of yourself first.

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3. Generalist Practice

Generalist Practice

When looking at generalist practice primary theories, the first question that may come to mind is *what is generalist practice*? Generalist practice introduces students to the basic concepts in social work which includes promoting human well-being and applying preventative and intervention methods to social problems at individual (micro), group (mezzo), and community (macro) levels while following ethical principles and critical thinking (Inderbitzen, 2014).

Now that you have some insight on what generalist practice is, we should discuss what a social work generalist does. A social work generalist uses a wide range of prevention and intervention methods when working with families, groups, individuals, and communities to promote human and social well-being (Johnson & Yanca, 2010).

Being a social work generalist practitioner prepares you to enter nearly any profession within the social work field, depending on your population of interest (Inderbitzen, 2014).

Micro, Mezzo, Macro Levels of Social Work

Micro level social work is the most common practice scenario and happens directly with an individual client or family; in most cases this is considered to be case management and therapy service. Micro social work involves meeting with individuals, families or small groups to help identify, and manage emotional, social, financial, or mental challenges, such as helping individuals to find appropriate housing, health care, and social services. Micro-practice may even include military social work like helping military officials and families cope with military life and circumstances (see Chapter 14), school social work which could involve helping with school related resources, Individual education plans, and so on (see Chapter 11), or a mental health case manager to help individuals understand and cope with their mental illnesses (see Chapter 10).

The focus of micro level practice is to help individuals, families, and small groups by giving one on one support and provide skills to help manage challenges (Johnson & Yanca. 2010).

Mezzo level social work involves developing and implementing plans for communities such as neighborhoods, churches, and schools. Social workers on the mezzo level interact directly with people and agencies that share the same passion or interest. The big difference between micro and mezzo level social work is that instead of engaging in individual counseling and support, mezzo social workers administer help to groups of people. Examples of work and interest that mezzo social workers could be involved in include the establishment of a free food pantry within a local church to help with food resources for vulnerable populations, health clinics to provide services for the uninsured, or community budgeting/financial programs for low income families.

Many mezzo social work roles exist; however social workers generally engage in micro and mezzo practice simultaneously (Kirst-Ashman & Hull, 2015).

Macro level social work is very distinct from micro and mezzo level. The focus of macro level social work is to help vulnerable populations indirectly and on a larger scale. The responsibilities for social workers on a macro level typically are finding the root cause or the why and effects of citywide, state, and/or national social problems.

They are responsible for creation and implementation of human service programs to address large scale social problems. Macro level social workers often advocate to encourage state and federal governments to change policies to better serve vulnerable populations (Kirst-Ashman & Hull, 2015).

Social workers that work on the macro level are often employed at non-profit organizations, public defense law firms (working pro-bono cases), government departments, and human rights organizations.

While macro social workers typically do not provide therapy or other assistance (case management) to clients,

they may interact directly with the individuals while conducting interviews during their research that pertains to the populations and social inequalities of their interest.

Although, social work is broad and allows practitioners to move within the micro, mezzo, and macro levels. All social workers begin at the micro level to understand the inequalities, disadvantages, and the needed advocacy for vulnerable populations.

Theories

Systems Theory

Systems Theory is an interdisciplinary study of complex systems. It focuses on the dynamics and interactions of people in their environments (Ashman, 2013). The Systems Theory is valuable to the social work profession because it assists social workers with identifying, defining, and addressing problems within social systems.

As social workers, we utilize the Systems Theory to help us understand the relationships between individuals, families, and organizations within our society. Systems theory allows social workers to identify how a system functions and how the negative impacts of a system can affect a person, family, organization, and society, by working together to cause a positive impact within that system (Flamand, 2017).

Ecological Systems Theory

The **Ecological Systems Theory** was created in the late 1970's by Urie Bronfenbrenner. According to Oswalt (2015), Bronfenbrenner developed the Ecological Systems Theory to explain how a child's environment affects their growth and development. The four levels that are described below are the different levels according to Bronfenbrenner that affect the different development stages of a child.

The main concept behind ecological approach is "person in environment" (P.I.E). The ecological approach implies that every person lives in an environment that can affect their outcome or circumstance. As social workers, our job is to improve a person's environment by helping them identify what is negatively impacting their environment.

When discussing this theory, it is important to understand the four systems that make up the ecological systems: microsystem, mesosystem, exosystem, and macrosystem.

The **microsystem** is the smallest system, focusing on the relationship between a person and their direct environment. The **mesosystem** is a step above the microsystem. This system focuses on the relationship between groups and the effects that one social group may have on another social group. The **exosystem** is a more generalized system as it shows the effect that a group has on interactions among other groups. Lastly, the **macrosystem** focuses on the bigger issues such as culture, politics, government, and society (Allen-Meares & Lane, 1987).

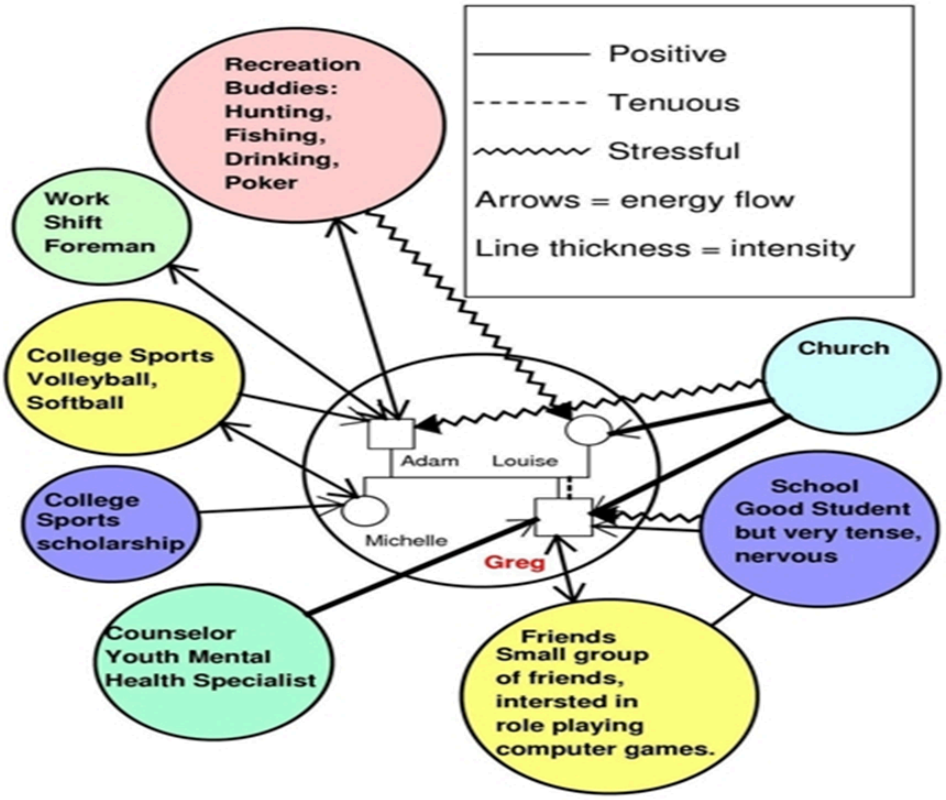
When focusing on a client by providing case management or support to an individual that is facing hardships, we often look at a person's microsystem. Looking at a person's environment allows us as social workers to help identify problem areas or what is negatively impacting their lives.

This is usually done by making an eco-map to give the client a visual aide during the identifying process. An **eco-map** is a diagram that shows the social and personal relationships of an individual with his or her environment. Eco-maps were developed in 1975 by Dr. Ann Hartman, a social worker who is also credited for developing the genogram (Genachte, 2009).

Below is an example of what an eco-map would look like once it is completed with your client.

Eco-maps will vary in what they look like as each map will cater to the specific client/family, and will highlight the stressors (negatives), positives, and relationships.

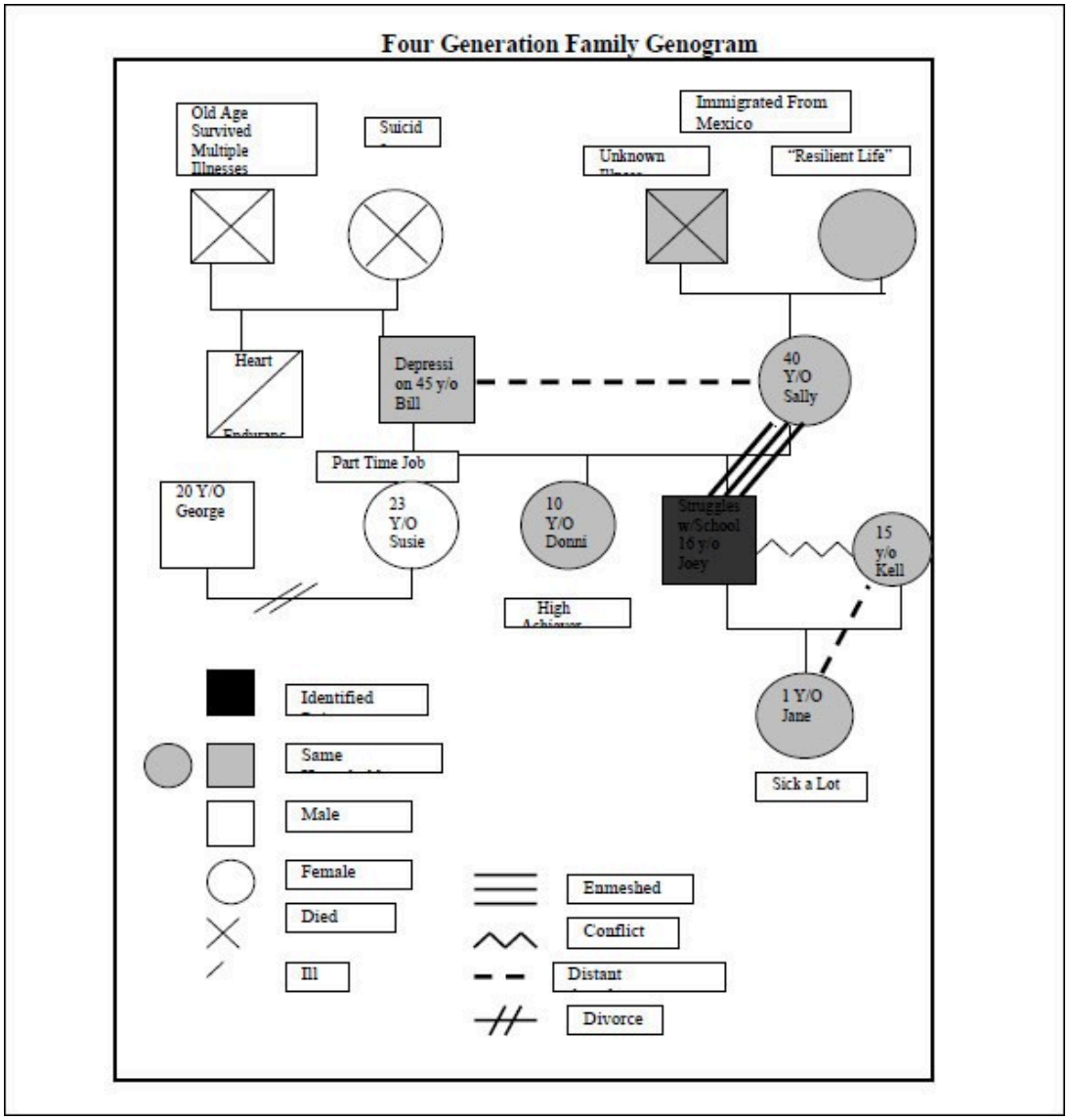
Greg's Eco-map



Example of an ecomap, http://www.genogramanalytics.com/

A **genogram** mimics a family tree. Normally when you look at a family tree you often find branches and each branch represent a family. A genogram digs deeper and identifies relationships, deaths, marriages, births, divorce, and adoptions just to name a few. When collecting information to complete a genogram it is useful to understand a family's dynamics (Johnson & Yanca, 2010.)

Here is an example of a genogram; this genogram along with other samples and variations can be found on www.sampletemplates.com. Genograms can help clients identify their roots and culture. While completing genograms also be aware that while unraveling a client's history, past trauma or closed wounds can be reopened. As a social worker you need to be prepared to discuss and address these issues to help your client address their past trauma.



Four Generation Family Genogram

Activity: In class or as homework complete and eco map and genogram of your own family. See how far you can go through family tree and connect your family, relationships, marriages, etc.

Strengths Approach

The development of the **Strengths Approach** began and has been led by Dennis Saleeby and staff at the University of Kansas. The Strengths Approach is based off two very important principles:

- every person, group, family, and community has strengths
- every community or environment is full of resources (Johnson & Yanca, 2010)

In the Strengths Approach, it is the social worker's job to help the client identify their strengths. Often clients with whom we work with are only able to identify the negative impacts of their lives and have a difficult time identifying the positive aspects of their lives and situations. When using the Strengths Approach not only is the social worker helping the client to identify their personal strengths, but the worker is also helping the client identify local resources to help the client needs.

This approach focuses on the strengths and resources that the client already has rather than building on new strengths and resources. The reasoning behind the strength approach is to help clients with immediate needs, and to help with finding solutions to immediate problems.

Planned Change Model

The planned change process was introduced to the social work profession in 1957 by Helen Harris Perlman. The **Planned Change Model** is the development and implementation of a plan or strategy to improve or alter a pattern of behaviors, a condition, or circumstance to improve a client's well-being or situation (Kirst-Ashman, 2012).

The Planned Change Model consists of a seven-step process which includes:

- Engagement
- Assessment
- Planning
- Implementation
- Evaluation
- Termination
- Follow-up

The **Engagement phase** is the first interaction between the social worker and their client. The engagement stage does not have a predetermined time frame; it can last for a couple of minutes to a few hours depending on the client and the circumstances. It is very important during the engagement phase that the social worker displays active listening skills, eye contact, empathy and empathetic responses, can reflect to the client what has been said, and uses questioning skills (motivational interviewing). It is appropriate to take notes during the engagement phase for assessment purposes or for reflection. Remember, during the engagement phase, the social worker is building a level of rapport and trust with the client.

The **Assessment phase** is the process occurring between social worker and client in which information is gathered, analyzed and synthesized to provide a concise picture of the client and their needs and strengths. The assessment phase is very important as it is the foundation of the planning and action phases that follow.

During the assessment stages, there are five key points:

- identifying the need problem (concern)
- identify the nature of the problem
- identify strengths and resources
- collect information
- analyze the collected information

(Johnson & Yanca, 2010)

The **Planning phase** is when the client and social worker develop a plan with goals and objectives as to what needs to be done to address the problem. A plan is developed to help the client meet their need or address the problem (Johnson, & Yanca, 2010). The planning phase is a joint process where the worker and the client identify the strengths and resources gathered from the assessment phase. Once the strengths and resources are identified, the social worker and the client come up with a plan by outlining goals, objectives, and tasks to help meets the clients goal to address the need or problem. During the planning phase, keep in mind that the goals should be what the client is comfortable with and finds feasible to obtain. The social worker's most important job during this phase is to help the client identify strengths and resources, not to come up with the client's goals for them.

The **Implementation/Action phase** is when the client and social worker execute a plan to address the areas of concern by completing the objectives to meet the client's goals. The action phase is also considered a joint phase as the social worker and the client act! The worker and the client begin to work on the task that were identified in the planning phase (Johnson & Yanca, 2010). The worker and the client are responsible for taking on different parts of the identified task; for example, the social worker may find a local food pantry or help with food assistance program if the client needs food. The client may work on making a grocery list of foods that will make bigger portions for leftovers to make food last longer for the family. However, the worker and the client are jointly working together to obtain the goal of providing food for the client and their family.

The **Evaluation Phase/Termination phase** is a constant. The worker should always evaluate how the client is doing throughout the process of the working relationship (Johnson & Yanca, 2010). When the plan has been completed or the goals have been met, the client and social worker review the goals and objective and evaluate the change and/or the success. If change or progress has not been made the client and social worker will review the goals and objectives and make changes or modifications to meet the goal. Once the goals have been met, termination of services follows if there are no further need for services or other concerns to address. Sometimes termination happens before goal completion, due to hospitalizations, relocation, losing contact with a client, financial hardships , or the inability to engage the client.

The **Follow Up phase** is when the social worker reaches out to the client to make sure they are still following their goals, using their skills, and making sure the client is doing well. The follow up may not always be possible due to different situations such as death, relocation, and change in contact information, to name a few.

The diagram below shows the process of the Planned Change Model when working with clients.

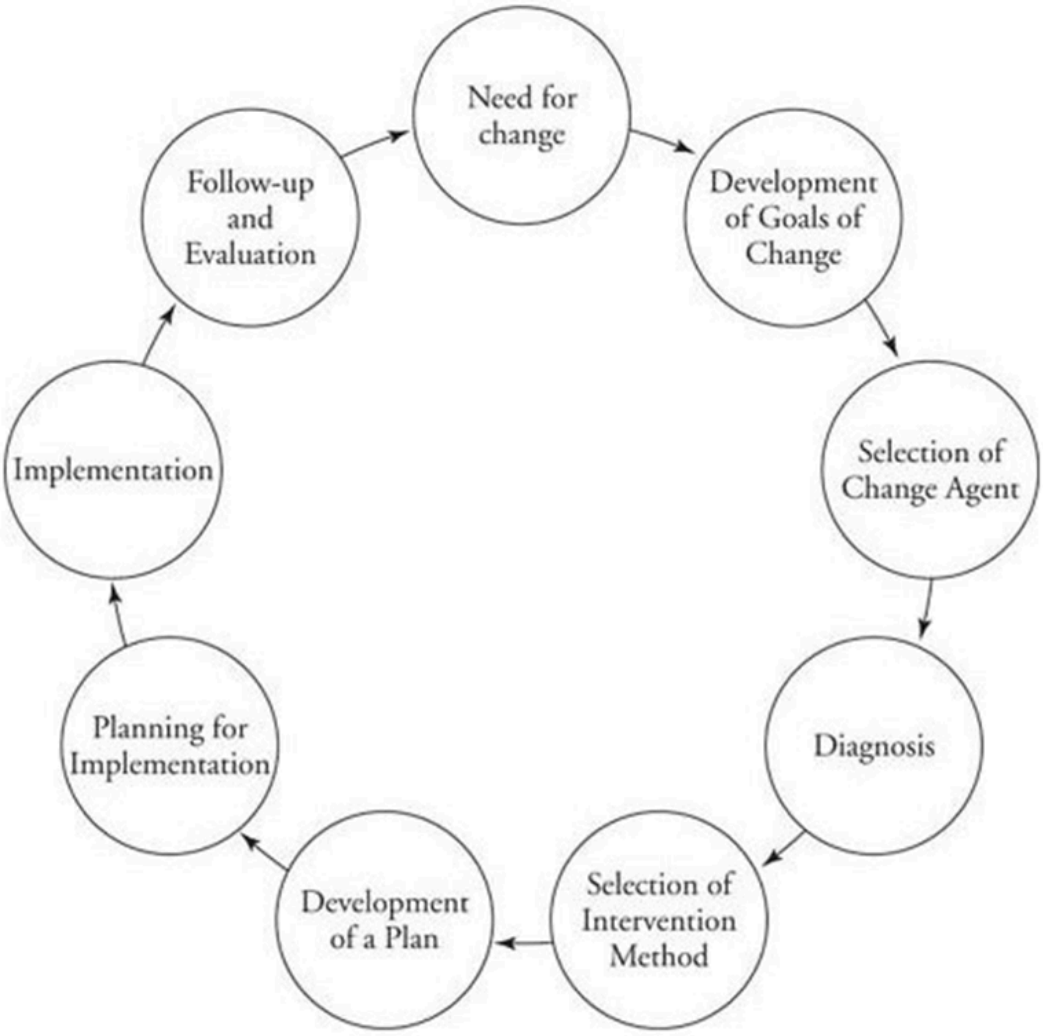


Figure 1 Stages of planned change.

Stages of Planned Change

Activity: Partner up with a classmate. Role play one person being the social worker and the other being the client. Come up with a problem or concern and try to go through the planned change process. I do not expect you to get through the whole process, but at least try to get through the first three stages. Remember to be creative and have fun while doing so!!

Evidence Based Practice (EBP)

According to David Sackett, evidence based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of a client. When working with clients it is important to combine research and clinical expertise. In the field of social work there is constant research being conducted to assess various assessment and treatment modalities. The research that is conducted provides the evidence that we as social workers use to help our clients improve their living situations and concerns. Lastly, keep in mind that our clients are the experts on their own lives. We must keep in mind what their personal values are and what their preferences are for the outcome of their life situation. This is very important and often can become frustrating as a social worker as we think we know what is right for our client, but it may not be their personal preference.

When working with clients and evidence based practices it is important to know that research is constant surrounding evidence based practices, and as a practicing social worker it is very important to stay abreast of the constant change of new information and changes. It is important to do your own research, and most importantly always respect your clients' personal values and preferences.

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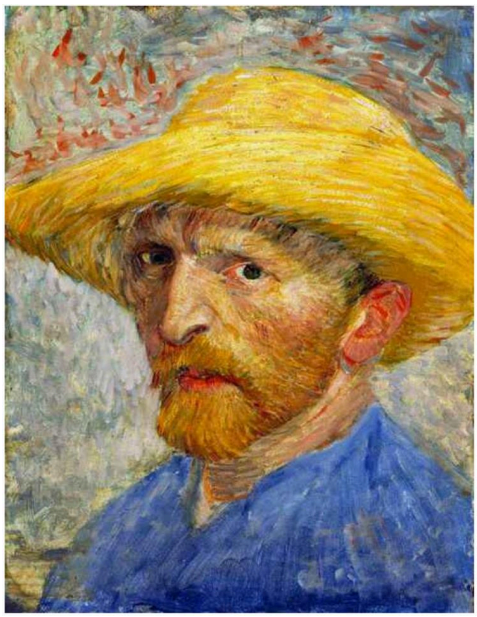
4. Mental Health and Substance Use

Introduction

Mental health and substance abuse are both multifaceted, challenging, and dynamic areas of the human service field. As professionals in this field, social workers help to make long lasting, life altering changes in people's lives.

While numerous books have been written about mental disorders and substance use both broadly and specifically, this chapter will seek to introduce you to current information about mental disorders and substance use in the United States. This chapter will include, among other things, a brief history of both mental health and substance use, the current terminologies and definitions that professionals use in the field, some of the most commonly occurring disorders and/or substances that a social worker is likely to encounter in general practice, and briefly discuss the co-occurrence of mental disorders and substance use.



Van Gogh's Man in a Straw Hat

Vincent Van Gogh (self-portrait: Above) may have suffered from numerous conditions including bipolar disorder or manic-depressive disorder (Wolf, 2001). He is an example of how mental disorders and creativity can go hand in hand and how people living with a mental disorder can still be productive members of society.

Before We Get Started

Before we begin, it is important to understand some of the keywords, definitions, and sources that will be used. These

are a small sample of the vast vocabulary that is used to identify and describe the mental disorders and substance use disorders that social workers may encounter in professional settings.

Key Terms

- **Behavior** – the response of an individual, group, or species to its environment
- **Co-occurring** – to appear together in sequence or simultaneously.
- **Delusion** – a false belief or opinion.
- **Dual Diagnosis** – when a person has two separate illnesses and each illness needs a treatment plan (DBSA, 2016).
- **Hallucination** – a sensory experience of something that does not exist outside the mind, caused by various physical and mental disorders, or by reaction to certain toxic substances, and usually manifested as visual or auditory images.
- **Inpatient** – a patient who stays in a hospital while receiving medical care or treatment.
- **Mania** – excessive excitement or enthusiasm; craze.
- **Manic** – pertaining to or affected by mania.
- **Mental Disorder** – any of the various forms of psychosis or severe neurosis.
- **Outpatient** – a patient who receives treatment at a hospital, as in an emergency room or clinic, but is not hospitalized.
- **Prevalence** – being widespread; of in wide extent or occurrence.
- **Psychosis** – a mental disorder characterized by symptoms, such as delusions or hallucinations, that indicate impaired contact with reality.

Definitions retrieved via Dictionary.com (2017), unless otherwise noted.

Mental Health

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013), also known as the DSM-5, is a living document created by social workers, psychologists, medical doctors and many other professions. The DSM-5 is the primary reference source social workers and other helping professions use to describe a mental disorder. In this text, just as in the DSM-5, "mental disorder" will be used as a broad term to describe several issues related to emotion, mental state, and behavior. However, this text is not enough to help people with a mental disorder. It takes a generalist approach from social workers, as well as other health professionals, to not just identify the disorder but then advocate on behalf of that person, provide supportive services, and work with the many challenges that accompany mental health disorders. Being a generalist means that the social worker employs various methods of treatment, expertise and skills to assist the client. Examples of methods used might be a *strengths based approach* where the client is encouraged to focus on and use their inherent strengths (not just physical ones) to improve other areas of their life. Social workers also focus on the *person in environment*. This means that social workers are aware of the impact the person has on their environment and how the environment impacts the person.

According to the National Alliance on Mental Illness (NAMI), approximately 1 in 5 adults in the United States experience some type of mental disorder in a given year. This means that, in a population of over 325 million people, over 43 million people will experience some form of mental health issue within a year. Among those that do experience a mental disorder, 9.8 million of those will experience a "severe" mental disorder meaning that it dramatically interferes

or limits their ability to function in their everyday life. Of all the adults in the United States with a mental disorder, only 41% received mental health services in the past year. For those with a severe disorder, only 63% received any form of treatment or services (NAMI, 2017). Looking at those numbers it is clear to see that the need to identify, de-stigmatize and help individuals living with mental disorders, will impact millions of people.

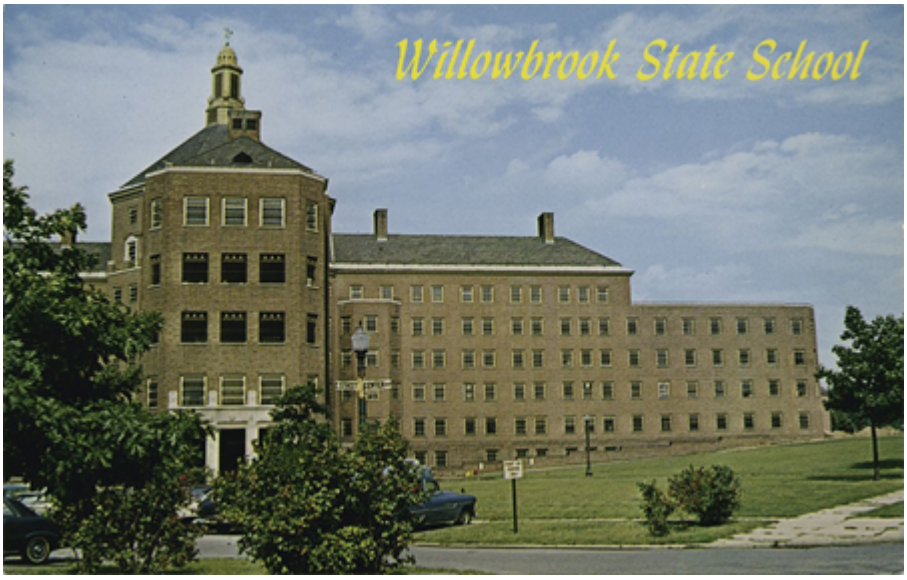
There are six categories of mental disorders that this chapter will focus on as well as the variety of disorders found within those categories. These categories contain some of the most common disorders that a social worker will encounter in her or his career. This chapter also provides a brief description of the disorders as well as the estimated occurrence, or prevalence, of each one within the United States.

The selected categories are:

- Anxiety Disorders
- Psychotic Disorders
- Bipolar Disorders
- Depressive Disorders
- Trauma Disorders
- Personality Disorders.

History of Mental Health

Historically, people suffering from a mental disorder have also suffered abuse, experimentation, torture, and even death. As you go forth as a member of the social work profession, it is imperative that you understand how long of a road it has been and how much further the profession needs to go in the ethical treatment of people with a mental disorder. This link to a 27-minute video provides an example of where we were at just a few decades ago. The Willowbrook State School in New York City is one example of a tragic and possibly disturbing look the past treatment of those with a mental disorder and the developmentally disabled.



Willowbrook State Institution

As you can see from the video, the Willowbrook Institute lacked funding, professionals, and knowledge of what their patients needed to be able to live successfully. Unfortunately, the Willowbrook Institute was not an isolated incident, nor

was it a new occurrence. Historically, those with a mental disorder have been looked down upon, shunned, stigmatized, vilified, criminalized or tortured. This kind of treatment has been documented as far back as the middle ages of Europe all the way to the mid 1900's- United States where those with a mental disorder were placed in either hospitals or prisons.

This treatment continued up until 1963 when John F. Kennedy signed the Community Mental Health Act. President Kennedy described it as "a bold new approach", and provided federal grants to states to construct community mental health centers (CMHC), to improve the delivery of mental health services, preventions, diagnosis, and treatment to individuals who reside in the community. To be able to supply federal funding for these statewide institutions, the Medicaid Act was passed in 1965. This Act allowed community-based care facilities to charge for reimbursement of funds while excluding payments to psychiatric institutions.

JFK signing The Community Mental Health Act

The Community Mental Health Act resulted in a mass "deinstitutionalization" across the country, and by 1980 nearly 75% of the psychiatric hospital population had declined. By 2009 less than 2% of those suffering from a mental health disorder remained in institutions. Unfortunately, this resulted in some unintended consequences. For example, community-based institutions could not keep up with the mass exodus of people from the psychiatric hospitals. This was the result of several factors such as a lack of space within the inpatient and outpatient settings, a lack of funding for proper care, and a lack of funding to improve care facilities. This lack of resources has negatively impacted the care and treatment of adults, children, families, and communities across the country.

Things to Be Aware Of

Having a mental disorder is often compared to having a physical illness (APA, 2015) and the comparison is one that professionals can often overlook. Just as there are varying degrees of physical illnesses, there are also varying degrees of mental disorders. The mental disorders can be managed in similar ways to physical ones. By maintaining medications, therapy, and problem-solving with the individual, social workers can help the person to not only stabilize, but excel in, their life. In fact, there are many successful individuals both in today's world and throughout history, such as Vincent Van Gogh, who have found ways to cope with their mental disorders. Van Gogh most likely had one, maybe even two,

mental disorders. Despite, or maybe because of, these challenges he was able to produce some of the most iconic and famous pieces of modern art to this date.

Being aware of the following mental disorders will allow you, as a social worker to better understand what the person is experiencing and how to help them meet their needs in the best possible way.

While every case is different, it is important to start thinking about some of the ways that mental disorders may present themselves. To assist you in this task some brief case studies have been provided throughout the chapter. These case studies are based on the experiences and case notes of real people and professionals.

All information and statistics following are from the DSM-5 unless otherwise indicated.

Anxiety Disorders:

Anxiety disorders are characterized by shared features like excessive *fear* (the emotional response to real or perceived imminent threat) and *anxiety* (anticipation of future threat) and other related behavioral disturbances.

• Social Anxiety Disorder or "Social Phobia" is an extreme fear of being judged by others in social situations. The fear is so intense that it will disrupt or impair the person's ability to function in their everyday life. There is about a 7% prevalence in the United States for this disorder.

• Generalized Anxiety Disorder is an excessive, often unfounded, feeling of worry about the numerous everyday activities that a person could engage in. Approximately 2.9% of adults in the United States report symptoms or seek treatment for this disorder.

• Phobias are, simply put, an irrational fear of something. You may have heard of arachnophobia (fear of spiders) or acrophobia (fear of heights). In the United States, approximately 7%-9% of the population reports having a specific phobia and around 75% of this population will fear more than one object.

• Panic Disorder is defined as a debilitating fear or anxiety that occurs without any reasonable explanation. It is estimated that 2%-3% of the United States adult population will experience an episode of panic disorder in a year.

Case Sudy: Kristen

Kristen is a 38-year-old divorced mother of two teenagers. She has had a successful, well-paying career for the past several years in upper-level management. Even though she has worked for the same company for over 6 years, she's found herself worrying constantly about losing her job and being unable to provide for her children. This worry has been troubling her for the past 8 months. Despite her best efforts, she hasn't been able to shake the negative thoughts.

Kristen has found herself feeling restless, tired, and tense. She often paces in her office when alone. When she goes to bed at night, it's as if her brain won't shut off. She finds herself mentally rehearsing all the worse-case scenarios regarding losing her job, including ending up homeless (Case Studies, 2015).

What do you think Kristen might be diagnosed with?

Psychotic Disorders:

Psychotic disorders among the most serious and challenging disorders. This is because these disorders affect an individual's interpretation of reality which then negatively impacts the person's ability to function in their environments. Across the spectrum of psychotic disorders there are common symptoms such as *hallucinations*, *delusions*, or *behaviors* that are considered socially abnormal.

• Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves (NAMI, 2016). These disturbances may present as hallucinations or delusions. Adults in the United States report a lifetime prevalence of 0.3%-0.7%, with an age of onset often occurring in the early to mid-20s.

• Delusional Disorder is the presence of one or more delusions. These delusions must be present for at least one

month to the DSM-5 definition for this disorder. The prevalence of this disorder occurs in 0.2% of adults in the United States.

• Schizoaffective Disorder is characterized by schizophrenic symptoms, such as delusions or hallucinations, but with an added component of a mood disorder like mania and depression. About 0.3% of the United States adult population with be diagnosed with schizoaffective disorder in a year (NAMI, n.d.).

Case Study: Martin

Martin is a 21-year-old business major at a large university. Over the past few weeks his family and friends have overheard him whispering in an agitated voice even though there is no one nearby. Lately, he has refused to answer or make calls on his cell phone, claiming that if he does it will activate a deadly chip that was implanted in his brain by evil aliens.

His parents have tried to get him to go to a psychiatrist for an evaluation, but he refuses. He has accused them of conspiring with the aliens to have him killed so they can remove his brain and put it inside one of their own. He has stopped attended classes altogether. He is now so far behind in his coursework that he will fail if something doesn't change very soon (Case Studies, 2015).

What do you think Martin could be diagnosed with?

Bipolar Disorders:

A bipolar disorder can be defined as a variance in brain functioning that can cause unusual shifts in mood, energy, or activity levels. These shifts interfere with the person's ability to carry out day-to-day tasks. These disorders can display a range of heightened emotions in the form of manic episodes (extreme ups) to depressive episodes (extreme downs) (NAMI, 2016).

• Bipolar Disorder I is a period of mania presented as persistently elevated, irritable mood, and persistently increased activity accompanied by feelings of euphoria (being excessively cheerful) or feeling "on top of the world." The prevalence of adults in the United States with this disorder is 0.6%.

• Bipolar Disorder II is a milder form of mood elevation, involving mild episodes of mania, where one feels hyperactive and elated, that alternate with periods of severe depression, feeling down or sad for no obvious reason. Across a one-year span in the United States, about 0.8% of adults will meet criteria for this disorder.

Depressive Disorders:

Depression affects an estimated 300 million people globally and more than 15 million adults (6.7% of the population) in the United States. There are several levels of depression as well as minor levels that co-occur with other disorders or that are brought on by substance use/withdrawal.

• Major Depressive Disorder is a period of low mood for at least two weeks that is present most of the time in most situations. This may look like low self-esteem, low energy, or loss of enjoyment in pleasurable activities. Major depressive disorder will affect about 6.7% of the adult population in the United States (Facts and Statistics, 2016)

• Persistent Depressive Disorder, while lacking the severity of major depression, is a chronic, or ongoing, period of depression, usually for at least two years. Approximately 1.5% of the adult population of the United States will qualify under its criteria (ADAA, 2016)

Case Study: Jessica

Jessica is a 28-year-old married female. She has struggled with significant feelings of worthlessness and shame due to her inability to perform as well as she always has in the past. Jessica has found it increasingly difficult to concentrate at work. Jessica's husband has noticed that she has called in sick on several occasions. On those days, she stays in bed all day, watching TV or sleeping. He's overheard her having frequent tearful phone conversations with her closest friend which have him worried. When he tries to get her to open up about it, she pushes him away with an abrupt "everything's fine."

Although she hasn't ever considered suicide, Jessica has found herself increasingly dissatisfied with her life. She's been having frequent thoughts of wishing she was dead. She feels like she has every reason to be happy, yet can't seem to shake the sense of doom and gloom that has been clouding each day as of late.

What do you think Jessica might be diagnosed with?

Trauma Disorders:

• Post-traumatic Stress Disorder (PTSD) can be brought on after experiencing, witnessing, or hearing about a traumatic event. This is most often associated with military personnel/veterans or victims of war. However, traumatic events can be shootings, physical assaults, or rape. After a month of being removed from the event a person may experience sleeplessness, increased heart rate, mood shifts, physically lashing out, or any combination of responses. These changes may be brought on by any stimulus in the environment that reminds the person of the terrifying event or from experiencing recurring thoughts about the event. In the United States, about 3.5% of adults will report experiencing some form of PTSD within a given year.

• Acute Stress Disorder can be described as the symptoms of post-traumatic stress disorder lasting for three days to one month. If it lasts for longer than one month, it than meets the criteria for PTSD. Acute Stress Disorder is reported in less than 20% of non-assault related events; it is reported in 20%-50% from related events like rape, assault, or witnessing a mass shooting.

Case Study: Josh

Josh is a 27-year-old male whose fiancée of four years was killed by a drunk driver 3 months ago. She died in his arms in the middle of the crosswalk. No matter how hard he tries to forget, he frequently finds himself reliving the entire incident.

He had to quit his job because his office was located in the building right next to the place of the incident. The few times that he attempted to return to work were unbearable for him. He has since avoided that entire area of town.

Normally an outgoing, fun-loving guy, Josh has become increasingly withdrawn, "jumpy", and irritable. He's stopped working out, playing his guitar, or playing basketball, all activities he once really enjoyed. His parents worry about how detached and emotionally flat he's become.

(*DeepDiveAdmin*, 2015)

What do you think Josh might be diagnosed with?

Personality Disorders:

A personality disorder is a pattern of inner experiences and behavior that deviates from the expectations of the individual's culture, is continuous, enduring and inflexible; it often has an onset in adolescence or early adulthood and leads to distress or impairment in the person's life.

These types of personality disorders are often experienced by people seeking community mental health treatment and the homeless population, both areas social workers are employed. Some personality disorders that you might encounter include:

- Paranoid personality disorder which is a pattern of distrust and suspicion of others' motives. These motives may be interpreted as malevolent or harmful to the person experiencing the paranoia. Paranoid personality disorder may be as prevalent as 4.4% among adults in the United States.
- Schizoid personality disorder is a pattern of detachment from social relationships and a restricted range of emotional expression. The prevalence of this disorder ranges from 3.1%–4.9% of the United States adult population.
- Antisocial personality disorder is a pattern of disregard for, and violation of, the rights of others. Those who display the symptoms of this disorder may habitually lie, commit aggressive or violent acts with little to no remorse, and violate social norms. The prevalence of this disorder ranges from 0.2%-3.3%.
- Borderline personality disorder is a pattern of instability in interpersonal relationships, self-image, and affect. People with borderline personality disorder may be overly impulsive or not understand social norms. It is estimated that 1.6% to as much as 5.9% of the United States adult population will be diagnosed with this disorder.
- Narcissistic personality disorder is a pattern of grandiosity, need for admiration, and lack of empathy. 6.2% of the adult population will report for this disorder within a year.
- Obsessive-compulsive personality disorder is a pattern of preoccupation with orderliness, perfectionism, and control. This preoccupation may impair their social lives, health, or ability to function in the outside environment. The prevalence for this disorder ranges from 2.7%-7.9% in a one-year period among the adult population in the United States.

Practice Settings

There are two main practice settings where you as the social worker are likely to encounter people with mental disorders: inpatient (hospitals, medical & psychiatric) and outpatient (mental health clinics). Though there are some similarities in goals and strategies, the differences are certainly worth noting.

Inpatient services in these settings are provided by social workers who work with individuals or groups to provide treatment in a variety of forms. The inpatient worker also works with friends, family, and employers to help the person return to their outside life. The social worker may advocate and work with other agencies to provide assistance or resources for individuals under their purview of care.

When a patient is ready to leave a psychiatric facility, the social worker may connect them to an outpatient clinic. In these settings, outpatient workers assist the individuals or groups in maintaining healthy functioning in their environment through therapy or clinical activities. The social worker in this setting will conduct therapy or planning sessions, contact outside agencies, and advocate for their client's best interests.

Vulnerable Populations

While many people living with a mental disorder live fulfilling lives those who have a "severe" mental disorder are considered a vulnerable population. When we refer to people or a population as vulnerable this means it is "the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters" (WHO, 2017). This vast population overlaps with several other populations that will/have been covered in this book:

- Veterans
- Children
- Poor/Disenfranchised
- LGBTQ+
- Minorities
- Homeless
- Prisoners
- Seniors

Things to Be Aware Of

The field of mental health is not perfect. Studies can only give us so much insight into the symptoms, behaviors, predictors, prevalence and other criteria used in identifying mental disorders. The DSM-5, while a useful tool, is still scrutinized for numerous reasons. For instance, this is the fifth edition of this text meaning that things have changed in definitions and classifications across the decades. The DSM-5, unlike its four previous versions, is being treated as a "living document" and will be amended more frequently in coming years than its previous versions. With this idea of a "living document" in mind, it is important to ask some questions. Is the DSM-5 a tool that attaches "labels" to people, thereby inhibiting the treatment that they seek? Is it a tool used only for insurance purposes? Does the collaboration between various backgrounds help or hurt the cause for proper mental health care? There are many more questions, critiques, and changes surrounding, not just the DSM-5, but therapy styles as well as our ever-improving understanding of the brain and we in the social work profession must be aware of them.

These changes have resulted in improvements to how we approach the concept of "mental disorders" as well as adhere more closely to the social worker core values and perspectives. For example, homosexuality used to be classified as a mental disorder but now we know that is simply not the case. Gender dysphoria is now more closely understood as the anxiety experienced due to the pressures of social norms rather than an internal struggle. There are many other changes, both big and small, between the DSM-IV and DSM-5 that are highlighted here.

But it's not enough to just be aware of what we do in clinical settings. We also must be cognizant of our understanding of trauma (in its many forms), of a client's resources and of society's perception of what a mental disorder is. These things will continue to morph throughout time so it is important to remain vigilant and flexible regarding the many changes that occur in our field.

Current Issues

At the time of this book's publication in late 2017, there are several pieces of legislation that could have important impacts on the services that social workers and other helping professionals offer. For example, the result of the debate over our national healthcare will have a profound impact on who receives Medicaid, how much the states

will receive to supplement the costs of Medicaid funding, and what types of services will be covered. In the State of Michigan, for example, the legislators are looking to implement a bill that would take funding from direct providers like Community Mental Health and direct it towards private organizations. This link gives further description of this bill and will allow you, the reader, to form your own opinions http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_76181—,00.html

Regardless of what your decisions or thoughts are on these issues are, the social work profession must always be vigilant to who/what/where/why/when of funding. We must also be aware politically of who's in charge, what their agenda is, and if it impacts our profession, impacts the people we serve, and if it is in line with our professional ethics.

Substance Abuse/Use/Dependence

For decades, a war has raged across the globe. The financial costs have been high, the lives impacted even higher. During this time, we have been told to "Just Say No" and many have been arrested and imprisoned for participating in this war. The enemy in this war has taken many forms and continues to persist in modern times. It is not terror and it is not a tyrannical government. This is a war against drugs.

History of Substance Use

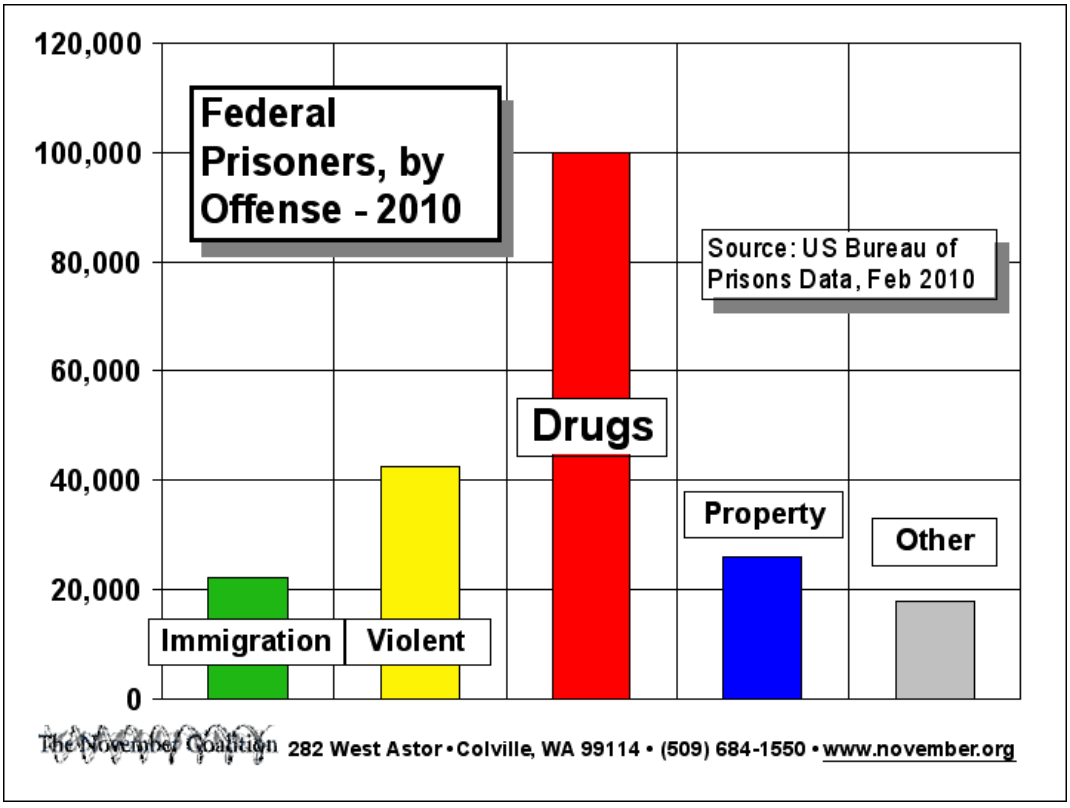
Discussing substance use/abuse would be incomplete without mentioning the "war on drugs" and the historical impact substances/drugs have had on our economy, population, education, law enforcement, and policy.

Made popular in 1971, President Richard Nixon declared drug abuse "public enemy number one." This statement came along with a dedication of more federal resources towards "prevention of new addicts and the rehabilitation of those who are addicted." This was not a new idea by any means. The drug war may have started as early as 1860 from certain laws at local levels. After that came the first federal law, the Harrison Narcotics Tax Act, which was signed into law in 1914. Then came Prohibition that, though ultimately unsuccessfully in its attempt to make alcohol illegal, was still an attempt at eliminating an object of public consumption (Thirty Years of America's Drug War a Chronology, 2014).

This is just the tip of the iceberg as far as the historical legislation of the war on drugs. But the question we should ask is: Are these policies and means of "combating drugs" really working?

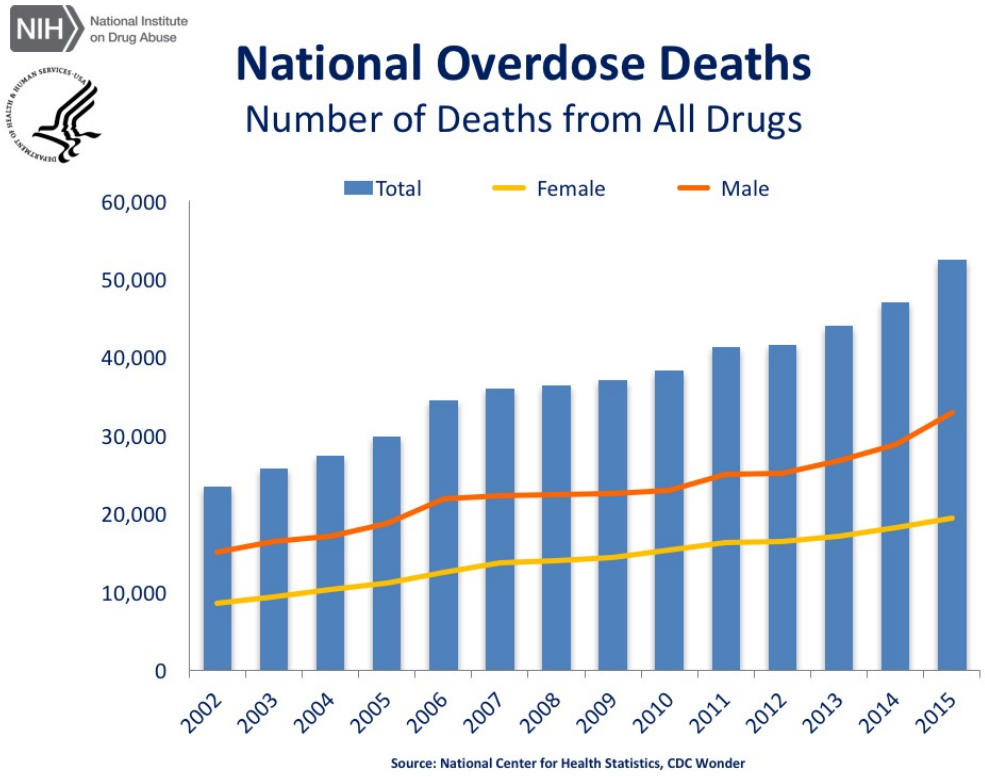
According to The National Center on Addiction and Substance Abuse (2017), over $51 billion dollars is spent annually in the United States to combat illegal drugs and their use. For every dollar spent however, only two cents goes towards prevention and treatment of those seeking assistance from a substance use disorder. The rest of the money goes towards prosecution, imprisonment, and hospital costs.

These policies have also lead to an increase the incarceration of individuals, many of whom are in jail or prison for possession, not selling or distribution (Bureau of Justice Statistics, 2007).



Federal Prisoners by Offense, 2010

And yet it has not helped address number of deaths from drug use.



National Overdose Deaths, Number of Deaths from All Drugs, 2002 – 2015

To be clear, this is not to say that there should not be drug laws. Rather, the suggestion here is to consider that maybe these laws and investments are causing more harm to the victims of drug use. Perhaps these laws are not designed to prevent their use or help users to rehabilitate, as Nixon originally intended all those years ago?

The World Health Organization (WHO) states:

"Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals." (WHO, 2017)

Things to Be Aware Of

It is important to note that the DSM-5 does not use the term "addiction" as a classification term. Some in the helping professions believe the term "addiction" can carry a negative connotation and is a very ambiguous definition. Therefore, the phrase "substance use disorder" is used as a more neutral term by these professionals for the purposes of describing the variety of ways that this disorder can be identified.

Key Terms

- **Abstinence** – the act or practice of restraining oneself from indulging in something.
- **Depressant**– a drug that reduces bodily functioning or instinct (ex. Tranquilizers, Klonopin, or Xanax.
- **Hallucinations** – perception like experiences that occur with an external stimulus; vivid/clear, involuntary, and can occur in all levels of sensation.
- **Hallucinogen** – a drug that causes hallucinations (ex. PCP, Ketamine and Peyote).Harm Reduction – a set of strategies aimed at reducing negative consequences from drug use. Also hold a belief in/respect for the rights of the people who use drugs.
- **Inhalants** – vapors introduced to the body by breathing it in (ex. Paint thinners and many household chemicals).
- **Stimulant** – a substance that increases attention, energy, heart rate, and respiration (ex. Cocaine and Ritalin).
- **Opioids** – a compound derived from the opium plant (ex. Morphine, methadone, and heroine).

Definitions retrieved via Dictionary.com (2017), unless otherwise noted

But, as you head into the social work profession you may find often times that the terms addiction, substance use, substance abuse, and dependency may be used interchangeably or be used to refer to the same thing. For example, the term "addiction" or "addict" can be seen on government websites whereas DSM-5 employs the term "substance use disorder". These words are explaining the same events, symptoms, and treatments but from two different professional standpoints, the medical (government) person centered.

The goal of the DSM-5, as well as the social work profession, is to mitigate or prevent the self-imposed and social

stigmas that can result from being labeled as "an addict." By limiting harmful stereotypes and using person centered language (i.e. saying someone has a disorder rather than calling them an addict), the client may view the disorder as a manageable part of their life rather than being all of who they are. This is an important concept for social workers to be sensitive to and it is with that in mind that this chapter will use the term Substance Use/Substance Use Disorder.

Substance Use Disorder (SUD)

Substance use disorder (SUD) is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance related problems.

There are four key criteria that people must meet to be considered as having a Substance Use Disorder are impaired control, social impairment, risky use, and pharmacological criteria.

All information and statistics following are from the DSM-5 unless otherwise indicated.

SUDs include but are not limited to things such as:

• Alcohol Use Disorder is defined by a cluster of behavioral and physical symptoms, which can include withdrawal, tolerance, and craving. The prevalence of this disorder is very common in the United States with an 8.5% rate among those 18 years and older.

• Cannabis Use Disorder consist of behavioral and physiological symptoms that result from a long or heavy duration of cannabis use. This use disorder will often co-occur with other, more severe, substance use disorders like alcohol, stimulants or hallucinogens. While the full prevalence may be underreported, a study by Hasin et al. (2015) reveal that three out of ten (30%) marijuana users will qualify as having a use disorder.

• Hallucinogens are any drug that can produce alterations in perception and mood (See: Key Terms). Across a twelve-month span, it is estimated about 0.5% of the adult United States population will report symptoms of this disorder.

• Inhalants are classified as any substance that people only consume through inhaling. The result of this type of use is a mind-altering nature. Inhalants include things like gasoline, aerosol spray, or prescription medicines called nitrites (National Institute on Drug Abuse, 2017). This use disorder is most common in youth with about .4% of 12-17-year-olds reporting misuse although 10% of 13-year-olds do report using inhalants at least once.

• Opioids are a class of drugs that include the illegal drug heroin as well as legal drugs like morphine and codeine. These drugs deliver pain relief and euphoria when consumed. The consumption of prescribed opiates like morphine or OxyContin, becomes a substance use disorder when the opioids are consumed outside of a controlled environment or through self-administered dosages. In the United States, the prevalence of opioid use disorder is approximately 0.37% in adults.

• Stimulant use disorder is an abuse of substances like cocaine or methamphetamines. Symptoms of this disorder include cravings for stimulants, failure to control use when attempted, spending a great deal time obtaining and using stimulants, and withdrawal symptoms that occur after stopping or reducing use (SAMHSA, 2015)

• Tobacco use disorder occurs in people who use tobacco products in greater amounts or longer durations than originally intended. There is a strong desire to consume tobacco, increase intolerance to nicotine, and people may be unsuccessful at quitting tobacco products. The prevalence in the United States of tobacco use disorder is 13% (DSM-5, 2013) – a substantial number considering the estimated 66.9 million smokers of tobacco products (SAMHSA, 2015).

Substance Use Practice Settings

A social worker choosing the field of substance treatment will find themselves in two primary settings: inpatient and outpatient. Similar to the practice settings of mental disorders, substance use clinicians can work in inpatient clinics that house people trying to alleviate themselves of their substance use as well as enhance their health, an example of this

can be seen in the film 28 *Days* starring Sandra Bullock. These types of facilities may have individual or group counseling sessions, provide drug screens, and provide time for the individual to reflect on their situation (Davis, 2013).

Outpatient clinics are another option for practice settings. These facilities offer potential clients scheduling flexibility and are not as intensive or hands on as inpatient facilities. These types of facilities allow clients to receive services like counseling, education, medication and support information at their own pace (AddictionCenter.com, 2017).

Current Issues

In 2017 there is a current drug use trend in the United States referred to as the Opioid epidemic. According to the Centers for Disease Control and Prevention (CDC) (2017), the majority of drug overdose deaths in the United States, six out of ten, in fact, involve some form of an opioid. This epidemic appears to be rooted in the use of prescription opiates. According to CDC statistics, nearly half of the opioid overdoses in the United States were linked to prescription pills like OxyContin, Methadone, and Vicodin (CDC, 2017).

But what happens when the person who has been using prescription opioids can no longer afford them? They turn to heroin. According to CNN reporter, Dr. Sanjay Gupta (2016), the price for heroin is almost one tenth the price per milligram than it is for a prescription. This may be one of the many reason we see such a rise in heroin use and, is often the case, death. They may also experiment with more dangerous drugs, such as fentanyl, as has been the case of the residents of Ohio (Opiate Action Team, 2017).

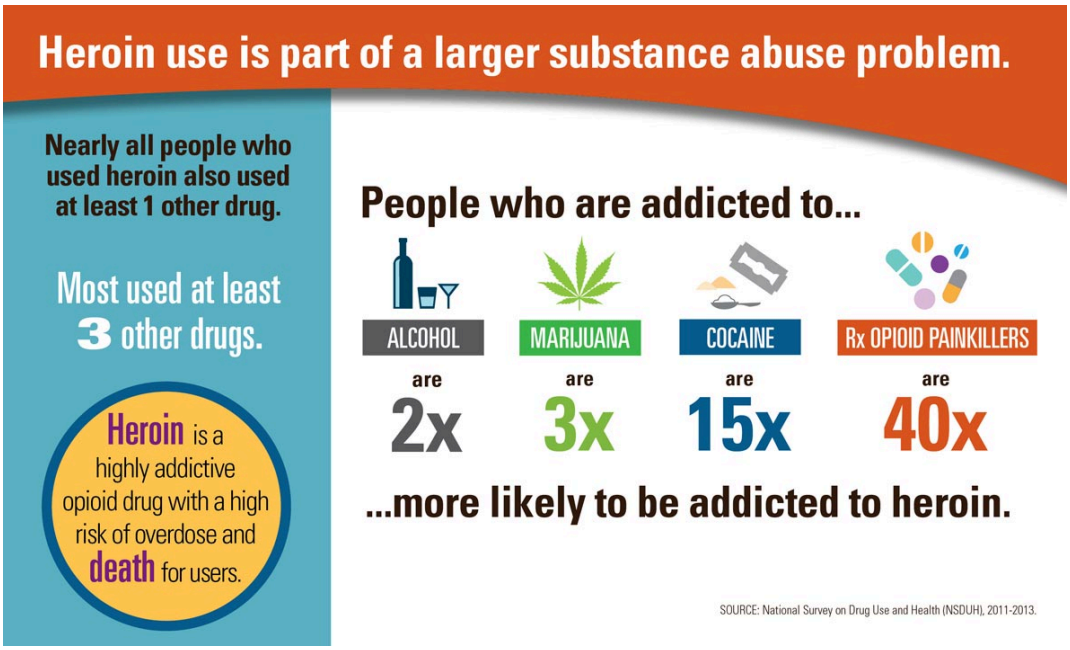


Chart showing that heroin use is part of a larger substance abuse problem

This increased trend in drug use has impacted a wide range of people and demographics, many of whom were never at "serious" risk for drug abuse before, like women, people with higher incomes, and the privately insured. Statistics show that 45% of people who used heroin were also addicted to some form of opiate painkiller (CDC, 2017).

Similar trends and concerns to that of Ohio can be seen across the United States.

https://www.hhs.gov/opioids/about-the-epidemic/index.html

http://www.npr.org/tags/141914251/opioids

http://www.radiolab.org/story/addiction

The above links provide examples of the impacts and strategies that people and agencies dealing with the dramatic impact that opioids are currently having, not just on the country but all over the world. According to a White House press release titled *President Trump's First Budget Commits Significant Resources to Fight the Opioid Epidemic* (2017), in the next year alone, the U.S. government will spend 12.1 billion dollars for treatment and prevention efforts. The U.S. will also provide 500 million dollars in grants so that states can work to reduce misuse, improve treatment, and increase access to treatment.

Social workers are at the forefront of combating this epidemic. Workers are meeting clients in hospitals as they recover from overdoses, counseling those seeking rehabilitation, work with insurance companies to distribute proper funds and ensure correct coverage, as well as educating youth on the dangers of opiates.

Philosophies of Treatment

As we can see, there is a large spectrum of substances that have different effects on the body and brain. If you choose to enter the field of substance treatment, you are bound to encounter different ways organizations or practitioners choose to treat their clients. Two main philosophies of substance treatment are Abstinence and Harm Reduction.

Some places may encourage the practice of *abstinence*. You may have heard this term regarding alcohol or sex because abstinence is defined as "the act or practice of restraining oneself from indulging in something" (Oxford Living Dictionaries, 2017). Some substance use treatment programs like Alcoholics Anonymous (AA) promote this type of behavior (DualDiagnosis.org, 2017).

According to *Principles of Harm Reduction* (2017), *harm reduction*, like many practices throughout social work, has the base philosophy of meeting people "where they are at" when it comes to their substance use. When working with a person who is suffering from a drug use problem (change the word problem) the social worker acknowledges that drugs are a part of part of this world, in both positive and negative terms (i.e. medications and illegal drugs). Rather than attacking or condemning the patient's behavior, the clinician works with the person to minimize the use as well as the harmful effects of these substances thereby reducing the overall harm that is being done.

Both strategies have their limitations. For example, is it reasonable to ask someone to abstain without relapsing? How does a relapse impact the individual's recovery? Will it be condemned or understood as part of healing? Can a person really get clean if they are still on a substance? Do we continually tolerate relapse or establish consequences for the undesired behavior? How much time is the counselor and client willing to take? Will the approach be safe for the client to participate in?

According to DualDiagnosis.org, 30% of people who participate in harm reduction or moderation type programs will end up in an abstinence-only program. However, according to a study conducted across a 33-month period, the success rate of abstinence only programs is very low – 5.9% for females and 9% for males (Recovery: Abstinence vs. Moderation, 2017). However, there is a current trend in this area of treatment moving more toward the use of interventions with evidence of effectiveness but information is currently limited.

Mental Disorder and Substance Abuse

Whether you are a social worker in mental health or substance treatment, inpatient or outpatient, there is an almost guarantee that you will encounter people who have both a mental disorder and substance use disorder in your career. This is referred to as a *dual diagnosis* where the presence of a mental disorder occurs along with the use of a substance.

According to the National Institute on Drug Abuse (2017), people who have a substance use disorder are nearly twice as likely to also be diagnosed with either a mood or anxiety disorder. However, a mental disorder can also lead to substance use in a sort of chicken vs. egg situation. For example, let's say there is someone who has a diagnosis of depression who also uses a stimulant to try to alleviate it. Or perhaps someone has a diagnosis of alcohol use disorder and because of this use, they have developed depression. These are two potential examples of a dual diagnosis.

Case Study: Katie

Katie is a 26-year-old female. She has come into services due to a previous suicidal attempt. Her initial assessment gives her a diagnosis of Major Depressive Disorder and a secondary assessment of Alcohol Use Disorder. She remembers drinking since she was about 12 years old; she reports that she drinks to lessen the feelings of "sadness and feeling down." She also reports that she feels "just as bad, if not worse" if she stops the drinking.Katie has attempted services in the past but discontinued them because she says, "I was fine after about 10 months of being with them so I stopped taking my medication and wanted to get on with my life." Katie reports that she has a boyfriend who is very supportive and a mother in town. Her father is out of the picture but Katie reports he also had a history of substance use.

Consider how you would approach this case: What are some things you would want to know? What would you address first? Why? Feel free to discuss this in class.

As you can see, it takes a discerning professional to figure out the best path of treatment, plan for change with the individual, provide supports, assist in maintaining healthy coping, and a vast array of other tasks and responsibilities.

Things to Be Aware Of

Mental disorders and substance use are more common than people would like to admit. It adversely impacts many parts of people's lives, whether directly or indirectly.

If you, or someone you know, is experiencing any signs or symptoms of a mental disorder or experiencing substance use please contact:

Mental Health Assistance 1

Mental Health Assistance 2

Substance Use Assistance

These websites are only an example of the many resources and supports available to people seeking help or assistance in navigating difficult life changes.

As a social worker in these fields, your role will be to help clients through these, potentially difficult, times. You will connect their clients to local resources, advocate for best practices to achieve client goals and outcomes, and offer non-judgmental supports to their clients. You yourself may even be that resource that people contact for individual therapy/counseling, or group therapy/counseling.

Techniques, Tools, and Strategies

Social workers can seek several avenues to assist their clients. As you may already be aware, social work strives to institute evidence based practice (EBP) when dealing directly with clients. These practices may include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, or Motivational Interviewing.

Social workers must also be familiar with medications that have been prescribed for treatment and their potential benefits, drawbacks, or chance for abuse (i.e. opiates).

Social workers working in inpatient settings may also help guide their clients through the process of detox. This process can be a long, painful, arduous process for many people and the support that a caring social worker can provide is an invaluable resource.

Social workers may lead support groups. These are organizations, generally outpatient, where clients gather to share their stories, successes, setbacks, hopes, and needs as they recover or maintain their mental or physical health regarding their disorder or substance use.

Finally, it behooves the social worker to know the person they are assisting. Establishing rapport, trust, and familiarity with the client's personality, lifestyle, family structure, culture, and environment are invaluable pieces of information. The impact that a mental disorder or substance use disorder can have on these different systems are not isolated to one; rather these systems impact each other.

For example, someone experiencing a substance use disorder may withdraw from work or family functions seeking out isolation. They may make friends with similar substance use disorders, thereby creating a new environment that encourages the behavior. The person then may not have the support to seek positive change when they decide to finally pursue help.

Similarly, someone who is diagnosed as paranoid schizophrenic may not be able to function in their working environment. This lack of employment may impact their social circles and places of enjoyment, even where they now shop. This change in lifestyle may, in turn, impact family dynamics. The family, once a great support, may now be uninformed, resentful, or frightened of the sudden change in their loved one. The rejection of family may then have an impact on the belief in oneself to recover, cope and maintain their mental health.

Career Outlook

The area of social work that specifically deals with mental disorders and/or substance use has been around for decades and shows no signs of slowing down. In 2014 the number of social workers employed in the mental health and substance use fields was 117,800. The field is projected to add 22,300 jobs over the next 10 years, resulting in 19% job growth (U.S. Department of Labor, 2017).

Unfortunately, the Bureau of Labor Statistics (2017) also indicates that the social workers in the mental health and substance use fields tend to make less than their peers. Workers in mental health and substance use can expect to make an average of $42,700 compared to the top average pay of $60,230 from fields like private clinical or veterans administration workers. (NOTE: Payment tends to be degree dependent; those with BSW degrees tend to make less than those with MSWs.)

Summary

Social workers have, and will continue to, advocate for the understanding of and pursuit of social justice for some of the most misunderstood and vulnerable among us. These workers will encounter a variety of individual and co-occurring disorders in their profession.

Social workers in the mental health and substance use fields continue to improve treatment outcomes with a better understanding of the brain, trauma, and evidence based practice (EBP) models to provide treatment and care. These treatments can be in a variety of settings from community mental health (CMH) facilities, to hospitals, to private clinics.

There are many challenges in the country, as well as the world, and social workers are well equipped to combat many of these challenges going forward. This field will continue to grow over the next decade although the funding and pay scale for services is currently in question.

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5. Child Welfare and Foster Care

> One hundred years from now it won't matter what car I drove, what kind of house I lived in, how much I had in my bank account, nor what my clothes looked like. But, the world may be a little better because I was important in the life of a child. – *Unknown*

In this chapter, you will learn many of the basics of child welfare and foster care. In addition, you will learn about family, what the basic definition of family is, the various family functions, and how these play a role in the child welfare system. Family is the foundation of the child welfare system. The child welfare system is necessary to help keep children safe, including providing safe places to live through other family members or even foster care. Before the welfare system existed, the safety of children was left up to the parents. They were able to punish and raise their children however they felt was necessary.

You will learn through this chapter that the necessity of the child welfare system is important to help families keep children safe. Also, some myths about the child welfare system may be refuted as well to hopefully give you as the reader a better understanding of what the child welfare system is and what it is not.

To get a good overview/understanding of what a child may experience with their family, abuse, and in the Child Welfare System (CPS and Foster Care), please follow this link and watch the two videos provided. Warning, this video may evoke some heavy emotions of sadness, so prepare yourself to watch this video: Removed Film (https://www.removedfilm.com/pages/watch)

Family

Family Structure

Families are the foundation of society. Family is where children learn the basic skills necessary to succeed. Children learn how to interact with others, learn what love is, and more. There are numerous types of family structures, and each culture has its own family practice. A basic definition of family, according to the United States Census Bureau, is a group of people (two or more) that are related in various ways including birth, marriage, or adoption, and share residence with one another. This section will outline various family structures along with highlighting some families within different cultures.

The family structure is ever changing and can have various effects on the family as they move forward. A traditional family, also known as nuclear family, is defined by Edwards (2007) as a married couple and their biological children. This is one of the more reinforced family structures in the dominant society. It should be noted that a child starts out with their traditional family, and as they grow, becomes more involved in outside activities, or even move out to live with others. Thus, the family grows to beyond relatives and includes friends. Another thing to keep in mind is the idea that a child may start out in one type of family structure and then the structure or dynamic of that family may change due to divorce, death, parents marrying again, or even just an addition to the family through adoption, foster care and more.

Single-parent families are families with one parent and their child/children. The parent has sole responsibility for caring for their child. Though most think of it being single mothers, this includes fathers as well, and can happen in various other ways. The parents could separate and/or divorce/break-up and do what is known as co-parenting. Edwards (2009), coins the term as co-custody family. This is shared responsibility, in which both parents take care of the child at different points (i.e one parent may have them for a week and the other would have them on weekends or every

other weekend). The co-parenting can be set up in various ways either through Friend of the Court, or just by mutual agreement. Single parent families can also occur by a spouse passing away. Grief counseling would then be a great tool for these families to utilize.

Key Term

Friend of the Court or FOC, is a section of the circuit court that investigates custody, parenting time, or even child support. They are directed by the judge, and is in a sense a third party to a lawsuit who is not the defendant or the plaintiff (the person who places the complaint in a lawsuit).

To learn more about what a FOC is and what their duties are, look at this FOC handbook provided by the Michigan Government. http://courts.mi.gov/administration/scao/resources/documents/publications/manuals/focb/focb_hbk.pdf

Often parents who are divorced or become a single parent by other means potentially remarry to others who may or may not have children of their own. This in turn creates what is known as step-family. Step-family refers to the dynamics of a re-married couple who have children but do not all share DNA. This means that the mother may have a child, but the child is only the fathers' responsibility through marriage and not by any other means (same with the father having a child who does not share DNA with the mother). Another aspect to consider when step-families are created is that when they then have children together it creates a blended-family. Though the children may not be biologically related to both parents, they can still have a secure and strong bond/attachment with said parent. Some children may refer to their step-parent as their mother or father, and some may refer to them by first name. When working with the children within this family structure, validate them by addressing their caregivers the same way they do. This in turn will help build the rapport with the child needed to be able to help them to the best of our ability.

An extended family is a family that includes members outside of the nuclear family. This term encompasses the grandparents, aunts, uncles, cousins and more. In some cultures, the extended family members, more specifically grandparents, live with the nuclear family. Now, especially in American society, we see a lot of the elderly being placed in nursing homes. Even if they do stay home, usually they rely on home health practitioners for support. To learn more about the area of gerontology and the social workers role within that population refer to Chapter 8.

Keep in mind that these are only a handful of the various types of family. Other types may include transnational, LGBTQ (this population is especially vulnerable due to difficulty with civil rights), and more.

Family Function

One of the foundational functions of a family is to care for their children. Clinical Psychologist Diana Baumrind founded three models of parenting styles. These include **authoritarian**, **permissive**, and **authoritative** parents. Enrique et al. (2007) added **uninvolved** parenting as a style in child rearing.

Authoritarian parenting is defined by Baumrind (1966) as a parenting style that attempts to shape or control a child's behavior with a set of absolute standards. They are typically the type of parents that lay out the rules with "no questions asked" mentality. Therefore, they expect their rules to be followed with no explanation at all.

Permissive parenting is known more as the responsive type rather than the demanding type. Characteristically, they are very "lenient, do not require mature behavior, and avoid confrontation" (Enrique et al., 2007). Baumrind (1966) describes permissive parenting as a style that does not expect or demand help around the house, orderly behavior and so on. However, she also describes them as parents who are more accepting of the child's behavior.

Authoritative parenting is described by Baumrind (1966) as the parent attempting to "direct the child's activities in a rational, issue oriented manner. Encourages verbal give and take," and more (p. 891). Authoritative parenting is seen

as more ideal and valued as this parenting style tends to encourage structure, and firmness with rules, but it does not restrict the child in any way.

Uninvolved parenting can take on many forms, but in every form the parents do not involve themselves in their child's lives. Enrique et. al (2007), discuss that with uninvolved parenting parents are either too involved in other activities (work, friends, etc.) that they do not have the time or energy for their child(ren), or they may have even rejected their child.

It is important to consider that the parenting styles listed above only describe normative behaviors; meaning, they are not taking into consideration homes with abusive parents or other variations that could occur. A "crucial role for parents is to influence, teach, and control their children" (Enrique et. al, 2007). In other words, caregivers have a tremendous amount of impact on a child's life. For example, a child who grew up in a household where the parents are accepting of everyone, non-judgmental, and respectful, may then portray the same behaviors in other environments. Thus, the four primary parenting styles simply describe some of the various ways in which parents attempt to interact and influence their children.

One of the foundational functions of a family is to care for their children.

Key Term

Antisocial Behavior: Antisocial Behavior is termed as Antisocial Personality Disorder in the DSM 5. This means that a person typically has no regard for others in the form of violence, and others, lack of remorse, no regard for safety, lack of empathy, and more.

To get more information refer to the DSM 5.

You can also follow the link provided to read more about it online: https://www.ncbi.nlm.nih.gov/books/NBK55333/ You can also learn more in Chapter 9: Mental Health and Substance Use.

Each parenting style has positive and negative aspects and having a balance is key. Baumrind (1966) discusses the various effects of different parenting styles and found that authoritative parenting tends to have a positive effect on children. She mentioned that having firm control was associated with conscious development and being too rigid could lead to hostility in children. Authoritative parenting, as mentioned above, is a mixture of give and take, and firm control. This typically allows the parents to have their children obey rules, and to discuss many variables as well to help the child understand the punishment.

Baumrind (1966) states that the key to avoiding negative outcomes when parenting children is to offer firmness and structure, but to not be repressive, hostile or restrictive. She goes on to mention that partaking in a more rigid and restrictive parenting style can lead to antisocial behavior, rebelliousness, and hostility. Authoritarian parenting, where the parents are more rigid – almost as if a drill sergeant – can have many negative effects, like hostility in children. Being more restrictive can lead to decreasing self-assertiveness in children, as well, according to Baumrind (1966).

Family Culture/Values

In the field of social work, it is highly important to remember that we are to validate the families we work with and not judge them. We must acknowledge the family's culture by respecting their belief systems and values. For example, if a family comes to you and you notice that the female is looking down and not making eye contact, consider the fact that in their culture that may be how the female shows respect to her husband, and possibly other authoritative figures. Thus, interacting with the family in the way they feel comfortable (i.e talking to the husband first etc.) will help one build a solid rapport (close relationship) with the family group.

Enrique et al. (2007), provides the following ideas for working with families:

Working with Families

1. Avoid stereotyping
2. When introducing new ideas, materials, and more respect the family's need for control
3. Recognize the parenting styles being utilized, and their boundaries
4. Recognize that everything may be a family affair with some families
5. Help families notice their strengths within each other
6. Ask for family's input when coming up with solutions to conflict
7. Encourage families to plan ways to increase stability and security (i.e. bedtime rituals etc.)
8. Observe and engage with the family to learn the different dynamics (i.e. male head of the household, or is it the female?)

9. Provide opportunities for the family to discuss what their beliefs are about children (should they be seen not heard etc.)
10. Maintain an objective viewpoint when working with conflict within the family system

Child welfare wordcloud

Child Welfare

Brief History

Child welfare is necessary in our society to help maintain child safety and keep families working cohesively. The Child Welfare Information Gateway (CWIG) (http://www.childwelfare.gov) defines child welfare as a field of services that aims to protect children and ensure family have the tools to care for their children successfully. Many people see this happen through an agency like the Department of Health and Human Services (DHHS) which is present in every state. To ensure the safety of children, DHHS is responsible for performing various tasks. These tasks include things like coordinating services to help prevent abuse or neglect, and providing services to families who need help protecting and caring for children. They are also responsible for investigating reports of potential abuse and/or neglect, and then determining if alternative placement of children is necessary. They are also in charge of various other aspects including support services to children, achieving reunification, and more. Child protective service workers and foster care workers are the more specific workers in which these work functions are performed.

According to Myers (2008), the first organization that was solely focused on protection was known as the New York Society for the Prevention of Cruelty to Children. This agency was established in 1875, and prior to that many children in our society went without protection, although many people were still prosecuted by the criminal justice system. Organized protection services came about after the rescue of 11-year-old Mary Ellen Wilson who was continuously beaten and neglected in her home.

If you want to learn more about how her story inspired the creation of the New York Society for the Prevention of Cruelty to Children follow this link: http://www.facesofchildabuse.org/mary-ellen-wilson.html

The federal government did not become more involved in child welfare until approximately 1935 when they became

more involved with the funding of the agencies. Thus, it was the Great Depression that sparked the start of the Child Welfare System. In 1975, Michigan passed the Child Protection Law available to view at the link provided below. This act defines various abuses, central registry and various other aspects that involve the child welfare system. The act provides guidelines for people to follow in regard to when to report (and what is grounds for a report, the court processes, and more).

https://www.michigan.gov/documents/DHS-PUB-0003_167609_7.pdf

Indian Child Welfare Act (ICWA)

ICWA is another segment of child welfare specifically for Native American families. "In 1958 until 1967 the Child Welfare League of America has contracted with the Bureau of Indian Affairs with the purpose of placing Native American children with white families in hopes of assimilating the children to mainstream culture." (ICWA Law Center). This practice often left the children in boarding schools severing the relationship with the families. In response, the Indian Child Welfare Act was put into place in 1978. This act highlights the recognition of tribal sovereignty, preservation of Indian families, and tribal and family connectedness. To learn more about the ICWA visit the link provided.

http://www.icwlc.org/education-hub/understanding-the-icwa/

Child Protection Services

Child Protection Services, or CPS, is a segment within the Department of Health and Human Services. The role of CPS is filled by a variety of disciplines including but not limited to Social Work, Criminal Justice, and Psychology. According to the Michigan Department of Health and Human Services website CPS is "responsible investigating allegations of child abuse and neglect" (MDHHS, 2017c). There are many rules and regulations when it comes to the process of a CPS investigation and the removal of a child from the home. Keep in mind that though many think of CPS workers as being "kid snatchers" the intent of CPS is not to remove children just because they feel like it. Instead, their goal is to keep the family together if possible. They remove children if their safety is being threatened. The link provided outlines in more detail the grounds for a removal. If services alone cannot help provide protection and safety to children then a removal is necessary. https://dhhs.michigan.gov/OLMWEB/EX/PS/Public/PSM/715-2.pdf

The process of a CPS investigation starts out with a report called in of a suspected child abuse/neglect case. Chapter 2: Social Work Values and Ethics provides a definition of mandated reporting as well as the people who are mandated reporters. After a report has been made, CPS has 24 hours to begin the investigation, unless there are mitigating circumstances in which the investigation needs to be started sooner. There are different priority levels in which an investigation takes place. This is explained in the Child Protective Services Manual.

Priority one is when the child is in immediate danger, and thus CPS has 12 hours to begin the investigation and 24 hours to interview the victim. Priority two is when it is determined that the child is not in immediate danger/risk. The CPS worker then has 24 hours to begin the investigation, and 72 hours to initiate an interview with the child. After the investigation has begun, CPS then has 30 days to complete the investigation (unless there are circumstances that cause a need for an extension) and to determine whether or not the child needs to be removed, if further support services are needed, or if there is no need for an intervention.

According to the Michigan Government, the investigation typically includes face to face interviews with the alleged victims, caregivers, and the person who supposedly committed the act of abuse. They do a thorough search of the home making sure that there is food, running water, electricity, a bed to sleep in and that the house is well kept and clear of any safety hazards. The investigator then digs into previous reports, potential criminal history, and school and medical reports as well. They do a safety risk assessment, and analyze the child's behavior and risk of future abuse/neglect, and then complete an assessment of the family's needs and strengths as well.

The purpose of the assessments and interviews is to get a well-rounded understanding of what is going on. They are searching for things like alternative explanations of what was reported, if the child has any injuries, the condition of the home, adequate supervision, and do the best they can in finding out if the caretakers are abusing or neglecting the child in any way and more.

The next step is determination for removal (follow this link, Removal, to learn more about what the state finds as grounds for removal). There must be enough evidence to prove that the child was abused or neglected in some way.

MDHHS identifies five categories in which a case is placed depending on the evidence that was found during the investigation. They range from Category I to Category V.

- **Category I:** Department determines that there is enough evidence of abuse or neglect and court petition is needed and required.
- **Category II:** Department determines that there is enough evidence of abuse or neglect, and the risk assessments show high risks
- **Category III:** Department determines that there enough evidence of abuse and neglect, and the risk assessments show a low or moderate risk
- **Category IV:** Department did not find enough evidence of abuse and or neglect and the department must then assist the child's family in participating in community based services.
- **Category V:** In this instance CPS was unable to locate the family, or there was no evidence of abuse or neglect. It is also possible that the courts may have declined to issue an order in which the family would be required to cooperate in the investigation.

These categories were listed at the Michigan government website (link below). In Category I and Category II cases, the person who committed the act of violence will be placed on the Child Abuse and Neglect Central Registry.

http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_7194-159484–,00.html

Though removals may be necessary, they are still traumatic for the child. The child has a bond with the caregiver, and that caregiver is all they know. If there is more than one child involved, CPS will try and keep the children together. A child who has been through any type of abuse in their home still has a strong emotional bond between all members of the family. That is why many people are confused as to why the victim may want to return to their families who harmed them. That is where their bond is, and it will take time for them to understand that what has happened is wrong and they deserve better.

CPS workers work in a high stress position. They often are entering into environments in which the safety of a child, and even their own safety, is of great concern. Vicarious Trauma (often known as secondary trauma) is another type of trauma in which CPS workers will need to be aware of. Vicarious trauma is defined by the National Children's Traumatic Institute as the "experience of professionals who are exposed to others' traumatic experiences and in turn develop their own traumatic systems and reactions" (NCTSN, 2012, p. 1).

Due to the high stress, and the emotional toll that this job can have on a person, self-care is highly important. Self-Care is in a sense something that a person does to help them cope with stress. This can be through meditation, doing an activity that they enjoy, going for a walk and more. YouTube, is a great resource to look up guided meditation videos. NCTSN (2012) discusses that without coping mechanisms, or even seeking out help for it, the reaction from one person can impact other workers until it spreads. The spreading is then as if the whole agency is one person who has experienced secondary trauma, thus burnout rates increase.

Key Term

Burnout: "prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by three dimensions of exhaustion, cynicism, and inefficacy" (Maslach, Schaufeli, Leiter, 2001, p. 397). In a sense, a person no longer has the passion or empathy they once had. The link below is an article that describes the signs of burnout, and what to do for prevention.

Prevention is the key to fighting against burnout. http://www.naswassurance.org/pdf/PP_Burnout_Final.pdf

Abused children often suffer from trauma throughout their adult lives. Patients that were exposed to trauma in early childhood can express their anxieties through drawings.

Types of Abuse/Trauma

Children involved in the Child Welfare System have often experienced trauma. Trauma is defined by the National Child Traumatic Stress Network as frightening events that are overwhelming to anyone who experiences them (NTCSN, 2017).

Often a person feels that their safety is a concern and are on high alert to anticipate what may or may not happen next. There are three different types of trauma: acute, chronic and complex.

Before defining the different types of trauma, one must understand that all types of trauma impact the brain. The stress hormone cortisol is released, then creating the fight or flight mentality. These reactions can occur any time after a traumatic experience. The link provided is a video that explains the effects of trauma on the brain and provides many explanations of how one can help others' who have experienced trauma: www.changingmindsnow.org.

Acute Trauma/Chronic Trauma

Acute Trauma is a single traumatic incident. An example would be a car accident or even a natural disaster. It may only be a single incident, but it can have lasting effects such as fear of being in a vehicle. Chronic Trauma is a traumatic experience that is repeated over a period of time. This type of trauma would include domestic violence, and war. Both have lasting effects on many people and the consequences can be hard to overcome.

Complex Trauma

Complex Trauma is a repeated traumatic experience that has been inflicted by a caregiver. This includes, but is not limited to, physical abuse, sexual abuse, and verbal/emotional abuse (also known as psychological abuse). Complex trauma leaves a child confused and conflicted. The person who inflicted harm was supposed to be the one protecting them and keeping them safe. When that does not happen the child is then in a predicament where they do not know who to trust. A main type of trauma that will be highlighted in this chapter is complex trauma. This type of trauma occurs in various forms of abuse which are defined below.

Abuse comes in many forms including physical, emotional/verbal, and sexual abuse. According to the National Child Traumatic Stress Network (NCTSN, 2017) physical abuse is defined as any act, completed or attempted, that physically hurts or injures a child. NCTSN also describes that acts of physical abuse include hitting, kicking, scratching, pulling hair, and more. Child Protection Services typically get reports of bruises, and other noticeable marks when investigating a report of physical abuse.

Emotional abuse is a nonphysical maltreatment of a child through verbal language. NSPCC (National Society for the Prevention of Cruelty to Children) states that emotional abuse includes "humiliation, threatening, ignoring, manipulating, and more." (https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/emotional-abuse/what-is-emotional-abuse/) Emotional abuse can be combined with other forms of abuse like physical and sexual abuse. Most reports emotional abuse is harder to prove and thus physical or sexual abuse tends to be the main cause of removal in a home.

Statistics about Sexual Abuse

- In 2012 26% of sexually abused victims were ages of 12-14 years. 34% were ages 9 or younger. (U.S Department of Justice, NSOPW).
- Center for Disease Control found that 1 in 6 boys and 1 in 4 girls are sexually abused before they reach the age of 18.

The link provided is where these statistics were found, and more statistics are available: https://www.nsopw.gov/(X(1)S(0otvrpqvguoplfo5wbafq5ag))/en-US/Education/FactsStatistics?AspxAutoDetectCookieSupport=1

Sexual abuse has many facets when it comes to a specific definition. Overall, sexual abuse is a "type of maltreatment, violation, and exploitation that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator. It includes contact for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities." (American Society for the Positive Care of

Children, 2017). The person who inflicted harm will typically use force, threats, or coercion to those who cannot/do not give consent.

A grooming process typically takes place when it comes to sexual abuse. According to the National Center for Victims of Crime, there are seven grooming steps that tend to take place when sexual abuse may or already has occurred. They are good steps to watch for to potentially help prevent a potentially abusive situation from occurring. Most, if not all, sexual abuse is inflicted by someone the victim knows and usually trust. Thus, the grooming process can be very easy for the potential abuser to enact on the victim. However, this is not intending to say that all sexual abuse is inflicted by someone the victim knows; it can be inflicted by those the victim does not know, as well.

Grooming Steps

- **Identify/Target Victim**: anyone can be a victim pending the type of person the offender may be attracted to
- **Gaining Trust/Access**: the person intending to inflict harm may look for vulnerabilities
- **Play a Role in Child's Life**: could be a mentor, may manipulate the relationship to make themselves appear to be the only one that knows the victim
- **Isolating the Child**: Offering rides away from current surroundings is an example.
- **Creating Secrecy Around Relationship**: reinforce the relationship through private communication. Coercion may be used like threatening harm to themselves, or others and more.
- **Initiating Sexual Contact:** At this point the offender has control of the relationship, may start as 'friendly' touching, but can lead to penetration or worse over time
- **Controlling the Relationship**: Secrecy is needed in order to keep the process going. Fear is usually the key factor as to why abuse is often not reported. Victim blaming (it's your fault I am doing this, no one will believe you,) often happens at this point along with continued threat of potential harm to them or their families

https://victimsofcrime.org/media/reporting-on-child-sexual-abuse/grooming-dynamic-of-csa

Abuse does not always have to be physical, sexual, or verbal assault. It can also be neglect. According to the National Society for the Prevention of Cruelty to Children (NSPCC), neglect is the failure to meet the basic needs of a child. The NSPCC website states that neglect is the most common form of abuse. According to Crossen-Tower (2010) there are three categories of neglect: physical, medical, and emotional. NSPCC adds educational neglect to the list.

Things to Remember When Working with Trauma Victims

When working with children who have been abused, or a family who has experienced trauma, remember that building resiliency is a key factor. Resilience is defined by the American Psychological Association (APA) as having the ability to adapt when facing adversity including trauma (APA, 2017) This, in a sense, means that one is able to bounce back after facing trauma. However, this does not mean that there will not be any kind of consequences or negative impact as a result of trauma. A resilient individual will have the tools needed to move past the traumatic experience and potential future traumas.

To help children build resiliency, the APA suggests a variety of different techniques (APA, 2017). One is to help the client build connections. Finding a support person they can be close to and trust will help them have the ability to attach and bond appropriately. This, in turn, will also help them be able to work through the events that they have experienced. Another factor is to help them find a positive view of themselves. Trauma can often have a negative effect on the

victims view of themselves. Building up their confidence will not only help them bounce back from present traumatic experiences, but give them the confidence to be able to move past future experiences as well.

Everyone deals with traumatic experiences differently. One child may be able to bounce back quickly after being abused or neglected, while another may be portraying heavy side effects such as resentment, anger, aggression, withdrawal and more. Here is a case example of how an adolescent has responded to a traumatic experience.

Case Study

** Disclaimer names have been changed to ensure confidentiality remained intact.

Jane Doe is a 16-year-old white female living with her mother, Amy Doe. Jane has been exposed to sexual abuse. The abuse that she has been exposed to has occurred since she was born. Jane Doe has negative behaviors as a result of the abuse that have taken place since the age of twelve. These behaviors include self-harm, and multiple suicide attempts. Other behaviors that can be linked to the trauma include hyperactivity, eating problems, excessive mood swings, chronic sadness, and presents herself with a flat affect. Jane Doe was referred to mental health services to receive counseling.

In the case of Jane Doe, what would you as a social worker do when working with this client? Why?

Childhood trauma is discussed heavily in this chapter as being some form of abuse or neglect, but that is not the only trauma to be aware of. The death of a loved one, car accidents, divorce, domestic violence, and negative experiences are equally as traumatic and age does not matter. There can also be medical trauma. Maybe you or someone you know has been diagnosed with an illness, or maybe you went in for a simple surgery and things did not go as planned so now there may be something else wrong. It is all trauma, and it is ALL IMPORTANT.

The intent of this chapter is to simply define the trauma that specifically relates to child welfare, not to minimize other traumatic events. Do not discredit yourself or others who may have been through a traumatic event that is not necessarily defined in this chapter. Go to www.nctsn.org to you will learn more about trauma, resiliency and more.

The National Child Traumatic Stress Network (NCTSN) uses a trauma screening checklist that lists various events that can be considered a traumatic event. This being said, we must take note that everyone has experienced some sort of trauma in their lives, and work in an empathetic way to help build resilience, and even just to educate them that what they have experienced was traumatic. The links provided below are checklists for different age groups – one is for ages 0-5 and the other for ages 6-18 – which provide the lists of traumas, and the emotional, and behavioral responses that may have occurred in response to the trauma. http://www.nctsn.org/sites/default/files/assets/pdfs/trauma_screening_checklist_0-18_final.pdf

Thus, when working with victims of trauma, regardless of the type, age, sex, and more, empathy (which is defined in Chapter 1) is an important tool to utilize. When working with a client avoid assuming that they are making anything up, or that their behavior that are being portrayed are intentional. As mentioned above, trauma has a huge impact on the brain. The primary areas of the brain in which are more heavily impacted is the hippocampus, medial prefrontal cortex, and the amygdala which is our alarm system (Bremmer, 2006). Work with the client and understand that they are protecting themselves the only way they know how.

Watch the video to gain more understanding of trauma on the brain, and what to do and what not to do when working with a victim of trauma. **Working with Trauma Victims https://www.youtube.com/**

watch?v=4-tcKYx24aA

Circle of friends

Foster Care, Guardianships, and Adoption

Foster Care

The foster care system has been around for years. According to The National Foster Parent Association, the United States foster care system developed from the English Poor Law of 1562. This law stated that children from poor homes would enter into indentured services until they were at an age in which they could care for themselves. The first child in the US to enter into the foster care system was in 1636, and he went by the name Benjamin Eaton. Charles Loring Brace was the first to initiate a free foster home movement in 1853, more information about the history of foster care can be found at this link: http://nfpaonline.org/page-1105741.

Today foster care is known as a temporary placement in which children who have been removed from their families take up residence either with other family members (first choice, or non-relatives (alternative if no family is able or available to step in). Children who are in foster care were usually abused or neglected in some way and the risk of them being abused again is very high. Referring back to the categories of the different case levels in CPS, category I or II would typically encompass cases where the children were placed into foster care. Foster care can be done through the state at DHHS, and other agencies like the Big Rapids branch of Bethany Christian Services. To learn more about Bethany Christian Services refer to the link provided: https://www.bethany.org/

Foster care is usually the last result, and is also considered to be a short-term intervention. Thus, immediately after removal reunification is sought after to bring the child back to their family. Reunification, according to DHHS, is simply stated as returning to their homes. At this point, when reunification is mentioned many people are shocked and ask, "How is that possible? They hurt their kids!" Remember, as stated above, that the children still have a strong bond with their caregivers even though they have been abused. DHHS will NOT let a child back into their family's home if it is deemed unsafe. For a parent to get their child back they have to prove to the courts through petitions that they are fit and can adequately care for their child. During this whole process foster care workers are looking out for the best interest of the child. If it is deemed that the parents have followed through with all of the recommendations made by CPS, foster care, and the courts, and that they have completed them successfully they have a chance to get their child back.

When a child is removed it does not necessarily mean that the parental rights are terminated. Foster care is intended to be short term, not a permanent solution. However, there are situations in which parental rights are terminated. Termination of parental rights ultimately means that they no longer have guardianship of their child. The Probate Code of 1939: Act 288 (http://legislature.mi.gov/doc.aspx?mcl-act-288-of-1939) outlines the protocols and reasons in which termination is permitted. An example that the act gives includes if the parent caused, or could have prevented, physical or sexual abuse and the courts deem that the abuse will most likely continue if they remain or return to their parents' home. Once a parents' rights are terminated they no longer have the ability to legally care for their child and may not have the opportunity to regain custody of their child. Thus, termination happens after sufficient evidence has been provided to the courts showing that the child would indeed be in imminent danger if returned to the parents.

Working with foster care is another high stress position as a child's response to trauma varies and is uncertain. Having people willing to be foster parents is highly necessary and there are many websites and associations to go to in order to seek out help including the National Foster Parent Association: http://nfpaonline.org/

Steps to Become a Foster Parents

On the other end there are many steps to take to become a foster parent. The Michigan DHHS website lists five steps that have to be completed in order for anyone to become official foster parents. These steps are listed below:

- **Call a Navigator**: Foster Care Navigators are experienced foster parents who can answer questions and find an agency.
- **Attend an Orientation**: Review guidelines, illustrate what to expect, and has representatives to help answer questions.
- **Complete Application**: agency chosen provides a licensing application packet (one must be licensed in order to officially become a foster parent). Refer to link to learn more about the application process.
- **Participate in a Home Evaluation**: Have to pass an on-site home evaluation performed by licensing agent. Interviews and home visits will be done multiple times.
- **Attend Free Training**: Agency will schedule a PRIDE (Parent Resources for Information Development and Education) training with the prospective foster parent. Must complete 12 hours and once they are licensed they have 18 months to go through it again.

http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7117—,00.html

Guardianships

With permanency being the goal, guardianship is one way to help provide permanency to children who may or may not be able to return home. This is an alternative to potentially avoid bouncing from one foster home to another.

Guardianships, however, do not necessarily mean that the parental rights are terminated. This option provides permanency yet allows the parents to still have access to the child through visitation. For this process, there is a court hearing and the court decides if the potential guardians are deemed appropriate. They have to pass home visits and more, just like a foster parent. Anyone can be a guardian, but it is common for other family members to apply for guardianships to help avoid the child having to go to people who are not within the family system.

Key Terms

Permanency: is essentially finding or creating a permanent place for home, and care.

Guardianship: In lieu of terminating parental rights, a guardianship allows caregivers to legally make decisions on behalf of a child who has been removed from their home.

(MDHHS, 2014)

Adoption

If a child cannot be returned to the family, and the parental rights have been terminated, adoption is sought after. At this point, parental rights had already been terminated and thus can no longer go home to their birth family. The goal is to find permanency as quick as possible. According to MDHHS, nearly 3,000 foster children are up for adoption at any point in time, and of those 3,000 children, about 300 do not find homes for adoption (MDHHS, 2017).

Many youth in the foster care system age out. Aging out simply means that the youth turned 18 before finding a permanent home. According to the organization, Children's Rights (www.childrensrights.org), more than 20,000 foster children aged out of the system in 2015. To top that off, they state that those who age out of the system are less likely to achieve a high school diploma. By the ages of about 26, 80% of youth who aged out of the foster care system were able to get a diploma or a GED in comparison with 94% of the general population. Michigan uses many private agencies in which their focus is finding parents to adopt children who cannot go back to their parents.

Social Work Roles in Foster Care and Adoption

Just like a CPS worker, a Foster Care worker can come from a variety of backgrounds including social work, criminal justice, and even psychology. Within the role of a Foster Care worker, their ultimate priority is to identify and place children who cannot remain with their parents due to safety concerns. MDHHS has protocols in place which outline the duties of a foster care worker. These include home visits and various other tasks such as interviews with biological parents and schools.

Before a child is placed with a foster family, or if the child is relocating to another foster home, there are protocols that a foster care worker follows. These protocols include providing Medicaid card/records, enrolling or insuring the children are attending school, and providing education records to the caregiver within five days of placement. If the child is attending the same school they previously attended then a transportation plan is to be discussed. One last example of what a Foster Care worker does is discussing any revision or plans for parents or siblings to be able to visit the child. Foster Care workers are responsible for visiting a child in the foster home. In a sense, they are searching for the same things a CPS worker would, mainly a safe place to live, ensuring that medical needs are taken care of and safe sleeping requirements are met, and then gathering information of how the child feels about being placed in that home. They meet with the caregivers as well to discuss various aspect of the child including medical (i.e doctor visits, dental visits etc.), education, and behaviors portrayed in the home.

There are also protocols set in place for human trafficking victims. Refer to Chapter 9 to learn more about human trafficking and what the definition of it is. In regard to foster care, there are seven behaviors or characteristics that a foster care worker must look for to determine whether or not the child indeed was a victim. The responses they gather will determine if further assessment and care is needed.

Foster Care and Human Trafficking Behaviors/Characteristics

- History of running away
- Withdrawal or lack of interest in previous activities
- Signs of current physical abuse, and/or sexually transmitted diseases
- Inexplicable appearance of expensive gifts, clothing, cell phones, tattoos, or other costly items
- Presence of an older boyfriend/girlfriend
- Drug addiction
- Gang Involvement

These behaviors may or may not indicate trafficking. However, more investigation should take place. If you, or anyone you know suspects that two or more of these items are happening call Centralized Intake at 1-855-444-3911. Foster Care workers are expected to call this number if the victim meets two or more of these assessment points. (MDHHS, 2015)

Summary

In this chapter, we have discussed family and what family is. We discussed various parenting styles and how they have an effect on children. There are many aspects that influence the family dynamics and how they function. We went on to discuss the history of child welfare, and discussed child protective services, trauma, and foster care, adoption, and guardianships. There is always more to learn about the child welfare system as it encompasses a wide range of services in our communities. Even the history of the system is a huge topic.

Key factors to remember are that a child has a right to be safe and cared for, and when the parents of the child fail to do just that, it is the duty of the state to step in and ensure that they are safe and can be kept safe. Regardless of rumors that people have heard (CPS workers being kid snatchers one of them), the state looks for the best interest of the child and that is the ultimate factor within this system.

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6. Working With Adolescents

The National Center on Substance Abuse and Child Welfare (NCSACW) developed this technical assistance (TA) tool to provide information to child welfare, substance use treatment providers, healthcare, and other community agencies serving adolescents at risk of misusing or abusing substances. This resource highlights adolescence as a unique stage of development-one that requires professionals to take a tailored and collaborative approach. It also provides a comprehensive array of adolescent services, terminology, policy considerations, and practice strategies to support those working with adolescents through a family-centered lens.

Substance use disorders (SUDs) affect the entire family. They can interfere with a parent's ability to be a caretaker and bond with a child, while also disrupting family health and well-being. Traditional SUD treatment focuses on the individual, despite evidence that parents and children are most effectively served through a family-centered treatment approach.

In 2019, parental alcohol or drug abuse factored into the removal of nearly 40% of all children who entered out-of-home (OOH) care. Adolescents made up 22.6%.' Youth who enter foster care between the ages of 13 and 17 are more likely to exit the child welfare system through emancipation rather than family reunification; that number increases for older youths.2 Child welfare workers indicate a much higher prevalence of parental substance use than reported in their caseloads. This is primarily due to the variation in the national data since states and counties differ in how they use screening tools and track substance use as a factor in child welfare cases. Research shows a significant relationship between child maltreatment and adolescent delinquency, including developmental pathways to substance abuse,3 4 5 Children affected by child abuse or neglect have a 59% greater likelihood of arrest as a juvenile, a 28% greater likelihood of arrest at as an adult, and a 30% greater likelihood of committing a violent crime.•

Adolescence is a time period with specific health and developmental needs. A successful transition from childhood to adulthood can be difficult even under the best circumstances. For youth in foster care, the trauma associated with removal, combined with a lack of guidance and support tailored to this stage of development, can further complicate the transition.

Professionals often overlook adolescent needs when addressing the family system since generalized services are geared toward two populations: adults and children ages O – 18. However, it is a critical time when the potential for SUDs and/or mental health concerns emerge. Consideration of each adolescent development domain supports a tailored approach for service delivery-effectively meeting the needs of this population and their families.

Youth need nurturing support to navigate the developmental milestones of adolescence. By focusing on development, protective factors, fostering healthy relationships and resilience, providing opportunities, and enhancing youth strengths, professionals can help these young adults reach full potential. The Center for the Study of Social Policy (CSSP) publications, *Youth Thrive: Promoting Youth Resilience* and *Youth Resilience: Protective and Promotive Factors*, suggest questions to ask youth; offer steps professionals can take to foster resilience, social connections, cognitive and social-emotional development; identify concrete supports in times of need; and provide activities to assist those working directly with youth.

DEFINING ADOLESCENCE

Adolescence is the transition period from childhood to adulthood, including physical and psychological changes beginning around puberty and extending to age 25.7 While the World Health Organization (WHO) acknowledges that age is a convenient way to define adolescence, it is just one characteristic. Age is often a more appropriate method to assess and compare biological changes, which are universal, than social transitions, which can depend more on cultural environment.

The practical definition of adolescence varies widely. For example, the Department of Health and Human Services (HHS)/Office of Population Affairs (OPA) notes adolescence beginning as early as age 8." WHO suggests this stage starts at 10,9 while the Centers for Disease Control and Prevention (CDC) lists the age as 12.10

NCSACW defines adolescence as ages 12-18. This correlates with the Substance Abuse and Mental Health Services Administration's (SAMHSA) definition," the National Institute on Drug Abuse's (NIDA) *Principles of Adolescent Substance Use Disorder Treatment*: A *Research-Based Guide,12 and* SAMHSA's *Treatment Episode Data* Set.13

Late adolescence or **young adulthood** is another critical life stage as individuals move toward independence-assuming responsibility for their own care and well-being, while also creating adult identities.14 Like adolescence, the exact definition of "young adulthood" remains imprecise. This stage includes psychosocial transitions such as gradual independence from family, as well as changes to residence, employment, education, finances, romance, and parenting status15-none of which are uniformly accomplished by a specific age. These factors also largely depend on culture.1• SAMHSA defines young adults as ages 18-25.11

Transitional age youth as defined in the U.S. Department of Education's *Foster Care Transition Toolkit* includes all youth transitioning out the child welfare system. This can be as early as **age 18 or as late as 23** in some states.18

States, through the John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee program), can provide financial, housing, employment, education, and other support services to prepare youth for the transition from foster care to living on their own. The program is available to youth who have experienced foster care at age 14 or older. The Family First Prevention Services Act (FFPSA) made amendments to the Chafee program in 2018 which permits states and Tribes to provide the program up to age 23 under certain circumstances.

THE 5 C's OF POSITIVE YOUTH DEVELOPMENT

The adolescent years are full of potential. While it is vital to encourage teens to avoid risky behaviors, it's also important to cultivate their positive qualities. Positive youth development views teens as having a lot to offer, while promoting the idea that adults can make a significant and positive difference in their lives by helping foster competence, confidence, connections, character, and caring.2°

ASSET	DEFINITION	HOW TO FOSTER IT
•	Perception that one has specific skills, either academic or hands-on	• Provide services that support training and practice in abilities and skills •
••	Internal sense of self-efficacy and positive self-worth	•• Provide opportunities for adolescents to experience success when trying something new

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Positive bonds with people and institutions
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Help to foster and encourage relationships between
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•
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—
youth and peers, teachers, parents and families of
• origin, and families of choice

•
A sense of right and wrong ••

(morality), integrity, and • respect for standards of •
Provide opportunities to practice increasing self-control and development of spirituality

correct behavior ••
••

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A sense of sympathy and • empathy for others •

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Care for young people

Adapted from The Teen Years Explained: A Guide to Healthy Adolescent Development by Clea McNeely, MA, DrPH and Jayne Blanchard

No single individual or agency can provide all the assistance young people need to thrive. It's crucial that communities come together to support adolescents with complex needs. Special adolescent populations include minority youth; children of parents with SUDs or other substance use issues; transitional aged youth; pregnant and parenting teens; youth with mental health needs and high Adverse Childhood Experiences (ACEs) scores; youth involved with both child welfare and juvenile justice (also known as crossover youth); young people in recovery; and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth.

Child welfare agencies should seek opportunities to work with substance use treatment providers, educators, mental health professionals, juvenile justice professionals, court staff, and others serving youth in foster care.21 This helps ensure an adolescent-focused framework that supports the complex needs of all involved. The Interagency Working Group on Youth Programs (Working Group) has developed a strategic plan, *Pathways for Youth: Draft Strategic Plan for Federal Collaboration*, as a first step. The plan helps partners address their common goals for youth; elevate strong models of youth programs, policies, and other supports; and articulate areas for future collaborative work with and for youth.

ADOLESCENT POPULATIONS

Many adolescent subpopulations, with either a personal or family history of using substances, present with different needs—especially youth with history in the child welfare system and transitional aged youth. Serving adolescents effectively means understanding potential youth at risk, youth currently misusing and abusing substances, and those in recovery. Staff can identify this subpopulation along the SUD continuum of prevention, intervention and treatment, and recovery supports.

•Youth of parents with SUDs
- High ACEs scores
- Mental health concerns
- Pregnant and parenting
- Minority youth
- LGBTQ youth
- Crossover youth
- Transitional age youth
- Foster age youth
- Youth diagnosed with SUD
- Young people in recovery
- Recovery supports

Youth with a history of family dysfunction, especially in the above groups, may be estranged from their family of origin (birth families) resulting in the creation of a "family of choice." Families of choice are people selected by an individual to support their personal journey for recovery; they're not limited to biological or legal definitions. Professionals should explore the definition of family for each youth and incorporate their chosen family as an opportunity for engagement.

Families are the most critical setting for child development. Risk factors such as poverty, single parenthood, dysfunction, abuse or trauma, parental mental illness, parental substance use, and family discord or illness negatively affect both the family unit and a child's life outcome in general.22 Adverse experiences (e.g., parental substance use, domestic violence, poverty), which often push youth into the at risk category, influence childhood maltreatment and trauma—linked to physical, psychological, and behavioral consequences later in life.23

"Youth at risk" is a general term for a range of circumstances that place young people at greater vulnerability for problem behaviors such as substance abuse, school failure, juvenile delinquency, and mental health disorders.24 Individual factors include development of an SUD; high Adverse Childhood Experiences (ACEs) scores; mental health concerns; and youth who experiment with substances placing them at risk for developing an SUD (especially in the presence of other risk factors). Minority and LGBTQ youth populations may also be at a greater risk.

Crossover youth, transitional age youth, youth diagnosed with an SUD, and foster age youth are special populations that may require more services.

ADOLESCENT DEVELOPMENT IS NOT "ONE SIZE FITS ALL"

Adolescence is the transition period from childhood to adulthood. It includes physical and brain changes that may begin as early as age 8 and extend until age 25.25 The brain's frontal lobes—especially the prefrontal cortex, which governs reasoning, decision-making, judgment, and impulse control—are the last parts to reach full development.26 This would explain typical teenage behaviors such as volatile emotions, risk-taking and boundary-testing, exploration and assertion of personal identity, navigation of peer relationships, and transition to independence.

"Plasticity" is the brain's ability to change and adapt as a result of experiences which becomes stronger and more efficient throughout adolescence. The adaptive plasticity of adolescence marks this period of development as a window of opportunity for change through whichever mechanisms of resilience, recovery, and development are possible.27, 28

The timing of physical and cognitive changes varies throughout adolescence. Early adolescence differs greatly from later adolescence, which in turn looks much different than young adulthood. Professionals can maximize this opportunity for positive change by starting with developmentally appropriate support at the onset of puberty, rather than waiting until concerns begin to emerge later in adolescence.

Child welfare agencies should consider developmental science when making decisions about transitional aged youth and the tasks associated with transitioning to adulthood. An earlier start for these important services can ensure teens have the necessary resources, relationships, and opportunities to thrive. Considering the family histories of many of these youth, transitional and independent living services should include educational information on the effects of substance use on families. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) is appropriate for youth who may be using substances and/or formally diagnosed with an SUD.

PARENTS/CAREGIVERS CONTINUE TO PLAY A KEY ROLE IN ADOLESCENT DEVELOPMENT

Youth develop in the context of relationships, and our actions in that relationship affect how their brains get rewired throughout development.29 The parent-child relationship helps teach kids and teens how to handle and respond to other relationships. Difficulties with attachment can stem from early experiences of abrupt or repeated separation from a parent/caregiver, or frequent changes in caregivers early in life (e.g., incarceration, SUD, frequent inpatient treatment episodes or hospitalizations, deployments, foster care, adoption, and/or deportation). Difficulties with attachment can last for years and continue to affect adolescents and young adults.30 Without identification and intervention, these difficulties can trigger a heightened lifelong risk for developing mental illnesses and SUDs, along with behavioral, social, and academic problems.31

Explore youths' motivation to change. Fear of change and/or failure is too often mistaken as lack of motivation. Labels can contribute to this in the form of learned helplessness. It's often necessary for professionals to hold these youths' hands at first and to "check in" to ensure the youths feel safe.32

Parental education and family engagement remain the centerpiece of service components in a child welfare case

plan for adolescents and young adults. For some at risk youth, parent education and family engagement can include individuals the youth views as family (such as extended family members and adult mentors, rather than traditional family relationships). Connections to siblings can serve as a protective factor; children who have positive relationships with siblings are less likely to exhibit internalizing behaviors (i.e., anxiety or depression, often directed inward or "kept inside") after experiencing a traumatic event.33

If LGBTQ youth experience family rejection, child welfare agencies can collaborate with LGBTQ-affirming community service providers to address rejecting behaviors, while helping families and youth in foster care work toward reunification.

Cultural diversity can influence understanding of and reception to supportive services and family engagement. Immigrant and culturally diverse families often come to an understanding of their child's needs while simultaneously interacting with an unfamiliar health care system and its practitioners. Supporting the family's culture and traditions may also contribute to the parents' engagement with interventions and services. With permission, working with cultural, community or religious organizations can be a source of support and collaboration.

ADOLESCENTS ARE BIOLOGICALLY MORE VULNERABLE TO THE NEGATIVE EFFECTS OF SUBSTANCE USE

Adolescence generally means increased exposure to peer pressure, risky behaviors, and substances with abuse potential. Substance use in teens can affect healthy brain development and long-term functioning associated with memory, attention, impulse control, and the ability to experience reward. It can also delay executive functioning such as judgment and meeting goals, while contributing to difficulties with emotion regulation, and increasing the probability of substance dependence and addiction later in life.34 Many youth in foster care come from families with histories of SUDs, placing the adolescent at risk as well. For adolescents involved in child welfare, disrupted brain development, as a result of maltreatment, can cause impairments to the brain's executive functions: working memory, self-control, and cognitive flexibility (i.e., the ability to look at things and situations from different perspectives)—all contributing to a heightened vulnerability for youth at risk from the effects of substance use.35 It is important to understand the propensity of developing an SUD.

Substances, at first, may alleviate emotional pain for adolescents dealing with trauma, mental illness, family dysfunction, grief, and many other common experiences for those with either a history in child welfare, or labeled "at risk". Youth at risk may experiment with substances and/or misuse prescribed or over- the-counter substances without carrying the clinical diagnosis of an SUD. For teenagers struggling with substance use and traumatic stress, the negative effects and consequences of one disorder compound the problems of the other. There is a strong connection between traumatic stress and substance use that has implications for children and families, whether the user is an adolescent or a parent.36

Child welfare, court, and SUD treatment professionals should establish joint policies and procedures for sharing information regarding assessment results to ensure a seamless transition to treatment services. The point at which family members are referred from one system to another (such as from child welfare to SUD treatment) is critical in setitng the stage for whether they engage and remain in services.

Some people have a genetic predisposition for developing mental disorders and SUDs; they may be at greater risk based on factors such as growing up in a home affected by a family member's mental health or history of substance use.37, 38 Providing adolescents with insight on their family dynamics, family health history, and predisposition for diseases— including mental health diagnoses and SUDs—is an important component of prevention and individualized treatment planning.

Family-based approaches to treatment highlight the need to engage the family. For some at risk youth, family-centered treatment includes those the child views as family—such as extended family members, older siblings, and

adult mentors—rather than traditional family relationships. Professionals should work to preserve connections and continuity by engaging parents, other connected relatives, and fictive kin with whom they have existing relationships. This can ensure frequent and meaningful family time experiences for children and their parents, as well as siblings placed separately.39

UNTREATED MENTAL HEALTH CONCERNS MAY PLACE YOUTH AT RISK

Half of all mental health problems begin by the age of 14.40 When left untreated, adolescent mental health conditions can lead to serious, even life-threatening consequences which extend to adulthood, impairing both physical and mental health, while limiting opportunities to lead fulfilling lives. Mental illness follows no single pattern. Some adolescents suffer a one-time, prolonged episode, while others experience problems episodically. Early intervention and treatment for these issues can help decrease the negative effects.

SUDs and mental health problems frequently co-occur, with national surveys showing that approximately half of all individuals experiencing one will also experience the other (NIDA, 2020).41 Symptoms of an SUD can be similar to those of a mental health disorder, and vice versa (Child Mind Institute & Center on Addiction, 2019).21, 42 Additionally, the disorders may have developed at the same time, or one disorder may have contributed to the other. For example, a youth may self-medicate to reduce overwhelming feelings of anxiety—or facilitate their avoidance of intense emotions—following a traumatic experience and/or episodes of post-traumatic stress disorder (PTSD). Since selecting the proper treatment depends on a correct diagnosis, referring youth who exhibit symptoms is critical."

Any concerns that professionals, child welfare workers, and family members have about an adolescent's mental health need prompt attention. Consulting a healthcare provider or mental health professional is vital. Take any comments about suicide or wishing to die seriously, especially those coming from children and teens.

Strong cultural identity is tied to lower rates of depression, anxiety, isolation, and other mental health challenges and contributes to mental health resilience, higher levels of social well-being, and improved coping skills, among other benefits.44 Assist youth in the exploration of their cultural identity by asking about practices and norms that are important to them and supporting access to cultural activities and community members. Think about cultural identity as a piece of well-being like housing, education, and safety when thinking about unmet needs and systemic change.44

- SAMHSA's *TIP 59: Improving Cultural Competence* helps professional care providers and administrators understand the role of culture in the delivery of mental health and substance use services. It describes cultural competence and discusses racial, ethnic, and cultural considerations.
- The Office of Minority Health offers free and accredited e-learning programs to improve cultural competency along with information on The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), framework and toolkit to guide organizations' efforts in evaluating their implementation of the CLAS standards.
- The National Center for Cultural Competence at Georgetown University offers resources, self-assessments and learning opportunities to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

THE CO-OCCURRENCE OF TRAUMA EXISTS IN ADOLESCENTS TOO

Trauma exposure is pervasive among children and adolescents. Epidemiological data indicate that nearly two-thirds

of U.S. children will experience a traumatic event before their 18th birthday" When children face abuse and neglect, their brain develops behaviors to survive the high stress and remain alert; eventually, those behaviors alter the brain.45 Even with healthy development, changes in brain chemistry and structure during adolescence create behaviors that might feel unfamiliar or challenging. But teens with prior trauma must adjust to those typical changes in addition to coping with the developmental effects of past experiences. Long after a child establishes safety and coping mechanisms to survive, the traumatic experiences remain, and can contribute to difficulties in development, interactions, and behavioral traumatic adaptations"

Adolescents with a history of trauma typically continue to face ongoing rejection, abandonment, and violence. This makes it increasingly more difficult for them to cope, gain stability, and establish meaningful connections since unresolved trauma can trigger mental illness, substance use, and other risk-taking behaviors. Family responses to LGBTQ youth who express gender and sexual identity may vary. Although some families may show support and acceptance, others could respond in a way that might traumatize youth.47

Professionals working with individuals and families that include adolescents should re-examine practice and policies to ensure that youth receive no further trauma through their involvement in services and systems. Ideally, teens can find a path to recovery and family wellness through individualized support that differs from generalized services for children.

Professionals should approach adolescents with a commitment to providing services that are welcoming, compassionate, and genuine, while seeking to understand how youth experience engagement in social services systems. Understanding and empathy can better support youth who are struggling and displaying difficult, disrespectful, and defiant behaviors. *Understanding the Links Between Adolescent Trauma and Substance Abuse, A Toolkit for Providers* offers primers for substance abuse and mental health providers as well as information on treatment recommendations.

When working with an adolescent with trauma, providers need a solid background in trauma informed care. SAMHSA's *Concept of Trauma and Guidance for a Trauma Informed Approach* provides a framework for becoming a trauma informed organization, system, or service sector.

Expect teens to test you. Adolescents naturally desire independence. Sometimes this transition from childhood to adulthood manifests as rebellious and disrespectful behavior, leading to great conflict with parents or other supports in their life.32,46

For high risk youth and/or youth involved in child welfare, given their life experiences, they have the right to be skeptical and suspicious. They won't easily risk being hurt again and want to know whether the social worker will abandon them or follow through. Professionals must avoid reinforcing those beliefs and the idea that adults can't be trusted.32

HEALTHY SEXUAL DEVELOPMENT INVOLVES MORE THAN SEXUAL BEHAVIOR

Healthy sexual development is not simply a matter of having sex; it also involves a young person's ability to manage intimate and reproductive behavior responsibly—without guilt, fear, or shame.48 It's the combination of physical sexual maturation known as puberty, age-appropriate sexual behaviors, the formation of a positive sexual identity, and a sense of sexual well-being.49 Expressions of sexual behavior and identity differ among youth. This may be especially challenging for LGBTQ teens. Perhaps feeling worlds apart from their heterosexual peers, family, or members of their community, they need support throughout adolescence more than ever. In addition, sexual and other stages of development may be different for sexual minority teens.

According to a study from the Child Welfare League of America, "rejection from families of origin, foster families, caseworkers, and others places LGBTQ youth at a greater risk for negative life outcomes, including increased chances of physical and mental health challenges, lower self-esteem, illegal drug use, HIV and STDs, and depression and suicide."50

The 2018 National Survey on Drug Use and Health (NSDUH) suggests that substance use patterns reported by sexual minority adults (individuals who describe themselves as lesbian, gay, or bisexual) are higher compared to those reported by heterosexual adults. LGBTQ individuals often enter treatment with more severe SUDs.51

Sexual minorities with SUDs are more likely to have additional mental health disorders.52 For example, gay and bisexual men, as well as lesbian and bisexual women, report greater odds of frequent mental distress and depression than their heterosexual counterparts.53 Transgender children and adolescents have higher levels of depression, suicidality, self-harm, and eating disorders than their non-transgender counterparts. Nearly one-third of LGBTQ youth had attempted suicide at least once in the prior year compared to 6% of heterosexual youth.54

Supportive services should include access to confidential, culturally sensitive, and nonjudgmental counseling and healthcare providers familiar with the full spectrum of sexual behaviors and gender identities. The American Psychological Association's pamphlet *Answers to Your Questions for a Better Understanding of Sexual Orientation and Homosexuality* is designed to provide accurate information for those who want to better understand sexual orientation and the impact of prejudice and discrimination on those who identify as lesbian, gay, or bisexual.

Developing trust is key to serving the adolescent population. Explain to them **what is and is not** confidential information. Providing the parameters at the start, and discussing together how to relay certain information to parents, will help to establish trust. Practitioners must stay informed on confidentiality issues. *Confidential Care forAdolescents in the U.S. Health Care System* provides information on federal and state protections and challenges for providers.

Some LGBTQ youth are more likely than their heterosexual peers to experience negative health and life outcomes. It is critical for service providers, supports, and family members of LGBTQ youth to have access to the resources they need to ensure LGBTQ youth receive support. Organizations can collaborate across systems (mental health, substance use treatment, homeless services, juvenile justice, courts, etc.) to ensure LGBTQ youth receive support through a coordinated system of care. Professionals can support transgender and gender non-conforming youth by asking about and using correct names and pronouns, protecting the right to express gender identity, providing access to needed mental and medical health services, and ensuring youth can safely access sex-segregated spaces (such as congregated care facilities and bathrooms).

- SAMHSA's guide, A *Practitioner's Resource Guide: Helping Families to Support Their LGBT Children*, offers resources to help practitioners in health and social service systems implement best practices to engage and help families and caregivers support their LGBT children.
- Advocates for Youth's toolkit, *Creating Safer Spaces*, highlights challenges faced by LGBTQ youth, offers insight on how they thrive, and enhances awareness among healthcare staff, educators, and additional youth-serving professionals about the existing disparities in order to provide safer spaces.
- *The Family Acceptance Project®* offers training and resources on an evidence-based family model of wellness, prevention, and care to strengthen families, while promoting positive development and healthy futures for LGBTQ children and youth.

ADDRESSING DISPARITIES

Structural barriers to successful development such as poverty, unequal allocation of resources, racism, bias, and discrimination can create inequities that amplify the risks of negative outcomes for youth.55

Professionals must show awareness and sensitivity to cultural diversity, life situations, and other factors that shape a person's identity.

There's a need to recognize how barriers disproportionately hurt marginalized communities; thus, professionals must also promote the delivery of affordable, accessible, integrated, and coordinated adolescent services. Reducing disparities to achieve equity of services for all adolescents requires long-term, coordinated, interdisciplinary, and intersectional strategy, with adequate resources to study, implement, evaluate, and sustain the strategy.56

- The National Academies of Science, Engineering, and Medicine (NASEM)'s 2019 report, *The Promise ofAdolescence: Realizing Opportunity for All Youth*, explains some of the most serious disparities in outcomes for adolescents, as well as the sources of these outcomes (e.g., wealth and resource inequality, differences in the way institutions respond to adolescents from different backgrounds, prejudicial or discriminatory atittudes or behavior by adults or peers who interact with adolescents).
- *Primer on How and What We Teach Youth about Racism and Xenophobia*, developed by Dr. Deborah Rivas-Drake and Bernardette Pinetta at the University of Michigan, offers resources focused on how to teach anti-racism to young people. This document includes links to helpful articles, research papers, webinars, podcasts, and organizations, as well as a wide-ranging list of books on social justice for children, adolescents, and adults.
- The Center for the Developing Adolescent's brief, *How Developmental Science Can Help Us Address Inequities During Adolescence*, highlights some of the key features of adolescent development to consider in any reimagining of the systems, policies, and programs serving young adults to help ensure equitable treatment and outcomes for all involved.

RESOURCES FOR PREVENTION

Positive Youth Development (PYO} 101 Online Courses is a series of short, interactive courses intended to introduce PYD to professionals, volunteers, and advocates. The series can be used independently or to supplement the training curriculum listed above.

The *Think, Act, Grow (TAG} Playbook* provides action steps for improving adolescent health outcomes and a game plan for engaging adolescents in promoting their health and healthy development.

Preventing Drug Use among Children and Adolescents identifies 16 key principles for prevention programs based on risk and protective factors, the type of program, and the delivery method. These principles, from the National Institute on Drug Abuse (NIDA), can help parents, educators, and community leaders think about, plan for, and deliver research-based prevention programs at the community level. The references following each principle are representative of current research.

Reframing Adolescent Substance Use and its Prevention: A *Communications Playbook* is a step-by-step guide to using evidence-based framing strategies to communicate about adolescent substance use.

Substance Misuse Prevention for Young Adults supports health care providers, systems, and communities seeking to prevent substance misuse among young adults. It describes relevant research findings, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers useful resources.

Preventing, Identifying, and Treating Substance Use Among Youth in Foster Care provides child welfare professionals with information about the extent and effects of substance use among youth in foster care, ways to identify substance use, how to support youth in care who currently use or are at high risk for using, and strategies for prevention. It also addresses how to collaborate with professionals in other fields.

SPECIALIZED PROGRAMS FOR YOUTH AT RISK:

Across Ages is a mentoring initiative designed to increase the resiliency and protective factors of at risk middle school youths through a comprehensive intergenerational approach. The overall goal is substance use prevention. **keepin' it REAL (kiR) Middle School Program** is a 10-week classroom-based universal substance use prevention program for youth ages 10-13. **kiR** is designed to reduce the risks of alcohol, tobacco, and other risky drug use as well as promote social and emotional competencies such as drug refusal efficacy. The weekly lessons are 45 minutes each using a "from kids, through kids, to kids" approach, **kiR** increases students' confident communication skills, decision-making skill, resistance skill efficacy, emotional intelligence (e.g., empathy, perspective taking, self-control), and awareness of social

support. Program examples, role-plays, and videos feature personal experiences of early adolescents. To help reinforce the messages from the 10 weekly lessons, there are 3 optional lessons on "how to make your own refuse, explain, avoid, and leave **(kiR)** videos." Multicultural program videos address e-cig use, vaping, and use of prescription medication. There are three culturally grounded versions: Multicultural, Rural, and Spanish.

WORKING WITH ADOLESCENTS: PRACTICE TIPS AND RESOURCE GUIDE

The Importance of a Trauma-Informed Child Welfare System outlines the essential components and features examples from state and local programs that incorporate trauma-informed practice. After providing a brief overview of trauma and its effects, the brief explores trauma-informed practice and the importance of strengthening families and communities to help them heal. The brief also highlights the ability of cross-systems collaboration to create a trauma-informed child welfare system that improves child and family well-being.

Understanding the Links Between Adolescent Trauma and Substance Abuse: A Toolkit for Providers focuses on the needs of youth with traumatic stress and substance abuse problems, while promoting evidence-based practices in clinical settings. This serves as a training guide for providers working with this population.

Youth Thrive: A Framework to Help Adolescents Overcome Trauma and Thrive examines how focusing on thriving complements the field's growing move to become trauma-informed. Previous efforts to identify protective factors targeted the developmental needs of children up to age 6, aiming to help parents promote healthy development (Horton, 2003). Youth Thrive posits a research-informed framework for building protective and promotive factors for adolescents and young adults, ages 9-26, particularly the most vulnerable (Harper Browne, 2014).

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents provides information on promoting healthy sexual development and sexuality.

YOUTH USING AND MISUSING: INTERVENTION AND TREATMENT

Navigating the treatment process can be overwhelming for anyone-especially an adolescent. To best serve them, a basic understanding of the treatment process helps relieve fears and anxiety. There are five steps to SUD treatment: 1) screening, 2) comprehensive assessment, 3) stabilization, 4) treatment, and 5) continuing care and recovery support.57

SBIRT is a comprehensive, integrated, public health approach to the delivery of an early intervention strategy focusing on substance use and motivation toward behavioral change for individuals with, or at the risk of developing, an SUD.58

- *Improving Adolescent Health: Facilitating Change for Excellence in Youth Screening, Brief Intervention and Referral to Treatment* {SB/RT) is a change package, or a practical guide, specific enough for clinicians to implement, test, and measure progress on an evidence-based set of changes, while general enough to use in multiple settings. Change packages are proven tools to promote practice transformation in primary care.
- *Using SBIRTto Talk to Adolescents about Substance Use: A Four-Part Series* introduces professionals to the SBIRT model as a way to learn from adolescents about their substance use, discuss what might motivate them to reduce or abstain (if needed), and execute a plan to do so.

Following the screening and assessment process for SUDs, an individualized treatment recommendation is made to place the adolescent in the proper level of care and develop their treatment plan. The American Society of Addiction Medicine's (ASAM) *Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* is the most widely used and comprehensive set of guidelines for placement in a treatment setting. The ASAM Criteria is composed of six dimensions to assess an individual holistically, taking into account their biological, social, and psychological aspects:

DIMENSION 1 ••

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DIMENSION 2 •

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ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL: assessing an individual's past and current experiences of substance use and withdrawal

BIOMEDICAL CONDITIONS AND COMPLICATIONS: assessing an individual's health history and current physical condition

DIMENSION 3

•• **EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS:** assessing an
• individual's thoughts, emotions, and mental health.
•

DIMENSION 4 •

••

READINESS TO CHANGE: assessing an individual's interest and readiness for change

DIMENSION 5

DIMENSION 6

• **RELAPSE, CONTINUES USE, OR CONTINUED PROBLEM POTENTIAL:** assessing an individual's
•• relationship with relapse, continued use, or problems with use.
•• **RECOVERY/LIVING ENVIRONMENT:** assess an individual's recovery and living situation including
•• people, places, and things.

PG 10

UNDERSTANDING QUALITY TREATMENT

Understanding the treatment resources provided in your community is critical to developing comprehensive case or service plans for adolescents. As a referring practitioner, it's essential to know the signs of quality treatment. SAMHSA provides an overview of the *Five Signs of Quality Treatment*, including accreditation, medication, evidence-based practices, families, and supports.

Child welfare, healthcare, and other community agencies and professionals who refer to treatment should know the quality SUD treatment available in their areas. Professionals can use the discussion questions in NCSACW's *Understanding Substance Use Disorder Treatment: A Resource Guide for Professionals Referring to Treatment* to help frame conversations with SUD treatment agencies and begin to establish collaborative relationships.

Child welfare professionals can share information about policies, protocols, and practices with treatment agencies. Collaboration benefits parents, children, adolescents, and families. Building collaborative relationships with treatment agencies takes time but often results in better referrals to more effective services and ultimately better outcomes for families.

In addition to looking for quality SUD treatment agencies, professionals might also search for youth-friendly clinical services to help engage adolescents in SUD treatment. Read Teen Network's Tip Sheet, *Characteristics of Youth-Friendly Clinical Services*, for more details.

RESOURCES FOR INTERVENTION AND TREATMENT

Principles ofAdolescent Substance Use Disorder Treatment: A Research-Based Guide provides scientifically tested, evidence-based approaches to the treatment of adolescent substance abuse.

SAMHSA's *TIP 31: Screening and Assessing Adolescents for Substance Use Disorders* provides guidelines for screening and assessing teens for substance use issues.

NIDA has launched two brief *Screening Tools for Adolescent Substance Use* online that providers can use to assess SUD risks among adolescents aged 12-17. With the American Academy of Pediatrics (AAP) recommending universal screening in pediatric primary care setint gs, these tools help providers quickly and easily introduce brief, evidence-based screenings into their clinical practices.

AAP's *Motivational Interviewing Strategies to Facilitate Adolescent Behavior Change* provides detailed strategies for increasing receptivity and decreasing resistance, guidance for behavior change plans, and worksheets for a motivational approach to counseling adolescents about health behavior change.

Recovery oriented care and support systems help people with SUDs and mental disorders successfully manage their conditions

long-term. Recovery is a process of change through which people improve their health and wellness while striving to reach their full potential. There are four major dimensions of recovery:

HEALTH—overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being

HOME—having a stable and safe place to live

PURPOSE—conducting meaningful daily activities and having the independence, income, and resources to participate in society

COMMUNITY—having relationships and social networks that provide support, friendship, love, and hope 59

To reinforce gains made in treatment and improve their general quality of life, recovering adolescents may benefit from recovery support services, which include continuing care, mutual help groups (such as 12-step programs) and peer recovery support services. Such programs provide a community setitng where fellow recovering youth can share their experiences, provide mutual support, and promote a substance-free lifestyle.59

Twelve-step groups are guided by a set of fundamental principles including: 1) Willpower alone cannot achieve sustained sobriety, 2) Surrendering to the group conscience must replace self-centeredness, and 3) Long-term recovery involves a process of spiritual renewal.59

Some youth may have difficulty connecting with 12-step groups due to their religious undertones. If so, several alternatives provide secular relapse prevention tools such as *Women For Sobriety*, *Self-Management and Recovery Training (*SMART), *Secular Organizations for Sobriety (*SOS), *LifeRing Secular Recovery*, and *Moderation Management*.60

Peer recovery support services, such as recovery community centers, help individuals remain engaged in treatment (and/or the recovery process) by matching them with peer leaders who have direct experience with addiction and recovery. This can take place one-on-one or in groups. Depending on the needs of the adolescent, peer leaders may provide mentorship, coaching, and connect individuals to treatment, 12-step groups, or other resources. Peer leaders may also facilitate or lead community-building activities, helping recovering adolescents build alternative social networks and find drug- and alcohol-free social options.59

Research indicates that most individuals with an SUD need at least three months in treatment to significantly reduce or stop their drug use—and the best outcomes occur with longer durations.61 Recovery frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses can occur and should signal a need for treatment to be reinstated or adjusted.

Professionals working with youth in substance use and mental health recovery should view treatment completion as the beginning of a long-term process, and include strategies to engage them in both short- and long-term recovery supports specific to their needs.

RESOURCES FOR YOUTH IN RECOVERY

The Research and Training Center for Pathways to Positive Futures' publication, *Implementing the Peer Support Specialist Role for Youth*, provides an example of how one locally initiated program has implemented the peer support specialist role for youth and young adults. The brief covers aspects of training, coaching, supervision, role definition, and financing—while describing challenges and solutions.

NCSACW's *The Use of Peers and Recovery Specialists in Child Welfare Settings* examines how child welfare agencies and family court programs have integrated peers and recovery specialists into their service delivery to support families affected by SUDs. Also included is an overview of two models of support for families: peer support by persons who have experienced SUDs and child welfare involvement, and professional support from recovery specialists. The brief also offers advice to professionals applying peer or recovery specialist models in their communities.

Youth MOVE National offers resources on youth peer support, best practices, assessing youth voice, publications, and TA tools. There's also a directory of over 60 chapters across the U.S. focusing on youth needs and community trends.

The National Technical Assistance Network for Children's Behavioral Health (TA Network)'s publication, *Providing Youth and Young Adult Peer Support Through Medicaid*, offers guidance, key considerations, and examples of young adult peer support programs.

For additional resources on recovery supports tools and resources for young adults, visit *Bringing Recovery Supports to Scale Technical Assistance Center Strategy* (BRSS TACS).

The Northwest Mental Health Technology Transfer Center Network's (MHTTC) webinar, *Supporting the Youth Peer Support Role Within Your Organization*, provides an overview of the responsibilities and boundaries of the youth peer support role, while offering tips on how to support this role (and these employees) in your agency.

To best serve the adolescent population it is critical to pay close attention to youth engagement. Young people in foster care may miss out on opportunities for decision-making, community engagement, and leadership—sparking a sense of powerlessness and isolation.62 Encourage adolescents and families to become stakeholders in their lives. Adolescents will typically engage when youth and adults teach, contribute, and learn from each other. Including adolescents in their own life decisions fosters their development and progress toward autonomy.

Engagement helps youth gain skills like knowledge, self-esteem, and feelings of connectedness.63 Engagement occurs when young people take responsible actions to create positive change; it also has the potential to create change within their community.

Organizations focusing on youth engagement can improve their programs through feedback, gain community recognition, and attract potential funders.

PROGRAMS AND INTERVENTIONS FOR YOUTH IN RECOVERY

SMART Recovery TEENS is a free self-help program that offers a place where teens can get together to try to look into and change behaviors that hurt themselves and others like smoking, drinking, fighting and using drugs.

SMART Recovery's *Young Adult Outreach Program* offers

SMART Meeting Facilitators onsite group training or a convenient self-study online training option for adults dealing with addiction in an educational or support seittng such as a high school university, or recovery community organization.

*Narcotics Anonymous (*NA)- *TEEN LINE* provides a directory of local supports, training and outreach programs, access to a teen message board and teen talk cell phone application and toll-free phone and text line as well as educational resources specific to teens.

Seeking Safety (adolescent version) is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format for adolescents (both females, and males) in various seitnt gs (e.g., outpatient, inpatient, residential, home care, and schools). *Seeking Safety* consists of 25 topics that can be conducted in any order and number.

Teen Anon is a behavioral and spiritual program for teens 12-19 based on the 12-steps adapted from Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Al-Anon, Alateen and Nar-Anon.

LiveWell Teens offers free online support groups led by trained facilitators and educators to help teens better monitor and manage their moods, increase well-being, and reduce symptoms of mental illness.

Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that seeks to increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery from substance abuse and dependence. The manual outlines an outpatient program that targets youth 12-25 years old with Diagnostic and Statistical Manual of Mental Disorders (DSM-5) cannabis, alcohol, and/or other substance use disorders. A-CRA also has been implemented in intensive outpatient and residential treatment seitnt gs.

MyClients+ includes Creative Teen Therapy Activities to help engage teens and build rapport.

Professionals who engage young people, and especially their caregivers, from diverse backgrounds, must learn the

cultural values and expectations that guide social interaction, mental health and substance abuse treatment, and salient themes in their communities.

It essential to build a rapport with adolescents while setitng parameters and boundaries. Get to know your clients and talk about what's important to them—all while providing a safe space. Authentic relationship building creates a positive environment to motivate change.

Be patient and allow trust to evolve naturally. High risk youths may not know how to develop healthy relationships, so this will take time. Many youths expect to fail and feel unworthy of help. Some may not develop the capacity to trust while they're involved with child welfare, so getitng to the point where they know their supports won't harm them is significant and allows for progress.32

Adolescents commonly resist support at the beginning of treatment. High risk youth have felt adults giving up on them, so they won't expect the relationship with new providers to be different.32 Adolescents involved in child welfare have heightened resistance due to frequently changing supports; they also may distrust service providers due to family and parental separations. Motivational interviewing is an effective strategy to encourage change, identify how current behavior may be interfering with long term goals, and address any resistance—all while working together.

Allow the adolescent to take the lead in identifying whom they view as family—such as extended family members, older siblings and adult mentors—rather than traditional family relationships. Remain aware of family of choice for transitional age youth and LGBTQ youth as they may be estranged from their birth families (families of origin). Many young adults in treatment for a SUD do not have the option of having their family of origin (biological members) participate in their treatment. Providers are encouraged to include family services to client's family of choice, as they are the "family" supporting the client in their recovery journey.

RESOURCES FOR ENGAGEMENT

Engaging, Empowering, and Utilizing Family and Youth Voice in All Aspects of the Child shows how family and youth voices are critical to a well-functioning child welfare system. It strongly encourages all public child welfare agencies, dependency courts, and Court Improvement Programs to ensure that these voices play a major role in child welfare program planning and improvement efforts.

Walking the Talk: A Toolkit for Engaging Youth in Mental Health provides an understanding of how youth engagement can directly benefit youth services and communities. It includes activities designed to engage youth such as team building, facilitation, hosting techniques, planning and evaluation. The toolkit also provides success stories.

Strategies for Authentic Integration of Family and Youth Voice in Child Welfare outlines key tasks in engaging families and youth at the system and agency levels, while offering child welfare managers tips, strategies, and stories from the field. Managers can use this tip sheet when engaging youth and families, considering policy to support engagement, or training staff. The tip sheet includes a matrix tool that focuses on the impact of the engagement along a continuum, from ineffective to effective.

Recruitment Strategies and Practices for Disconnected Youth explores emerging findings from a two-year study of the Urban Employment Demonstration Grants for Youth and Young Adults, funded by the U.S. Department of Labor (DOL), Chief Evaluation Office (CEO). In 2015 DOL's Employment and Training Administration (ETA) awarded seven cities with two-year grants to develop projects addressing the workforce needs of disconnected youth and young adults (ages 16-29). The grants focused on communities experiencing high unemployment, crime, and poverty rates, along with low rates of high school graduation.

The Center for Nonprofits at the University of Wisconsin-Madison explores how Assets Coming Together (ACT) for Youth communities responded to the challenges of youth engagement. Staff presented lessons learned, identified strategies and outcomes at the community level in *Strengthening Communities Through Youth Participation*, and

offered guidance on the *Youth Participatory Evaluation* (YPE) through which young people evaluated the programs, organizations, and systems designed to serve them.

Youth.gov offers the *Youth Involvement and Engagement Assessment Tool* as part of a continuous quality improvement. Organizations and community-based partnerships complete the assessment every six months.

Child Welfare Information Gateway (CWIG) developed the *Family Engagement Inventory* (FEI), a cross-disciplinary collection of information that can help professionals understand the differences and commonalities regarding family engagement, while improving collaboration and outcomes for families across child welfare, juvenile justice, behavioral health, education, and early childhood education.

LEARN MORE

- NCSACW has many TA resources including publications, webinars, and tools that child welfare workers, court professionals, and communities can use to better serve families affected by SUDs. These are available at: *https://ncsacw.samhsa.gov*.
- In crisis or life-threatening situations, call 911, contact the National Suicide Prevention Lifeline (a 24-hour toll-free hotline at 1-800-273-8255 (TALK)) or go to your nearest hospital emergency room. For more details and to identify treatment options in your area, visit SAMHSA's treatment locator at *https://www.samhsa.gov/find-treatment* or *call* 1-800-662-4357 (*HELP*).
- The National Alliance on Mental Illness (NAMI) offers a six-week education program titled "NAMI Basics" for parents and family caregivers of children and teens experiencing symptoms of mental illness or who already have a diagnosis.
- Parent Encouragement Program's parent education course for parents of adolescents, *Thriving with Teens.*

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WORKING WITH ADOLESCENTS: PRACTICE TIPS AND RESOURCE GUIDE

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7. Interpersonal Violence

HANDOUTS

8. Working with the Elderly

Gerontology

One of the fastest growing populations that social workers provide services to is the elderly. For social workers, the elderly offer unique challenges that are not present in other populations. This section will discuss the various aspects and challenges that social workers will encounter when working with the aging population.

Key Terms

Gerontology: the scientific study of old age, the process of aging, and the particular problems of old people.

Dementia: a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning.

Geriatric: relating to old people, especially regarding their health care.(Merriam-Webster's collegiate dictionary, 1999)

The Aging Population

The biggest contributing factor to the fast-paced growth of the aging population, is the Baby Boomers. The Baby Boomers are the generation of individuals born in the years following WWII. What once was a large population of babies and children has now aged into a large population of aging and elderly individuals. With the advancement of modern medicine, people are now able to live longer than any other period in history. This aging population has posed many benefits and challenges to our society. Western culture has moved away from Eastern ideals of providing and caring for our elderly. Shifting cultural ideals has led to the rise of assisted living and nursing facilities in the United States and other parts of the world, which will be discussed later in this chapter. Social workers must be prepared to work with the ever-changing landscape of gerontology.

An aging population

Challenges of Aging

There are many challenges that the elderly face in our society which range from medical and mental health to financial concerns. Below are some common challenges that the elderly face in this country that social workers will have to be familiar with.

Dementia and Alzheimer's Disease

Among the most common of challenges facing the elderly are medical conditions that attack cognition. Dementia and Alzheimer's Disease are the most common medical conditions that the elderly suffer from; both directly impair cognition to various levels. Dementia is a general term for loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by physical changes in the brain (Alzheimer's Association, 2017). The rates of dementia are so high in the elderly that special facilities and whole units of nursing facilities are dedicated to working with those who suffer from it.

There are various forms of dementia ranging from Lewy Body Dementia to Frontotemporal Lobe Dementia. The most common form of Dementia is Alzheimer's disease. It is estimated that 60-80% of dementia cases are Alzheimer's disease (Alzheimer's Association, 2017). Each form of dementia has different symptoms and physical impact on the brain. Social workers will need to be versed on the various types of dementia and the interventions available to best address their elderly clients need.

Health Complications

Along with medical conditions that impact cognition, there are also many illnesses and diseases that impact physical health. As we age, our body begins to break down over time. Our immune systems are no longer able to fight off infections and illnesses that it could earlier in the lifespan. There are multitude of illnesses and diseases that the elderly population are more susceptible to. These health complications range from simple infections such as urinary tract infections to major diseases such as Parkinson's disease. The elderly are at a disadvantage when it comes to such diseases, as the older we get the less capable we are able to maintain health. All too often, physical health deterioration leads to elderly individuals to be placed in nursing facilities, as they can no longer care for themselves without medical professionals available around the clock.

Did You Know…

Urinary tract infections (UTIs) can cause unique symptoms in the elderly. With symptoms ranging from confusion, agitation, hallucinations, fallings, and delirium. It is due to these symptoms that some UTIs in elderly individuals are mistaken for earlier stages of dementia. (Solitto, 2016)

Mental Health

Not only are the elderly more prone to diseases that impact physical health and cognition, but the population has their own unique set of mental health concerns. There are many elderly individuals that have suffered from mental illness much of their lives. As we age, there are also mental health concerns that are a direct result of growing older. One of the most prevalent mental illnesses that the elderly face is depression. Depression is common among the elderly population due to a variety of reasons. Grief and loss are two contributing factors to elder depression. As we get older, we are subjected to a number of losses. There is the loss of loved ones through death, the loss of our physical capabilities and health, even the loss of financial independence. These series of losses can impact the mental health of the elderly.

Isolation is also a contributing factor for depression in the elderly. It does not matter if an elderly individual is living in the community, assisted living, or a nursing facility. Isolation rates for the elderly are high due to physical immobility and lack of transportation. Too often, our elderly are secluded from the rest of society, leading to feelings of loneliness and depression. Social workers working with this population must address grief, loss, and isolation with their clients to provide better mental health care.

The Cost of Aging

Another major challenge of aging is the simple cost to age. Most elderly are unemployed due to advanced age and physical health. Many live off Social Security and retirement benefits and many utilize Medicare and Medicaid for insurance. Those who live in assisted living communities or nursing facilities have a clear majority of their income allocated for their care. The cost of medications, general living expenses, and food often monopolize the fixed income of our elderly. With the constant political turmoil regarding nationwide health care, the elderly are not guaranteed health insurance in this country. These factors contribute to the rising cost of aging.

Remaining in the Community

One way to ease the growing cost of aging would be to implement support for elders so that they can stay in the community for as long as possible. Assisted living and nursing facilities are costly, even with health insurance and retirement benefits. The cost of being placed in a facility can absorb all an individual's resources. Remaining in the community for as long as possible can save both the elderly and the taxpayers' money in the long run.

However, there are potential dangers to the elderly who remain in the community. The risk of falls which can lead to life threatening complications is increased for those living in the community. According to the National Council on Aging, there are approximately 2.8 million falls a year. One fourth of elderly Americans over the age of 65 fall each year (2017). Isolation and depression rates can also increase for the elderly in the community, as lack of mobility and transportation can impede social interaction. While living in the community may seem like the most economically suited option, it can pose a risk to the elderly who need more medical assistance than the home can provide.

Caregivers

One way that the elderly can stay in the community longer is by having caregivers present in the home. Caregivers can be medical professionals, family members, or everyday individuals that provide care for the elderly in the home. Caregivers often come in the form of family such as adult children taking care of their elderly parents. Caregivers are a key role in enabling the elderly to remain in the community for as long as possible.

Caregiving is a demanding and strenuous role. Caregivers are often faced with the challenges of working outside the home while still trying to provide care. Caregivers also have to provide medical care that they may not be fully trained or competent in. Some caregivers are not suited to provide care and can pose a risk to the elderly individual. Unqualified

caregivers can also be potentially dangerous, abusing their elderly charge in a variety of ways. Many caregivers do not have the proper physical, emotional, or mental support to deal with the stress that comes with the role. Lack of support can lead to feelings of burnout, resentment, and physical ailments for many providing care for the elderly.

Perspectives on Aging

Theoretical perspective	Major assumptions
Disengagement theory	To enable younger people to assume important roles, a society must encourage its older people to disengage from their previous roles and to take on roles more appropriate to their physical and mental decline. This theory is considered functionalist explanation of the aging process.
Activity Theory	Older people benefit themselves and their society if they continue to be active. Their positive perceptions of the aging process are crucial to their ability to remain active. This theory is considered an interactionist explanation of the aging process
Conflict theory	Older people experience age-based prejudice and discrimination. Inequalities among the aged exist along the lines of gender, race/ ethnicity, and social class. This theory falls into the more general conflict theory of society.

One of the first explanations was called disengagement theory (Cumming & Henry, 1961). This approach assumed that all societies must find ways for older people's authority to give way to younger people. A society thus encourages its elderly to disengage from their previous roles and to take on roles more appropriate to their physical and mental decline. In this way, a society effects a smooth transition of its elderly into a new, more sedentary lifestyle and ensures that their previous roles will be undertaken by a younger generation that is presumably more able to carry out these roles. Because disengagement theory assumes that social aging preserves a society's stability and that a society needs to ensure that disengagement occurs, it is often considered a functionalist explanation of the aging process.

A critical problem with this theory was that it assumes that older people are no longer capable of adequately performing their previous roles. However, older people in many societies continue to perform their previous roles quite well. In fact, society may suffer if its elderly do disengage, as it loses their insight and wisdom. It is also true that many elders cannot afford to disengage from their previous roles; if they leave their jobs, they are also leaving needed sources of income, as the opening news story discussed, and if they leave their jobs and other roles, they also reduce their social interaction and the benefits it brings.

Today most social gerontologists prefer activity theory, which assumes that older people benefit both themselves and their society if they remain active and try to continue to perform the roles they had before they aged (Choi & Kim, 2011). As they perform their roles, their perception of the situations they are in is crucial to their perception of their aging and thus to their self-esteem and other aspects of their psychological well-being. Because activity theory focuses on the individual and her or his perception of the aging process, it is often considered a social interactionist explanation of social aging.

One criticism of activity theory is that it overestimates the ability of the elderly to maintain their level of activity: Although some elders can remain active, others cannot. Another criticism is that activity theory is too much of an individualistic approach, as it overlooks the barriers many societies place to successful aging. Some elders are less able to remain active because of their poverty, gender, and social class, as these and other structural conditions may adversely affect their physical and mental health. Activity theory overlooks these conditions.

Explanations of aging grounded in conflict theory put these conditions at the forefront of their analyses. A conflict theory of aging, then, emphasizes the impact of ageism, or negative views about old age and prejudice and discrimination against the elderly (Novak, 2012). According to this view, older workers are devalued because they are no longer economically productive and because their higher salaries (because of their job seniority), health benefits, and other costs drive down capitalist profits. Conflict theory also emphasizes inequality among the aged along gender, race/ethnicity, and social class lines. Reflecting these inequalities in the larger society, some elders are quite wealthy, but others are very poor.

One criticism of conflict theory is that it blames ageism on modern, capitalist economies. However, negative views of the elderly also exist to some extent in modern, socialist societies and in preindustrial societies. Capitalism may make these views more negative, but such views can exist even in societies that are not capitalistic.**References**

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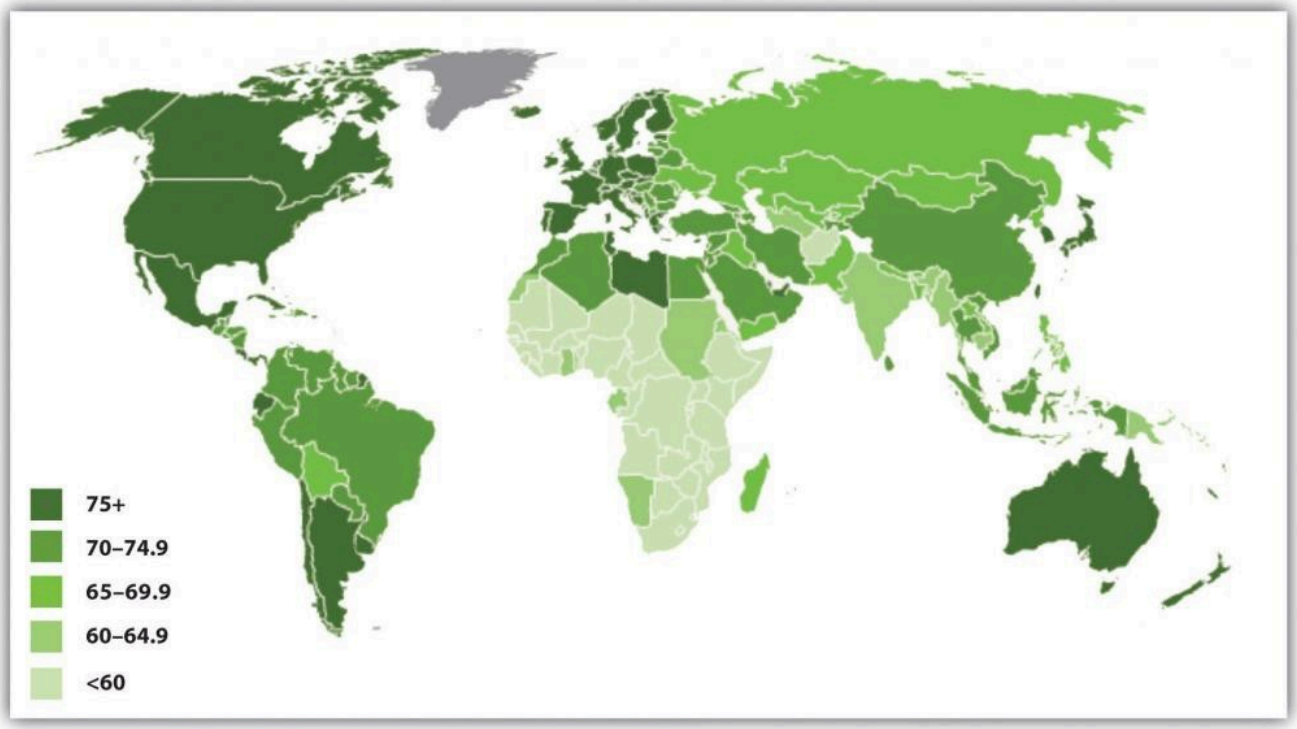
Life Expectancy and the Graying of Society

When we look historically and cross-culturally, we see that *old age* is a relative term, since few people in preindustrial times or in poor countries today reach the age range that most Americans would consider to be old, say 65 or older. When we compare contemporary societies, we find that life expectancy, or the average age to which people can be expected to live, varies dramatically across the world. As Figure 6.1 "Average Life Expectancy across the Globe (Years)" illustrates, life expectancy in North America, most of Europe, and Australia averages 75 years or more, while life expectancy in most of Africa averages less than 60 years (Population Reference Bureau, 2011).

Figure 6.1 Average Life Expectancy across the Globe (Years)



Source: Adapted from Population Reference Bureau. (2011). The world at 7 billion: World population data sheet: Life expectancy. Retrieved from http://www.prb.org/publications/data...x#/map/lifeexp.

Biological and Psychological Aspects of Aging

Like many other societies, the United States has a mixed view of aging and older people. While we generally appreciate our elderly, we have a culture oriented toward youth, as evidenced by the abundance of television characters in their twenties and lack of those in their older years. As individuals, we do our best not to look old, as the many ads for

wrinkle creams and products to darken gray hair attest. Moreover, when we think of the elderly, negative images often come to mind. We often think of someone who has been slowed by age both physically and mentally. She or he may have trouble walking up steps, picking up heavy grocery bags, standing up straight, or remembering recent events. The term *senile* often comes to mind, and phrases like "doddering old fool," "geezer," and other disparaging remarks sprinkle our language when we talk about them. Meanwhile, despite some improvement, the elderly are often portrayed in stereotypical ways on television and in movies (Lee, Carpenter, & Meyers, 2007).

How true is this negative image? What do we know of physical and psychological changes among the elderly? How much of what we think we know about aging and the elderly is a myth, and how much is reality? Gerontologists have paid special attention to answering these questions (Novak, 2012).

Biological changes certainly occur as we age. The first signs are probably in our appearance. Our hair begins to turn gray, our (male) hairlines recede, and a few wrinkles set in. The internal changes that often accompany aging are more consequential, among them being that (a) fat replaces lean body mass, and many people gain weight; (b) bone and muscle loss occur; (c) lungs lose their ability to take in air, and our respiratory efficiency declines; (d) the functions of the cardiovascular and renal (kidney) systems decline; (e) the number of brain cells declines, as does brain mass overall; and (f) vision and hearing decline. Cognitive and psychological changes also occur. Learning and memory begin declining after people reach their seventies; depression and other mental and/or emotional disorders can set in; and dementia, including Alzheimer's disease, can occur.

Elder Abuse

For elders both inside facilities and outside facilities, there is a potential for abuse. While some abuse is unintentional, unfortunately there are multiple cases of elder abuse every year. Elder abuse can be committed by family members, medical staff, and anyone associating with the elderly on a regular basis.

Forms of elder abuse:

- Physical abuse. Use of physical force that may result in bodily injury, physical pain, or impairment.
- Sexual abuse. Non-consensual sexual contact of any kind with an elderly person.
- Emotional abuse. Infliction of anguish, pain, or distress through verbal or non-verbal acts.
- Financial/material exploitation. Illegal or improper use of an elder's funds, property, or assets.
- Neglect. Refusal, or failure, to fulfill any part of a person's obligations or duties to an elderly person.
- Abandonment. Desertion of an elderly person by an individual who has physical custody of the elder or by a person who has assumed responsibility for providing care to the elder.
- Self-neglect. Behaviors of an elderly person that threaten the elder's health or safety.

(National Center on Elder Abuse, 2005)

Case Study: Gloria Fielding

Adult Protective Services (APS) received a report that Gloria Fielding, a very frail 88-year-old woman, needed care for all activities of daily living. Ms. Fielding was legally blind, extremely hard of hearing, unable to walk and suffered from dementia. She was confined to a hospital bed placed in the basement of her home by her caregiver. Ms. Fielding owned two houses. Her primary residence was so severely neglected as to be

uninhabitable. The caregiver stated that the dilapidated condition of the house was the reason Ms. Fielding was moved into the basement, while the caregiver resided in Ms. Fielding's other home.

When the APS worker investigated the report of abuse, she heard yelling coming from Ms. Fielding's garage but could not gain access to the house. A neighbor offered to help the APS worker by calling the caregiver. The caregiver drove to Ms. Fielding's house and upon arriving, opened the garage door and drove her car right into Ms. Fielding's bed, knocking it with her bumper.

The basement had no furniture beside the hospital bed. The floor was littered with used hypodermic syringes. The caregiver stated that Ms. Fielding's medical doctor pre-filled the syringes and instructed her to inject Ms. Fielding whenever she requested.

Upstairs, numerous photographs of Ms. Fielding's physician were found throughout residence. The APS investigation discovered that the M.D. had received large monetary gifts from Ms. Fielding, had engaged in sexual relations with her and had recommended the caregiver to Ms. Fielding.

Despite Ms. Fielding's frailties, when the APS worker interviewed Ms. Fielding, she reported that she was being abused by her doctor and caregiver.

(National Adult Protective Services Association, 2017)

What to do in the event of elder abuse.

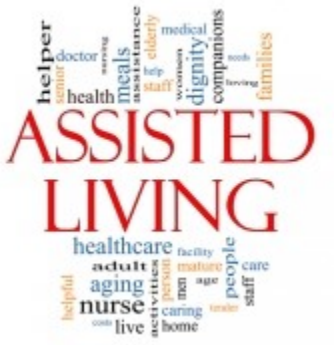
- Contact your local Adult Protective Services
- For Michigan call **855-444-3911**
- Contact your local police department
- Call 911
- Contact the local Long-Term Care Ombudsman for residents of assisted living, nursing homes, and adult foster care (AFC) care.

Assisted Living

As mentioned previously, one form of care for the elderly is assisted living facilities. Assisted living facilities are generally small communities or facilities that provide limited assistance for elderly individuals. Most often, elderly couples and individuals who are still in relative good health will reside in these forms of care. To the outside, assisted living facilities will often look like small apartment buildings with special features such as ramps and rails throughout the units. This forms of care often provides limited medical assistance such as having nurse aids employed to provide basic health care. Often, cleaning services and landscaping services will be provided as part of the fee.

Assisted living options offer more independence for those who reside in them, however there are other components to be considered. Some health insurance policies do not cover this form of assistance and even with health insurance, living in this form of community can be costly. Assisted living facilities are also not monitored by the State (which heavily monitor nursing facilities), thus leaving room for lack of quality and proper procedure. Assisted living facilities normally do not employ social services, for the elders who need these services they must be sought outside of assisted living

services. Larger assisted living communities may contract with outside social service agencies to provide services, but rarely employ them on site.



Assisted living wordcloud

Nursing Facilities (Nursing Homes)

Nursing facilities have become a norm in our country for providing care for the elderly. They provide 24-hour medical care for those who can no longer remain in the community and need extra support than what assisted living facilities provide. Those who reside in these facilities are referred to as "residents" as most will remain in the facilities for the remainder of their lives. Many nursing facilities also provide rehabilitation services such as physical therapy, generally for those recovering from surgery or serious illness. These services are short-term and most of those who utilize them discharge back to the community.

Nursing facilities provide a wide range of services for residents. All meals and domestic services are covered by staff. There are a variety of medical professionals that are employed by these facilities such as certified nursing aids (CNAs), licensed practicing nurses (LPNs), and registered nurses (RNs). These professional provide medical care for the residents. For medical needs that are outside the scope of practice in nursing facilities, outside services are utilized. Most elderly living in nursing facilities have their expenses covered by health insurances such as Medicare and Medicaid. There are some who pay for their stay privately, but this is costly. U.S. News reported in 2013 that the general cost of living in a nursing facility $222 dollars a day for a semi- private room, which is about $81,000 per year (Mullin, 2013). The price of nursing home stays are on the rise and many cannot afford to stay in these facilities without health insurance.

Along with nursing staff, nursing facilities generally employ a large range of professions to best provide services. Social workers, dietitians, physical therapists, maintenance staff, and environmental services are just some professions outside of nursing that are employed in these types of facilities. Those professions that provide medical and mental health services work together as an Interdisciplinary Team (IDT). IDTs work collaboratively to provide the best care for each resident. The size and number of IDTs is determined by the size of the facility. One facility can have as many as five IDTs. Social workers in nursing facilities are tasked with the residents' mental health and emotional well-being. The day to day tasks of social workers in these facilities can range depending on employment, but generally have common themes. Social workers in these facilities most commonly work with residents who are experiencing depression, anxiety, grief and loss, and dementia. MSWs will also oversee psychotropic monitoring (not prescribing) and will make medication recommendations. Social workers often play a major role in nursing facilities as they help with admissions, day-to-day activities, mental health and emotional well-being, and discharge planning.

Many residents, due to cognitive impairments and health complications, are no longer able to make decisions for themselves. Those who have been declared incompetent by two medical doctors, have in place a guardians' or durable power of attorney (DPOAs). These individuals can be family, friends, or public guardian services. When one has a

guardian or DPOA in place, they can no longer make medical or financial decisions for themselves. This process aims to protect residents from poor decision making.

Many interpret having a guardian or DPOA in place as having no rights of their own. This is not true. In the United States, every individual is guaranteed rights. Residents have a special Bill of Rights in place to insure they are being treated with respect and dignity. Residents who feel that their rights are being impeded upon can contact their local Ombudsman (information provided above).

Did You Know...

Nursing facilities that accept Medicaid and Medicare as funding must be certified and go through an annual State Survey as a requirement of federal law. Each state's Health Department is in charge of the process. (Nursing Home Alert, 2017)

Key Term	Definition	Source
Abuse	Harm or threatened harm to an adult's health or welfare caused by another person. Abuse may be physical, sexual or emotional.	(State of Michigan, 2019)
Aging Shock	The uncovered cost of prescriptions drugs, medical care not paid by Medicare or their private insurance and the actual cost of the private that is expected to pay the gaps that Medicare does not pay and the uncovered costs of long-term care.	(Knickman & Snell, 2002)
Bereavement	A form of depression with anxiety symptoms that is a common reaction to the loss of a loved one. It may be accompanied by insomnia, hyperactivity, and other effects. Although bereavement does not necessarily lead to depressive illness, it may be a triggering factor in a person who is otherwise vulnerable to depression.	Bereavement (2001)
Burnout	A process involving gradually increasing emotional exhaustion in workers, along with a negative attitude toward clients and reduced commitment to the profession (Maslach, 1993)	(State of Michigan, 2019)
Compassion Fatigue	A set of physical and psychological symptoms appearing in social workers who are exposed to client suffering that occurs as a result of traumatizing events such as physical or sexual abuse, combat, domestic violence, or the suicide or unexpected death of a loved one (Figley, 1995).	(State of Michigan, 2019)
Compassion Stress	Is the residue of emotional energy from the empathetic response to the client and is the on-going demand for action to relieve the suffering of a client.	(State of Michigan, 2019)
Elderly	Any person that is 65 years of age or older.	(Niles-Yokum & Wagner,2015)
Empathetic Response	Is the extent to which the psychotherapist makes an effort to reduce the suffering of the sufferer through empathetic understanding.	(State of Michigan, 2019)
Exploitation	Misuse of an adult's funds, property, or personal dignity by another person.	(State of Michigan, 2019)
Exposure to the Client	Is experiencing the emotional energy of the suffering of clients through direct exposure.	(State of Michigan, 2019)
Grief	A nearly universal pattern of physical and emotional responses to bereavement, separation, or loss. It is time linked and must be differentiated from depression. The physical components are similar to those of fear, hunger, rage, and pain. The emotional components proceed in stages from alarm to disbelief and denial, to anger and guilt, to a search for a source of comfort, and, finally, to adjustment to the loss.	Grief (2001)
Life Disruption	Is the unexpected changes in schedule, routine, and managing life responsibilities that demand attention (e.g., illness, changes in life style, social status, or professional or personal responsibilities).	(State of Michigan, 2019)
Material abuse	Including theft, fraud, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.	(O'Connor & Rowe, 2005, p. 48)

Neglect	Including the failure of a designated care to meet the needs of a dependent old person, forced isolation from services or supportive networks, or failure to provide access to appropriate health or social care.	(O'Connor & Rowe, 2005, p. 48)
Physical abuse	Including physical harm or injury, physical coercion and physical restraint	(O'Connor & Rowe, 2005, p. 48)
Prolonged Exposure	Is the ongoing sense of responsibility for the care of the suffering, over a protracted period of time.	(State of Michigan, 2019)
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation and verbal abuse.	(O'Connor & Rowe, 2005, p. 48)
Sexual Abuse	including rape, sexual assault or sexual acts to which the vulnerable older adult has not consented, could not consent, or was pressured into consenting.	(O'Connor & Rowe, 2005, p. 48)
Stigma	A mark of shame or disgrace. A strain.	(Merriam-Webster, 2019)
Self-care	Promote specific outcomes such as a "sense of subjective well-being".	(Lee & Miller, 2013, p. 97)
Senescence	Refers to the aging process, including biological, emotional, intellectual, social, and spiritual changes.	(Lee & Miller, 2013, p. 97)
Vulnerable	A condition in which an adult is unable to protect himself or herself from abuse, neglect, or exploitation because of a mental or physical impairment or advanced age.	(State of Michigan, 2019)

Statistics of Elderly Population: Prior to the 17th century, statistics show the elderly made up less than 2% of the population in the United States. A male's life expectancy estimated 30 to 38 years of age due to lack of proper health care, farming accidents', unhealthy working conditions, war fatalities and lack of proper nutrition. A women's life expectancy was significantly decreased due to bearing many children and suffering poor medical services during childbirth (Egendorf, 2002). Following World War II, we experienced the fastest growth in population, this generation is known as the baby boomers. This population has now become our highest elderly population and with this significant increase, the influx poses both benefits and challenges to our society (Tice & Perkins, 1996).

Seventy-six million people were born between 1946 and 1964 making this the largest and longest-lived generation in the history of the United States. (Torres-Gil, 1992). This is identified as the baby boomer generation. As a result of the baby boomer generation, the number of Americans aged 65 or older is projected to more than double from 46 million today to over 98 million by 2060, increasing from 15% to 24% (Mather, 2016). As a result of improved healthcare, better working conditions and families choosing to have less children, the life expectancy for a man is now 74 years of age and women's life expectancy is now 80 years of age (Merck Manual, 2004). This produces many new challenges to our current social structure. Social security and medical costs have increased, including the cost of uncovered expenses of medications and long term care.

Diversity of Population

Baby boomers have introduced a new lifestyle, building careers, having fewer children and waiting till later in life to have children. It is estimated since this population is not reproducing at a rate much less than historically, the population in the United States will decrease as a result (Colby, S., & Ortman, J., 2014 p.2). The decrease in population will help to stabilize the social structure and medical costs.

Populations representing about 16% of the elder population: 8% African American, 5.5% Hispanic, 2.1% Asian-Pacific Islander and less than 1% American Indian and native Alaskan. The majority elder population is comprised of whites, at a rate of 74%. (Older Americans, 2000, p.1). In order to understand the needs and circumstances of the diverse population in the United States, it is important to know the demographics of the clients we are serving. One plan does not fit all solutions. Some fail miserably. The various demographics we must know of the population we attempt to serve include: health, age, work, marital status, sex, sexual orientation, race and culture. Whether they have family support, access to transportation and disposable income. We must establish wants and needs before determining what services and products will be put into place. If we do not understand the needs of the population we are serving, we will likely fail when creating services to help. (ODPHD, 2013).

Stages of Development

"Growing older and dealing with long-term care includes help from many people, family members, friends, medical professionals and practitioners in the community. Sometimes aging is gradual and sometimes it's abrupt with many bumps and emergencies. As people age, the majority develop at least one health problem resulting in functional decline" (Marak, C. 2016, p 1). Many seniors live healthy, independent lives, without experiencing the stages of decline.

Stage 1: Self Sufficiency. Seniors are more independent and able to manage their own health issues. They may begin to acknowledge what the community has to offer for seniors and determine if their homes may need safety features in the future. But for the present time, the elderly enjoys the sense of accomplishments their independence offers. Programs established to help seniors remain in their own homes are Area Agency on Aging, Senior SAFE Program and Life Alert, to name just a few.

Stage 2: Interdependence. Seniors may begin relying on others such as a partner, older children or friends for assistance. Many seniors view this stage as a time of decline because they are no longer able to accomplish the tasks they once could. This is the stage where help may be brought in to assist with minor tasks on a regular basis. It is also a time when safety and security should be addressed by installing safety bars in the bathtub and hallways, ramps for wheelchairs and walkers and obtaining life alert pendants in the case of a fall or emergency.

Stage 3: Dependency. As the aging process continues, the need for more assistance with activities of daily living (ADL's) may increase. These activities include bathing, toileting, cooking, and shopping. There may also be a decline in memory or psychological functions. At this stage, the senior may experience more physical ailments and chronic pain. As these conditions advance, it may be necessary to move to a senior facility with the level of care necessary for the senior. More often, the needs can be provided by a caregiver for more advanced care and needs Other medical issues, including increased pain can be managed by the primary care physician. This option can become very costly and as additional care is needed, for the safety and care of the elderly, a move to a facility may be the best option.

Stage 4: Crisis Management. In the event of continued decline, the family may recognize they are unable to continue providing the level of care necessary to keep their loved one safe or manage their needs. In this case, family will make decisions regarding the best options for appropriate care such as seeking constant in-home care by a professional or moving the senior to a facility where the care needs can be met.

Stage 5: End of Life. If the senior is able to remain in the home with sufficient care and pain management, many are able to remain in the home until their demise. If hospice is involved, they assist to manage pain and help the family to deal with complex end-of-life decisions. Many professions such as home health aides, nursing home personnel, hospice providers and care physicians are involved at this stage. If the senior is in a facility or needs to be moved for care during the end of life stage, they will be cared for by professionals in a skilled nursing facility (Marak, C., 2016, p 1).

Elderly will progress through the stages of development differently. Some will live life without pain and suffering and pass easily, while others may suffer Alzheimer's disease or symptoms of dementia and require the care offered by a memory care facility. As we are all very different and have been exposed to different lifestyles, we will move through these stages, each at our own pace and tolerances (Marak, C. 2016).

Physical Changes

According to Busse, (1989), there may be several meanings to the word "aging". "As a biologic term, it is used to describe those inherent biologic changes that take place through time and ultimately end with death." (Busse, 1989 pg. 3-4). This definition is at odds with the process of growth and development. Aging begins the moment a person is born. A baby develops into a child, teen and then an adult. But at some point, the aging process changes. The body begins to decline in function, ultimately leading to death. The term used to describe the beginning decline is called senescence. As aging occurs, the body's cells age and the organs functioning declines.

- Change in vision is one of the most undeniable signs of aging.
- A seniors hearing may also decline, resulting in the need for hearing aids.
- The skin becomes thinner, less elastic, drier and finely wrinkled.
- A elder's ability to taste and smell may also diminish as they age.
- Bones and joints become less dense and weaker due to the decrease in the body's ability to absorb calcium. This causes high risk of falls and broken bones.
- The elder loses muscle tissue over time and muscle strength tends to decrease.
- The heart and blood vessels change. The walls of the heart become stiffer and the heart fills with blood more slowly.
- The artery walls become thicker and the blood flow changes.
- The aged lungs may weaken, and the kidneys and urinary tract are often affected by age.
- The most common reported chronic conditions among the elderly are arthritis, high blood pressure, heart disease, hearing loss, problems of bones and tendons, cataracts, chronic sinusitis, diabetes and vision loss. This is a condensed list (Merck Manual of Health and Aging, 2004, pp 7-16).

Mental/Emotional Changes

As with the body, the mind is also susceptible to illness. Among the most common challenges facing the elderly are medical conditions that attack the brain, specifically the memory. Alzheimer's disease and dementia are the most common and both directly affect cognition at various levels. Dementia is a general term for loss of memory as well as other mental and physical abilities severe enough to interfere with daily activities. Dementia is not a disease, rather a multitude of symptoms that do not lead to a known disease and is caused by physical changes in the brain. Dementia is common among stroke victims (Mayo Clinic, 1998). There are 9 types of dementia. Alzheimer's Disease comes in three known forms. Early onset which occurs in those under age 65, usually age 40 to 45, experiencing memory loss and difficulty with daily activities. Late onset occurs in those over 65 years of age and is the most common form of Alzheimer's disease. The third and most rare form is called Familial Alzheimer's Disease. It occurs in less than 1% of all cases of Alzheimer's and is a gene known to exist in at least two generations of the family. (Alzheimer's and Dementia, 2017). For those suffering Alzheimer's Disease or dementia, it is not uncommon for them to experience a multitude of behaviors and symptoms. Along with memory loss, a senior suffering Alzheimer's or dementia may incur loss of

communication skills, loss of attention, perceptual problems, depression, agitation, suspiciousness, angry outburst, delusions and hallucinations.

Although depression is a common for those with Alzheimer's disease and dementia, it is also very common among the elderly in general. Charles M. Schulz, Peanuts author and illustrator provided a scenario that perfectly depicts the emotional pain many feel as indicated by Charlie Brown.

> "Charlie Brown was sitting at Lucy's psychiatric booth. He asked, "Can you cure loneliness?" She replied, "For a nickel I can cure anything." Charlie Brown then asked, "Can you cure deep down, black, bottom of the well, no hope end of the world, what's the use loneliness?" Lucy protested, "For the same nickel?!" (Blazer, 1990, p.62-63).

Depression among elderly is a serious condition. Many become depressed due to the decline in their ability to function as they did in early years. Others are fearful of thoughts of end of life, while many suffer severe loneliness as the traditional family unit has changed so drastically over the years. Many lose their spouses and find it difficult to continue on while the severe loneliness and depression sets in. Many elderly men served in wars and suffer Post Traumatic Stress Syndrome.

Suicide is the 8th leading cause of death in the U.S. Persons 65 and older make up 12.5 of the total U.S. population and account for 20.9% of suicides annually. Suicide rates among the elderly increased significantly following the Great Depression, then declined until 1981 through 1987, again increasing from 17 to 20 per 100,000 persons. Among older men, suicide rates increase with age. Among women, the rates are lower at 6.6 per 100,000. Women are more likely to commit suicide at midlife. Although many factors can account for the reasons a senior may consider suicide, such as failing health, lack of independence, loss of spouse, it has been found a relationship between major depressive condition and death by suicide has been identified (Blazer, 1990)

Paranoia, suspiciousness and agitation are common behaviors among elderly. As the memory begins to fail, many elderly people become paranoid and suspicious about things they do not understand or cannot remember. The feeling of not knowing where they are or who the people are around them brings on much anxiety. If the anxiety increases, sudden outbursts often are the outcome of the paranoia or suspiciousness and agitation. When working with people who suffer these behaviors, it is necessary to make them feel safe and validate their thoughts but to also help them understand they do not need to feel fearful or frustrated. It is essential to help the senior feel safe when experiencing these episodes of paranoia, suspiciousness and agitation.

Additional emotional issues are often a result of alcohol abuse by elderly. Alcohol is a depressant and if used long term or abused can lead to more severe depression and many physical issues such as memory loss called alcohol amnesiac disorder which causes difficulty with both short- and long-term memory and an inability to learn new information. This is also identified as one of the 9 types of dementia. (Blazer, 2004).

Often seniors want to feel valued and listened to, especially as they evaluate their life. Oftentimes we deny them the privilege to share with us the knowledge and invaluable presence that we too could offer future generations. The history and knowledge of the elderly is priceless.

Social

The elderly struggle with a multitude of social issues. Some have been identified in other sections of this chapter but apply to their involvement in society as well. The most pertinent issues identified by both social workers and the elderly who were questioned provided the following list from (Aging Care, 2019):

-
  - Loneliness from losing a spouse and friends

- Inability to independently manage regular activities of living
- Difficulty coping and accepting physical changes of aging

- Frustration with ongoing medical problems and increasing number of medications
- Social isolation as adult children are engaged in their own lives
- Feeling inadequate from the inability to continue to work
- Boredom from retirement and lack of routine activities
- Financial stresses from the loss of regular income

- STD's are currently on the rise with the senior population
- Younger generation taking advantage of elderly's vulnerability (Aging Care, 2019)

Spiritual

For most elderly, religion plays a major role in their life, with approximately half attending religious services weekly. "Older adults' level of religious participation is greater than that in any other age group. For older people, the religious community is the largest source of social support outside of the family and involvement in religious organizations is the most comon type of voluntary social activity" (Kaplin & Berkman, 2019, p.1).

When caring for the elderly, religion and spiritual beliefs often play a significant part in the care provided for the seniors. As the elderly ages and necessary increased care is provided, the elderly may have special wishes in accordance with their religious beliefs or spiritual beliefs. It is essential to know if spirituality or religion are important to the elderly as the beliefs may offer assistance with the elderly coping skills acceptance of their declining health and decreased fear of their final demise (Erichsen & Bussing, 2013, p. 1).

Myths/Stigmas

There are many myths and stigmas that have been associated with elderly population. A myth as defined is, "a usually traditional story of ostensibly historical events that serves to unfold part of the world view of a people or explain a practice, belief, or natural phenomenon" (Merriam-Webster, 2019, p.1). Stigma is defined as, "a mark of shame or discredit" (Merriam-Webster, 2019 p. 1). The term stigmatization is evident in the prevailing of "if I can buy enough pills, cream, and hair, I can avoid becoming old" (Esposito, 1987). Seniors efforts to avoid the uncontrollable outcomes of old age reveal the stigma and negative attitudes associated with advanced age. "Ageism refers to the negative attitudes, stereotypes and behaviors directed toward older adults based solely on their perceived age" (Frankelstein, Burke & Raju, 1995, p.662-663).

Ideally ageism will be replaced by truths. For instance, mental health issues among the elderly can decline with mental health services. Further, older adults are not the victims of deterioration that comes with age but are the survivors of life and the strengths of the elderly must be recognized and celebrated and used as the cornerstone in intervention and prevention services (Zastrow, 1993). The way a senior ages depends on several factors including their lifestyle choices, culture they live in, as well as their supports (Thornton, 2002). This is a bulleted list as follows of different myths and stigmas that have been negatively associated with the elderly population.

The following is a list of negative stigmas and beliefs about seniors:

- All elderly people are ill or disabled (Thornton, 2002).
- Pain is a normal part of life and the aging process (Ellison, White, & Farrar, 2015).
- Elderly people live boring lives and do not have romantic and sexual relationships.
- Elderly are uneducated or even able to learn as the world is continuously changing around us (Thornton, 2002).
- The elderly people are mentally incompetent and are able to be educated and learn new tasks just as a younger person is able to.
- The elderly people are a financial drain on our medical institution (Zastrow, 1993).
- Barriers to delivering mental services to older people is ageism, the "negative image of and attitudes toward people simply because they are old. (Zastrow, 1993).

The invaluable presence of an elderly person is one that is too often overlooked. Positive attributes and beliefs about the elderly population:

- They provide the social and cultural continuity that holds our communities together.
- Wisdom comes with age and experience. The older generation is also a great storehouse of knowledge and history.
- Like a tree needs its roots for growth and nourishment, a society needs roots to keep it grounded in its traditional values and history.
- Grandparents are often available for babysitting and spending quality time with their grandchildren, teaching values and respect.
- Families who have active, healthy grandparents living nearby have the opportunity to develop strong relationships between the kids and their elderly relatives that can greatly enrich the lives of both generations. They can also provide positive role models for young children who probably have little contact with older adults and may regard aging as something negative and depressing.
- For many seniors, old age is a time to become deeply engaged in their churches, local politics, schools and cultural and community organizations.
- They know how to socialize and treat other people in face-to-face conversations without the need for modern technology.
- Many are more conscious of their diet and their health. They watch what they eat, and exercise in order to stay active.
- Seniors have time for themselves, to vacation, volunteer, take classes and garden, among many other activities they may not have had time to do when raising a family.
- Seniors become active in senior centers and organizations to meet other elderly people for social purposes such as dances, playing cards, bingo and dating (Pitlane Magazine, 2019).

Working with the Elderly

In the field of social work, it is important to be able to work with other disciplines of work including physicians, nurses, nurse assistants, chaplains, dietitians, volunteers, dentists, and other social workers at various agencies. There is a need to have client centered goals and plans of care from all disciplines that work with the client (Wright, Lockyer, Fidler, & Hofmeister, 2007).

Discipline	Role	Source
Social Worker	• Helps the client and family with funeral arrangements • Provides financial assistance • Provides resources • Psychosocial support needs to the clients and their families • Identifies and assists with environmental factors and barriers that arise • Assessments for mental health concerns	(Csikai & Weisenfluh, 2013) (Monroe & DeLoach, 2004) (Reese & Raymer, 2004)
Physician	• Attend's to client's long-term care needs • Leader of the team • Collaboration	(Wright, Lockyer, Fidler, & Hofmeister, 2007)
Nurse	• Informs team of medical concerns • Monitors client's vitals and measurements • Explains medications and health care needs	(Greene, 1984)
Nursing Assistant	• Help the client 's with activities of daily living (ADLs) including feeding, bathing, and dressing. • "Nurse aides' duties include functional, psychosocial, and delegated care activities such as physical care and emotional support"	(Huey-Ming, 2004)
Chaplain	• Spiritual Care • Provide education and support both with religion and non-religious support to clients and staff members. • bereavement supports • Help with funeral home decisions as well as help with leading a memorial service	(Williams, Wright, Cobb, & Shiels, 2004)
Dietitian	• Monitor for proper nutrition • Monitor weight • Assess for malnutrition	(Kang et al., 2018)
Volunteer Coordinator	• Completes volunteer requests/referrals • Attends weekly meetings to discuss volunteers	(Claxton-Oldfield, & Jones, 2012)
Volunteers	• Make phone calls • Provide emotional support as being a friendly visitor • May aid with rides for various client needs	(Ghesquiere et al., 2015)

Elder Abuse and Neglect

Elder abuse and neglect are under reported in the United States for many reasons including fear and embarrassment by the elderly (O'Connor & Rowe, 2005). Elder victims of abuse risks that include; functional disability, lack of social supports, poor physical health, cognitive impairment, mental health issues, lower social economic status, gender, age, and financial dependence (Pillemar, Burnes, Riffin, & Lachs, 2016). There is an Adult Protective Services (APS) Hotline for reporting a suspected abuse or neglect situation referred to as centralized intake: 855-444-3911 (State of Michigan, 2019). It is important to understand that all social workers are mandated reporters of elder abuse and neglect (State of

Michigan, 2019). There is not one specific cause for elderly abuse and neglect. There are many reasons including various dynamics, cultural norms, negligence and lack of education and support (Muehlbauer & Crane, 2006). Potential causes of abuse could be due to mental illness, substance abuse, and the need to abuse from the perpetrator (Pillemar, Burnes, Riffin, & Lachs, 2016). There are several types of abuse defined as follows in Table 1: Kinds of Elder Abuse and their Definitions (Muehlbauer & Crane, 2006, p.44).

TABLE 1

KINDS OF ELDER ABUSE AND THEIR DEFINITIONS

Kind of Abuse	*Definition*
Physical	Use of force that causes unnecessary pain or injury, even if the reason is to help, can be regarded as abusive behavior. Physical abuse can include deliberate or inadvertent hitting, beating, pushing, kicking, pinching, burning, biting, overmedicating, undermedicating, or force-feeding; improper use of physical or chemical restraints; and exposure to severe weather.
Emotional or psychological	Behavior that causes an older adult to have fear, mental anguish, or emotional pain or distress can be considered abusive. This kind of abuse can include name-calling, intimidation, insults, and threats; treating the older adult like a child; and isolating the older adult from family, friends, and social contact by force, threats, or manipulation.
Neglect	Neglect can range from withholding appropriate attention from the individual to intentionally failing to meet the older adults' physical, social, or emotional needs. It can include failure to provide food, water, clothing, medication, or assistance with activities of daily living or personal hygiene. In addition, failure to manage older adults' money responsibly and withholding necessary health care can be considered neglect.
Sexual	Any nonconsensual intimate contact, such as inappropriate touching, photographing the individual in suggestive poses, forcing the individual to look at pornography, forcing sexual contact with a third party, or any unwanted sexual behavior can be considered sexual abuse. This kind of abuse may also include acts such as sexual exhibition, rape, sodomy, or coerced nudity. Sexual abuse is not often reported as a kind of elder abuse.
Financial	Financial exploitation includes fraud, taking money under false pretenses, forgery, forced property transfers, purchasing expensive items without permission, or denying older adults access to their own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships, as well as a variety of scams by salespeople, health-related services, mortgage companies, or friends.

Adapted from Kleinschmidt (1997).

It is important as a social worker to be able to assess the signs and symptoms of elder abuse. It can be difficult to recognize the signs and symptoms of abuse as some elderly are nonverbal and unable to share what is occurring (Muehlbauer & Crane, 2006). Table 2 below lists common signs and symptoms of elder abuse (Muehlbauer & Crane, 2006, p.46).

TABLE 2

SIGNS AND SYMPTOMS OF ELDER ABUSE

Kind of Abuse	*Sign or Symptom*
Physical	• Bruises or grip marks around the arms or neck • Rope marks or welts on the wrists or ankles • Repeated unexplained injuries • Dismissive attitude or statements about injuries • Refusal to go to the same emergency department for repeated injuries
Emotional or psychological	• Uncommunicative and unresponsive attitude • Unreasonably fearful or suspicious behavior • Lack of interest in social contacts • Chronic physical or psychiatric health problems • Evasiveness
Sexual	• Unexplained vaginal or anal bleeding • Torn or bloody underwear • Bruised breasts • Venereal diseases or vaginal infections
Financial	• Life circumstances that do not match the size of the estate • Large withdrawals from bank accounts, switching accounts, or unusual automated teller machine activity • Signatures on checks that do not match the older adult's signature
Neglect	• Sunken eyes or loss of weight • Extreme thirst • Bed sores

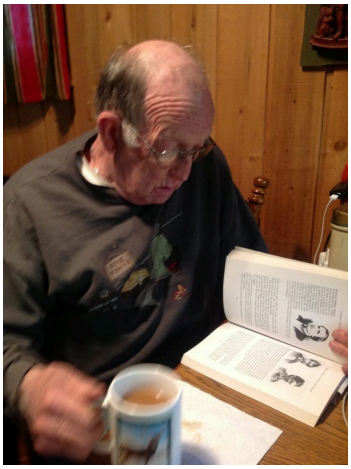
One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/exploringhumanservices/?p=130#oembed-1

Adult Protective Services (APS) Case Study:Janice

Janice, a 50 year old women is diagnosed with Schizophrenia and Bipolar Disorder. She was fired from her job as a professor from a University due to not taking her medications and making threats and allegations of a "witch hunt" for her. This client lives alone in a trailer in the middle of the woods. There is no heat or electricity in the home. Several medical professionals have called and reported that she is unable to take care of herself on her own. This client has not been deemed incompetent by two physicians. The APS worker attempts to visit the client and each time is asked to leave the premises. The APS worker noticed some bruises on Janice's wrists and her arms. The APS worker attempts to address the bruises when Janice says, "Get off my property and never come back or I will call the police!" The APS worker has reported these allegations to her supervisor as well as to the police department. The client has been hospitalized for her medications, but once out of the hospital the client does not continue taking medications. The client is currently not able to pay her bills and the home is in the process of being foreclosed from the client. The bank has reported that there have been several cash withdrawals from the account from ATMs all over the state. The client has refused the APS worker to assist and will not leave the home. The APS worker is unaware of any family or friends of this client in the area. There are also no shelters in the area that will take a client that is non-compliant with taking medications.

- If you were the APS worker, what other resources could you reach out to?
- What would you do to help the client?
- As the APS worker, can you identify any ethical dilemmas, explain?

Medical Care and Insurance



Medicare

Medicare is a supplemental insurance that was created in the U.S. after the Social Security Amendment in 1965 (Rajaram & Bilimoria, 2015). People are eligible for Medicare if they are at least 65 years of age, have end stage renal disease or amyotrophic lateral sclerosis, or have another specific disability (Rajaram & Bilimoria, 2015). There are certain needs that Medicare does not cover including long term skilled nursing facility stays. There are four different sections of Medicare including Part A, Part B, Part C, and Part D (Rajaram & Bilimoria, 2015). This link https://www.ssa.gov/benefits/medicare/is where a senior can apply for Medicare. Rajaram & Bilimoria (2015) explain the four parts of Medicare as:

Part A	• Inpatient hospitalizations • Short term stays in skilled nursing facilities • Home health care • Hospice care
Part B	• Outpatient services • Primary care appointments • Medical equipment • Lab tests • Vaccinations • Cancer screenings
Part C	• Have all benefits of Part A and B • Private health plans • Vision • Dental
Part D	• Prescription drug coverage

Case Study: Jacob

You are working as the social worker for a Commission on Aging agency and one of your clients, Jacob walks into your office. Jacob is an 88-year-old Native American male. He is an U.S. Marine Corps Veteran. Medicare is Jacob's only insurance. Jacob shares with you that he was unable to purchase his medications last week because the cost is too high with his fixed income of social security.

- What would you do as the social worker to help Jacob?
- What resources do you think could be available for Jacob?

Advanced Directives

As seniors, we have many choices regarding health care and end of life wishes. The Do-Not-Resuscitate orders and Comfort Care Only orders are important for family members who may not know the wishes regarding life sustaining practices. Therefore, if these decisions are made prior and family is made aware , the wishes of the loved one is often carried out with much less stress and ease to both the family and the senior making the decision. If the decision is not made prior to the time it becomes necessary, the loved one may not have the opportunity to have their wishes known. If the DNR or the Advance Directive is not in place, the doctor will make every effort to resuscitate a senior. The Advance Directive and DNR is done in the event an elder is incapacitated to guide decisions about medical treatment.

A Living Will is a document that directs the care in the event of an elderly's mental incapacitation. A Durable Power of Attorney is a document in which a senior will appoint a person to make decisions in the event they are incapacitated and unable to make the decisions themselves. A Living Will is a document or type of Advance Directive in which a

person gives specific directions about treatments that should be following in the event of his or her incapacitation, and usually addresses life-sustaining medical treatment such as removal from life supports, providing food and drink (Pietsch ad Braun, p. 41). Understanding rights as an elderly regarding your wishes for health care is essential as it alleviates much stress for those who would otherwise need to make these decisions. Most seniors have decided under which circumstances they would wish to be resuscitated. It is imperative that each senior make family members or their physician aware of their decisions. Most hospitals will allow these documents to be signed and notarized and filed at the hospital in the event of crisis. It is very important to have documents signed and available for use In the event of an emergency. (Pietsch and Braun, 2000, p. 41).

Placement

In many cases elderly people find they are unable to manage their own care in their homes without some assistance and modifications to their homes for safety purposes. Seniors can make their homes safe by installing ramps, safety bars in bathing areas and widen doorways for walkers and wheel chairs. Oftentimes, the first step taken to keep the elderly in their own home or a family members home, is to hire a caregiver to aid with activities of daily living, medication management and meal preparation. The caregiver will often provide transportation to doctor and dental appointments, errands and any other travel.

https://youtu.be/L0MAZog6IMs

Independent Living Facilities

Many elderly people find that it is either too costly to safely update their own homes or may live in a property with many stairs that are difficult to climb. In the event they need a safer environment, many will seek out independent living facilities where they live in a community of other elderly people where the apartments or homes are built with safety features already I place within the units and where there are many activities and social events specifically designed to help the resident avoid isolation and make new friends. Independent living is typically for those who do not have healthcare needs, but some may need a caregiver to come in and assist with bathing, household chores or to run errands. Many Independent living facilities have a dining room for meals and transportation available for medical appointments and weekly trips to run errands and outing for the residents (National Institute on Aging, 2019).

Assisted Living Facilities

Once care levels increase and the resident is unable to manage their own care without the assistance of daily caregivers, the resident may be encouraged to move to an assisted living facility. Many independent living facilities offer assisted living units on the same property, so the move is minimal. An assisted living level of care, depending on the needs of the senior are often set up to allow one to two to a room, where they may set up their own living areas and meals are often taken in the dining room. The seniors may need assistance ambulating to the dining room resulting in a staff member to assist them with a walker or in a wheel chair. In assisted living facilities, the seniors are usually able to move about the facility without much help, but staff and medical care is available 24/7. There are activities provided for the seniors to encourage them to leave their rooms and engage in social events. Many seniors who move to assisted living facilities state they wish they had moved much sooner as the facilities offers the seniors the opportunity to socialize with others their age and offer a plethora of activities and day trips that seniors who remain in their own homes may have been missing out on. It is not uncommon for family members to take their loved ones out for outside medical appointments, such as dental, medical tests not performed on site and family time. Some seniors are able to be checked out for a night or two in order to spend time with family. For those families who wish to take their loved one out of town, they may make arrangements with another facility in the town they are visiting to place their loved one in an assisted living facility, so as not to interrupt their care, but to allow the senior to continue to be part of the family actives. This is all coordinated with both assisted living facilities prior to travel (Caregivers Library).

Adult Group Homes

Another option for the elderly who are unable to socialize and ambulate, but do not need the level of care of skilled nursing, a group home might be an option for them. The social activities are limited, and the level of care is more

individualized with 24/7 care and generally only 10 to 20 seniors living in the home at any given time. All transportation is generally offered, and meals are served family style with all seniors eating together. Many of the seniors in elderly group homes are unable to participate in social activates or engage in extensive conversation. This option is generally utilized once they are unable to manage to ambulate in the assisted living facility and has deteriorated to a high level of care but are not yet bed bound . Many senior can remain in the group home until end of life with hospice care. Some group homes offer "field trips" such as color tours and outings to see the holiday lights. These trips are short, and the seniors generally do not leave the bus (National Institute on Aging, 2019).

Skilled Nursing Facilities

Skilled nursing facilities, often referred to as nursing homes are designed for those who need constant care and are unable to ambulate or perform any of their own ADL's. This is often the final placement prior to their death. Many suffer significant illness or have been deemed unsafe and unable to be provided the level of care in any offer type of facility. Meals are provided to the residents in their rooms where they do not need to leave their beds. For those who can ambulate but need extensive medical care, there is often limited social activities for them. They may meet in common areas to socialize but rarely do they leave the facility unless a family member checks them out for the day (Caregivers Library).

Memory care facilities are also essential for the elderly who suffer Alzheimer's disease or dementia. These are often locked wings of assisted living facilities or locked group homes. The care is specialized and considered high level of care as the senior often cannot remember how to toilet themselves, dress, eat by themselves or shower. They need 24/7 care and are a risk for wandering which is the purpose of a locked facility (National Institute on Aging, 2019).

Elderly and the Community

As has been indicated in the above portion of this chapter, the elderly struggle with a variety of issues. But in accordance with their integration and acceptance in the community, various conditions of each community may make a difference in the severity of struggles they endure. Some communities are much more understanding of the needs of their elderly residents and provide social outlets for them. They also redesign their public areas with the elder's needs in mind and utilize the experiences and intelligence of this population. This is often found in smaller upscale towns where the elderly population is high, and their needs are heard.

For those living in low income or medium income areas in their own homes, many live in areas where the lifestyle is fast paced, transportation is limited to local buses or trains and businesses do not cater to the elderly. Many times, the elderly become victims due to their vulnerability and inability to keep up. Society as a whole tends to have little patience for the aged. They are concerned for their own time and space; they often miss the opportunities they could take to assist someone in need. Understanding that we will all be old one day and know how it feels to be left behind (Merck Manual of Health and Aging, 2004), should keep us all humble and aware of the needs of the older population.

There are many organizations available for elders in need of services. Both public and private social service agencies can either provide services or will have social workers to help locate the appropriate resources for the elderly.

Some agencies included, but are not limited to:

- American Association of Retired Persons
- Area on Aging
- Rotary Club
- Veterans organizations
- Masonic Orders
- United Way
- AARP
- Salvation Army

These are only a few and many more may be available to those living in larger cities (Phillips and Roman, 1984, p. 105-108).

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Video shows people laughing (Closed Caption)

Hospice Care

The original concept of hospice care comes from England and has become more popular in the United States (Holden, 1980). There are over three thousand hospices within the United States (Monroe & DeLoach, 2004). Hospice has continued to evolve and develop and has been integrated into the health care system (Monroe & DeLoach, 2004). The concept of hospice started when physician, Dame Saunders, worked with dying clients in 1948. Saunder's work inspired the creation of St Christopher's Hospice in 1967 (National Hospice and Palliative Care Organization, 2016). Hospice was established in the United States in 1974 in Connecticut (National Hospice and Palliative Care Organization, 2016). It took a while to progress with hospice and achieve the hospice benefit through Medicaid in Tax Equity and Fiscal Responsibility Act of 1982. Then in 1984, "JCAHO initiated hospice accreditation" (National Hospice and Palliative Care Organization, 2016) Once the Medicare Hospice Benefit (MHB) was created in 1982, hospice care began to become more popular in the United States. Specifically, in 2005 when hospice care clients reached 1.2 million people. (Connor, 2008) As displayed in the chart below by Connor (2008):

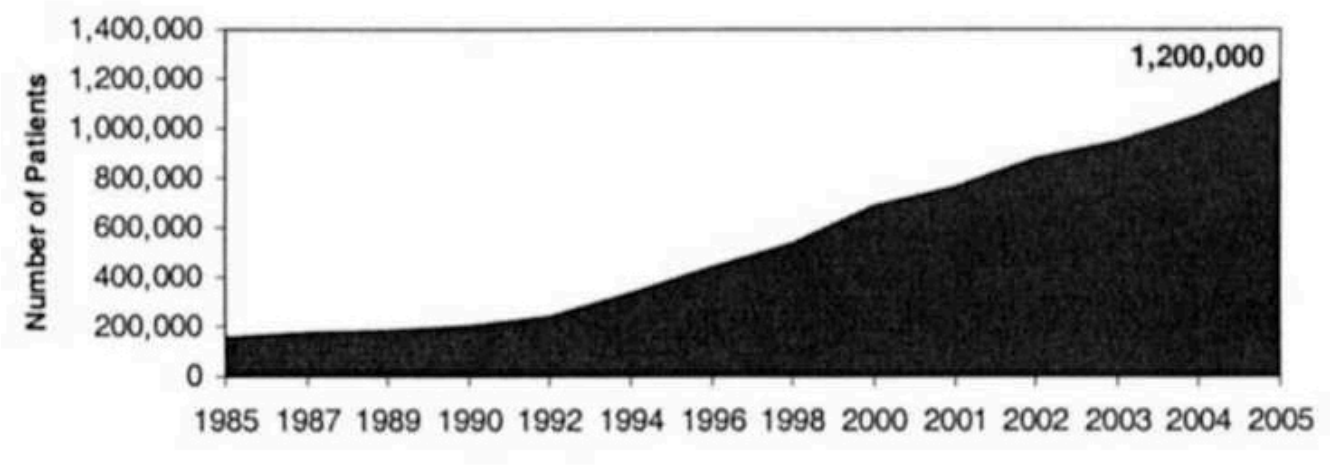

Figure 1. Hospice patients served 1985-2005.

As found by National Hospice and Palliative Care Organization (2015) there needs to be two physicians that give a senior a life limiting diagnosis of 6 months or less. Clients can be on hospice at any place that they are comfortable being. The National Hospice and Palliative Care Organization (2018) asserted:

Hospice services can be provided to a terminally ill person wherever they live. This means a client living in a nursing facility or long-term care facility can receive specialized visits from hospice nurses, home health aides, chaplains, social workers, and volunteers, in addition to other care and services provided by the nursing facility. The hospice and the nursing home will have a written agreement in place in order for the hospice to serve residents of the facility (p.1).

There are for-profit, and non-profit hospices (Hospice Analytics, 2018). Hospice care has turned into a competition among hospices to give the best quality of care to the clients. There is a great benefit to having many different options for hospice care. It allows the client to have more control over their end of life decisions. There are more than 5,000 hospices in the United states. The hospices participate in the Medicare program, the first program began in 1974 and has expanded significantly since then across the United States (Fine, 2018). Hospice is growing as the baby boomer generation is aging, in 2020 it is predicted that 20 percent of the population will be elderly in the United States (Niles-Yokum & Wagner,2015).

What Hospice Care Offers

Hospice allows clients to be in the comfort of their homes and not be in a hospital environment. As stated by Holden (1980), "High person, low technology" is a good phrase to explain the idea of getting rid of all the hospital equipment and make the client more comfortable (Holden, 1980). Hospice care is not about dying; it is about living and having a good quality of life with celebration. Having an interdisciplinary team implies that all the needs are being met for the client both spiritually, emotionally, and physically (McPhee, Arcand, & MacDonald, 1979). An interdisciplinary team is a group made up of the "physicians, nurses, social workers, chaplains, physiotherapists, dietitians, and volunteers" (McPhee, Arcand, MacDonald, 1979, p.1).

Hospice care is a valuable resource for those near the end of life. It can be a great resource for clients regardless of

where their home is. It is beneficial for the clients in nursing homes because they get more professional care experts to a client (Amar, 1994).

National Hospice and Palliative Care Organization (2018) states the following:

> Hospice care is available 'on-call' after the administrative office has closed, seven days a week, 24 hours a day. Most hospices have nurses available to respond to a call for help within minutes, if necessary. Some hospice programs have chaplains and social workers on call as well (p.1). Both the social worker and nurse are suggested to be present for family at the time of death to offer support to family members and answer questions (Donovan, 1984).

Differences between Palliative Care and Hospice Care

Palliative Care	• Comfort care that allows for aggressive treatment (U.S. National Library of Medicine, 2018). • Can be used from start of diagnosis until death (American College of Physicians, 2018). • Serves hospital bound clients (American College of Physicians, 2018).
Hospice Care	• Does not serve clients that are in the hospital's care unless that is the only way to control the severity of the pain sympto • Care begins after treatment of the disease is stopped and when it is clear that the person is not going to survive the illne • Most often offered only when the person is expected to live 6 months or less (The U.S. National Library of Medicine, 201
Both	• Offered to any person regardless of demographics, including: race, gender, religion, ethnicity, social economic status, an • Provide comfort (The U.S. National Library of Medicine, 2018)

Barriers to Hospice Care

Hospice can be a very difficult discussion and it can be challenging to bring this up to loved ones or a professional hospice staff member. This can be prevented by having the discussion earlier on before the last stages of life (National Hospice and Palliative Care Organization, 2018). Most people have little education on what hospice can offer and what the mission, values, and goals are (Cagle et al., 2015).

Many hospice clients have a great deal of pain. One of the barriers of hospice care is the controversial topic of opioid usage for pain particularly in older adults (Spitz, Moore, Papaleontiou, Granieri, Turner, & Reid, 2011). There are drugs that cause sedation to help with restlessness and pain. However, the ethical issue becomes whether it is better to allow the client to be in pain and able to communicate and eat on their own (Dean, Miller, & Woodwark, 2014). There are barriers to finding appropriate medications for pain management (Cagle et al.,2015). There is a concern about addiction, dependence, and abuse of the medications (Spitz et al., 2011). A fear that the opioids may not reach the client due to unethical doing by a caregiver is another reason to refuse opioid distribution (Spitz et al., 2011). Many physicians are hesitant to distribute opioids and look for alternatives to pain management for clients such as massage therapy (Spitz et al., 2011).

There are negative stigmas that have been associated with hospice and the end of life process. An idea to have a longer stay on hospice by using hospice to treat conditions that could not be stabilized while being at home (McPhee, Arcand, MacDonald, 1979). There is the stigma attached with hospice that is a form of giving up. There are false perceptions that taking medications makes a senior a drug addict or weak for needing pain management control (Cagle et al., 2015).

Hospice clients may feel suicidal and depressed due to the fact they are near the end stages of life (Fine, 2001). Some agencies may monitor the length of visits, which can cause clients not to get the best care or feel as though they were engaged in an appropriate amount of time needed for a life review intervention (Csikai & Weisenfluh, 2013).

It could be very difficult knowing that your lifespan has 6 months or less to be lived. Some clients feel they have unfinished business to attend to. There is a primal fear of death. It may or may not been an unexpected diagnosis (Kumar, D'Souza, & Sisodia, 2013). Some elderly may be living a normal life and suddenly have pain. Once going to a doctor for a checkup, a client may be given an untreatable life-threatening diagnosis. However, some clients may be sick for a long time and not be afraid of dying and be completely at peace with the dying process. Suicidal ideation is common among hospice clients and it is important address why a client is having suicidal feelings.

Barriers are specifically formed when members of the interdisciplinary team do not collaborate appropriately prior to client care (Donovan, 1984). This causes a ripple effect for the client 's care. There are barriers with the services and resources available to the care team depending on the area. There may be resources available for client benefit in rural compared to urban areas.

Barriers can be very challenging to work through. It is critical to work with the team, which includes: a social worker, nurses, nurse aides, medical director, volunteer coordinator, music therapists, chaplains, and volunteers to brainstorm solutions to these barriers. Education is a good way to help people understand various aspects of social work that many have been mis conceptualized.

Ethical Considerations in Hospice Care

There are ethical dilemmas in all aspects of social work. Csikai (2004) asserted, "During this process hospital social workers may encounter ethical dilemmas regarding quality-of-life, privacy, and confidentiality, interpersonal conflicts, disclosure and truth telling, value conflicts, rationing of health care, and treatment options" (Csikai, 2004, p.1). Euthanasia and assisted suicide are also ethical dilemmas that comes up in conversations with clients on occasion (Csikai, 2004). People have seen this as a legal option in some states and staff struggle with this because it is not legal in all states to practice even when that is the client 's wish (Csikai, 2004).

Ethical Dilemmas in End of Life Care

It is important to talk about ethical dilemmas when needed and many refer to ethical committees or to their interdisciplinary teams (Csikai, 2004). In the National Association of Social Work (NASW) Code of Ethics to empower a client and give them control. It is mentioned in the NASW Code of Ethics the importance for social workers to promote self-determination under the value of dignity and worth of a person. However, the social work field is not black and white; this causes a struggle when a clinician has to decide if a client is competent to make a decision(Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002). Many ethical dilemmas occur daily and hospice staff must address concerns with their supervisors or managers as needed to give the client the best outcome (Fine, 2001, p.131).Here are some examples of ethical dillemmas as follows in chart below.

- There is worry that the motives for suicide may not just be about the quality of life, but related to finances, feeling like a bother, and other ethical issues (Ganzini et al., 2002).
- There are concerns with the opioid epidemic and risks for abuse and addiction of drugs (Csikai, 2004).
- Is the client is safe in their own home? A client may be at risk of falling while alone, but if they are competent, they can choose to live alone in unsafe environments (Wilson, Gott, & Ingleton, 2011).
- Clinicians should assess for the risk of suicide in all client s who are depressed (Fine, 2001, p.131).

Death and Dying

There are several signs and symptoms that are common during the last few months of a client 's life. Some of the

symptoms include respiratory issues, skin irritations, weakness, swelling, restlessness, confusion, and fatigue (Kehl & Kowalkowski, 2012). There is always a chance that a client may not experience these symptoms at all during the last few days of a client's life (Kehl & Kowalkowski, 2012). During the last few weeks hospice staff may refer to the client as "transitioning" meaning they are nearing the end of life (Kehl & Kowalkowski, 2012). Donovan (1984) explained, the social worker has a vital role within the hospice team. The social worker helps the client and family with funeral arrangements, financial assistance, resources, and support. Life review is one intervention that does reduce physical pain and depressive symptoms, improving the client's quality of life (Csikai & Weisenfluh, 2013).

The social worker and the nurse work hand and hand with the client. Both the social worker and nurse are suggested to be present for family at the time of death to offer support to family members and answer questions (Donovan, 1984). The social worker should be present throughout the client's journey through hospice to help with any issues that may arise (Reese & Raymer, 2004). Monroe & DeLoach explained, "The hospice social worker also makes clinical assessments, provides referrals, facilitates discharge planning, ensures continuity of care, serves as an advocate, offers crisis intervention, and serves as a counselor" (Monroe & DeLoach, 2004).

Grief and Loss

Every person will experience grief differently and will have various bereavement risk levels depending on the person and situation. As the social worker you will complete a bereavement risk assessment based on a specific scale. Most people will be able to function and return to their daily life activities following acute grief process. However, some may develop a mental health diagnosis because the grief may influence a person's ability to function in their daily lives (Ghesquiere, Aldridge, Johnson-Hürzeler, Kaplan, Bruce, & Bradley, 2015). If grief becomes severe and is left untreated or assessed it may lead to thoughts of suicide or even suicide (Ghesquiere et al., 2015). The social worker should do a bereavement assessment and this information should be distributed to the entire hospice care team especially the Bereavement Coordinator (Ghesquiere et al., 2015). There are different types of grief such as normal grief, anticipatory grief, and complicated grief.

Normal Grief	• An individual's behavior is acceptable for the circumstances and requires normal bereavement follow up (Egan & Arnold, 2003).
Anticipatory Grief	• "occurs before a death, usually at the time of diagnosis. A client may anticipate loss of good health (and in some cases a body part), independence, financial stability, cognitive ability, autonomy, and life itself" (Egan & Arnold, 2003, p.44)
Complicated Grief	• When a death is unexpected, the death is prolonged and even painful, or the relationships are complex and have past tension, and little support or resources (Egan & Arnold, 2003). • Symptoms of reactive distress to the death (e.g., disbelief or bitterness) and disruption in social relationships or identity" (Ghesquiere et al., 2015, p.1).

Self Care and Social Work

There is a need to practice self-care as it has shown to be beneficial to an elder's health and resilience (Lee & Miller, 2013). There has been a link between effective self-care and being able to cope with stress and traumatic situations. Self-care can help a social worker become a better advocate and have a life long career in social work (Lee & Miller, 2013). Social work leaders recognize the seriousness of the consequences of work-related fatigue, stress and compassion fatigue. "Figley (1995) coined the term Psychological symptoms of this type of secondary traumatic stress include depression, anxiety, fear, rage, shame, emotional numbing, cynicism, suspiciousness, poor self-esteem, and

intrusive thoughts or avoidance of reminders about client trauma". Physiological symptoms include hypertension, sleep disturbances, serious illness and a relatively high mortality rate in helping professionals (Beaton & Murphy, 1995).

Burnout has been an ongoing issue with workers in the human service field. It is a gradual emotional exhaustion that may lead to a negative attitude toward clients and reduced commitment to the profession (Maslach, 1993). When the work demand are high with limited rewards and appreciation, burnout occurs at a significantly high rate.

https://youtu.be/da-4GEaWK4I

Some effect means of self-care include:

- Start a "positivity" file.
- Get up and move.
- Shake up your routine
- Write it down (and throw it away).
- Activate your self-soothing system
- Take time out for yourself
- Work should be left at the office or job site.

Strengths and Challenges (Both)

There are benefits and barriers to the aging process and the transition into an elder. One challenge is that a selective few are forced to move from their home they have lived in their entire life into some type of facility due to not having caregivers or being able to care for themselves (Ellison, White, Farrar, 2015). Many elderly people also have experienced a significant amount of losses in their life including family, friends, a spouse, partners, and even children as they have aged (Ellison, White, Farrar, 2015).

During the aging process doctor visits may multiply, medical costs are rising, which can impact one's retirement budget. Challenges also include the declining of health that threatens a senior's day to day activities. Although it is inevitable health issues progress with age, it is important to prepare mentally prior to the occurrence by learning more about coping skills related to health issues. Challenges also include completing simple tasks once easily accomplished but escalating in difficulty as the body ages and weakens. It may become necessary to have a home care provider to assist with daily tasks. The elderly often worry about financial security. Most live on fixed incomes and are unable to afford the comforts of life they used to enjoy. Loneliness is a major concern of the elderly. They are unable to move about as they once did and find socialization difficult due to lack of mobility. Financial predators are those unscrupulous people looking to prey on the vulnerability of senior citizens by trying scare tactics to get them to provide banking information to them or to sell them unnecessary services or goods (Best for Seniors Online, 2019). Other challenges experienced by seniors are abuse and neglect in the nursing homes and assisted living facilities due to under-staffing issues, leading to discontented staff. Transportation and lack of mobility are also challenges of the elderly. They often must rely on others for help getting to doctors' appointments, grocery shopping or other necessary errands. Likely the hardest hurdle for seniors to manage is the continuous changes in technology that hinders those who are not familiar with current technology (Agency for Health Care Administration, 2013).

Although challenges are experienced by the elderly, many seniors experience positive and healthy benefits as they age. Seniors who believe in themselves and their capabilities, remain active and stay engaged intellectually have a higher

probability of a less challenging experience as they age. Also, those who have strong spiritual beliefs often handle adversity due to their resiliency and faith. Focusing on the strengths and encouraging active and healthy lifestyles can make significant improvements in an elder's health of their body and mind (Merck Manual of Health and Aging, 2004). Seniors have a lifetime of valuable information to pass on to their family and friends. Many still believe a handshake is all that is needed to make an agreement. The elderly tend to hold to their values and beliefs of hard work and honesty. " By not listening, society is allowing parents, grandparents, and great grandparents to slip away without allowing them the opportunity to teach. As they leave us, we are refusing them the privilege to share with us the knowledge and invaluable presence that we too could one day offer our own children.

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9. People with Disabilities

People with Disabilities

There are many populations that social workers provide services for daily. One such population is People with Disabilities. Disabilities can take many forms, such as physical, cognitive, or mental illness (Centers for Disease Control and Prevention, 2016). The broad range of potential disabilities can pose many unique challenges for social workers. It is also important to note that while disabilities can be a singular occurrence for some individuals, often disabilities span across many population segments. It is common for people with disabilities to suffer from victimization, stigmatization, and segregation in our society. Therefore, all social workers no matter what area of social work they are in should knowledgeable on the types of disabilities and those who live their lives with them.

Forms of disabilities

Forms of Disabilities

There are various forms of disabilities that people can suffer from. The three major forms of disabilities are physical, cognitive, and mental illness, with most disabilities falling within these three categories. To better understand disabilities, let's consider the three categories.

Key Terms

Physical Disability: a limitation on a person's physical functioning, mobility, dexterity or stamina.

Cognitive Disability: a generalized disorder characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors that appears before adulthood.

Mental Illness: a wide range of mental health conditions — disorders that affect mood, thinking and behavior.(Merriam-Webster's collegiate dictionary, 1999)

Physical Disabilities

Physical disabilities can take many forms and can occur at any time in an individual's life. Many physical abnormalities can occur before a person is born, developing in utero. Known as congenital disorders and most commonly referred to as birth defects, these impairments can take many forms. Some can be a minor as a birth mark or as severe as a missing limb or internal abnormalities (Nemours, 2017). When a birth defect proves to be severe and long lasting, it has the potential to develop into a disability. Infants born with missing limbs or improperly developed physical traits will often grow to have a physical disability. Some physical birth defects can be corrected or improved with medical technology, such as surgeries to correct cleft palates; however there are many physical birth defects that cannot be corrected potentially leading to a physical disability.

There are also physical disabilities that occur after birth at any time in an individual's life. Major accidents are the most common cause of physical disabilities after birth. Car accidents are a common accident that can cause physical disabilities at any time in life. Car accidents can lead to minor injuries, but in severe cases can cause lifelong physical disabilities such as severed limbs and brain injuries (Disabled World, 2015). Military personnel are also at high risk of procuring physical disabilities through outside means. War can lead to various physical disabilities due to military engagements. The most recent military conflicts have led to high numbers of physical disabilities resulting from IEDs (Intermittent Explosive Devices) which have caused loss of limbs and traumatic brain injuries.

Physical disabilities can impact individuals in a variety of ways. Depending on the nature of the physical impairment individuals may be limited on where they can travel, the type of employment they can procure, and even their personal relationships. Social workers must be prepared to not only address the physical limitations that a physical disability can pose, but also the emotional impact that one may have on a client. Working with clients who have a physical disability can be a unique and rewarding experience. Each client will require an individualized approach, as not everyone who has a physical disability will cope in a uniformed way.

Cognitive Disabilities

Cognitive disabilities, also known as intellectual disabilities, are other forms of disabilities that social workers will encounter in the field. There are many types of cognitive disabilities that can vary in severity.

Some common types of cognitive disabilities are:

- Autism
- Down Syndrome
- Traumatic Brain Injury (TBI)
- Dementia
- Dyslexia
- ADHD
- Learning Disabilities

Cognitive disabilities, like physical disabilities, can be present at birth. Cognitive disabilities at birth can be almost impossible to distinguish and usually begin to present in early childhood. Some indicators of cognitive disabilities can be present in infancy, such as the infant failing to meet certain milestones or presenting with unusual symptoms such as lack of sleep and inconsolable crying. While these indicators can be present, it is often difficult for medical professionals to diagnose cognitive disabilities in infants and toddlers.

Most cognitive disabilities are diagnosed in childhood and early adolescence. There are several assessments that can be conducted to determine the presence of a cognitive disability. While many medical professionals may suspect a cognitive disability, most often patients are referred out to have the appropriate assessments completed. Once a diagnosis is made there are several forms of therapy that can be performed depending on the type of cognitive disability.

Even with the advancements in medical technology, unfortunately there are no "cures" for cognitive disabilities. While various therapies and some medications can help improve cognition and stall deterioration in some, there is no way to fully heal the cognitive disability. Cognitive disabilities can impact individuals on many levels, from employment to personal relationships. Depending on the severity of the cognitive impairment, some individuals may never be able to

live independently or function in mainstream society. Social workers working with this population must be prepared for the diversity within and the individual challenges faced by those with cognitive disabilities.

Mental Illness

While many may not consider mental illness to be a category of disability, there are several mental illnesses that impact an individual's life in such a way that it can be classified as a disability. Mental illnesses such as Schizophrenia, Borderline Personality Disorder, and Bipolar Disorder can be so severe that an individual's everyday life is impacted. When a mental illness impairs an individual's ability to function, it can be considered a disability.

For some mental illnesses, medication can help alleviate symptoms. This is especially true regarding disorders such as Schizophrenia and Bipolar disorder. While there is no cure for these disorders, medication in combination with behavioral therapies can reduce the symptoms. However, there are some mental illnesses that even with medication and therapy can still make coping difficult. Agoraphobia is one disorder that can severely impact everyday functions, to the point where the individual may not even be able to leave their home due to anxiety.

Mental illnesses in themselves can be considered disabilities when they impact an individual's life to the point of impairing functioning. Mental illnesses can also contribute to other health concerns and behavioral symptoms that greatly impact lives. For more information on mental illness please see Chapter 10: Mental Health and Substance Use.

Did You Know...

Agoraphobia consists of an individual experiencing marked anxiety in at least two of the following: using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, being outside of the home alone. (DSM-5, 2013, p. 217)

The Americans with Disability Act (ADA)

The Americans with Disability Act (ADA) was put into place in 1990. It guarantees equal rights for those with disabilities in the United States. It prohibits discrimination against those with disabilities "in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public" (ADA National Network, 2017). While this policy has created great advancements for those with disabilities, especially in education and employment, discrimination still takes place on a daily basis in our country.

ADA Compliance sign

Youth with Disabilities

As mentioned previously in this chapter, the age of diagnosis of disabilities can vary depending on the type of disability and potential origin. Most cognitive disabilities such as learning disabilities and autism are diagnosed in early childhood. Symptoms can vary in type and severity, the less severe generally being observed later. Children who are diagnosed with any type of disability face many challenges. Physical disabilities are often able to physically seen, therefore being diagnosed much sooner. Cognitive disabilities and mental illnesses do not manifest in a physical manner, therefore leading to later diagnosis. Parents, caregivers, and teachers are often the first to notice symptoms of a cognitive disability and/or mental illness. While cognitive disabilities have standard procedures for diagnosing, mental illnesses in children can often be difficult to diagnose. Many mental health professionals may be hesitant to make a mental illness diagnosis for a young child, as the brain is just beginning to develop and symptoms can vary.

The K-12 Education System

For cognitive disabilities and mental illnesses, the K-12 education system can pose particular challenges and resources for children. Depending on the geographic area, children with disabilities may find either a helpful system with resources or an overtaxed system with an inability to adequately help.

Higher Education System

The higher education system can also pose some unique challenges for people with disabilities. While many universities and community colleges have disability accommodations, the quality of these accommodations can vary depending on the institution. For many with physical disabilities, colleges and universities can be difficult places to maneuver – literally. There have been instances of universities failing in snow removal so that those who require mobility assistance such as wheelchairs are not able to traverse the campus. There have also been accounts of buildings being poorly designed so that doorways are not easily accessible for those who are not able to walk.

Accommodations for those with cognitive disabilities can also vary depending on the institution. Many higher education institutions have made efforts to be inclusive for those with cognitive disabilities, per ADA requirements. Most offer accommodations for those who qualify such as tutoring, alternate exam areas to allow for more time and individuals who are dedicated to helping those with cognitive disabilities succeed. People with cognitive disabilities in the higher education system most often have resources available to them provided by the institution, which is a change from the past, where even fifty years ago they would not have been accepted into the system.

The Workplace

For people with disabilities, the workplace can present certain difficulties. Discrimination in the work place for people

with disabilities is unfortunately all too common. No matter what form of disability, employers can be quick to judge an individual's abilities based solely on their disability. This is most common with physical and cognitive disabilities as they are more visible. Those with mental illness will also face discrimination in the work place as employers may see them as "too challenging" to employ. Some discrimination can be unintentional as well. Employers may make unnecessary accommodations for their employees with disabilities or may conduct themselves in a manner that is unintentionally condescending. Discrimination in the workplace can be both intentional and unintentional (Workplace Fairness, 2017).

While some employers can be hesitant or outright refuse to hire people with disabilities, others do not share such reservations. For employers who hire people with disabilities, accommodations must be made at times. The ADA requires that all public buildings be wheelchair accessible and many businesses have made great strides towards that goals. For those with cognitive disabilities and mental illnesses, accommodations can be made to make employment more inclusive such as training for other employees and trying to be educated on the topic.

Health insurance is a major factor for employers when hiring people with disabilities. Many employers may be hesitant to hire people with disabilities due to their health insurance provider. Some health insurance companies offer less coverage, some do not even offer mental health services in their packages. This could influence whether people with disabilities will be hired at certain workplaces, as the health insurance coverage may not be adequate to cover specialized medical care.

Aging with a Disability

As stated in the Gerontology portion of this chapter, aging with a disability can pose particular challenges. Often as those with disabilities begin to age, the familial caregivers become unable to provide care or pass away. This leads many with more severe disabilities to being placed in assisted living facilities, adult foster care, or nursing facilities. Nursing facilities provide around the clock medical care; however assisted living facilities and adult foster care homes do not.

Health insurance is also a major issue for those aging with a disability. For some, health insurance can be easily obtained. Medicaid and Medicare are the two main health insurances utilized by the aging. With the current political climate, it is unsure how available these resources will be for those with disabilities or what services they will provide. Social workers must be ready to contend with an ever changing political landscape of the country.

Elderly man sitting in a wheelchair

Abuse and Neglect

People with disabilities, like any other section of the population, are at risk for abuse and neglect. For children with disabilities, any suspected neglect or abuse should be reported to your local Child Protective Services. For adults with disabilities, any suspected abuse or neglect should be reported to your local Adult Protective Services.

Case Study: Carolyn Grant

Case Study: Carolyn Grant

Carolyn is 21-years-old, and autistic with moderate intellectual disabilities. She attends a special school program to assist with her disabilities. On a recent field trip, Carolyn's teacher left her and two male students unsupervised in the school van for a brief period of time. While the teacher was gone, one of the young men took Carolyn's shirt off, fondled her bare breasts, and took a picture of them. When the students returned to school, he showed the pictures to other students. Carolyn told her mother about what happened and her mother contacted APS for help.

(National Adult Protective Services Association, 2017)

What to do in the event of abuse/neglect for children with disabilities

- Contact your local Child Protective Services
- Contact your local police department
- Call 911

What to do in the event of abuse/neglect for adults with disabilities

- Contact your local Adult Protective Services
- For Michigan call **855-444-3911**
- Contact your local police department
- Call 911

Summary

People with disabilities face challenges in modern society that other population segments do not experience. With the various and sometimes limited resources offered, social workers must know how to navigate a system to better provide for their clients. With the rising cost of health care and an ever changing political environment, social workers are tasked with advocating and serving those in the population who may not be able to do so themselves. Both people of advanced age and people with disabilities are valuable contributing members of our world and as social workers we must stand to make a better future for all.

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10. Military and Veterans

Introduction

You will likely find veterans in just about every facet of the social work profession. For example, veterans are young and old, and come from very diverse backgrounds. Veterans have families, spouses, and children. They struggle with poverty and experience homelessness. They seek aid from state and federal assistance programs, and struggle with mental and physical health disorders, both military-related and non. Veterans pursue employment, and often struggle to bridge the gap between military and civilian life, battle addictions, and are part of the criminal justice system. Though military core values stress excellence and a "never lose" mentality, veterans are no strangers to defeat. Regardless of whether you set out to work with veterans or not, it is very likely that you will interface with them at some point or another. Throughout this chapter, general background information on cultural aspects of veterans, as well as common benefits and services available to former members of the armed forces will be discussed. Specific to this section of the chapter, the question of "what is a veteran?" will be reviewed, and will include some key characteristics of military life, rank, and pay. Some insight on basic military organization and structure, core values and some common misconceptions, will also be addressed, along with the differences between Active Duty and Part-time components. Additionally, common military language and how it might impact services will also be provided. Hopefully better prepare you for the day a veteran knocks on your office door seeking aid.

With all that in mind, it's important to stress that when talking about any cultural information, it is impossible to avoid generalizations. We, the authors, as veterans ourselves, feel safe talking for some, but not for all. This is basic information, after all. We have a chapter to define what could easily take volumes to adequately articulate. With that in mind, the views and opinions shared from this point forward are that of our own, and were peer-reviewed by members of academia and by those currently working in and/or are a part of the veteran community.

Section I. Components of the Military

Army

https://www.army.mil/

Seal – Department of the Army

The United States Army serves as the land-based branch of the U.S. Armed Forces. The U.S. Code of Military Justice (UCMJ) defines the Army in Section 3062 of Title 10, U.S. Code of Military Justice. It's mission is to preserve the peace and security, provide a defense for the United States and the Commonwealths and possessions and any areas occupied by the United States. It supports the national policies implementing the national objectives overcoming any nations responsible for aggressive acts that imperil the peace and security of the United States.

Navy

http://www.navy.mil/

Seal – Department of the Navy

The mission of the United States Navy is to protect and defend the right of the United States and our allies to move freely on the oceans and to protect our country against her enemies. UCMJ defines the Navy in Section 3062 of Title 10, U.S. Code of Military Justice.

Marines

http://www.marines.com.mil/

Seal – United States Marine Corps

The United States Marine Corps (USMC) is a branch of the United States Armed Forces responsible for providing power projection, using the mobility of the US Navy to deliver rapidly, combined-arms task forces on land, at sea, and in the air.

Air Force

http://www.af.mil/

Seal – Department of the Air Force

According to the National Security Act of 1947 (61 *Stat*. 502), which created the USAF: §8062 of Title 10 US Code defines the purpose of the USAF to preserve the peace and security, and provide for the defense, of the United States, the Territories, Commonwealths, and possessions, and any areas occupied by the United States. The stated mission of the USAF today is to "fly, fight, and win in air, space, and cyberspace."

U.S. Coast Guard

https://www.uscg.mil/

The Coast Guard is one of our nation's five military services. It's core values—honor, respect, and devotion to duty – are the guiding principles used to defend and preserve the United States of America. The Coast Guard protects the personal safety and security of our people; the marine transportation system and infrastructure; our natural and economic resources; and the territorial integrity of our nation–from both internal and external threats, natural and man-made. We protect these interests in U.S. ports, inland waterways, along the coasts, and on international waters.

Each branch of service has their own traditions, trademarks, flags, uniforms, requirements, boot camp, and way of training; however, combined they stand together for the protection of freedom, equality, and rights govern to us by us. The men and women who serve the United States are regular people but when they join the military service a higher standard of personal conduct, integrity, respect, honor, and sacrifice is expected.

Different branches of the military have different uniforms, histories, and tradiations

Section II. Military Culture

Military culture is comprised of the environment veterans have been a part of, and has had a major impact on the lives lead since exiting the military. It is important for those that have never served in the military to be familiar with some fundamentals of military service. Before moving on to specific information, there are a few key terms and characteristics that help describe some common threads that make up the backbone of military culture. These components include *Camaraderie*, *Pride and Esprit de Corps*, *Tradition*, and *The Mission.*

Camaraderie

The first term, *camaraderie*, is arguably the largest component of military culture. The relationship dynamics that arise out of a group of individuals whose success or failures dictates the groups' fate is a hint of the camaraderie experienced in the military. The companionship that comes out of that type of environment is lifelong.

To further reinforce this point, refer to the following quote from an article from the newspaper that focuses and reports on matters concerning the armed forces, *Stars and Stripes*:

"It's an unbreakable trust and kinship forged as men push their brains and bodies to the limits each day, together, in an environment that won't forgive them should one man mess up. One guy keeps the next guy going, to keep all the brothers from falling."

(Ziezulewicz, 2009)

This TED talk by Sebastian Junger entitled *Why Veterans Miss War* might help describe the strong sense of camaraderie a little better. https://www.youtube.com/watch?v=TGZMSmcuiXM

Pride and Esprit de Corps

Pride is undoubtedly a term you are familiar with. To a member of the military, pride (which could also be called Military Bearing) is a driving force behind much of our actions. The uniforms and the way they are worn, the walk, the talk: it is very explicit, strenuously orchestrated, and delivered with the highest possible standards of excellence. It's meant to present an imposing force that inspires faith in our allies, and fear in our enemies. It stirs competition between service members, especially with those in different branches of the military (Sion, 2016). It boosts confidence to the point of thinking and feeling invincible. Pride is understandably a huge driving force in the actions of all those who don the uniform (Schumm, 2003, p.837). All of this is magnified by what the military refers to as esprit de corps.

Esprit de corps is essentially the glue that keeps a group of military men and women united; the common spirit that invokes enthusiasm, devotion, and pride in the unit a service member is part of. With hope and aspirations of being the best, they strive to bring honor to those serving with them and to those that served before them in the same unit. A phenomenal example of this can be found in the following video, *Marine Corps Silent Drill Platoon Stun a Packed Arena.* On the surface, this is a spectacle aimed to entertain. Under the surface, the preparation, precision, and delivery are all aspects of pride. Pride in themselves, pride in their brothers and sisters they serve with, pride in their unit (esprit de corps), and meant to invoke pride in the country's military. The next component, tradition, has its roots in pride and esprit de corps.

Tradition

Four generations of a military family from Cumberland County, Tennessee

Any group of Soldiers, Marines, Airmen, or Seamen are organized into various-sized groups commonly referred to as units. (More on military organization will be detailed further in this chapter.) Each unit has its own traditions and each military member is part of those traditions, carrying on a *tradition* of honor, pride, ability, courage, and competence.

The things service members do while assigned to that unit echo throughout time and bring honor or shame to those the individual is serving with, and those that served before him or her. In the HBO series *Band of Brothers*, the Army's 82nd Airborne Division was glorified for their valor, courage, and bravery during various operations of World War II. Such a fine example can be tarnished and that reputation dwarfed by just a few poor decisions of an overzealous service member.

The Mission

The last term is potentially the most important one, and potentially the most ambiguous. The *mission* is any task that a service member or group is focused on at any given moment. And that task becomes the embodiment of their being until the task is completed. That task can be small or large and may require individual effort or a group approach. Furthermore, each specific unit within the military carries on its own specific mission, regardless of the size of the unit. Within the military, the Mission, especially when in combat, always comes first. It is placed in higher priority than hopes, dreams, health, and safety.

What is a Veteran?

So now that you have a basic understanding of what it is like to serve in the United States military, the next topic to be addressed is the term Veteran. What is a Veteran? This may seem a simple question at first, but in actuality it is a very murky subject. This is evident by conducting a quick online search for "what is a veteran." Search results yield a new definition for practically every different site you go to. Quite frequently, the various sites contradict one another, as well. While most declare that anybody who has served in the military is a veteran, regardless of any other details, some sources include more specific categories, such as total time served in the military, if they served at times of conflict or war, or type of discharge character. To make matters worse, there is confusion among former service members as to what a veteran is, as well.

The safest answer can be gathered from the Department of Veterans Affairs (VA). The following exert helps to clear some of the fog: "Title 38 of the Code of Federal Regulations defines a veteran as a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable (Veterans Authority, 2017)."

The different branches of the military, differences between Active Duty and the part-time components, as well as the different discharge characters will be detailed later in this chapter. For now, the above definition suggests that if they served at all in any branch of the military and were not dishonorably discharged, they are classified as a veteran. This same definition will be utilized for the purposes of this chapter. However, the initial question of what is a veteran is not entirely answered yet.

As a social worker, rarely will you yourself have to award veteran status to any individual. If and when you do, the program you are working with will have its own detailed and specific criteria to establish veteran status. For example, when this author (Brian) administered the Supportive Services for Veteran Families (SSVF) grant, a veterans-exclusive, VA-funded grant with aims of ending homelessness among veterans, the criteria stated that a veteran was an individual who had served at least one day on active duty outside of initial training, and also received any discharge character other than dishonorable (Department of Veterans, 2016).

Other veteran benefits awarded through the VA have their own eligibility criteria. This means a veteran may be eligible for some benefits, such as healthcare, and be ineligible for others, such as education benefits or small business loans. This may help in explaining why some veterans are not fans of the VA. Likely due to a lack of consistent definition, there are many former service members who do not view themselves as veterans. Some may even get defensive or react with guilt or shame when asked, "are you a veteran?" The most important take away from this portion of the text is that the term veteran is foggy at best. If you need to know if an individual was formerly affiliated with the military for whatever reason, you may find the best approach is to simply ask if they ever served in the military. This removes "veteran" from the equation entirely, and may assist in developing rapport with the individual as well (Conard, Allen, & Armstrong, 2015).

Rank Structure and Pay

All individuals affiliated with the military are given a rank in some form or another. Even civilian contractors that are affiliated with the military often have a rank structure that, according to some, has corresponding weight and gravitas as military rankings. Each different military branch has its own unique rank structure. Very specific information regarding the various rank structures can be found at Military.com via the following link: http://www.military.com/join-armed-forces/military-ranks-insignias.html)

To provide a very basic overview, each branch of the military has essentially two separate rank structures: *enlisted* and *officers*.

Enlisted: Enlisted service members are those who were recruited into the military via a recruiter and do not have a military commission. This category can be additionally separated into three categories: *lower-enlisted*, *non-commissioned officers*, and *Senior non-commissioned officers*.

Beginning with the lower-enlisted, these men and women are typically either new to the military, or as a result of disciplinary action have been demoted. In all branches of the military, ranks E-1 through E-4 would fit into this category. They are typically new, have little responsibility outside of taking care of themselves and their assigned equipment, and have the lowest level of pay.

Non-commissioned Officers (ranks E-5 through E-6), also referred to as NCOs, are enlisted personnel that have been awarded their rank through a designated promotion board, have a wide range of knowledge regarding their assigned specialty and of various military regulations and doctrine, and can also be found leading small- to medium-sized groups of service members.

Senior NCOs includes ranks E-7 through E-9, have an abundance of experience and training, having served in their respective branches for at least 15 years or more, are the highest trained enlisted service members. They typically have mastery over multiple specialties and can be found leading medium- to large-sized groups (Military.com, n.d.a).

Officers: Officers are traditionally the leaders within the military and are responsible for strategy. An officer might command *what* to do, and it typically falls to a lower-ranked officer or (more likely) an NCO to figure out *how* to do it. There are significantly fewer officers in the military than enlisted personnel, and all officers are higher ranked than any enlisted service member. In other words, an O1 brand new to the military technically outranks an E9 with 35 years of experience. A subsection of officers exists which are Warrant Officers. Warrant Officers do not have quite as much authority as standard officers, per se; however, Warrant Officers are often experts of their given specialty, and their knowledge and experience affords them just as much (though usually more) respect as their officer kin (Military.com, n.d.a).

As for pay, a chart of all paygrades, which are equivalent to the individual's rank, can be found at the below link. It must be noted that this is a basic pay scale, and does not include information regarding the various additional funds an individual can receive, such as Basic Allowance for Housing (BAH), Basic Allowance for Sustenance (BAS), Hazardous Fire Pay, and Family Separation Pay. **http://militarybenefits.info/2017-military-pay-charts/**

General Organization

If you've ever heard such phrases as Platoon, Company, Battalion, Squadron, Wing, or Regiment, these are words that describe the size of the unit, which command the unit belongs to, and a general description of its capabilities and potential purpose. A ton of information is available about all the specific words, acronyms, and annotations, but the specifics are not necessarily important here. Suffice it to say, the military is organized in an incredibly intricate manner, and has accompanying policy that dictates precisely how much personnel and equipment it needs to accomplish its unique mission. Very basic information pertaining to military structure can be found **here** (Vetfriends.org, n.d.).

As a social worker, the takeaway from this section is this: the unit each individual veteran has served in is often at the

core of the pride he or she has for his or her time in the military. These units are incredibly important to veterans. It may be greatly beneficial for you to look into some background history of your client's unit, as nearly every unit within the military has its own website detailing its history and traditions. This could be a very quick and easy way to gain a lot of rapport with your client.

Active Duty and Part-Time Components

Each branch of the military is comprised of those on Active Duty, and those as part of either the Reserve or National Guard components. The differences between them are fairly obvious: Active duty is serving in the military full-time, while National Guard or Reservists typically serve in the military one weekend each month, with an additional two-week training event each year. It is important to note that while Active Duty and Reserve members are federally funded and monitored, National Guard members are state-funded and report to the Governor of whichever state they originate from. National Guard units are the modern equivalent of state militias (National Center for PTSD, 2012).

Beyond how often the various components don the uniform and serve, or who signs their paychecks, there is a very explicit difference in the benefits and prestige of each component as well. Refer back to the section where what a veteran is was discussed. As far as the majority of federal VA benefits are concerned, National Guard members or Reservists are not viewed as veterans unless they have served on Active Duty in support of either a local or state emergency or combat operation. For example, National Guard members and Reservists deployed to assist the areas struck by Hurricane Katrina were likely placed on Active Duty (effectively making them Active Duty members, albeit temporarily) and henceforth qualified for a variety of benefits they were otherwise ineligible for. Meanwhile, those that honorably completed their weekend duties and two-week training exercises per year with no other periods of service likely found themselves with little to show for it after their military contracts expire, aside from the memories and experiences, and a pension if they served long enough (Veterans Authority, 2017).

Core Values

Much as Social Workers follow the NASW Code of Ethics, each branch of the military has its own unique set of values that all members adhere to. Those values are as follows:

Army – *Loyalty*, *Duty*, *Respect*, *Selfless Service*, *Honor*, *Integrity*, *Personal Courage*

Navy, Marine Corps – *Honor*, *Courage*, *Commitment*

Air Force – *Integrity first*, *Service before self*, *and excellence in all we do*

Whilst serving in the military, the above core values become each individual's creed while they serve, and each veteran likely still follows those values well after their terms of service ends. As some of you may have noticed, the one common value in all of them is honor. With that in mind, as you work with veterans in the future, if you establish yourself as an honorable person you will likely earn the respect and trust of your client. Adversely, if you do not display honorable qualities, you will lose that respect and trust and will likely not get it back. Consistency and honesty is the key. In our experience, veterans are typically apprehensive to work with civilians, and some may be actively looking for a reason not to trust you. Make it hard for them to not trust you. Earn respect, and you will likely be awarded with an intense loyalty (Department of Defense of Core Values, 2009).

Communication

Within the military, clear, concise communication is a requirement. Lives depend on it. The military often utilizes a phonetic alphabet to aid in this. This means that while civilians would say A, B, C, a veteran would likely say *Alpha*, *Bravo*, *Charlie*, etc. It isn't necessarily to learn the phonetic alphabet (though it couldn't hurt and might create some common ground with you and your client), but being clear on your communication is paramount. Veterans are trained to pay close attention to the words others say, and will likely let you know that your message was received and understood (*Roger*, *Lima Charlie/Loud and Clear*, *Wilco/Will Comply*, ring any bells?). Veterans will cling to the words you use, and will likely follow them like it's their mission. Help them out and be very clear.

For example: *I will see you next Thursday, June 15th, at 2:15 pm in my office. Bring documents 1, 2, and 3. You'll need a pen and a pad of paper to write on.* Not *See you Thursday around 2 with the stuff we talked about.* Talking in ambiguities will likely cause anxiety for a veteran, and could potentially impact your relationship. Furthermore, for those of you soft-spoken social workers out there: those veterans with hearing disturbances notwithstanding, speaking softly or quietly to the point you can barely be heard or understood is likely to frustrate the veteran, not to mention cause undue stress at not fully receiving or understanding your message.

Common Misconceptions

Before this section comes to a close a few common misconceptions exist, and might cloud perspective on veterans. Some of these are warranted. Others are not. For those that are not, it is necessary to shine some light on them and hopefully readjust potentially faulty thinking. It is hoped that clearing up some of these issues that may be skewing your understanding of service members may make it easier for you to work with veterans.

All-Volunteer Military: Though there is still the Selective Service, which actively identifies individuals for the Draft should the need arise, there are no "draftees" currently serving in the military. The Draft has been out of commission since 1973. All current US Military members enlisted at their own free will, conquering the arduous enlistment process and clearing all the rigorous specifications (USA.gov, 2017).

Political Mono-Partisan: It seems that many view members of the military as being a part of the conservative or Republican party. This is not necessarily true. Though research acknowledges that military members and veterans slightly favor conservative beliefs, there is still a large percentage of veterans that maintain progressive or liberal views, as well. Veterans belong to an incredibly diverse array of demographics and backgrounds, and have a variety of political affiliations (Newport, 2009).

Humans, not robots: Ingenuity, thinking out of the box, following instincts is highly encouraged within the military, and development of such skills begins during the initial training, and continues throughout the military experience. Veterans do not just blindly follow orders. Veterans prepare, coordinate, assess, complete, and when necessary, question. However, veterans also recognize a purpose greater than themselves, and will do whatever is necessary. And as always, the mission comes first.

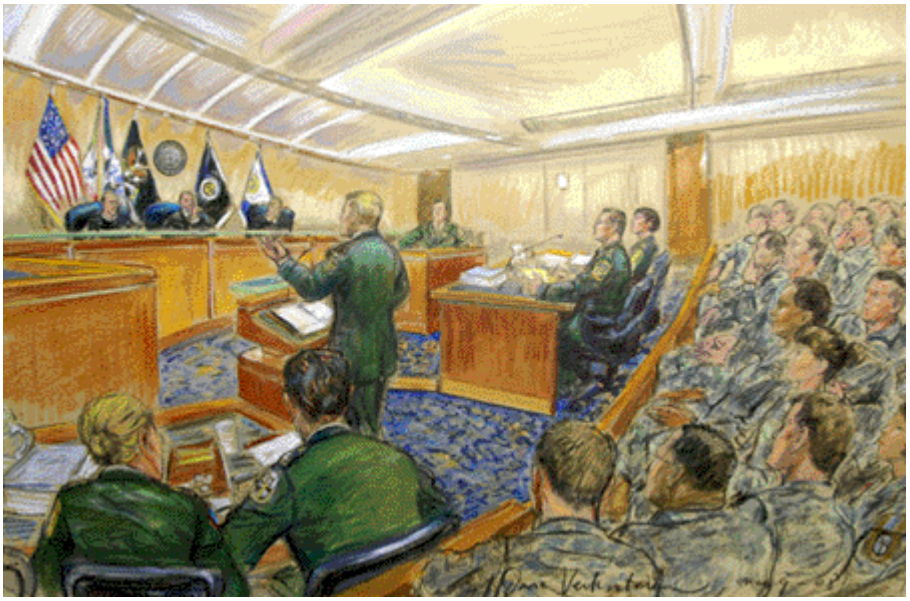
Not stupid: The complex initial testing to enlist in the military aside, veterans strive to make themselves better and more capable. This is done for individual value and sense of worth, but also for the betterment of the unit and to increase its abilities to assist those we are fighting with (Military.com, 2014).

War is missed, but not enjoyed: War is part of the job. In fact, one could easily argue that it is *the* job. When service members are not in combat, they are preparing for it. Though combat can bring about thrills, adrenaline, and excitement unlike any other (potentially on a manic level), there isn't a veteran out there who hasn't experienced fear at the thought of going to war (Davis, 2012).

Veterans are not violent: They are capable and ready for violence, true. But that is not to say all veterans are prone to violence. For the most part, those in the military do not wish to harm others. War is hell, and can create

extremely stressful and chaotic circumstances. The result is typical of the environment they are in. It is human nature to ensure one's own continued survival. When in combat, situations might necessitate action. Those same actions are not glamorized or romanticized. Rather, they are typically the material that makes up the veteran's nightmares and regrets and that is carried throughout the veteran's life. Though it is easy to pass judgement, please remember that there is a world of difference between being there and watching it on television (Davis, 2012).

Section III. Uniform Code of Military Justice



Artist's drawing inside a military courtroom

The Uniform Code of Military Justice (UCMJ), is the foundation of military law in the United States. It was established by the United States Congress in accordance with the authority given by the United States Constitution in Article I, Section 8, which provides that "The Congress shall have Power… To make Rules for the Government and Regulation of the land and naval forces (UCMJ, 2008)." http://www.au.af.mil/au/awc/awcgate/ucmj.htm

UCMJ exists separate from the Unites States (US) Constitution. Military members "rights" are not as extensive as civil rights because members of the armed services are bound by discipline and duty. UCMJ is the only form of "constitutional law" where individuals, whom serve in the armed forces, are subjected to "double" jeopardy which means individuals can be convicted by "civilian law" and "military law" for the same offense.

Discharges

There are seven types of discharge and two categories of due process: administrative and punitive. Administrative covers such military discharge as honorable, general, other than honorable (OTH), and entry level separation (ELS). Punitive covers bad conduct (BCD), officer discharge (dismissal), and dishonorable discharge.

Honorable disocharge papers

Honorable Discharge: When a military member receives good or excellent rating for their service time.

General Discharge: When a military member receives a satisfactory rating and does not meet all expectation of conduct.

Other than Honorable: The most severe type of administrative due process. Examples include: security violations, misuse of violence, conviction by a civilian court system, or being found guilty of adultery.

Entry Level Separation: If an individual leaves the military prior to completing 180 days of service. These individuals are not recognized by their state or federal government as "veterans."

Bad Conduct Discharge: Only passed on to enlisted military member and is processed through court martial. This due process often comes with military prison time.

Officer Discharge: Because commissioned officers cannot receive a BCD or dishonorable discharge nor can they be reduced in rank, they receive a dismissal notice. This notice equates to a dishonorable.

Dishonorable Discharge: When a service member's actions are considered reprehensible. Examples are murder, sexual assault (adult or minor), and child abuse or maltreatment. Individual's whom receive such punitive action are not allowed under Federal law to own or possess a firearm and forfeit all military and veteran benefits.

The UCMJ was enacted by Congress in 1950. The purpose of the UCMJ was to establish a set of standards that outline procedure, substantive criminal law, and procedural safeguards. Prior to the UCMJ each system of military (Navy, Airforce, Army, and Marine Corps) established their own form of law known as Articles of War. The UCMJ united all systems of law developed by individual entities to ensure that military members accused of violating a "law" were subject to the same administrative or punitive charges and procedural rule(s) (UCMJ, 2008).

The UCMJ provides three levels of court systems known as court-martials (general, special, and summary). General court martial handles the more serious offenses and is similar to civilian trial courts. Special court martial handles intermediate level offenses. Special court martial impose such sentences like: six months of confinement (an individual is restricted to barracks, ship, or base movement only and for a certain amount of time allowed for personal reasons), forfeiture of pay, reduction in rank, and bad-conduct discharge. A summary court martial is issued by a commanding officer who handles minor offenses. The maximum penalties include confinement for one month, forfeiture of two-thirds of a month's pay, and reduction in rank.

Court of Criminal Appeals (CCA) hear all cases involving death, punitive discharge (bad conduct, dismissal, or dishonorable), or imprisonment for a term of one year or more. Each branch of service has their own CCA judges and a CCA typically involves a panel review of three judges. The U.S. Court of Appeals for the Armed Forces (USCAAF) is the highest civilian court which is responsible for reviewing the decision of all military courts. Any case(s) where the death penalty is imposed are forwarded by the judge advocate to the USCAAF.

Additional information can be found at the below links.

- https://www.loc.gov/rr/frd/Military_Law/pdf/background-UCMJ.pdf
- https://www.jagcnet.army.mil/Sites/jagc.nsf/0/EE26CE7A9678A67A85257E1300563559/$File/Commanders%20Legal%20HB%202015%20C1.pdf
- https://www.youtube.com/watch?v=ZrapxpNMwhQ
- https://www.youtube.com/watch?v=x6zFbTihfEk
- >https://www.youtube.com/watch?v=7NDiigSOI2A

Key Words

Uniform Code of Military Justice, court martial, court of appeals, dishonorable, honorable, other than honorable, entry level separation, bad conduct, general, officer discharge

Section IV: Family Life

Throughout this chapter, the intricacies of military culture, the military's own unique judicial system, and the differences between the various military branches has been discussed. A closer look at the day-to-day events and family life is appropriate. Though it may be hard to believe, day to day life within the military is not too different from civilian life. There's a job to be done, a daily routine to follow, and outside responsibilities that need attention. Bills, expenses, debt, school, professional development, and goal-setting are part of the life as well. Service members have hopes, dreams, and desires much like anybody else. They also have families. This section will review some more specific information regarding the family life of service members and veterans.

Army Captains Ron and Rikki Opperman play with their children outside their home here. (U.S. Army photo by Capt. Antonia Greene/ Released)

Family life within the military can be successful and rewarding. Extra levels of support and protection are in place to ensure family life stays as consistent as possible and every opportunity of success is offered. Alternatively, it can also be a very precarious environment. We've been at war for a generation now; the young men and women currently fighting overseas could be as young as two or three years old when airplanes collided with the World Trade Center nearly 16 years ago. It's understandably hard to maintain stability within a relationship when the knowledge that your wife or husband, the father or mother of your children, could be called upon to go overseas and potentially never come home. That knowledge is something that lingers overhead like the worst of storm clouds, and adds tension to

relationships that already come with their own intrinsic difficulties. Relationships are tough. Even more so when added stressors are brought to the forefront by the daily challenges and risks that being part of the military can bring.

Military Spouses and Dependents

Spouses and Dependents of service members are an integral part of military life. It is certainly within the realm of possibility to have both service members with spouses and children, or with families with multiple service members. In fact, if you'd reviewed the pay scales previously noted in this chapter, you might have noticed that service members are awarded additions to their paycheck for each dependent they have. These funds are increased by a fair amount when on deployment in support of combat operations overseas (Military Benefits, 2017).

It's important to remind you that the mission always comes first. Always. Men and women who wear the uniform are called upon to serve their country wherever necessary, and under any circumstances (within reason). When that call goes out, it's answered. However, it's important to note that the military is not in the habit of leaving dependents without their beneficiaries, at least without a plan. Each branch of the military has supportive elements in place for service members and their dependents. The military understands an individual cannot perform to their full potential whilst being concerned with what is happening with their wife, husband, or children at home. With that said, service members are required to have a plan in place for their dependents should that call be made. Who is going to take care of your dependents? For how long? How are the finances being taken care of? What happens when crises occur? These are just basic questions that need to be answered for the plan to be accepted. And once the plan is made, it can rarely be deviated from (Duttweiler, n.d.).

These plans are crucial. In fact, service members with dependents might be deemed as "non-deployable" without such plan in place, and may be blocked from participating in deployments. Though this may seem a quick and easy way to avoid heading to combat, it's not quite that simple and could result in UCMJ disciplinary action up to and including discharge from the military. To conclude this matter, a service member cannot deploy with his brothers- and sisters-in-arms unless a plan is in place for his dependents, and to not be deployable is essentially a taboo within the military and can be punishable by discharge. This rule applies in households with one service member involved. In families when both spouses are service members, this rule applies doubly so: each service member must come up with a plan as mentioned earlier, and must also include the scenario of both service members being deployed at the same time. The mission does come first, but that does not mean the military is disinterested in the safety and well being of its members' spouses and children (Duttweiler, n.d.).

Deployment Cycles

As already mentioned, the United States has been at war for quite some time. The military has adjusted its own tactics and most units within the military are on a specific deployment cycle. Before the specifics of such cycle is covered, it should be noted that there are several supportive-based units within the military that are not necessarily part of this cycle. Not all service members are responsible for conducting combat operations. Some, in fact, are exempt from these rotations, and are strictly devoted to other tasks.

A variety of units within each branch of the military are devoted to training; their overall mission is to train the next generation of soldiers, sailors, marines, or airmen. In a rotation that runs consistently throughout the year, new service members hoping to earn the right to serve in the military are cycled in and out, and either successfully join the ranks of their respective branches, or do not and either fail, quit, or are rejected.

Additionally, some units within the military are tasked with operating designated training zones and their mission is to prepare units by conducting combat-related training prior to deployment. Fort Polk, Louisiana's Joint Readiness

Training Center (JRTC), and Fort Irwin, California's National Training Center (NTC) and a variety of others, for example, host year-round wargames (for lack of a better term) with a variety of different units from all branches of the military to ensure they are as ready as can be for any scenario they might face whilst in combat (U.S. Army, 2014).

Another example are the various support units that keep the military running. It takes a large host of men and women to keep these efforts in line and working smoothly. The military, believe it or not, is an incredibly well-oiled machine. This is not achieved by accident. Many service members and civilian contractors are in place to keep things running smoothly.

The rest of the men and women serving in the military who are not part of the above examples typically operate as part of a deployment cycle. These units train independently, with other units, at the training facilities such as NTC or JRTC mentioned above, and even with other militaries from allied nations. This occurs for a set amount of time, and concludes with a deployment in support of combat operations overseas. These deployment cycles vary in length between units and branches of the military. And while some units within the military have advanced training and can be deployed to combat zones in as little as 72 hours, such deployments are typically scheduled months or years in advance. This means that, for the most part, current deployments are usually not a surprise. They obviously are in the event a new conflict occurs. This is why readiness is such a crucial aspect of military life (Pincus, House, & Adler, n.d.).

Divorce Rates

There was a time when divorce rates were significantly higher in the military. A fairly large spike in divorce rates occurred in the early 2000's shortly after the war on terrorism saw hundreds of thousands of service members deploy in support of combat operations overseas. A study posted in the Huffington Post found that of the 462,444 military marriages that occurred between 1999 and 2008, those that occurred prior to the attacks on September 11, 2001 "were 28 percent more likely to divorce within three years of marriage if one or both spouses experienced a deployment to Afghanistan or Iraq that lasted at least one year" (Military divorce risk, 2013, para. 2).

As mentioned earlier, it seems this would not remain consistent. The same article suggested that those who married after 9/11/2001 had a lower divorce rate, suggesting that perhaps they knew what they were getting into and expected frequent stints of being away from one another. This decline in divorce rates amongst service members continues according to **this** article on Military.com, and further suggests that not only have military families grown accustomed to frequent deployments and stints of separation, but have also weathered the storm, as deployments are not happening in quite as rapid succession. In fact, divorce rates have nearly returned to their pre-9/11 rates (Philpott, 2012).

Section V. Health Related Concerns

In 2008, The Department of Veterans Affairs (VA) introduced a new mental health handbook that provides guidelines for VA hospitals and clinics across the US. The new handbook specifies exactly what mental health services VA hospitals and clinics are required, by federal law, to offer all veterans and their families (Department of Veterans Affairs, 2014).

These guidelines include the following mental health requirements:

- Focus on Recovery: This approach requires the focus on individual strengths, a strength base approach.
- Coordinated Care for the Whole Person: VA workers collaborate to provide health care for each veteran to give safe and effective treatment.
- Mental Health Treatment in Primary Care: Each VA clinics uses Patient Aligned Care Teams (PACTs) manage the Veteran's healthcare. A PACT is a medical team that includes mental health experts.
- Mental Health Treatment Coordinator: Mental Health Treatment Coordinator (MHTC) provide specialty mental

health. The MHTC is goal oriented, providing individual or group care.

- Around-the-Clock Service: Mental health care is to provide seven days a week, 24 hours a day. If a VA facility does not offer such service, they are required to provide service through non- VA medical clinics.
- Care that is Sensitive to Gender & Cultural Issues: VA requires each PACT team to receive training regarding military culture, gender differences, and ethnicity.
- Care Close to Home: More VA clinics are opening in rural areas. Mobile clinics are becoming available. The VA is collaborating with community services to provide a larger scope of health services.
- Evidence-Based Treatment: Evidence-based treatments (EBT) are interventions backed by research to provide effective care for multiple health concerns. Each mental health team receives training on current EBT's to ensure the best updated care is being offered.
- Family & Couple Services: In many cases veterans and their families/guardians also require treatment(s): family therapy, marriage counseling, grief counseling, drug addiction, anger management, etc.

Research provided by the VA (2014) suggests, the following mental health concerns rank the highest among veterans; posttraumatic stress disorder (PTSD), depression, substance abuse, traumatic brain injury (TBI), suicide, chronic pain, and sexual assault. Social workers that work with military members and/or families should be familiar with each issue listed.

The VA (2014) defines these mental health concerns as follows:

- PTSD occurs after an individual has experienced, witnessed, or viewed a traumatic event. Symptoms may include relieving the event, avoiding places or things associated with the event, an increase of negative thoughts and emotions, feeling numb, and/or tense (hyperarousal) (Litz, 2009).
- Depression disorder interferes with one's personal life, daily routine, and normal functioning. These symptoms do not pass over a short period of time (Lapierre, 2007).
- Substance use disorder (SUD) is identified as the tolerance to drink greater amounts of alcohol over time, inability to stop drinking or use of drugs, and withdrawal (feeling sick when trying to stop drinking or using drugs) (Bennett, 2014).
- Traumatic Brain Injury occurs when a person experiences a blow to the head or a joggling of the brain. People who experience TBI often experience a change in consciousness, disorientation, loss of memory, and confusion. Most TBI's occur during "combat" conditions (Hoge, McGurk, Thomas, et al., 2008).
- Suicide is behavior which actively seeks self-destruction. Such behaviors are often provoked by the feeling/emotion(s) of loss or hopelessness (Jakupcak, Cook, Imel, et al., 2009).
- Chronic pain is pain that last for six or more months and limits daily activities (work, depressed mood or increase anger, sleep disturbance, withdrawal from family or friends, or hard to participate in physical activities). Chronic pain is different from *acute pain* because it last beyond the healing of an injury (Brandt, Goulet, Haskell, et al., 2012).
- Sexual assault is intentional sexual contact utilizing force, physical threats, abuse of authority, acts of adultery, acts that violate the Uniform Code of Military Justice (UCMJ), or when a person is unable to consent to sexual activity (Burns, Grindlay, Grossman, et al., 2004).

Social workers who work within the VA follow a mission statement that maximizes health and well-being of all military members, families, and communities through the use of EBT. Their vision is leading by example, setting high standards, and establishing innovative psychosocial care and treatment.

"The values established by the VA and UCMJ suggest, that all social workers who serve military members, veterans, military communities, and their families must advocate for optimal health care by respecting the dignity and worth of the individual, understanding military socio-cultural environments, empower veteran's as the primary member of their PACT, respect the individual role and expertise of the veteran, focus on the needs of at-risk-population within military communities/families, promote learning (fostering knowledge, enhances clinical social work practice, advances

leadership, and focuses on administrative excellence), exemplifies and models professional and ethical practice, and promotes conscientious stewardship amongst organizational member(s) and within community services" (VA, 2014).

The Veterans Bureau General Order (1926) was the first to establish a social work program inside the VA. This program allowed 14 social workers who were predominately highered to work on psychiatric and tuberculosis victims. From 1926 to 1946, Irene Grant Dalymple, pioneered the social work medical environment into the current mental health settings seen in today's VA. Her involvement set the stage for the current social work programs that were instrumental in establishing health care systems adapted by the VA after World War I. Prior to WWI, social work services were contracted outside the VA to non-military service type facilities. Due to her contributions, the VA now provides services of health care, mental health, group and family care plans, vocational and psychosocial rehabilitation, and programs to assist with adjustment/coping skills to be reunited back into civilian society.

Today, social workers working in the VA have evolved into a professional service responsible for the treatment of military members, military communities, and family members. These responsibilities include but are not limited to treatment approaches which address individual social problems, acute/chronic conditions, terminal patients, and bereavement. "VA social workers ensure continuity of care through the admission process, evaluation procedure, treatment, and follow-up treatment" (VA, 2017, July 24, para. 8). All continuity of care must include discharge planning and providing case management services.

Populations of veterans needing services are: homeless, the aged, HIV/AIDS patients, spinal cord injury, Ex-Prisoners Of War, Operation Enduring Freedom/Operation Iraqi Freedom veterans, Vietnam and Persian Gulf Veterans, WWI and WWII Veterans, Korean War Veterans, Active/Inactive/Reserve/National Guard members, and their families.

Social workers help coordinate program such as:

- Community Residential Care (CRC)
- Financial or housing assistance
- Getting help from such agencies as Meals on Wheels
- Applying for benefits (health care, vision, optical, mental health, dental, financial, educational, and more)
- Ensuring that members of the PACT know your concerns and decisions
- Arranging for respite care
- Marriage or family counseling
- Moving into an assisted living or nursing home
- Bereavement
- Substance Use Disorder prevention or treatment
- Abuse, mistreatment, being taken advantage of, maltreatment, or need of a guardianship
- Parents who feel overwhelmed with child care
- Parents or spouses dealing with failing health concerns
- Mental health or medical needs
- Need direction of services or other unspecified needs

How can Social Workers help Veterans with problems and concern?

VA social workers have experience in assessment, crisis intervention, high-risk screening, discharge planning, case management, advocacy, education, and psychotherapy. Social workers help with all types of services, plus many more. The VA social workers motto: "If you have a problem or a question, you can ask a social worker. We're here to help you!" (U.S. Department of Veterans Affairs, 2017, July 24, para. 13).

Key Words

Uniform Code of Military Justice, Veteran Administration (VA), Evidence-based treatment (EBT), posttraumatic stress disorder (PTSD), traumatic brain disorder (TBI)

Section VI: Resources for Veterans

It could easily be argued that as long as our nation is involved in conflicts overseas, there will continue to be great efforts to ensure the men and women involved in those conflicts are well taken care of when they return home, and even more so when they retire their uniform and exit the military. There are many available services for veterans, yet access can be challenging. Veteran services are largely area-specific. Web links to state and federal programs will be included in each of the following subsections, but to learn about all the services available will require some searching on your part.

The Department of Veterans Affairs

This is the largest source of support for veterans. The Department of Veterans Affairs is a federal agency within the United States government whose purpose is to fulfill President Lincoln's promise "[t]o care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans" (United States Department of Veterans Affairs, (2015). When it comes to providing services to veterans, the race starts here. This agency has the incredible burden of assisting with millions of pensions, service-related disability claims, education benefits, life insurance claims, healthcare benefits, and much, much more. If you've been paying attention to the news over the past several years, it's no surprise to hear they are struggling to meet the ever-growing needs of service members and veterans. Regardless, the VA is the primary service provider for veterans. For a generalized look at what this organization can provide, check out their website's benefits section **here**. Additionally, for a look at state-funded veteran services, take a look **here**.

County VA offices and VSOs

Like the federal Department of Veterans Affairs, there are also County Veteran Affairs offices. While they are directly linked to the federal VA, they are funded by the local county and usually employ Veteran Service Officers (VSOs). These VSOs assist veterans in completing the rigorous paperwork involved in applying for benefits. And since they are typically locally funded, they likely have access or knowledge of local programs, grants, and services that are not directly administered by the VA. A listing of VSOs can be found **here**.

Mental Health

In addition to Department of VA offices and County VA offices, many larger cities often have Community-Based Outpatient Clinics (CBOCs). Though these CBOCs are often primarily utilized to provide veteran health care, they are typically staffed by one or more Licensed Masters level Social Worker (LMSW), Licensed Professional Counselor (LPC), or Psychologists. Vet Centers are also available in select cities. Vet Centers are connected with the VA, but typically operate independently with the sole purpose of providing individual- and group-therapy to veterans in their identified *catchment* area or area of responsibility. For smaller communities that may not have a CBOC or Vet Center, the VA likely has an agreement or contract setup with a local private agency, though this is not always the case. It's a safe bet that the smaller the city, the more likely a veteran will have to travel to get access to veteran-specific services. Utilizing the *Hospital Locator* here is a quick and effective way at finding local VA mental health services. Take a look!

Veteran Suicide

One last section is necessary when talking about veterans and mental health struggles. Sadly, veteran suicide rates are high. According to a report posted in the *Military Times*, roughly twenty veterans commit suicide every day, and despite making up only 9% of the population, represent 18% of all American suicides.

> The VA has a 24/7/365 Crisis hotline that can be reached via phone (800.273.8255), text (838255) or via online chat regardless if they are registered for any veteran services or not (Suicide Prevention).

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11. Poverty

Povery wordart

Introduction to Poverty

> *"Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time.*
>
> *Poverty has many faces, changing from place to place and across time, and has been described in many ways. Most often, poverty is a situation people want to escape. So poverty is a call to action — for the poor and the wealthy alike — a call to change the world so that many more may have enough to eat, adequate shelter, access to education and health, protection from violence, and a voice in what happens in their communities." – The World Bank Organization*

Although poverty is one of the most familiar and enduring conditions known to humanity, it is a highly complicated concept to understand fully. Above is a definition of poverty given by The World Bank Organization. To date there is no one standard definition of poverty, but numerous definitions and descriptions. All current definitions and descriptions agree that poverty is a complex societal problem.

Regardless as to how poverty is defined, it can be agreed that it is a problem requiring everyone's attention. It is important that all members of our society work together to provide opportunities for all members to reach their full potential. It helps all of us to help one another.

Poverty looks different across the world. Commonly when we think of poverty, we relate it to the images we see

on television of malnourished children living in developing countries. However, poverty is all around us. Even in the wealthiest of countries poverty still exists. Individuals who are living in poverty are made up of all races, ethnicities, ages, backgrounds, and geographic locations (Rodgers, 2015). For many individuals living in poverty, their lives are characterized by low wages, unemployment, underemployment, little property ownership, no savings, and lack of food reserves. The ability to meet even the most basic needs is in constant jeopardy. Feelings of helplessness, dependence, and inferiority develop easily under these circumstances (Sue, Rasheed, & Rasheed, 2012).

Absolute and Relative Poverty

When discussing poverty the terms absolute poverty and relative poverty are often used (Iceland, 2013). Absolute and relative are the two most common forms of poverty delineated in our society and around the world (Pierson & Thomas, 2010).

Absolute poverty

Absolute poverty refers to the amount of money necessary to meet basic needs such as food, clothing, and shelter. The concept of absolute poverty is not concerned with the broader quality of life issues or with the overall level of inequality in society but is based strictly on whether or not basic needs are being met (UNESCO, 2017). Examples of absolute poverty would include not knowing when or where your next meal will come from, not having access to clean drinking water, and not having an adequate place to sleep each night.

Relative poverty

Relative poverty refers to the lack of resources to obtain the types of diet, participate in the activities, and have the living conditions and amenities that are customary to maintain the average standard of living in society (Pierson, & Thomas, 2010; Poverty eradication, 2012). Relative poverty defines poverty in relation to the economic status of other members of the society, therefore determining if people are poor by gauging if they fall below normal standards of living in a given society (UNESCO, 2017). Examples of relative poverty would include not being able to have your children participate in after school activities, not being able to afford to dine out, or not being able to take vacations.

Three degrees of poverty

Evaluating poverty can be broken down into three different levels; the first and most severe is extreme poverty, the second is moderate poverty, and the third is relative poverty.

Extreme poverty

Extreme poverty is the most extensively discussed and researched degree of poverty due to its widespread effect around the world. Those living in extreme poverty are considered the poorest in the world (Harack, 2010). Individuals and families who live in extreme poverty cannot meet their basic needs for survival. These individuals frequently may not have access to food, safe drinking water, shelter, medical care, clothing, and educational opportunities, making everyday life a challenge (Poverty eradication, 2012, The World Bank, 2015).

Moderate poverty

Moderate poverty can be characterized when individuals and families can usually meet their basic needs but commonly face struggles in doing so (Poverty eradication, 2012). Individuals living in moderate poverty are in less danger than those living in extreme poverty. These individuals usually lack much, if any disposable income, but the majority, if not all of their basic needs are being met. Those living in moderate poverty may not be struggling to survive, but this type of poverty does make it difficult for individuals to progress in society and escape poverty completely (Harack, 2010).

Relative poverty: refer to the section above.

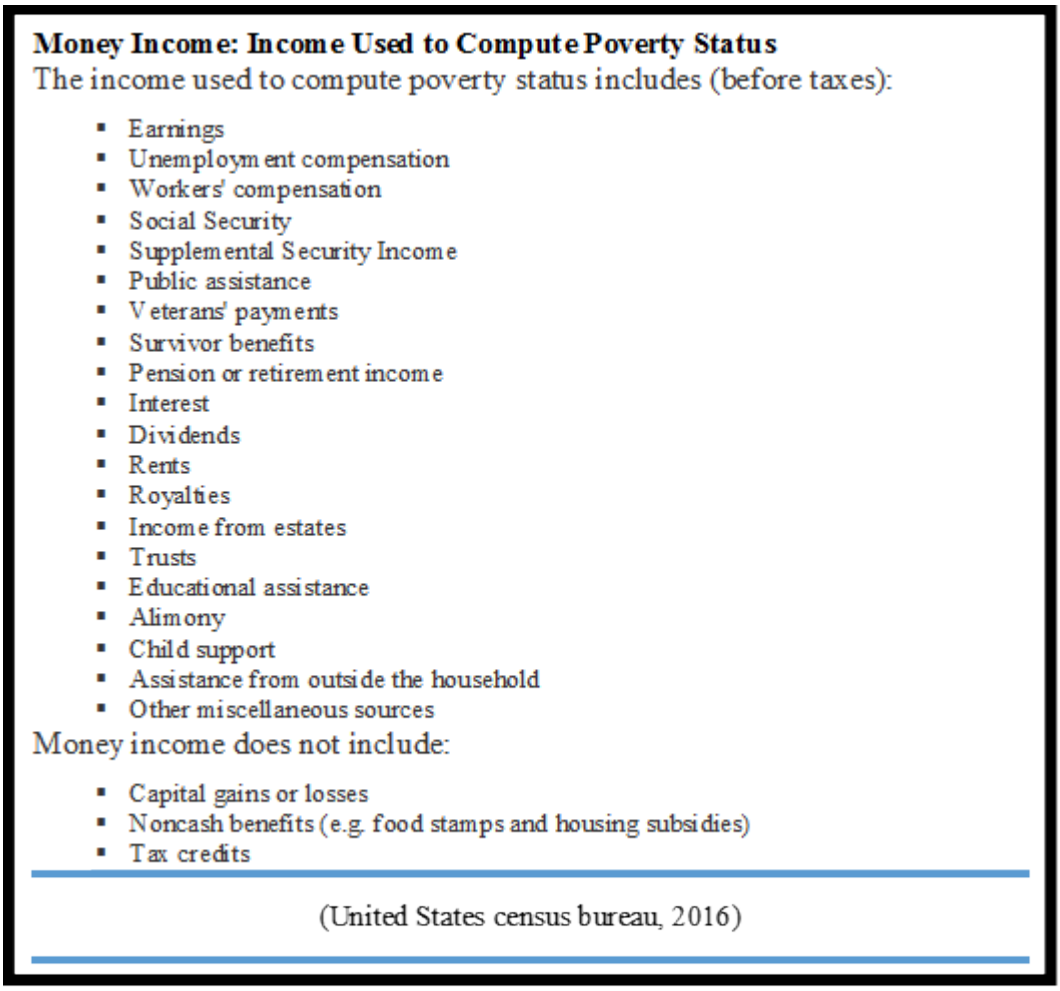
Measuring poverty in the United States

In the United States, there are two official poverty measures. Poverty thresholds are the primary version of the federal poverty measure and the second measure being poverty guidelines.

Poverty thresholds

Poverty thresholds were developed in the mid-1960s by Mollie Orshansky, a staff economist at the Social Security Administration. Orshansky created the poverty threshold by determining the cost of a minimum food diet and then multiplied the cost by three to account for other family expenses (United States Census Bureau, 2016). The U.S Census Bureau updates the threshold annually to account for inflation using the Consumer Price Index (Institute for Research on Poverty, 2016).

The U.S. Census Bureau determines poverty status by comparing pre-tax cash income against the threshold that has been set for that year (Institute for Research on Poverty, 2016). If the family's total income is less than the family's threshold, then that family and every individual in it is considered to be living in poverty (United States Census Bureau, 2016). According to the U.S Census Bureau in 2015, the most recent year for which data is available, the poverty threshold for a family of four was $24,257, and the official poverty rate was 13.5 percent (Institute for Research on Poverty, 2016). Based on the poverty threshold data it was concluded there were 43.1 million people in the United States living in poverty in 2015 (Institute for Research on Poverty, 2016; Proctor, Semega, & Kollar, 2016).



Money income: Income used to compute poverty status

The poverty thresholds are primarily used for statistical purposes which include tracking poverty over time, poverty

rates, and comparing poverty across different demographic groups. Furthermore, the data obtained from the poverty thresholds is used to create and develop annual poverty guidelines. (United States Census Bureau, 2016; Institute for Research on Poverty, 2016)

U.S. Census Bureau Poverty Thresholds, 2015, released September 2016

U.S. Census Bureau Poverty Thresholds, 2015	
Size of Family Unit	Poverty Threshold
One person (unrelated individual)	$12,082
Under age 65	12,331
Age 65 or older	11,367
Two people	15,391
Householder under age 65	15,952
Householder age 65 or older	14,342
Three people	18,871
Three people with two related children	19,096
Four people	24,257
Four people with two related children	24,036
Five people	28,741
Five people with two related children	28,995
Six people	32,542
Six people with two related children	33,342
Seven people	36,998
Seven people with two related children	38,421
Eight people	41,029
Eight people with two related children	43,230
Nine people or more	49,177
Source: U.S. Census Bureau, Poverty Thresholds for 2015 by Size of Family and Number of Related Children Under 18 Years, released in September 2016.	

(United States census bureau, 2016)

Poverty guidelines are the other official federal poverty measure used in the United States. The poverty guidelines are a simplification of the poverty thresholds utilized by the federal government to determine an individual's eligibility for select federal programs (DHHS, 2017).

Updated poverty guidelines are issued every year by the U.S. Department of Health and Human Services (DHHS) (Institute for Research on Poverty, 2016). The 2017 poverty guidelines were determined using data taken from the 2015 poverty thresholds; the updated guidelines take economic changes taken into account.

Examples of federal programs that use poverty guidelines to determine eligibility include the following:

- Department of Health and Human Services: Community Services Block Grant, Head Start, Low-Income Home Energy Assistance
- Department of Agriculture: Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamp Program), National School Lunch Program, Child and Adult Care Food Program
- Department of Energy: Weatherization Assistance for Low-Income Persons
- Department of Labor: Job Corps, National Farmworker Jobs Program, Workforce Investment Act Youth Activities

(Institute for Research on Poverty, 2016)

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,180 for each additional person.	
1	$12,060
2	$16,240
3	$20,420
4	$24,600
5	$28,780
6	$32,960
7	$37,140
8	$41,320

(United States census bureau, 2016)

2017 Povery Guidelines for the 48 Contiguous States and the District of Columbia

Even though the current official poverty measures have been used consistently since the 1960s, there are widespread concerns that the federal poverty measure is flawed. There is an overarching agreement that the Census Bureau does not identify all individuals living in poverty. The Census Bureau is unable to obtain exact numbers because many low-income individuals live with others or are frequently moving, and are in many cases homeless; furthermore, those residing in psychiatric hospitals, college dorms, nursing homes, serving in the military, and/or in jails or prisons are not

counted. It is estimated that several million individuals who likely would fall below the poverty threshold and poverty guidelines are not counted each year (Rodgers, 2015).

For annual updates on poverty thresholds and poverty guidelines and further information on measuring poverty, please visit:

- United States Census Bureau at https://www.census.gov/topics/income-poverty.html
- The U.S Department of Health and Human Services at https://aspe.hhs.gov/poverty-guidelines

Measuring Global Poverty

International poverty line

Currently, global poverty is measured by the international poverty line. The international poverty line is a monetary threshold under which an individual is considered to be living in extreme poverty. It is calculated by taking the poverty threshold from each country, given the value of the goods needed to sustain one adult, and converting it to dollars (The World Bank, 2015).

The international poverty line was developed by The World Bank Organization and a team of independent researchers in order to gauge the number of individuals living in poverty around the world. The researchers examined national poverty lines from most impoverished countries around the world and converted the lines into a common currency by using purchasing power parity (PPP) exchange rates. The PPP exchange rates warrant that the same amount of goods or services are priced equivalently across the nation. Once converted into common currency, it was determined that the value of the national poverty line was $1 per day per person in the 1990s (The World Bank, 2015).

Since the first national poverty line was developed, it has been revised twice, first in the mid-2000s when the line rose to $1.25 per person per day after the collection of additional countries' poverty lines and further data on internationally comparable prices were collected. The second and most recent revision was released in 2015 when the international poverty line rose again to $1.90 per person per day (The World Bank, 2015). Unlike the United States, official poverty measures for the international poverty line does not have a set schedule as to when or how often the line is revised.

For further information on global poverty and how it is measured please visit: The World Bank http://www.worldbank.org/

Poverty in America

Poverty in America is much different than the poverty in third world countries. The standard of what constitutes poverty in the United States is much different than the global standard of poverty (Iceland, 2013). Even though the United States is one of the wealthiest countries in the world, the effects of poverty are crippling.

An example of what living in poverty looks like in America is a single parent who works full time, but still can't afford to pay for food, rent, child care, medical bills, and the costs of transportation to work (Results, 2017).

Each year millions of Americans live in poverty. The United Sates Census Bureau reports that in 2015, there were 43.1 million people in poverty (Proctor, Semega, & Kollar, 2016). A wide array of Americans from all races, ethnicities, ages, backgrounds, and geographic locations make up the 43.1 million people currently living in poverty. Some groups

are more vulnerable to poverty. The most vulnerable groups make up most of the impoverished population (Rodgers, 2015). The groups that are more susceptible to suffer poverty include single parent families (especially those headed by women), minorities, unemployed or under-employed adults, individuals with mental illness or disabilities, and the elderly (Rodgers, 2015).

Poverty is said to be America's most serious and costly social problem (Rodgers, 2015). High levels of poverty result in many serious social and political consequences. Individuals living in poverty frequently feel alienated from a conventional society which can provoke social disorder. Individuals living in poverty also often feel overlooked in the political realm, further reducing the individual's confidence in democratic institutions (Iceland, 2013).

Each year hundreds of billions of public and private dollars are spent on efforts to prevent poverty and assist those living in poverty (Rodgers, 2015). To many, it may seem that the efforts put forth to end poverty have not made an impact. However, the most up to date data attainable from the United States Census Bureau shows that there have been improvements. In 2015, for the first time in five years, the number of individuals living in poverty had decreased. The official poverty rate was down to 13.5%, 1.2% lower than in 2014, equaling 3.5 million fewer people living in poverty (Proctor, Semega, & Kollar, 2016). Although we may never see poverty completely eradicated in our lifetime, it is hopeful that poverty will continue to decrease in the coming years.

Find a Place to Live Simulation

Online poverty simulation game; click link to play: http://playspent.org/html/

Homelessness

Similar to the term poverty, there are numerous definitions for the term homeless or homelessness. We have chosen to use the definition of homeless used by the Department of Health and Human Services (DHHS) that was created by, and in conjunction with, the Health Resource and Service Administration (HRSA). It is as follows:

"A homeless individual is defined in section 330(h)(5)(A) as 'an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the

streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation' (National Health Care for Homeless Council, 2017, para. 2).

Who is experiencing homelessness?

The current 2016 statistics on homelessness in the United States are derived from *The 2016 Annual Homeless Assessment Report* (AHAR) to Congress.

- According to the AHAR the number of individuals experiencing homelessness on any given night in 2016 was 549,928.
- Among the 549,928 individuals who experience homelessness each night in the United States vary by age, race, sex, and other classifiable characteristics.
- According to AHAR, 69% of homeless individuals were over the age of 24, 22% were children and adolescents under the age of 18, and 9% were between the ages of 18 and 24.
- The AHAR reports that 60% of the individuals experiencing homelessness were men, 40% were women, and less than 1% were transgender.
- As for race, the AHAR reports that nearly half of all people experiencing homelessness were white totaling 48%, African Americans 39%, multiracial individuals 7%, and Native Americans, Asians, and Pacific Islanders made up the remaining 6%.

The data collected from the 2016 AHAR to Congress further concluded that homelessness and poverty affects all individuals regardless of age, sex, or race.

Picture of homelessness

Sheltering the Homeless

All information below is from The 2016 Annual Homeless Assessment Report (AHAR).

There are various resources for homeless individuals within the United States to gain safe shelter overnight or for temporary amounts of time. The following are some of the well-known homeless resources in the United States:

Emergency Shelter is a facility with the primary purpose of providing temporary shelter for homeless people

Rapid Rehousing is a housing model designed to provide temporary housing assistance to people experiencing homelessness, moving them quickly out of homelessness and into permanent housing.

Safe Havens are projects that provide private or semi-private long-term housing for people with severe mental illness and are limited to serving no more than 25 people within a facility.

Transitional Housing Programs provide people experiencing homelessness a place to stay combined with supportive services for up to 24 months.

Even with the implementation of the programs listed above, many homeless individuals remain unsheltered on any given night within the United States. Statistics show that 68% (373,571 people) were staying in emergency shelters, transitional housing programs, or safe havens, while 32% (176,357 people) were staying in unsheltered locations.

Rural vs Urban Homelessness

In our society, homelessness is often depicted as an urban problem. Urban areas are known to have a higher population of homeless individuals than in rural areas of the county. However, there is an increasing number of homeless individuals in rural America (National Alliance to End Homelessness, 2010). Geographical location makes a difference to the resources available for those experiencing homelessness, and sadly those living in rural America are often overlooked.

Rural areas face different barriers than urban areas when it comes to serving individuals experiencing homelessness. These barriers include lack of available, affordable housing, limited transportation methods and limited employment opportunities; federal grants and programs also tend to be dispersed in more urban areas (National Alliance to End Homelessness, 2010). The lack of federal funding in rural areas causes a problem when trying to house the homeless. Due to this lack of funding there typically are not homeless shelters in rural areas, causing individuals experiencing homelessness in these areas to sleep in cars, campers, tents because shelter is not available.

Affordable Housing:

There are countless reasons as to why or how an individual becomes homeless, but research shows the key reason as to why he or she cannot escape homelessness is because the individual cannot afford housing. The United States is currently experiencing an extreme shortage of affordable housing (National Alliance to End Homelessness, 2017). The two main types of affordable housing are Public Housing and the Housing Choice Voucher Program (HCVP) which was formerly known as Section 8. It is not uncommon for Public Housing programs and the HCVP to have wait lists that are several years out.

Housing Voucher Program: This program provides vouchers to low-income households to help them pay for housing in the private market and has been found to sharply reduce homelessness (National Alliance to End Homelessness, 2017).

Public Housing: Federally-funded housing that is rented at subsidized rates to eligible low-income families, the elderly, and persons with disabilities.

Federal Government Response to Poverty: Welfare

The United States laid its foundation for a national welfare system in response to the Great Depression that started in 1929 and went through most of the 1930s. The Social Security Act of 1935 was the first of many government policies and welfare programs created to combat poverty and economic hardships (Rodgers, 2015).

The welfare system in the United States consists of government programs which provide financial assistance to individuals and families who cannot support themselves. Welfare programs are funded by taxpayers and allow people to cope with financial stress during challenging periods of their lives. The goals of welfare include the attainment of work, education, and an overall better standard of living and decrease in economic hardship and poverty.

Welfare programs

Since the establishment of Social Security Act of 1935, the federal government has continued to develop numerous welfare programs to attempts to eradicate poverty and the economic hardships faced by millions of Americans.

Key programs to combat poverty include but are not limited to the following:

All information below is from the Center for Poverty Research

1935: The Social Security Act

Part of President Franklin Roosevelt's New Deal legislation, the original act included grants to states for unemployment compensation, aid to dependent children and public health. Today, Social Security is the largest safety net program in the U.S.

1935: Unemployment Insurance

Unemployment insurance was a part of President Franklin Roosevelt's 1935 Social Security Act. Today's U.S. Department of Labor Unemployment Insurance (UI) programs provides benefits to eligible workers who become unemployed through no fault of their own and who meet certain requirements.

1964: Head Start

This pre-school education program was a part of the 1964 Economic Opportunity Act that was designed to reduce disparities among young children. The 1994 Head Start Act Amendments established the Early Head Start program, which expanded the benefits of early childhood development to low-income families with children under three years old.

1964: Supplemental Nutrition Assistance Program (SNAP)

The first Food Stamp program ran from 1939-43, but the program we know today was established with the 1964 Food Stamp Act. The program is now known as the Supplemental Nutrition Assistance Program.

1965: Medicare/Medicaid

These health programs were established with amendments to the Social Security Act in 1965. Today, Medicare provides health insurance for people over 65 years of age and some younger than that but who have certain disabilities or diseases. Medicaid is a Federal and state partnership that provides health coverage for people with low income.

1972: Supplemental Security Income Program (SSI)

SSI is a Federal program that provides income people 65 or older as well as to blind or disabled adults and children.

1972: Women, Infants, and Children (WIC)

WIC is a nutrition program that benefits pregnant women, new mothers and young children who live near poverty and who are at nutritional risk. WIC is not an entitlement program, so the number of people who receive the benefits depends on the amount Congress allots for the program from year to year.

1972: Federal Pell Grant Program

Pell Grants help pay for tuition and other expenses for low-income college students.

1975: The Earned Income Tax Credit (EITC)

The EITC is a tax credit that benefits working people who have low to moderate income, especially families.

1996: Temporary Assistance for Needy Families (TANF)

TANF issues federal grants to states for programs that provide temporary benefits to families with children when the income does not provide for the family's basic needs. Programs include job preparation, family planning, and other benefits as well as cash assistance.

1997: Children's Health Insurance Program (CHIP)

CHIP provides health coverage to nearly eight million children in families who cannot afford private health insurance but who have incomes that are too high to qualify for Medicaid.

According to the United States Census Bureau in 2012, there were approximately 52.2 million (or 21.3 %) people in the United States receiving some sort of assistance through government funded welfare programs (United States Census Bureau, 2016). To receive assistance from government funded programs individuals must meet a certain criteria to be eligible; each program has their own distinct criteria. To apply to these programs individuals must go through state Departments of Health and Human Services (DHHS).

For further information on government funded assistance programs please visit:

- The U.S. Department of Health and Human Services, at https://www.hhs.gov/programs/social-services/index.html
- Benefits. Gov Your Path to Government Benefits, at https://www.benefits.gov/

Poverty Stigmas and Stereotypes

Stigmas

In the United States individuals living in poverty are not only faced with their day to day hardships but also with the harsh stigmas that society has surrounding poverty. When evaluating stigmas surrounding poverty, they typically fall into three categories: institutional, social, and personal stigmas (Bell, 2012; Inglis, 2016):

Institutional Stigmas: institutional level stigma can be seen in laws, policies and institutional practices that discriminate against, or shame individuals living in poverty (Inglis, 2016). Institutional stigma is that which arises from the process of claiming benefits (Bell, 2012)

Social Stigmas: Social stigma includes public attitudes toward poverty and welfare, and are typically measured through national surveys (Inglis, 2016). Social stigma is the feeling that other people judge claiming benefits to be shameful (Bell, 2012)

Personal Stigmas: Personal stigma occurs when individuals internalize the various forms of stigma and discrimination that they experience or perceive from others (Inglis, 2016). Personal stigma is a person's own feeling that claiming benefits is shameful (Bell, 2012).

Stereotypes

Furthermore, society holds many stereotypes about individuals living in poverty. A stereotype can be defined as an often unfair and untrue belief that many people have about all people with a specific characteristic (Stereotype, 2017). The stereotypes that society has labeled individuals living in poverty are usually false. Some of the most common stereotypes and misconceptions of individuals living in poverty include:

- Individuals living in poverty are lazy and have weak work ethics

  In reality, there is no suggestion that individuals living in poverty are lazier or have weaker work ethics than individuals from other/higher socioeconomic groups. In fact, poor working adults work, on average, 2,500 hours per year, the rough equivalent of 1.2 full-time jobs often patching together several part-time jobs in order to support their families (Gorski, 2013)

- Individuals living in poverty have problems with substance use

  In reality, research has shown that low-income individuals are less likely to use or abuse substances than their wealthier counterparts (Gorski, 2013).

Stigmatizing and stereotyping individuals living in poverty only further creates a divide between low-income people who are living in poverty and those who are not (Inglis, 2016). Society's harsh views on poverty cause impoverished individuals to further feel socially excluded and ashamed of the situation they are in. Research has shown negative

effects on an individual's self-esteem, self-concept, and mental and physical health due to being stigmatized and stereotyped so severely by society (Inglis, 2016).

Theories and Explanations of Poverty

There are many theories that attempt to explain poverty and why it exists. A theory in simple terms can be defined as idea or a structure of ideas intended to explain something (Theory, 2017). You will learn more about theories in-depth in higher level social work courses.

The following are some of the most commonly used theories to explain the existence of poverty.

The Culture of Poverty

The culture of poverty theory was created by the anthropologist Oscar Lewis in 1959. The culture of poverty is the theory that certain groups and individuals persist in a state of poverty because they have distinct beliefs, values, behavior, and attitudes that are incompatible with economic success (Pierson, & Thomas, 2010). Therefore, the individuals are unable to get out of poverty.

The Cycle of Poverty

The cycle of poverty is also commonly known as the cycle of deprivation. The cycle of deprivation is a theoretical explanation for the persistence of poverty. The theory focuses on how attitudes, values, and behaviors are passed on from one generation to the next, further explaining the ongoing cycle of low educational attainment, unemployment, poor housing and so on within families and communities (Pierson & Thomas, 2010).

As discussed in the explanation of the cycle, poverty is passed down generationally, meaning that children and adolescents are targeted victims falling into the cycle of poverty and not getting out of it. There is much research that indicates that children and adolescents who grow up in poverty suffer significant disadvantages, not just as children but throughout their lifespan. Alarming statistics report that children who grow up in poverty are twice as likely to drop out of school and are one and half times more likely to be unemployed (Rodgers, 2015), further contributing to the ongoing cycle of poverty.

Structural/Environmental Explanation:

Structural explanations propose that poverty is based on the social structure of society (Kirst-Ashman, 2013). To put it simply, the structural explanation suggests that poverty and its ongoing existence results from problems in society that lead to a lack of opportunity and a lack of jobs (University of Minnesota, 2010). Structural and environmental factors that play a role in this explanation include fluctuations in the economy, not having enough jobs in the job market, low paying jobs or jobs with no benefits, lack of affordable housing, and discrimination (Ritter, 2014). An example of this would be: poverty occurs when wages are too low and that there are not enough adequate paying jobs (Kirst-Ashman, 2013).

Individualistic Explanation:

Similar to the culture of poverty theory, the individualistic explanation of poverty suggests that poverty results from the fact that poor people lack the motivation to work and have certain beliefs and values that contribute to their poverty (University of Minnesota, 2010). Individual factors that contribute to a person living in poverty may include lack of job skills, educational deficits, mental illness, declining health or disabilities, substance use, single parenting, lack of childcare, and lack of reliable transportation (Ritter, 2014). An example of this would be: a person who lost their job due to being late so many days in a row and now he or she cannot afford rent and may be at risk of becoming homeless.

Poverty and Social Work

National Association of Social Work

As discussed in chapter two, social workers abide by the National Association of Social Work (NASW) Code of Ethics. One of the six values in the NASW code of ethics is social justice. The definition of the ethical principle from the NASW states, "Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice," (NASW, 2008). With the NASW Code of Ethics acting as the professions guiding light

it is highly important for social workers to have knowledge and understanding of poverty and its severity within our society and around the world.

Social work's role

The social work profession has an extensive history of working to assist poverty at the micro, mezzo, and macro levels (National Association of Social Workers, 2017). The following are examples of social work roles on each of the three levels.

Micro

Case Study: Micro Level Social Work

"A social worker has an intervention with a young woman living in a poor urban community. When she first appeared for social services, the young woman was pregnant, depressed and unable to pay her rent. However, she was determined to improve her life circumstances and those for her unborn child. She couldn't save money because she had another child to support. Although he was emotionally supportive, her partner was unable to financially contribute to her support. During their work together, the social worker was able to develop a plan of action with her client. By following up on leads, the young woman was connected with several sources of tangible help in her community. Over the next few months, she was able to identify subsidized housing, obtain prenatal care, and receive treatment for her depression and to enroll in a part-time job training program. Her partner was also able to find employment through a community job bank. By the time her baby was born, the young woman's outlook on life was brighter."

(NASW, 2017)

Micro level practice works with an individual or a family on a one-on-one basis (Giffords, & Garber, 2014). Micro level social workers are the clinicians who often work most hands- on with individuals who are living in poverty. Micro practice, as it relates to poverty, may include linking a client to unemployment resources, housing resources, assisting individuals in applying for welfare programs, and helping the individual cope with the hardships of living in poverty.

Mezzo

Intervening at the group level constitutes mezzo practice (Giffords, & Garber, 2014). Some focuses on mezzo level social work practice in regards to poverty include facilitating groups that focus on employment skills, working in schools to help low-income children learn to read and write better, and working with community organizations and agencies that assist with poverty and homelessness.

Macro

At the Macro level social workers focus on effecting systematic change that can benefit individuals at a societal level (MSW careers, 2017). In regards to poverty some of the ways macro level social workers can assist include advocating for laws that affect those living in poverty, developing programs to assist individuals and families living in poverty, and educating the community on the need for social change.

For further information on micro, mezzo, and macro social work please refer back to Chapter 4.

Summary

After reading this chapter it is my hope that you have expanded your knowledge and understanding of poverty and how it closely relates to the social work profession. As previously stated social works focus on poverty stems back the NASW Code of Ethics which acts as the professions guiding light.

Regardless as to what career path you take in the field of social work it is anticipated that you will serve individuals and families who fall below the poverty line and face financial hardships. Therefore, as future social workers it is important that you have an adequate understanding of what poverty is and the effects it has on individuals and society as a whole.

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12. LGBTQ+

"Transgender," vs. "Transgendered," "Trans," "Trans*," "Non-binary," "Genderqueer," "Genderfluid," "Agender," "Transsexual," "Cisgender," "Cis"

Transgender generally refers to individuals who identify as a gender not assigned to them at birth. The term is used as an adjective (i.e., "a transgender woman," not "a transgender"), however some individuals describe themselves by using transgender as a noun. The term **transgendered** is not preferred because it emphasizes ascription and undermines self-definition. **Trans** is an abbreviated term and individuals appear to use it self-referentially these days more often than **transgender**. **Transition** is both internal and social. Some individuals who transition do not experience a change in their gender identity since they have always identified in the way that they do. **Trans*** is an all-inclusive umbrella term which encompasses all nonnormative gender identities (Tompkins 2014). **Non-binary** and **genderqueer** refer to gender identities beyond binary identifications of man or woman. The term genderqueer became popularized within queer and trans communities in the 1990s and 2000s, and the term non-binary became popularized in the 2010s (Roxie 2011). **Agender,** meaning "without gender," can describe people who do not have a gender identity, while others identify as non-binary or gender neutral, have an undefinable identity, or feel indifferent about gender (Brooks 2014). **Genderfluid** people experience shifts between gender identities. The term **transsexual** is a medicalized term and indicates a binary understanding of gender and an individual's identification with the "opposite" gender from the gender assigned to them at birth. **Cisgender** or **cis** refers to individuals who identify with the gender assigned to them at birth. Some people prefer the term **non-trans.** Additional gender identity terms exist; these are just a few basic and commonly used terms. Again, the emphasis of these terms is on viewing individuals as they view themselves and using their self-designated names and pronouns.

#LiA Living History of the LGBT Movement Since The 1800svingHistory

The Life and Death of Marsha P Johnson https://www.youtube.com/watch?v=00U7rnz6trk

"Queer," "Bisexual," "Pansexual," "Polyamorous," "Asexual,"

Queer as an identity term refers to a non-categorical sexual identity; it is also used as a catch-all term for all **LGBTQ** (**lesbian**, **gay**, **bisexual**, **transgender**, **queer**) individuals. The term was historically used in a derogatory way, but was reclaimed as a self-referential term in the 1990s United States. Although many individuals identify as queer today, some still feel personally insulted by it and disapprove of its use. **Bisexual** is typically defined as a sexual orientation marked by attraction to either men or women. This has been problematized as a binary approach to sexuality, which excludes individuals who do not identify as men or women. **Pansexual** is a sexual identity marked by sexual attraction to people of any gender or sexuality. **Polyamorous** (**poly**, for short) or **non-monogamous** relationships are open or non-exclusive; individuals may have multiple consensual and individually-negotiated sexual and/or romantic relationships at once (Klesse 2006). **Asexual** is an identity marked by a lack of or rare sexual attraction, or low or absent interest in sexual activity, abbreviated to "**ace**" (Decker 2014). Asexuals distinguish between sexual and **romantic attraction**, delineating various sub-identities included under an **ace umbrella.** In several later sections of this book, we discuss the terms **heteronormativity, homonormativity,** and **homonationalism**; these terms are not self-referential identity descriptors but are used to describe how sexuality is constructed in society and the politics around such constructions.

The Stonewall Riots: How the gay rights movement began
#TheStonewallRiots
#GayRights
#GlobalNewsExplains
Unit II: Challenging Binary Systems and Constructions of Difference

The Sex/Gender/Sexuality System

The phrase "**sex/gender system,**" or "**sex/gender/sexuality system**" was coined by Gayle Rubin (1984) to describe, "the set of arrangements by which a society transforms biological sexuality into products of human activity." That is, Rubin proposed that the links between biological sex, social gender, and sexual attraction are products of culture. Gender is, in this case, "the social product" that we attach to notions of biological sex. In our **heteronormative** culture, everyone is assumed to be heterosexual (attracted to men if you are a woman; attracted to women if you are a man) until stated otherwise. People make assumptions about how others should act in social life, and to whom they should be attracted, based on their perceptions of outward bodily appearance, which is assumed to represent biological sex characteristics (chromosomes, hormones, secondary sex characteristics and genitalia). Rubin questioned the biological determinist argument that suggested all people assigned female at birth will identify as women and be attracted to men. According to a biological determinist view, where "biology is destiny," this is the way nature intended. However, this view fails to account for human intervention. As human beings, we have an impact on the social arrangements of society. Social constructionists believe that many things we typically leave unquestioned as conventional ways of life actually reflect historically- and culturally-rooted power relationships between groups of people, which are reproduced in part through **socialization** processes, where we learn conventional ways of thinking and behaving from our families and communities. Just because female-assigned people bear children does not necessarily mean that they are always by definition the best caretakers of those children or that they have "natural instincts" that male-assigned people lack.

"Kid Girl Doll Child Expression Cute Face Baby" by Max Pixel is in the Public Domain, CC0

For instance, the arrangement of women caring for children has a historical legacy (which we will discuss more in the section on gendered labor markets). We see not only mothers but other women too caring for children: daycare workers, nannies, elementary school teachers, and babysitters. What these jobs have in common is that they are all very female-dominated occupations AND that this work is economically undervalued. These people do not get paid very well. One study found that, in New York City, parking lot attendants, on average, make more money than childcare workers (Clawson and Gerstel, 2002). Because "mothering" is not seen as work, but as a woman's "natural" behavior, she is not compensated in a way that reflects how difficult the work is. If you have ever babysat for a full day, go ahead and multiply that by eighteen years and then try to make the argument that it is not work. Men can do this work just as well as women, but there are no similar cultural dictates that say they should. On top of that, some suggest that if paid caretakers were

mostly men, then they would make much more money. In fact, men working in female-dominated occupations actually earn more and gain promotions faster than women. This phenomenon is referred to as the **glass escalator.** This example illustrates how, as social constructionist Abby Ferber (2009) argues, social systems produce differences between men and women, and not the reverse.

Gender and Sex – Transgender and Intersex

A binary gender perspective assumes that only men and women exist, obscuring gender diversity and erasing the existence of people who do not identify as men or women. A gendered assumption in our culture is that someone assigned female at birth will identify as a woman and that all women were assigned female at birth. While this is true for **cisgender** (or "cis") individuals—people who identify in accordance with their gender assignment—it is not the case for everyone. Some people assigned male at birth identify as women, some people assigned female identify as men, and some people identify as neither women nor men. This illustrates the difference between, **gender assignment**, which doctors place on infants (and fetuses) based on the appearance of genitalia, and **gender identity,** which one discerns about oneself. The existence of **transgender people**, or individuals who do not identify with the gender they were assigned at birth, challenges the very idea of a single sex/gender identity. For example, trans women, women whose bodies were assigned male and who identify as women, show us that not all women are born with female-assigned bodies. The fact that trans people exist contests the biological determinist argument that biological sex predicts gender identity. Transgender people may or may not have surgeries or hormone therapies to change their physical bodies, but in many cases they experience a change in their social gender identities. Some people who do not identify as men or women may identify as **non-binary**, **gender fluid**, or **genderqueer,** for example. Some may use gender-neutral pronouns, such as ze/hir or they/them, rather than the gendered pronouns she/her or he/his. As pronouns and gender identities are not visible on the body, trans communities have created procedures for communicating gender pronouns, which consists of verbally asking and stating one's pronouns (Nordmarken, 2013).

The existence of sex variations fundamentally challenges the notion of a binary biological sex. **Intersex** describes variation in sex characteristics, such as chromosomes, gonads, sex hormones, or genitals. The bodies of individuals with sex characteristics variations do not fit typical definitions of what is culturally considered "male" or "female." "Intersex," like "female" and "male," is a socially constructed category that humans have created to label bodies that they view as different from those they would classify as distinctly "female" or "male." The term basically marks existing biological variation among bodies; bodies are not essentially intersex—we just call them intersex. The term is slightly misleading because it may suggest that people have complete sets of what would be called "male" and "female" reproductive systems, but those kinds of human bodies do not actually exist; "intersex" really just refers to biological variation. The term "hermaphrodite" is therefore inappropriate for referring to intersex, and it also is derogatory. There are a number of specific biological sex variations. For example, having one Y and more than one X chromosome is called Kleinfelter Syndrome.

Does the presence of more than one X mean that the XXY person is female? Does the presence of a Y mean that the XXY person is male? These individuals are neither clearly chromosomally male or female; they are chromosomally intersexed. Some people have genitalia that others consider ambiguous. This is not as uncommon as you might think. The Intersex Society of North America estimated that some 1.5% of people have sex variations—that is 2,000 births a year. So, why is this knowledge not commonly known? Many individuals born with genitalia not easily classified as "male" or "female" are subject to genital surgeries during infancy, childhood, and/or adulthood which aim to change this visible ambiguity. Surgeons reduce the size of the genitals of female-assigned infants they want to make look more typically "female" and less "masculine"; in infants with genital appendages smaller than 2.5 centimeters they reduce the size and assign them female (Dreger 1998). In each instance, surgeons literally construct and reconstruct individuals' bodies to fit into the dominant, binary sex/gender system. While parents and doctors justify this practice as in "the best interest of the child," many people experience these surgeries and their social treatment as traumatic, as they are typically performed without patients' knowledge of their sex variation or consent. Individuals often discover their chromosomal makeup, surgical records, and/or intersex status in their medical records as adults, after years of physicians hiding this information from them. The surgeries do not necessarily make bodies appear "natural," due to scar tissue and at times, disfigurement and/or medical problems and chronic infection. The surgeries can also result in psychological distress. In addition, many of these surgeries involve sterilization, which can be understood as part of eugenics projects, which aim to eliminate intersex people. Therefore, a great deal of shame, secrecy, and betrayal

surround the surgeries. Intersex activists began organizing in North America in the 1990s to stop these nonconsensual surgical practices and to fight for patient-centered intersex health care. Broader international efforts emerged next, and Europe has seen more success than the first wave of mobilizations. In 2008, Christiane Völling of Germany was the first person in the world to successfully sue the surgeon who removed her internal reproductive organs without her knowledge or consent (International Commission of Jurists, 2008). In 2015, Malta became the first country to implement a law to make these kinds of surgeries illegal and protect people with sex variations as well as gender variations (Cabral & Eisfeld, 2015). Accord Alliance is the most prominent intersex focused organization in the U.S.; they offer information and recommendations to physicians and families, but they focus primarily on improving standards of care rather than advocating for legal change. Due to the efforts of intersex activists, the practice of performing surgeries on children is becoming less common in favor of waiting and allowing children to make their own decisions about their bodies. However, there is little research on how regularly nonconsensual surgeries are still performed in the U.S., and as Accord Alliance's standards of care have yet to be fully implemented by a single institution, we can expect that the surgeries are still being performed.

The concepts of "transgender" and "intersex" are easy to confuse, but these terms refer to very different identities. To review, transgender people experience a social process of gender change, while intersex people have biological characteristics that do not fit with the dominant sex/gender system. One term refers to social gender (trans*gender*) and one term refers to biological sex (inter*sex*). While transgender people challenge our binary (man/woman) ideas of gender, intersex people challenge our binary (male/female) ideas of biological sex. Gender theorists, such as Judith Butler and Gayle Rubin, have challenged the very notion that there is an underlying "sex" to a person, arguing that sex, too, is socially constructed. This is revealed in different definitions of "sex" throughout history in law and medicine—is sex composed of genitalia? Is it just genetic make-up? A combination of the two? Various social institutions, such as courts, have not come to a consistent or conclusive way to define sex, and the term "sex" has been differentially defined throughout the history of law in the United States. In this way, we can understand the biological designations of "male" and "female" as social constructions that reinforce the binary construction of men and women.

#ThisIsWhatNonBinaryLooksLike

This Is What Non Binary Looks Like

Challenging Binary Systems and Constructions of Difference

Alternatives to Binary Systems'

Through all these examples, we hope to show that binary ways of understanding human differences are insufficient for understanding the complexities of human culture. Binary ways of thinking assume that there are only two categories of gender, race, and class identities among others, and that these two categories are complete opposites. Just as men are defined as "not women" in a binary system, straight people are defined as "not gay," white people are defined as "not Black," and middle-class people are defined as "not poor." Oppositional, binary thinking works strategically such that the dominant groups in society are associated with more valued traits, while the subordinate groups, defined as their opposites, are always associated with less valued traits. Thus, the poles in a binary system define each other and only make sense in the presence of their opposites. Masculinity only has meaning as the opposite of femininity. In reality, identities and lives are complex and multi-faceted. For one, all categories of identity are more richly expressed and understood as matrices of difference. More than that, all of us have multiple aspects of identity that we experience simultaneously and that are mutually constitutive. Our experience of gender is always shaped by our race, class, and other identities. Our experience of race is particular to our gender, class, and other identities as well. This is why taking an intersectional approach to understanding identity gives us a more complex understanding of social reality. Each of our social locations is impacted by the intersection of several facets of identity in a way that should give us pause when we encounter blanket statements like "all men are _____" or "all Latinas are _____" or "all lesbians are____." The social world is complex, and rather than reducing human difference to simple binaries, we must embrace the world as it is and acknowledge the complexity.

Sexualities

As discussed in the section on social construction, heterosexuality is no more and no less natural than gay sexuality or bisexuality, for instance. As was shown, people—particularly sexologists and medical doctors—defined heterosexuality and its boundaries. This definition of the parameters of heterosexuality is an expression of power that constructs what types of sexuality are considered "normal" and which types of sexuality are considered "deviant." Situated, cultural norms define what is considered "natural." Defining sexual desire and relations between women and men as acceptable and normal means defining all sexual desire and expression outside that parameter as deviant. However, even within sexual relations between men and women, gendered cultural norms associated with heterosexuality dictate what is "normal" or "deviant." As a quick thought exercise, think of some words for women who have many sexual partners and then, do the same for men who have many sexual partners; the results will be quite different. So, within the field of sexuality we can see power in relations along lines of gender and sexual orientation (and race, class, age, and ability as well).

Adrienne Rich (1980) called heterosexuality "compulsory," meaning that in our culture all people are assumed to be heterosexual and society is full of both formal and informal enforcements that encourage heterosexuality and penalize sexual variation. Compulsory heterosexuality plays an important role in reproducing inequality in the lives of sexual minorities. Just look at laws; in a few states, such as Indiana, joint adoptions are illegal for gay men and lesbians (Lambda Legal). Gay men and lesbians have lost custody battles over children due to **homophobia**—the fear, hatred, or prejudice against gay people (Pershing, 1994). Media depictions of gay men and lesbians are few and often negatively stereotyped. There are few "out" gay athletes in the top three men's professional sports—basketball, baseball, and football—despite the fact that, statistically, there are very likely to be many (Zirin, 2010). Many religious groups openly exclude and discriminate against gay men and lesbians. Additionally, **heteronormativity** structures the everyday, taken-for-granted ways in which heterosexuality is privileged and normalized. For instance, sociologist Karen Martin studied what parents say to their children about sexuality and reproduction, and found that with children as young as three and five years old, parents routinely assumed their children were heterosexual, told them they would get (heterosexually) married, and interpreted cross-gender interactions between children as "signs" of heterosexuality (Martin 2009). In this kind of socialization is an additional element of normative sexuality—the idea of **compulsory monogamy**, where exclusive

romantic and sexual relationships and marriage are expected and valued over other kinds of relationships (Willey 2016). Therefore, heteronormativity surrounds us at a very young age, teaching us that there are only two genders and that we are or should desire and partner with one person of the opposite gender, who we will marry.

Just like gender, sexuality is neither binary nor fixed. There are straight people and gay people, but people are also bisexual, pansexual, omnisexual, queer, and heteroflexible, to name a few additional sexual identities. Also, sexual attraction, sexual relations and relationships, and sexual identity can shift over a person's lifetime. As there are more than two genders,,there are more than two kinds of people to be attracted to and individuals can be attracted to and can relate sexually to multiple people of different genders at once!

Another common misconception is that not all transgender people are sexually queer. This belief may stem from the "LGBT" acronym that lists transgender people along with lesbians, gay men, and bisexuals. A trans man who previously identified as a lesbian may still be attracted to women and may identify as straight, or may identify as queer. Another trans man may be attracted to other men and identify as gay or queer. This multiplicity suggests that the culturally dominant binary model fails to accurately encapsulate the wide variety of sexual and gender lived experiences

"It Gets Better" — Love, Pixar

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/exploringhumanservices/?p=146#oembed-1

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13. Social Work and the Health Care System

Medical social work is viewed as one of the most significant fields in practice. It has been acknowledged as the first subspecialty discipline to practice in hospital, public health, and clinical settings (Allen & Spitzer, 2016).

Medical Social Work

Medical social work can be defined as a specific form of specialized medical and public health care that focuses on the relationship between disease and human maladjustment (NASW, 2012; Gehlert, 2011).

In the 20th century, social service departments in hospitals were developed to address problems associated with the increase of immigration and poverty. The need for medical social work in the United States has intensified due to the substantial inequality of health care resources. Individuals and families that live in poverty or who are a part of certain ethnic communities are additionally at a disadvantage because they are more prone to experience higher rates of acute and or chronic illnesses. Therefore, the unequal distribution of healthcare insurance coverage in the United States hinders some people from seeking medical treatments due to their socioeconomic status. In 2013, more than 42 million people in the United States were uninsured. Today, the number has only increased (NASW, 2016).

Medical social workers practice in a variety of healthcare settings such as hospitals, community clinics, preventative public health programs, acute care, hospice, and out-patient medical centers that focus on specialized treatments or populations. These professionals help patients and their families through life changing and sometimes traumatic medical experiences. They often monitor and evaluate a patient's mental and emotional health as they transition through a variety of medical treatments. Medical social workers also often find themselves helping the patient and family solve problems be that of financial difficulties or one-to-one counseling to help cope with new stressors (Mizrahi & Davis, 2008; NASW, 2016).

All medical social workers must familiarize themselves with cross-cultural knowledge in order to provide effective health care. They do this by familiarizing themselves with an array of different ethnicities, cultural beliefs, practices, and values that shape their family system. Medical social workers must have the ability to recognize how oppression can affect an individual's bio-psycho-social-spiritual well-being. As future social workers, being able to understand and identify these issues will enhance your skills as a professional to provide excellent health care (Mizrahi & Davis, 2008; NASW, 2016).

For more information regarding cultural competency in social work, refer to Chapter 3.

Goals of Practice

The National Association of Social Workers (NASW) *Standard for Social Work Practice in Health Care Setting* (2016), describes eight standards of practice for health care social workers to follow. The eight goals were created as a guideline so that medical social workers would deliver excellent care.

Eight Standards of Practice for Health Care Social Workers

- All medical social workers in the healthcare arena must practice in accordance with the social work code of ethics.
- Advocate for client's right to self-determination, confidentiality, access to supportive services and resources, and appropriate inclusion in decision making that affects their overall health and well-being.
- Encourage social work participation in the development, refinement, and integration of best practices in health care.
- Enhance the quality of social work services provided to clients and families in health care settings.
- Promote social work participation in system wide quality improvement and research efforts within health care settings.
- Provide a basis for the development of continuing education materials and programs related to social work in health care settings.
- Promote social work participation in the development and refinement of public policy at the local, state, federal, and tribal levels to support the well-being of clients, families, and communities served by the rapidly evolving U.S. health care system.
- Inform policymakers, employers, and the public about the essential role of social workers across the health care continuum.

The first and second standards of practice are extremely important to remember as you become professional social workers. All medical social workers must practice in accordance to the social work code of ethics. The social work code of ethics is rooted in a set of core values. Social work's primary goal is to provide excellent service and to promote social justice for all patients, thereby ensuring that all medical and psychological services are met. Medical social workers must also embrace the importance of human relationships by building a positive and lasting rapport with clients. Always strive for professional competence by increasing the use of education and research and applying them to practice (NASW, 2016). For more information, please refer to Chapter 2 regarding the social work code of ethics.

Medical social workers advocate for the patient's right to self-determination. Every patient is entitled to make their own decision based on treatment recommendations. The treatment team may desire and advocate for the best medical care for their patient; however, it is ultimately the patient's decision to follow through with treatment. There are times when a patient may not be able to speak for themselves. You could encounter these situations when the patient is a child or if an adult has a cognitive impairment that enables them to make decisions for themselves. In these cases, the family has the authority to make the decision based on what they feel is the best course of action (NASW, 2016).

Case Study

In 1983, the University of Arizona was beginning to perform an experimental procedure on infants who were born with a congenital heart defect called Transposition of the Great Arteries (TGA). Katherine Frasier was born with this rare heart condition. Katherine's parents realized that their options to save their daughter's life were minimal because of the lack of research on TGA. The medical team insisted that they wait to do the procedure until Katherine has gone into congestive heart failure. The physicians at the hospital insisted the new experimental medical procedure would save their daughter's life. The team of physicians, social workers and nurses corresponded with the University of Boston Children's Hospital whom at the time was the only hospital who could successfully perform this operation.

At that time, Ms. Frasier's family did not have the financial resources to travel to Boston as a family. Traveling also meant that Katherine's father would not be able to attend because of his job in the military. The physicians repeatedly told her parents that this procedure was the only option and recommendation for treatment. However, they did not take into account that the procedure had never been done by the cardiologists at the

University of Arizona. Katherine's parents decided that it would be best if the physicians found another form of treatment.

The pediatric social worker stayed in contact with the family hourly and provided emotional support to Katherine's family. She also insisted that the treatment team expand to other disciplines for more possible options.

Dr. Copeland, a world renowned heart transplant surgeon, was recommended to join the team. Dr. Copeland knew of another way to repair Katherine's heart. Katherine's parents agreed to allow him to operate that same day. Through the dedication of the social worker and treatment team that advocated for the Frasier's right to self-determination, Katherine is still leading a productive and fulfilling life advocating for her pediatric patients the way her social worker did 30 years ago.

Team Work

The use of multidisciplinary team is an effective part of healthcare treatment. A multidisciplinary team is defined as a group of professionals that specialize in different disciplines that come together to deliver quality health care that addresses the patient's well-being (Mitchell, Tieman & Shelby-James, 2008; Nancarrow et al., 2013; Allen & Spitzer, 2015). Using this approach allows the team to provide better-quality outcomes and to enhance client satisfactions.

There are also two other types of treatment teams in the healthcare setting:

1) An interdisciplinary team involves members from the same disciplinary background. An example would be: a team of medical social workers discuss possible treatment plans according to the results of a patient's assessment. Working in a team allows for individual ideas to be heard and as a group develop a specific treatment plan.

2) An interdisciplinary team that includes individuals from different disciplines who collaborate to resolve a variety of issues. Medical social workers, physicians, nurses, and activity therapists experience different types of interactions with patients in which different behaviors are assessed. Together these disciplines paint an overall picture of how team work can increase a patient's quality of life (Allen & Spitzer, 2015).

Biopsychosocial-Spiritual Assessments

The recommended health care approach to psychological evaluations is through the use of a biopsychosocial-spiritual assessment (NASW, 2016; Social Work Licensure Exam, 2008). This approach focuses on the individual as a whole and takes into account their biological, psychosocial, social, and spiritual sense of self. Together the interdisciplinary team can focus on the individual's treatment from all professional perspectives. Using this approach allows for each practice the ability to provide optimal health care (Gehlert & Browne, 2011).

The term biopsychosocial assessment or biopsychosocial-spiritual assessment is an approach you will hear throughout school. This model examines not just the medical aspect of care whose primary focus is on the biological causes of a disease. Rather, the biopsychosocial-spiritual model examines a patient's well-being through a holistic approach (Gehlert & Browne, 2011; McDaniel, Hepworth & Doherty, 2014; Allen & Spitzer, 2015).

Biopsychosocial Spiritual Assessment

The Biopsychosocial Spiritual (BPSS) Assessment offers a historical context for what the client presents with and assesses the client's history, strengths, and resources.

How do these four areas contribute to the client's current functioning?

Biology: basic needs – the client's access to food, shelter, etc.

Psychosocial: history, personality, self-concept, medication, diagnosis and treatment history

Social: support system (friends, family, social environment). Knowledge of life stages and development are essential

Spiritual: sense of self, sense of meaning and purpose in life, religion and its context in client's life

ROPES method of identifying strengths: Resources, Options, Possibilities, Exceptions, and Solutions

(*Social Work Licensure Exam*, 2009)

Medical Social Work Job Descriptions

Overall Functions of a Medical Social Worker

According to *The Social Workers in Hospitals and Medical Centers Occupation Profile* (2017), medical social workers employ a myriad of skills and approaches to ensure quality health care.

The following list is an example of tasks that most medical social workers use when providing services.

- Conducting initial psychosocial-spiritual assessments and screenings for patients and making referrals for individual, family and or group therapy if needed;
- Educating the patient and family members of the individual's illness and treatment options as well as possible consequences of various treatments or refusal of treatment;
- Helping patient and their families adjust to the hospital dynamics and exploring emotional and social responses to the illness and treatment;
- Educating the patient and family on the roles of the healthcare team. Assisting patients and their families in communicating with one another and to the members of the multidisciplinary team;
- Facilitating decision making on behalf of patients and families.
- Educating hospital staff on patient's psychosocial issues;
- Coordinating patient discharge with a safety plan and continued care planning by providing patient navigation services;
- Arranging resources/funds for finances, medications, medical equipment and other special needs services

(National Association of Social Workers, 2016)

Emergency Room Social Worker:

Emergency room social workers provide services to triage patients. One of their main functions is to diagnose and assess patients who show signs of mental illness. The medical social worker also performs discharge planning as a means of assurance that every patient will have a safety plan when discharged from the hospital (Fusenig, 2012).

The following is a list of tasks that emergency room social workers may perform:

- Performs mental health assessments and suicide evaluations;
- Conduct stress evaluations;
- Death notifications to family members;
- Counsels victims of violent crimes, domestic violence, substance abusers and families of deceased or terminally ill patients;
- Refers patients to community resources;
- Provides financial assistance;
- Conducts child and adult protective service reporting;
- Conducts domestic violence and sex trafficking screenings;
- Diagnoses and conducts mental health intake evaluations to establish proper psychiatric care;
- Conducts discharge planning; knowledge of community resources and services

(Fusenig, 2012)

Hospice or Palliative Care Social Workers:

Hospice social workers work in a variety of different medical settings. At times, there are hospice organizations that come into a hospital to provide assistance to those who are nearing the end of their life.

The following is a list of tasks that hospice and palliative care social workers perform:

- Ensuring that patients and family members have access to resources that will provide physical comfort;
- Providing emotional and or spiritual support to patients and their family members;
- Lead support groups for family members and in-service trainings to nurses, physicians, and other social workers who are involved in the treatment process;
- Ensure proper medical transitions from palliative care to hospice care if needed;
- Act as care coordinators; providing treatment planning with other members of the patient's treatment team

(SocialWorkLicensure.Org, 2017)

Pediatric Cardiology Social Worker:

https://www.onlinemswprograms.com/in-focus/interview-with-andrea-kido-lcsw-on-clinical-social-work.html

The above link takes you to an interview with a pediatric and clinical social worker from Marin Community Clinics (MCC). She explains her role on the pediatric intensive care unit. She describes daily activities and the different types of challenges that one may experience working with children and their families (Louie, 2017).

Summary

Medical social workers play a very important role in the care and needs of all patients in the health care system. Above was brief introduction to the different types of medical social work job descriptions. Always keep in mind, as you pursue your education in social work, and possibly later in the health care field; the profession will always be centered on the code of ethics. Everything we do is focused on the rules and regulations of the social work code of ethics.

Recommended Readings and Videos

Video:

What does a medical social worker do? Kristin Scheeler, MSSW, CAPSW, OSW-C

https://www.youtube.com/watch?v=K5tWk4brXYw

Websites:

Interviews With Medical Social Workers

NASW Standards for SocialWork Practice in Health Care Settings

Books:

Allen, K. M., & Spitzer, W. J. (2015). *Social work practice in healthcare: Advanced approaches and emerging trends.* Los Angeles: SAGE.

Gehlert, S., & Browne, T. (Eds.). (2011). *Handbook of health social work.* (2nd ed.). Hoboken, NJ: Wiley.

Public Health Social Work

Public health social work originated in the early 20th century to control communicable diseases, poverty, sanitation, and hygiene. It is defined as a collection of human service programs that has one common goal: identify, reduce and or eliminate the social stressors among the most vulnerable populations. A public health social worker's main role is to establish preventative measures and to intervene in the health and social problems that affect communities and populations.

Epidemiological Approach

Public health social workers focus on the epidemiological approach to identify health related issues and diseases that

affect certain populations. Epidemiology is a branch of medicine that researches the occurrence, delivery and possible control of diseases (CDC, 2017).

To better understand this approach, think of epidemiology as the basic science of public health. Epidemiology is a method that is used to develop and test a hypothesis (CDC, 2017).

Consider this: public health social workers and medical researchers are concerned with the occurrence and patterns of health events. In 2016, it was estimated that the population of Big Rapids, Michigan, is 10,475. Three-thousand students and faculty at Ferris State University in 2016 developed the same strain of bronchitis within a three-month period. The results allow public health workers to compare the same outbreak of bronchitis to other populations in the state of Michigan. A pattern has been established by the number of students and faculty at the university and in other cities that have the same strain of bronchitis. The occurrences also depend on the following variables: has the strain appeared in the same seasons? It is more prone to males or female? What is the average age of the individuals? Has it happened during the same weeks? Has it happened daily? The overall question is: what will public health social workers do about it?

Having the ability to compare the universities outbreak and the outbreaks throughout the state with the same symptomology will help to determine how the outbreak started and possibly the location where it began. In the end, findings will help provide evidence that will allow public health social workers to develop prevention and education interventions to help contain the outbreak.

Roles of a Public Health Social Worker:

- Find people who need help
- Assess the needs of your clients, their situations and support networks
- Come up with plans to improve their overall well-being
- Help clients to make adjustments to life challenges, including divorce, illness and unemployment
- Work with communities on public health efforts to prevent public health problems
- Assist clients in working with government agencies to receive benefits
- Respond to situations of crisis, including child abuse or natural disasters
- Follow up with clients to see if their personal situations have improved

(Allen & Spitzer, 2015)

Ethical Dilemma in Public Health

A good example of an ethical dilemma that most social workers would consider a concern is when public health clinics in hospitals call an individual who has contracted a sexually transmitted disease (STD). When women and men go into their family doctor for a yearly physical, they always check for STDs. If the results come back positive, the individual is notified by the doctor's office to discuss an intervention. The next phone call is from a public health department either in a hospital or out-patient clinic.

In order for public health officials to gather information concerning STDs in the community, they have the right to gain certain information that will help to control the disease. For a clearer understanding, let's refer to what is known as Health Insurance Portability and Accountably Act (HIPAA) (DHHS, 2003).

Whenever you go to the hospital you always sign a HIPAA disclosure form. By signing this form, you are allowing health care providers the means to share medical information without written consent. HIPAA also allows healthcare

providers to share important information regarding an individual's treatment plan, diagnosis and medications to another healthcare provider (DHHS, 2003).

For example: Jane Doe goes to see her primary health physician at Spectrums Family Health Center in Grand Rapids Michigan. Jane Doe is rushed to the emergency room the same day at Spectrums Children's Hospital. The emergency room technicians will already have Jane Doe's information because it has been documented and saved on Spectrums Health Care System Network.

Going back to the example of STDs, if a person is at risk of contracting or spreading a disease their healthcare provider has the right to disclose information. The information is revealed because it is a public health concern that effects the community. Health care providers release this information to help prevent and control another incident (DHHS, 2017).

Advocacy and Policy for Medical and Public Health Social Work

One of the most important roles of all social workers is to advocate for their clients. In the healthcare system, social workers do this by representing, promoting change, speaking on behalf of the client, assessing rights and benefits, and securing social justice. It is pertinent that all receive fair and equitable access to all medical services and benefits (NASW, 2012).

The healthcare system is driven by policies that outline the rules and regulations of the organization. Policies are developed based off the organizations ideas of acceptable and well-defined standards of healthcare practices. These policies are also implemented to reduce chaos, confusion, and legal issues that may arise due to unethical practice.

Some of these policies include:

- Patient care recipient rights.
- Abuse and neglect, investigation policies.
- Administrative policies
- Information management policies – HIPAA
- Accreditation Standards
- Medication Procedures

All physicians, nurses, social workers, administrative staff, and patient care workers must abide by all policies to produce effective outcomes for the organization.

Summary

Not all public health social workers will be found in the scenario above. One of the main roles of a public health social worker is to provide communities and vulnerable populations with the resources to help eliminate a social epidemic. This is usually done through community outreach programs and governmental agencies that focus on interventions and education to help improve community living.

Intimate Partner Violence

Intimate partner violence

> "*Violence sprouts in intimacy. Except for police and army, family is, probably, the most violent social group and a home is the most violent social space of our society. A person is most likely to be hit or killed in his/her own home by another member of the family than anywhere else or by anyone else*" (Stark & Flitcraft, 1996)

Intimate partner violence has been recognized in the United States and other countries as a significant public health issue. This type of violence is universally condemned due to its heinous nature. The term, intimate partner violence (IPV) is defined as any incident or pattern of behaviors (physical, psychological, sexual or verbal) used by one partner to maintain power and control over the relationship. IPV is also considered to be an act of violence that takes place between intimate partners (heterosexual, cohabitating, married, same sex or dating (McGarry, Ali, & Hinchliff, 2016; Stark & Filtcraft, 1998).

Internationally the definition of intimate partner violence is "the use of power, threatened actions against oneself, another person, or a group or community, that either results in the likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (Haegerich & Dahlberg, 2011, p. 392-393). This definition is important because IPV also affects other cultures, ethnicities, sex, and races differently. In some countries, such as the Democratic Republic of Congo, intimate partner violence is not considered a crime. Spousal rape has been accepted as a marital tradition. Domestic and sexual violence against children and young women has been an acceptable practice by older males. In Egypt, domestic violence "is firmly entrenched in the country's Muslim traditions" for example, Sharia Law (Achieng, 2017, p. 1).

Historically, in the United States, IPV has been considered an act of violence committed by men towards women. Although, this is still a societal belief, according to the *National Intimate Partner and Sexual Violence Survey of* 2010 – 2012, more than "1 in 4 men (28.5%) in the United States have experienced rape, physical violence and or stalking by an intimate partner in their lifetime and 1 in 7 men (13.8%) have experienced severe physical violence by an intimate partner (e.g., hit with a fist or something hard, beaten, slammed against something at some point in their lifetime" (Achieng, 2017, p.2).

Four Types of Violence

There are four different types of intimate partner violence. The most prevalent are defined in the text box below.

Physical Violence consists of touching or painful physical contacts that include intimidation of the victim through pushing, slapping, hair pulling, arm twisting, disfiguration, bruising, burning, beating, punching, and use of weapons.

Sexual Violence consists of making degrading comments, touching in unpleasant means of harm, addressing a partner in a degrading way during sexual intercourse which includes marital rape.

Psychological & Emotional Violence consists of threatening, intimidating, killing of pets, deprivation of fundamental needs (food, clothing, shelter, sleep), and distorting reality through control and manipulation.

Mandatory Reporting of IPV

In many intimate partner violence cases, victims have the tendency to not disclose to medical professionals or law enforcement due to possible repercussions from the offender. Many victims fear retaliation, family separations, violation of confidentiality and security. In these instances, a social worker could do more harm than possibly helping the situation.

As of 2002 only seven states have laws that make it mandatory to report actual or suspected victims of IPV (Hamberger, 2004). Most states have laws where reporting is an option, however conditions apply for protecting an individual's identity. Social workers can be put into these challenging positions because of confidentiality and following an ethical obligation. Some argue if an individual is in a IPV situation it should be reported to the police because it is considered a punishable crime.

Potential positive outcomes and limitations from mandatory reporting by medical social workers include:

- Increase victim's safety due to early detections and interventions;
- Improvement of patient care due to early identifications. This would allow
- physicians and social workers to preform rape kits, treatment of any diseases or injuries due to the assault;
- Allow social workers to immediately assess trauma and to advocate for resources as soon as the incident occurred;
- Could improve hospitals resources and outcomes by better documentation of DVA into medical records which will increase the availability of data to facilitate future research and;
- Mandatory reporting could undermine a key component of DV interventions of empowering the individual's rights to self-disclosure

(Hamberger, 2004)

Prevention of IPV in Healthcare

There are four primary steps that medical and public health social workers take to insure a prevention plan. Public

health and medical social workers focus primarily on the individual, family, and community to help reduce violence and its consequences. To reduce the occurrences of violence, social workers and community action agencies develop interventions to educate communities through public awareness using television commercials, billboards, radio broadcasts, DV trainings, self-defense classes, and DV screenings in hospitals (Haegerich & Dahlberg, 2011).

Four approaches to prevention of IPV include:

- Measure the incidence and burden over time through public health surveillance.
- Identify factors that place people at risk for, or protect people from, experiencing violence as the victim or perpetrator.
- Developing and testing strategies through rigorous evaluation that modify risk and protective factors to prevent violence from occurring.
- Facilitating the dissemination, adoption, and adaptations of effective strategies in communities to affect change

(Dahlberg & Haegerich, 2011)

Recommended Readings, Websites and Videos

Readings

The National Partner and Domestic Violence Survey 2011

Violence Prevention: The Evidence

Domestic Violence Websites

National Domestic Violence Hotline

National Network to End Domestic Violence

Sex and Human Trafficking

Human trafficking isn't talked about

Human trafficking is defined as the recruitment, transportation, and or harboring of a person by means of threat, force or another form of coercion, abduction, fraud, and deception. It is through the abuse of power over vulnerable individual's that perpetrators are able to exploit them. It is often combined with extreme violence, torture and degrading treatment that leave psychological wounds for the rest of their lives. Human and sex trafficking is a violation of human rights. It is estimated to effect more than two million victims worldwide (Ahn, Albert & et.al, 2013; Gajic-Veljanoski & Stewart, 2007).

There are two different forms of human tracking: 1) forced labor and 2) sex trafficking. This section will focus on sex trafficking due to the increased prevalence in the United States. Additionally, this section will also focus on the roles that public and medical social workers take to identify victims and to provide proper medical care (Gajic-Veljanoski & Stewart, 2007).

Sex trafficking is defined as a commercial sex act which is conducted by force, fraud, coercion, or in which the child or adult is made to perform sexual acts for money. A majority of victims in the United States come from countries such as east and south Asia, Latin America, Russia, and Eastern European countries (Salett, 2006).

Medical social workers play a vital role in the identification of victims. Below is a list of clues that social workers and other medical professionals look for when assisting patients in hospitals. Victims have a tendency to not disclose their issues due to the fear of law enforcement, repercussions to family members and most are not aware of agencies that offer services specifically to the population.

Medical social workers can also help eliminate the potential of sex trafficking by:

- Identifying victims and assist them with the proper resources for medical, psychological and shelter;
- Serve on organizational committees or as board members who specifically focus on assisting sex trafficking victims and help to improve rehabilitation and reintegration into society and;
- Educate vulnerable populations such as children in schools or prostitutes that come through the emergency room on possible preventative measures and signs to look for when being encountered by certain populations

(Salett, 2006; Ahn, Albert & et.al, 2013)

What to Look For

- Multiple people in a cramped space
- People living with their employer
- Inability to speak to individuals alone
- Employers holding identity documentation
- Inability to move or leave current job
- Bruises or other signs of battery
- Submissive, fearful or depressed demeanor
- Little or no pay
- Recent arrivals from Asia, Latin America, Eastern European Countries, Canada, Africa or India

(Salett, 2006)

Facts and Statistics

The following facts and statistics were taken from the U.S. *Department of State Trafficking in Persons Report* (2017):

- Traffickers usually recruit victims from vulnerable populations such as: 1) young children who have run away from home. 2) adult females and males who have been involved in prostitution or escort services, 3) desire for a better future, 4) poor education, 5) history of abuse or violence, 6) single-parenting families, and 7) desperate socioeconomic status;
- Estimated global earnings of more than $31 billion a year;
- Worldwide, between 4 – 27 million individuals have been or are victims of sex trafficking or forced labor;
- The majority of victims (80%) are women and girls;
- Over 70% of trafficked women with children are single mothers;
- During recruitment processes, some are promised substantial earnings and jobs as nannies, waitresses, and modeling;
- In 2016, the National Center for Missing & Exploited Children estimated that 1 in 6 endangered runaways reported to them were likely sex trafficking victims;
- In a 2014 report, the Urban Institute estimated that the underground sex economy ranged from $39.9 million in Denver, Colorado, to $290 million in Atlanta, Georgia and;
- In 2016, we learned of 8,042 cases of human trafficking.

Summary of Intimate Partner Violence and Sex Trafficking in the United States

In health care settings, medical social workers will encounter victims and survivors of domestic violence and sex trafficking often. Having the knowledge of the increased prevalence of these two societal epidemics will allow social workers to identify victims, promote educational resources and to prevent the increase of violence.

Summary

This chapter examined the roles of medical and public health social workers. Medical social work is a sophisticated and challenging practice that is conducted in multidisciplinary and fast-paced environments. Therefore, professional social workers in this field need to have a clear and concise understanding of the NASW code of ethics and how it relates to patient care. Medical social workers are in charge of advocating for diverse, sometimes vulnerable individuals and communities. Hospitals and insurance companies have become engrossed with enhancing the intake of profits. Because of that, it seems they lack the desire to enhance and develop a promising health care system that will support all populations.

As incoming first-year students, it is important to educate yourselves by researching and enhancing your knowledge of all social work arenas. Medical social work is so important because it embraces the importance of team work, advocacy, and a true commitment to the individual's medical and personal health care.

Also remember, just because you may not hear about a societal epidemic (sex trafficking and domestic violence) does not mean it is not around you. Be a change agent who develops new therapeutic interventions that will enhance the quality of health care to the world.

Resources

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14. Social Work in Criminal Justice Settings

Kassandra Weinberg is a recent graduate of Ferris State University as of August, 2017. Her undergraduate degrees are from Olivet College double majoring in Psychology and Criminal Justice, which was the inspiration behind requesting to complete this chapter. Her professional experiences have consisted of completing various internships within settings combining criminal justice and social work including the Ingham County Youth Center, Children's Protective Services, Eagle Village, and Bethany Christian Services working as a counselor. As of summer 2017 when this project was completed she was eagerly planning her upcoming wedding, and also enjoys reading, watching netflix, and spending time with her family and four cats.

Introduction

As you have learned from previous chapters, a social worker can find themselves involved in numerous diverse systems depending on their client population and area of specialty. One of the most intimidating and controversial of these systems is the United States criminal justice system. Whether a social worker is tasked with working with inmates housed in jail/prison, rehabilitating individuals on probation/parole, investigating potential child abuse, or defending the rights of crime victims, the criminal justice system is sure to have an enormous impact on nearly every aspect of a client's case and personal life. In order to best aid clients who have found themselves wrapped up in this complex system it is crucial that we as social workers have at least a basic knowledge of what the system is, how it works, basic terminology, and most importantly, the rights held by not only our clients but each person who is a citizen of this country.

What is Criminal Justice?

The United States Criminal Justice System

The United States criminal justice system is the set of agencies and processes established by the United States government to control crime and impose penalties on those who violate laws. It is directly involved in apprehending, prosecuting, defending, sentencing, and punishing those who are suspected of criminal offenses. Contrary to popular belief, there is no one system of justice within the United States, but rather a combination of multiple smaller jurisdictions which are determined by the individual's area of residence, type of offense, and more. The most common of these include state (police) and federal (FBI) jurisdictions. The simplest way to compare these two is to think of an individual who commits multiple crimes in one state with an individual who commits one or multiple crimes in one state and then moves to another. Since the individual in the second scenario has moved, the two states involved would be competing for jurisdiction, making it necessary to involve the Federal Bureau of Investigations (FBI) as they have national jurisdiction. Other examples of jurisdictions include county, city, tribal government, or military installation (NCVC, 2008a).

Components of Criminal Justice

These descriptions are taken from NCVC's The Criminal Justice System *unless otherwise noted.*

Most of these criminal justice systems consist of five components- law enforcement, prosecution, defense attorneys, courts, and corrections. Each of these play a unique but critical role in criminal justice proceedings.

Law enforcement officers are tasked with hearing and investigating reports for crimes which happen in their jurisdiction. These officers investigate crimes by gathering and protecting evidence, making arrests, providing testimony during court processes, and conducting follow-up investigations as needed.

After law enforcement officers investigate a criminal offense, it is up to the prosecution to represent the state or federal government throughout the court process. Prosecutors must review the evidence gathered by officers and determine whether to file formal charges against the suspect or to drop the case. They are also tasked with presenting the evidence in court, questioning witnesses, determining what charges a suspect will be charged with, and more.

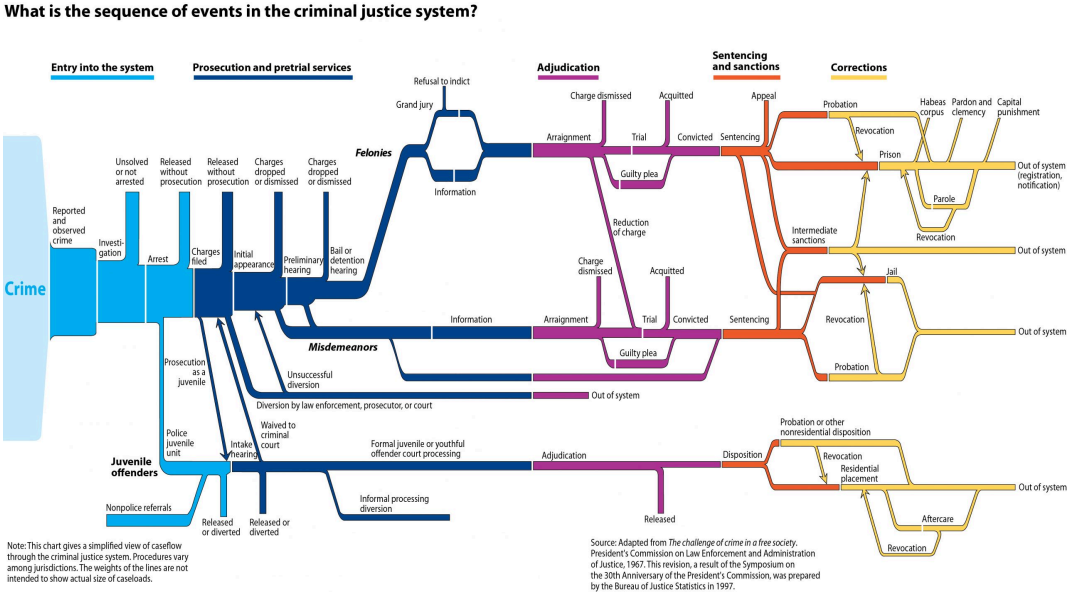
While the prosecution represents the state or federal government, it is the job of defense attorneys to represent the individuals accused of a criminal offense. They can either be hired by the defendant themselves or assigned by the court since legal representation is a basic right outlined in the Constitution.

Both the prosecution and defense attorneys are involved in the courts which are run by judges. Their role is to ensure that the law is followed along with overseeing what happens in court. Judges are able to determine whether or not to

release offenders before a trial, accept or reject plea agreements, oversee trials, and sentence individuals convicted of illegal acts. Judges are easily some of the most powerful individuals in the criminal justice system.

Finally, after an individual has been investigated, tried, convicted, and sentenced, they enter the last criminal justice component of corrections including jails and prisons. These terms are often used interchangeably, but in reality jails are used to house individuals sentenced to less than one year of incarceration as well as those awaiting trial, while prisons house individuals sentenced to be incarcerated for a year or more. Correction officers are tasked with supervising convicted individuals in jail or prison, and also include probation (jail) and parole (prison) officers who are responsible for monitoring these individuals either after they have completed their sentence or in some cases in lieu of incarceration. Corrections officers typically prepare pre-sentencing reports on the individual which are used to help judges decide on sentences as well as overseeing the day to day custody of incarcerated inmates (NCVC, 2008a).

*The image provided outlines the process from arrest to incarceration including the components discussed above. As a social worker within criminal justice settings it is often beneficial to be aware of the complexity of criminal justice proceedings as well as basic timelines in order support and advocate for clients. For more information and detailed descriptions of each step in the criminal justice system process, see The American Bar Association's guide, *How Courts Work*.



What is the sequence of events in the criminal justice system? https://www.bjs.gov/content/justsys.cfm

The Courts

In order to understand the role of a social worker in court room proceedings, a basic understanding of the various types of courts and their roles are first required. Look to the next sections to learn a few of the most common types of courts that a social worker may find themselves involved in.

Courthouse in Washoe County, Nevada

The descriptions below were obtained from Michigan Courts, The Learning Center website.

United States Supreme Court

The Supreme Court of the United States is the "highest" court in the land. It has ultimate authority to hear appeals in nearly all cases decided in the federal court system. It can also hear appeals from state high appellate courts that involve a "federal question," such as an issue involving a federal statute or arising under the Constitution of the United States. This essentially means that an individual who disagrees with a decision reached in a lower court has the right to apply for a second opinion from a higher court. They are able to practice this right by moving all the way from local courts to the top of the diagram, the US Supreme Court which can not be overruled. With that said, fewer than 100 cases are actually heard and decided by the Supreme Court each year.

There are currently nine justices on the Supreme Court: one chief justice and eight associate justices. These individuals can be thought of as a team of judges who are considered to be some of the most ethical individuals in the country nominated only by the President of the United States. The key to the number of justices is that it is an odd number when the decision on a case comes down to a vote. In order for a decision to be reached, a minimum of five justice votes are required either for or against the defendant. After each side's argument has been presented the justices crafts a written explanation of their decision called an opinion. With that said, there can be more than one "opinion" since not all of the Justices need to agree in order for a decision to be reached. Most commonly opinions are either titled as "the majority opinion", or "the minority opinion" and outline the details of the "winning" and "losing" arguments.

The main conditions for a Justice to hold office is found in Article III Section 1 of the Constitution, "[t]he Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behavior, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office" (Constitution, 2017).

Essentially this means that Justices serve for life, only being replaced due to death, retirement, or impeachment for unethical behavior. Since 2005, John G. Roberts Jr. has served as the Chief Justice and the oldest and longest serving justice is 80-year-old Anthony Kennedy appointed in 1988.

Supreme Court facts and landmark cases are available through the following links at ConstitutionFacts.com:

https://www.constitutionfacts.com/us-supreme-court/fascinating-facts/

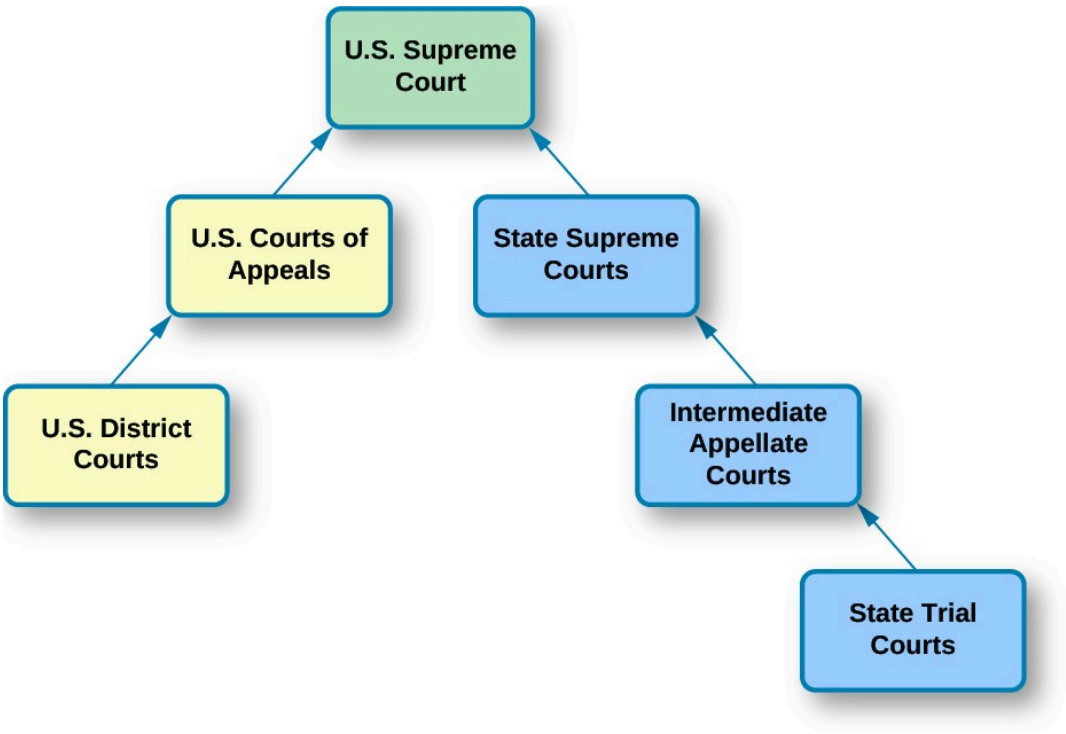
https://www.constitutionfacts.com/us-supreme-court/landmark-cases/

Michigan Supreme Court

The State of Michigan Supreme Court is the highest court in the state and can be overruled only by the Supreme Court of the United States. The Michigan Supreme Court has seven justices, one of whom is elected to be the Chief Justice as in the US Supreme Court. Following the diagram provided below, the state and federal court systems can be thought of like a pyramid starting with local courts and working all the way to the US Supreme Court. At this level, if an individual is dissatisfied with a decision from the Michigan Court of Appeals they can complete a written "application for leave to appeal". This essentially means that they would like to invoke their right to appeal a court decision which they believe is unjust. The Michigan Supreme Court receives approximately 2,000 applications each year and "grants leave" – meaning they will hear the case – in about 100 of these cases. Unlike the US Supreme Court however, in order for a decision/majority opinion to be reached at this level, a minimum of four of the seven Justices must agree.

Michigan Court of Appeals

The Court of Appeals is a relatively new court that began in 1965. It is an "intermediate" court between the Circuit Court (where trials take place) and the State Supreme Court. Individuals who are dissatisfied by a Circuit Court decision go first to the Court of Appeals. In most cases, the person who loses in Circuit Court has the right to appeal to the Court of Appeals where the case will be argued before three judges who must reach a majority decision (2 out of 3) much like the higher courts described above. The Court of Appeals hears about 6,000 cases each year, and listens to arguments regularly in Detroit, Lansing, and Grand Rapids, and Northern Michigan.



Flowchart of the U.S. court system

Local Courts

Circuit Court

The Circuit Court is a general trial court. It has jurisdiction in all civil cases involving more than $25,000, all felony cases, all serious misdemeanor criminal cases, and all family cases. The Family Division has jurisdiction over divorce, child custody, child support, paternity investigations, adoptions, name changes, juvenile proceedings, emancipation of minors, parental consent, and personal protection proceedings. The Family Division also houses the Friend of the Court, which handles cases involving child custody, parenting time, and support.

Probate Court

The Probate Court handles wills, administers estates and trusts, orders treatment for individuals who are developmentally disabled, and appoints guardians and conservators. In 2013, Probate Court handled 64,114 case filings.

District/Municipal Court

The District Court handles most traffic violation cases and hears both criminal and civil cases, including small claims and landlord-tenant disputes. All criminal cases for people 17 years old or older originate in district court. The defendant is told the charges, rights, and possible consequences. If the charge is a misdemeanor punishable by less than one year in jail, the District Court conducts the trial. For charges punishable by more than one year, the case goes to Circuit Court.

Small Claims Court

A division of the District Court, the Small Claims Court hears civil cases of $5,500 or less. A case may be presented to a judge or an attorney magistrate. In 2013, 55,719 claims were filed here. A magistrate is a civil officer with the power to administer and enforce laws similar to a judge.

Court of Claims

The Court of Claims is part of the Court of Appeals. The court hears and determines all civil actions filed against the State of Michigan and its agencies. These cases include highway defect, medical malpractice against state-owned

medical facilities and state-employed medical practitioners, contracts, constitutional claims, prisoner litigation, tax-related suits, and other claims for money damages.

Amendments of the Constitution

The criminal justice system is ultimately governed by the Constitution of the United States of America. The Constitution is responsible for outlining the basic, inalienable rights of each citizen of the United States. Obtaining an understanding of these rights is particularly relevant to social workers working with criminal justice populations in order to be able to determine if a client's rights are being denied and what protections have been put in place to defend these rights.

Some examples most pertinent to criminal justice populations include Amendment 4 which protects individuals against unlawful search and seizure, and Amendment 8 which protects against cruel and unusual punishment.

To review these amendments as well as the entire Constitution, please follow this link: http://constitutionus.com/

The Constitution of the United States – Preamble

What is a Criminal Justice Social Worker?

Now that you have an idea of what the criminal justice system is and how it functions, how does social work come into play? With today's increasingly controversial, challenging, and ever-changing legal system, criminal justice social work (also referred to as forensic justice social work) is rapidly rising as a vital public service for offering psychological and behavioral services in the criminal justice system (Coyle, 2017). Although the field of criminal justice social work is relatively new, the number of court cases and growing prison populations nationwide are creating a large demand for social workers with knowledge and/or experience within the criminal justice system.

While many mistakenly believe that criminal justice social work is limited to evaluating and treating criminal defendants in psychiatric hospitals, it is important to realize that the field is much broader and includes all social services within the civil and criminal justice systems on nearly every level. It is also important to note that, like many aspects of society, the media's portrayal of criminal justice social work is highly inaccurate. For example, these workers are often depicted as performing and analyzing lab work which is rarely the case unless the workers specializes in research roles. It is also unlikely as a worker that you will run into the Jeffrey Dahmers of the world on a regular basis,

rather you will be treating and advocating for individuals who often have significant histories of trauma and have simply made poor life decisions. So, if in reality this career is not what the media portrays it as, what exactly does a criminal justice social worker do? (Coyle, 2017).

A criminal justice social worker's day-to-day activities largely include providing consultation to law enforcement personnel, law makers, attorneys, paralegals, community members, correctional officers, doctors, and psychiatrists on interdisciplinary teams (NCVC, 2017a). Criminal justice social workers often provide their clients with emotional support, guidance in navigating the court/legal systems, connections to relevant resources, housing application assistance, and individual and policy advocacy. Further, criminal justice social workers typically use their legal expertise to work within court systems in settings such as child and family agencies, hospitals, mental health agencies, substance abuse agencies, correctional facilities, prisons, and faith-based institutions.

Criminal justice social workers are also responsible for diagnosing criminal populations, making recommendations about mental status, serving as expert witnesses, training law enforcement personnel, referring defendants to community resources, and developing advocacy programs in the criminal justice system. These roles are more than likely where the inspirations for television and other media forms stem from. However, although diagnosing criminal populations is part of what criminal justice social workers do, this task realistically makes up very little of a worker's activity and is not nearly as glamorous and intense as one might see in a movie. For example, while again it is accurate that a criminal justice social worker may work with criminal populations, other vulnerable populations served include but are not limited to: incarcerated youth and adults, recently released inmates, children who are victims of neglect, and victims of domestic or sexual abuse (MSW Guide, 2017). In order to better outline the types of populations criminal justice social workers commonly work with and what they do, please refer to the following case study:

Case Study

"Jonathan" is a 37-year-old, Caucasian male who identifies as heterosexual and non-religious. He is currently in prison for domestic assault against his wife of 11 years. Although he claims to love his wife, Jonathan states that he frequently struggles to control his anger, especially after a night of heavy drinking. After being interviewed by the prison social worker it was revealed that Jonathan was abused by his father while he was a child, and he also commonly saw them fight both verbally and physically. During the initial interview Jonathan struggled to make the connection between his own traumatic upbringing and his current beliefs and behaviors.

Cases such as these are incredibly common within the criminal justice system since, as outlined in previous chapters, unresolved traumas can so often be linked to negative behaviors as adults. For Jonathan's case the main tasks of a criminal justice social worker would include assessing Jonathan's risk to himself or others based on his past and current behaviors, developing a treatment plan to combat symptoms of anger and possible substance abuse, educating Jonathan on various coping skills to control his anger/ drinking, working to increase communication skills as an alternative to violence, meeting weekly or bi-weekly for individual therapy with subjects such as adjustment to prison and childhood trauma, detailed documentation of all activities, advocacy, testifying in court, and more. Although this case study does present a common issue that bridges social work and the criminal justice system it is just one of countless possible client populations.

For additional examples of specific career opportunities and client populations, refer to the next section.

Prisoners in a group therapy session

Specific Careers as a Criminal Justice Social Worker:

As a social worker in the criminal justice system there are a wide array of career options each with specific skill requirements, education requirements, salary ranges, and of course daily tasks. Although the previous sections discuss the most common tasks of a criminal justice social worker, each of the many career options listed below are equipped with their own unique challenges and rewards. This section will outline just a few of the countless job prospects for individuals with a mental health degree as well as a passion for helping those caught up in the criminal justice system.

If you are interested in learning more about any of the following career options including degree requirements, salary, job outlook, and more, please visit the website www.payscale.com.

CPS/APS Worker

CPS and APS are common acronyms that future social workers are sure to see in their careers. They stand for Children's Protective Services (CPS) and Adult Protective Services (APS). These careers are easily some of the most controversial and emotionally taxing that a social worker can enter (Education Career Articles, 2012). The job titles can be broken down into Investigations and Ongoing services, which are tasked with determining whether or not an allegation of abuse on a child or adult is true (investigations), or are responsible for working directly with families who have been substantiated for some form of abuse or neglect (ongoing). Unlike the common misperception these workers are not solely responsible for the removal of children from their parents, although this is a necessary part of the job in the most severe of situations for the safety of the child.

However, these workers also rely heavily on providing parenting training and other necessary resources with the ultimate goal of keeping families together. Similar to CPS, APS investigations workers determine when a vulnerable adult (mentally ill, elderly, etc.) is being improperly taken care of or taken advantage of. A common example of this is elderly adults who are being physically or financially abused by family members or other care providers. Although these individuals are not "removed" in the same sense as a victimized child may be, it is the role of the APS worker to see that the abusive situation is terminated.

The most common social work skills utilized by CPS/ APS workers include case management, investigation, documentation, collaboration with other agencies and families, and quick decision-making. These careers also require frequent traveling within the worker's county of employment in order to attend home visitations and/ or court. (Education Career Articles, 2012).

Youth Correctional Counselor

Counselors working with youth in the criminal justice system help rehabilitate young offenders (Study.com, 2017b). Counselors generally work in a juvenile correctional facility, such as a detention center or residential facilities that

youth are referred to by the Department of Health and Human Services, Children's Protective Services, or Foster Care. Here counselors are responsible for supervising the youth by enforcing discipline, making and maintaining records, and implementing constructive activity programs. Counselors may also be responsible for making recommendations such as the appropriate destination for a youth after they are released from placement. For example, a counselor who believes a youth is not capable of being unsupervised, may be unsuccessful, or simply has nowhere to go, may recommend an additional residential facility, foster care, or may even help the individual obtain independent housing in his or her community. In addition to working through various traumas with the incarcerated youth, juvenile justice counselors frequently work with youth and their families together in order to teach new skills designed to strengthen the support system of the youth, minimize conflict if/ when the youth is able to return home, or even provide specialized interventions including addiction recovery and anger management. (Study.com, 2017b).

Prison/jail social worker

Also commonly referred to as correctional social workers, prison social workers are trained mental health professionals with the purpose of reducing rates of recidivism (re-arrest) in the future. Prison social workers use their knowledge and skills to prevent recidivism by addressing psycho-social issues such as past trauma, providing education, and offering social service recommendations to successfully reintegrate offenders into the community upon release. A prison social worker's responsibilities include performing psychological assessments to determine inmates' level of mental health functioning, evaluating the presence of mental health or substance abuse disorders, providing individual or group counseling sessions, teaching inmates life skills in rehabilitation groups, and preparing inmates for their release. Along with the clinical duties prison social workers are responsible for a wide array of administrative tasks such as authoring treatment plans, documenting thorough notes/ files, and communicating with other professionals on inmates' cases. (Social Work Degree Guide, 2017).

Probation and Parole Officer

Parole officers identify and supervise offenders who are eligible for conditional release from prison before they have completed their sentences (Roberts, 2017). In order to earn parole, prisoners must obey prison rules, perform prison jobs well, and show progress in rehabilitation and therapy programs.

In comparison, probation officers are responsible for monitoring those offenders who will be placed on probation as an alternative to jail time. The key difference between the two comes down to sentence length with prison almost always housing offenders with sentences of more than one year, while jails house both offenders awaiting sentencing and those whose sentences are less than one year. The tasks of probation and parole officers are essentially the same aside from the slight difference in the populations of offenders served (Roberts, 2017).

Some probation/ parole officers work inside correctional institutions, preparing reports for parole boards. They assess prisoners' lives before and during incarceration; how prisoners' families will affect their rehabilitation; and what job prospects prisoners might have if released. Based on the officers' reports and interviews with the prisoners and their families, the boards choose certain prisoners for release. Field officers on the other hand work with parolees once they have returned to their communities. Their daily tasks include helping the offenders find jobs, schools, or therapy programs, meeting with them regularly, performing drug tests, and completing detailed paperwork including meeting notes, progress reports, and treatment recommendations. Some officers also supervise halfway houses in which small groups of offenders live together to share experiences and lend each other support. (Study.com, 2017a).

Sex offender clinician

Counseling individuals convicted of sexually motivated crimes is easily one of the most difficult and emotionally taxing career paths available to social workers within the criminal justice system. It is certainly not a job that is right for everyone, and requires a great deal of confidence as well as the ability to treat all people with dignity/ respect regardless of how you view their actions. On a daily basis, sex offender clinicians are responsible for psychological testing, counseling groups, conducting sex offender programming therapy sessions, interviewing inmates for psychosexual evaluation and recommendation purposes, emergency evaluations and management, diagnosing, case management, working with case managers and contracted professionals, psychological consultation to prisons, testifying in court, and more (Hubbard, 2014).

It is most common for this job to exist within a prison setting or in a support group that is required for sex offenders

on parole within the community. This is one of the highest paid positions for therapists within the criminal justice system because of its intense nature and specialty; these positions are almost always reserved for the most experienced professionals within the field due to their difficult nature (Hubbard, 2014).

Victim advocate

If advocacy and helping those in crisis is your calling, a career as a victim advocate may be perfect. Rather than working with offending populations as is most common for a criminal justice social worker, victim advocates, as the name implies, are tasked with assisting victims of crimes on many different levels. Victim advocates are professionals trained in mental health or criminal justice related professions, but often require only a bachelor's degree. These workers offer victims information about legal processes and their rights, emotional support after experiencing a traumatic crime, assistance finding resources and completing paperwork, and more. Victim advocates often support their clients by accompanying them to court and even offer clinical services when appropriately trained. Many advocates are employed by crisis hotlines or the courts themselves or as group counselors within the community. For this career path, the ability to speak a second language is particularly valuable. (NCVC, 2008b.).

Substance abuse counselor

A substance abuse counselor is another example of the specialized populations with which clinical social workers in the criminal justice system can work (Substance Abuse, 2017). These counselors work with individuals who use or abuse drugs and alcohol with the goal of overcoming addiction. As you may recall from previous chapters, substance abuse is a notoriously difficult mental disorder as it almost always involves relapse. Due to the difficult nature of this particular career, a substance abuse counselor must be patient, non-judgmental, and especially careful to treat clients with dignity and respect. Frequently done in group therapy sessions, a substance abuse counselor works with clients to overcome the both the motivations to use substances and the effects of their use on their personal and professional lives. These professionals also act as a key support system to aid individuals in making a plan to become substance free and maintain sobriety for years to come.

The main tasks of a substance abuse counselor include creating and monitoring a personalized recovery plan for each individual client on a case load. These plans help clients identify their motivations to use, behaviors which encourage use and/or sobriety, outline consequences of use, identify strategies to prevent relapse, and of course the creation of goals throughout the treatment process. As with most social work careers, a career as a substance abuse counselor involves a great deal of paperwork, case documentation, and collaboration with outside professionals including probation/ parole officers when applicable. (Psychology School Guide, 2017).

Mitigation Specialist

A mitigation specialist (mitigate=reduce severity) is a member of a defense attorney team that participates in courtroom proceedings (NLADA, 2016). These specialists possess clinical skills and must be extremely organized and detail oriented. The overall job function of a mitigation specialist is to reduce the potential punishment of his/ her client by identifying a factor that warrants a reduction in severity for sentencing. Social workers are often sought after for these positions due to their clinical skills and ability to extract sensitive information from clients in a positive and professional manner.

These specialists are responsible for compiling biopsychosocial assessments, analyzing the significance of the information obtained as it relates to personality/behavioral development, and determining the need for services such as counseling. One example of a typical case for a mitigation specialist may be to complete a psychosocial assessment (a type of life history interview) with a client and learning that although the individual may be responsible for their crime, their IQ is well below average. This information is then used in order to mitigate or "reduce the severity" of the individual's sentence. As with victim advocacy, the ability to speak a second language is considered highly valued in this field. (NLADA, 2016).

Counselor Working with Mandated Clients

Although this is not a specific job title, counseling individuals who are mandated to attend therapy poses its own unique set of challenges. Essentially the word "mandated" means that individuals are required to attend counseling and are often entering services unwillingly (Shallcross, 2010). These populations commonly include individuals caught up within the criminal justice system due to courts frequently referring individuals who are deemed to be a risk to

themselves or others for counseling services. Some examples of these populations include some of those listed above such as: individuals who abuse substances, individuals who are violent (often discovered through violent crimes), those who are found to be responsible for the abuse/ neglect of a child or adult, people who commit sexual offenses, and more. Although it consists of many of the same therapeutic techniques as a general counselor, those who do not enter counseling willingly have the potential to be extremely difficult to work with. For example, while most individuals who voluntarily enter counseling are willing to openly discuss their reasons for seeking services, individuals such as those on probation/parole who have been referred to mandatory counseling are often unable to recognize why counseling is even necessary.

Counselors working with these populations have to be particularly skilled in communication as it is common for mandated clients to refuse to participate in counseling. This difficulty poses yet another problematic situation for workers as they are frequently required to report client progress to probation/ parole officers. Since social workers typically want to help their clients, the idea of reporting to court officials often creates ethical dilemmas about how much to share considering how the reports can impact their clients (Shallcross, 2010).

The following tips were obtained from *Counseling Today* and can be found by following the link provided: https://ct.counseling.org/2010/02/managing-resistant-clients/

- Avoid acting like an expert (focus on client goals)
- Empathize with clients
- Gently confront excuses
- Let the client set the pace
- Do not engage in power struggles
- Always treat clients with dignity and respect

*If you feel that your client is potentially dangerous, look to these additional tips:

- Inform coworkers that you will be in session with this client (develop a code word signifying that you need help)
- Ask your supervisor about installing panic buttons in therapy offices
- Avoid working alone/ at night with this client (or at all if possible)
- Do not allow the client to position themselves between you and your exit
- Make an excuse to leave if you feel uncomfortable
- Limit sharing personal information
- Know your agency's emergency policies

Tips for Testifying in Court

Now you have a basic understanding of what the various court systems are and how they interact with each other, but where do social workers fit in? In short, as a citizen of the United States it is always helpful to have a fundamental understanding of the legal system which governs us. For social workers, however, this becomes even more critical as so many of the clients we work with become involved in the legal system in combination with our own services. Without holding at least a minimal understanding of what our clients are facing, it is almost certain that we would struggle to help them to the best of our ability by offering advocacy and comfort. With that said, a social worker should never offer

legal advice to a client as it is not their area of expertise and, as you learned in the ethics chapter, could result in a breach of the NASW core value of competence.

While much of what a social worker does in relation to court is offering support to clients, it is not uncommon for their role to involve testifying in court which essentially involves providing spoken evidence to the court. This is especially true for professions including CPS/ foster care workers and probation/ parole officers. For even the most seasoned social workers the idea of testifying regarding a client's case can stir up fear and dread. Having to speak in court is almost always a nerve racking experience in and of itself, but when social workers must also balance the legal requirement to tell the truth while on the stand with wanting to do what is right for their client, the situation becomes even more tricky and potentially ethically ambiguous.

The next section will offer a number of helpful tips to avoid being stumped on the stand by even the most talented attorney, and has been adapted for social workers based on the website listed here: https://www.justice.gov/usao-mdpa/victim-witness-assistance/tips-testifying-court

Refresh Your Memory

Before you testify in court perhaps the most crucial piece of advice that can be given is to review your notes and plan ahead. Since it is often part of a social worker's job to provide the court with documentation it is not uncommon for court officials to provide you with these documents while you are on the stand. However, this should never be expected and a good social worker will always come prepared with their own case documents. Also, it is often helpful to highlight any particularly meaningful events, dates, or times in these notes for easy access. Never feel as if you cannot refer to your notes before answering a question; simply ask for a moment to review the facts to be sure. It is always better to take that time to check than to be wrong! Doing this will help you avoid suggestions by attorneys. Do not agree with their estimates or conclusions unless you arrive to the same one independently. Finally, it is important to note than any documents brought in by a worker can be seized as evidence by the judge. In order to avoid this, it is best to bring only documents already submitted to the court, and always analyze possible consequences for both the client and yourself if a document were to be seized as evidence.

Speak In Your Own Words

Don't try to memorize what you are going to say. Doing so will make your testimony sound "pat" and unconvincing. Instead, be yourself, and prior to trial go over in your own mind the matter about which you will be questioned.

Appearance Is Important

A neat appearance and proper dress in court are important. An appearance that seems very casual or very dressy will distract the jury during the brief time you're on the stand, and the jury may not pay attention to your testimony.

Speak Clearly

Present your testimony clearly, slowly, and loud enough so that the juror farthest away can easily hear and understand everything you say. Avoid distracting mannerisms such as chewing gum while testifying. Although you are responding to the questions of a lawyer, remember that the questions are really for the jury's benefit.

Do Not Discuss the Case

Jurors who are or will be sitting on the case in which you are a witness may be present in the same public areas where you will be. For that reason, you MUST NOT discuss the case with anyone. Remember too, that jurors may have an opportunity to observe how you act outside of the courtroom.

Be Professional

When you are called into court for any reason, be serious, avoid laughing, and avoid saying anything about the case until you are actually on the witness stand.

Being Sworn In As A Witness

When you are called to testify, you will first be sworn in. When you take the oath, stand up straight, pay attention to the clerk, and say "I do" clearly.

Tell the Truth

Most important of all, you are sworn to TELL THE TRUTH. Tell it. Every true fact should be readily admitted. Do not stop to figure out whether your answer will help or hurt either side. Just answer the questions to the best of your memory.

Do Not Exaggerate

Don't make overly broad statements that you may have to correct. Be particularly careful in responding to a question that begins, "Wouldn't you agree that…?". The explanation should be in your own words. Do not allow an attorney to put words in your mouth.

Listen Carefully

When a witness gives testimony, they are first asked some questions by the attorney who called them to the stand. For you, this is an Assistant United States Attorney (AUSA). The questions asked are for the purpose of "direct examination." When you are questioned by the opposing attorney, it is called "cross examination." This process is sometimes repeated several times in order to clearly address all aspects of the questions and answers. The basic purpose of direct examination is for you to tell the judge and jury what you know about the case. The basic purpose of cross examination is to raise doubts about the accuracy of your testimony. Don't get mad if you feel you are being doubted during the cross examination. The defense attorney is just doing their job.

Do Not Lose Your Temper

A witness who is angry may exaggerate or appear to be less than objective, or emotionally unstable. Keep your temper. Always be courteous even if the attorney questioning you appears discourteous. Don't appear to be a "wise guy" or you will lose the respect of the judge and jury.

Respond Orally To The Questions

Do not nod your head for a "yes" or "no" answer. Speak aloud so that the court reporter or recording device can hear and record your answer.

Think Before You Speak

Listen carefully to the questions you are asked. If you don't understand the question, ask to have it repeated, then give a thoughtful, considered answer. NEVER give an answer without thinking about phrasing and potential consequences for both you and your client. While answers should not be rushed, pauses to simple questions are unnecessary and could imply a lack of knowledge or professionalism.

Explain Your Answer

Explain your answer if necessary. Give the answer in your own words, and if a question cannot be truthfully answered with a "yes" or "no", it's okay to explain your answer.

Correct Your Mistakes

If your answer was not correctly stated, correct it immediately. If your answer was not clear, clarify it immediately. It is better to correct a mistake yourself than to have the attorney discover an error in your testimony. If you realize you have answered incorrectly, say, "May I correct something I said earlier?" Sometimes witnesses give inconsistent testimony – something they said before doesn't agree with something they said later. If this happens to you, don't get flustered. Just explain honestly why you were mistaken. The jury, like the rest of us, understands that people make honest mistakes.

Do Not Volunteer Information

Answer ONLY the questions asked of you. Do not volunteer information that is not actually asked for. Additionally, the judge and the jury are interested in the facts that you have observed or personally know about. Therefore, don't give your conclusions and opinions, and don't state what someone else told you, unless you are specifically asked. Also, remember that as a social worker or even a non-professional witness, you can only provide your OPINION on a case or client. It is ok to specifically designate that a statement that you are about to make is your opinion as a professional.

Don't Set Yourself Up For Error

Unless certain, avoid generalizing statements such as, "That was all of the conversation," or "Nothing else happened." Instead say, "That is all I recall" or "That is all I remember happening." It may be that after more thought or another question, you will remember something important and by making generalized statements you could appear not knowledgeable, unprofessional, or in extreme cases could appear to be attempting to withhold information from the court.

Objections By Counsel

Stop speaking instantly when the judge interrupts you, or when an attorney objects to a question. Wait for the judge to tell you to continue before answering any further.

Only Testify To What You Know

Although you should be confident and definitive in your answers whenever possible, it is important to understand that, when testifying regarding client behavior, you can only discuss personal opinions based on your professional experience. When asked a question regarding client behaviors it is helpful to begin your answer with "In my professional opinion." This is done in case any additional information or analyses change the worker's clinical interpretation which can then be adjusted in court without appearing not knowledgeable.

*In addition to these tips, the NASW-Endorsed professional liability program which regularly assists NASW members in preparing to testify as a witness can serve as an excellent resource. For more information, follow this link: http://www.naswassurance.org/malpractice/malpractice-tips/witness/

Conclusion

The criminal justice system in the United States is immensely complicated and fascinating system which holds a great deal of power over the many lives it governs. Through reading this chapter you should now be able to identify various components of the criminal justice system including the courts, the process from arrest to incarceration, the Constitution of the United States, and more. In addition to these facts readers should be aware of the numerous ways in which the criminal justice system and the field of social work overlap. Combining these professional fields results in an incredibly interesting career path, as well as an extremely difficult one.

Possessing a strong passion for advocacy is vital to success within this career path due to the highly contrasting viewpoints of mental health and criminal justice workers. Although it is sometimes easy to forget, the social work profession believe in the fact that each person, regardless of their offenses, is worthy of dignity and respect. This is not always a belief that is respected in society as a whole and particularly within a system which often promotes punishment in opposition to rehabilitation. This only makes it that more important that social workers become involved. Ultimately if you are passionate about advocating for vulnerable individuals, believe that each person has rights, can be unbiased and non-judgmental, and love the idea of working in a challenging, fast-paced, and rewarding field, this could be just the career path for you.

Legal Terminology for Social Workers

*****All definitions were obtained from *Michigan Criminal Law & Procedure, third edition (Beatty et al., 2014).*

Abuse – The cruel or violent treatment of a human or animal.

Accessory – Someone who intentionally helps another person commit a felony (examples – giving advice before the crime, helping to conceal the evidence or the perpetrator). An accessory is usually not physically present during the crime.

Accomplice – Someone who helps another person (known as the principal) commit a crime. Unlike an accessory, an accomplice is usually present when the crime is committed. An accomplice is guilty of the same offense and usually receives the same sentence as the principal.

Accused – A person or persons formally charged but not yet tried for a crime.

Acquittal – A legal judgment, based on the decision to either a jury or a judge, that an accused is not guilty of the crime for which he or she has been charged or tried.

Actus Rea – The guilty act, otherwise states as a wrongful deed rendering the actor criminally liable.

Adjudication – The trial phase of a juvenile criminal proceeding.

Admissible Evidence – The evidence that a trial judge or jury may consider, because the rules of evidence deem it reliable.

Admission – Confession of a charge, an error, or a crime; acknowledgment.

Affidavit – A written statement made under oath, swearing to the truth of the contests of a document.

Allegation – A claim or statement of what a party intends to prove; the facts as one party claims they are.

Arraignment – The first appearance of the defendant before a judge or magistrate following his or her arrest in which the defendant is formally advised of charges, attorney may be appointed, and bail is set.

Arrest – The taking, seizing, or detaining of another person.

Assault — An attempt to commit a battery or an illegal act that caused the victim to reasonably fear a battery.

Bail/Bond – The money or property given to the court as security when an accused person is released before and during a trial with the agreement that the defendant will return to court when ordered to do so. Bail is forfeited if the defendant fails to return to court.

Battery — A forceful, violent, or offensive touching of the person or something closely connected with the victim.

Brief — A written argument by counsel arguing a case, which contains a summary of the facts of the case, pertinent laws, and an argument of how the law applies to the fact situation. Also called a memorandum of law.

Chain of Custody — The one who offers real evidence must account for the custody of the evidence from the moment it reaches his or her custody until the moment it is offered into evidence.

Custody — The person is under arrest or the person's freedom has been deprived in any significant way.

Defense Attorney — An attorney who safeguards guaranteed rights of the accused.

Delinquent — A juvenile offender.

Deposition — An interview under oath.

Domestic Relationship — For purposes of the Domestic Violence Statute, a relationship that includes spouse or former spouse, resident or former resident of the same household, or persons who have a child in common.

Domestic Violence — An assault or assault and battery that occurs within a domestic relationship.

Due Process of Law — Procedures followed by law enforcement and courts to ensure the protection of an individual's rights as assigned by the Constitution.

Entrapment— Occurs if (1) the police engage in impermissible conduct that would induce an otherwise law-abiding citizen to commit a crime in similar circumstances, or (2) the police engage in conduct so reprehensible that it cannot be tolerated by the court. 1

Felony — An offense for which the offender may be punished by death or imprisonment in state prison for more than one year.

Guardian Ad Litem — A guardian appointed by the court to represent the interests of infants, the unborn, or incompetent persons in legal actions.

Hearsay — A statement, other than the one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

Holding — A court's determination of a matter of law, a specific legal principle contained in an opinion, or a court's ruling concerning a specific question.

Indictment— A formal written accusation issued by a grand jury or similar entity charging one or more people with a crime.

Indigent — An individual who has been found by a court to be indigent (stricken by poverty) within the last 6 months, who qualifies for and receives assistance, or who demonstrates an annual income below the current federal poverty guidelines.

Interrogation — Questioning in a criminal investigation that may elicit a self-incriminating response from an individual.

Jail — A facility that is operated by a local unit of government for the detention of a persons charged with, or convicted of, criminal offenses. Houses those convicted of offenses with sentences less than one year as well as those awaiting trial.

Jurisdiction — The official power to make legal decisions and judgements.

Jury — A body of people (typically twelve in number) sworn to give a verdict in a legal case on the basis of evidence submitted to them in court.

Magistrate — Magistrates assist the district court judge and are responsible for hearing informal civil infraction hearings, issuing search and arrest warrants, and set bail/ accept bond.

Mens Rea — Guilty mind (motive).

Mentally Incapable — When a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable of appraising the nature of his or her conduct. (Also referred to as NGRI- Not Guilty By Reason of Insanity).

Miranda Warning / Miranda Rights — By law (*Miranda v. Arizona* ruling by the United States Supreme Court) anyone being questioned by authorities must first receive a 'Miranda Warning'. This requirement exists to prevent the police or other authorities from taking advantage of a person who does not know or fully understand their rights and thus speaks to the police and answers their questions without an attorney present. The Miranda Warning consists of the authorities explaining certain rights to a person before questioning them. These include: 1) You have the right to remain silent. 2) If you choose to speak, anything you say can be used against you in court. 3) If you decide to answer any questions, you may stop at any time and all questioning must cease. 4) You have a right to consult with your attorney before answering any questions. You have the right to have your attorney present if you decide to answer any questions, and if you cannot afford an attorney, one will be provided for you or appointed for you by the court without cost to you before any further questions may be asked.

Misdemeanor — A violation of a penal law of this state that is not a felony or a violation of an order, rule, or regulation of a state agency that is punishable by imprisonment or a fine that is not a civil fine.

Neglect — To fail to sufficiently and properly care for an individual or animal to the extent that the individual or animal's health is jeopardized.

Notice to Appear — For minor offenses of 93-day misdemeanors or less, an appearance ticket may be issued in lieu of custodial arrest except in the cases of domestic violence and Personal Protection Order violations.

Perjury — Occurs when a person knowingly makes a false statement that is material to the case after taking a recognized oath.

Petition — A request for court action against a juvenile or removal for protective services.

Preliminary Breath Test (PBT) — A hand-held instrument utilized to determine presence or amount of alcohol in a person's system.

Preliminary Examination — A hearing to determine if probable cause exists to believe a crime has been committed and to determine if probable cause exists that the defendant committed the offense.

Prison — A facility that houses prisoners committed to the jurisdiction of the department of corrections. Individuals housed here are must be sentenced to a minimum of one year.

Privilege — Certain confidential communications that cannot be used against a person (attorney/ client).

Probable Cause — Facts and circumstances sufficient to cause a person of reasonable caution to suspect the person to be arrested is committing or has committed a crime, or that the place to be searched contains the evidence sought.

Prosecuting Attorney — The chief law enforcement officer in a county, who authorizes complaints and represents state and county in all civil and criminal matters in county courts.

Protective Order — A personal protection order entered pursuant to law; conditions reasonably necessary for the protection of one or more named persons as part of an order for pretrial release, probation, removal from home, etc.

Reasonable Suspicion — An objective basis, supported by specific and articulable facts, for suspecting a person of committing a crime.

Ruling — The outcome of a court's decision on a specific point or a case as a whole.

Search Warrant — A legal document authorizing a police officer or other official to enter and search premises.

Specific Intent — The prosecution must prove not only that the defendant did certain acts, but that he or she did the acts with the intent to cause a particular result.

Subpoena — A writ or order commanding a person to appear before a court or other tribunal, subject to a penalty for failing to appear.

Summons — A writing used to notify a person of an action that was commenced against him or her.

Testimony — The evidence given by a witness under oath. It does not include evidence from documents and other physical evidence.

Vulnerable Adult — An individual age 18 or over who, because of age, developmental disability,mental illness, or physical disability requires supervision or personal care or lacks the skills to live independently.

Warrant for Arrest (Bench Warrant) — Document issued by a judge if the information contained in the complaint establishes probable cause to substantiate the offense charged.

Write – A judicial order directing a person to do something

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15. Cultural Competence

"I believe that strong and vibrant cultures themselves nurture tolerance and justice. All cultures worth the name protect support and encourage diversity; and justice is the practical mechanism which enables them to do so." —*Dr. Nafis Sadik, former UNFPA Executive Director*

Introduction

What is culture? Many individuals think of culture as something that is different from them. They may think of culture as something they desire to have; they mistakenly do not realize that everyone has culture. Culture is something that all of us have but because we live it, we do not realize that it is there. When we think of culture, we think of many different ways of life for others; we often neglect to understand that what we do in our everyday lives is different than others. We simply think of our lifestyles as "normal," not cultured.

This chapter will explore various aspects of human diversity with a focus on the importance of understanding culture specifically for social workers to perform their ethical responsibility to be culturally competent. In this chapter we will clarify basic concepts, define key terms, discuss a variety of different cultures and begin to understand why this topic is of utmost importance to the social work profession. Let's begin with defining culture.

Culture

Culture

Many different disciplines perceive culture and cultural identity differently; therefore we will begin with a general definition then expand to a more specific definition as it relates to social work.

General Definition

Several general definitions of culture include:

1. A configuration of learned behaviors and results of behavior whose component elements are shared and transmitted by the members of a particular society (Linton, 1945)
2. The shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them (Lederach, 1995)
3. Learned and shared human patterns or models for living; day-to-day living patterns, these patterns and models pervade all aspects of human social interaction

(Damen, 1987)

Culture has been defined in a number of ways, but most simply as the learned and shared behavior of a community of interacting human beings (Useem & Useem, 1963).

Social Work Definition

There is no standard popular definition or explanation of 'culture' in social work literature. ***Culture*** is often used synonymously and confusingly with the word 'ethnicity'. From a social work perspective, culture has been defined well by Cindy Garthwait, MSW (2012) as: customs, beliefs, ideology, world-view, and values common to a group of people and which guide their individual and social behavior. More specifically, it is the product of the values, ideas, perceptions, and meanings which have evolved over time. These values, ideas, perceptions, and meanings constitute the individual's knowledge and understanding of the world in which he or she lives.

They derive from:

- physical environment of birth and upbringing
- language
- institutions
- family and social relationships
- child rearing
- education
- systems of belief
- religion, mores and customs
- dress and diet
- particular uses of objects and material life

Culture embraces all of these, and the individual may regard each of them, or any number of them, as culturally significant. There is some consensus that culture is shared patterns of behavior and interactions, cognitive constructs and understanding that are learned by socialization. No matter the culture of an individual, one thing is for certain, it will change. Culture appears to have become key in our interconnected world which is made up of so many ethnically diverse societies, but also riddled by conflicts associated with religion, ethnicity, ethical beliefs, and the elements which make up culture. Culture is no longer fixed, if it ever was. It is essentially fluid and constantly in motion. This makes it difficult to define any culture in only one way.

image

Race and Ethnicity

Now that we have an understanding of the concept of culture, let's discuss race and ethnicity. First, we need to have a basic understanding of ethnocentrism and how it affects our thinking and judgments. ***Ethnocentrism*** is a commonly

used word in circles where ethnicity, inter-ethnic relations, and similar social issues are of concern. The usual definition of the term is "thinking one's own group's ways are superior to others" or "judging other groups as inferior to one's own." "Ethnic" refers to cultural heritage, and "centrism" refers to the central starting point… so "ethnocentrism" basically refers to judging other groups from our own cultural point of view. But even this does not address the underlying issue of why people misjudge others.

Most people, using a superficial definition, believe that they are not ethnocentric, but are rather "open minded" and "tolerant." However, everyone is ethnocentric and there is no way not to be ethnocentric; it can neither be avoided because we only know what we have experienced in our own reality nor can it be willed away by a positive or well-meaning attitude. Yet this can have consequences within our own society and in international relations. We may be well meaning in inter-ethnic relations, for example, but can unintentionally offend others, generate ill feelings, and even set up situations that harm others. For example, it is easy *not* to see the life concerns of others (particularly minorities and the disadvantaged) or conversely to pity them for their inabilities to deal with life situations (like poverty or high crime rates). How do *we* feel when someone doesn't recognize our concerns or feels sorry for us because we can't "just let go" of a stressful situation?

A lack of understanding can also inhibit constructive resolutions when we face conflicts between social groups. It is easy to assume that others "should" have certain perspectives or values. How often are *we* prone to address conflicts when others tell us how we should think and feel? It can, however, be an opportunity to recognize and resolve our own biases and to learn more about potentials we all have for being human… a lifelong process of learning and growth.

What is the difference between race and ethnicity? Many people tend to think of race and ethnicity as one and the same. Often the words are used interchangeably. Looking up the definition in a dictionary doesn't usually make it any clearer. However, these two words do have separate meanings. Understanding their distinctions is significant and increasingly important, particularly because diversity in the world is continuing to grow. This is especially important as social workers in terms of advocating and practicing non-discrimination.

What Is Race?

Race is a powerful social category forged historically through oppression, slavery, and conquest. Most geneticists agree that racial taxonomies at the DNA level are invalid. Genetic differences within any designated racial group are often greater than differences between racial groups. Most genetic markers do not differ sufficiently by race to be useful in medical research (Duster, 2009; Cosmides, 2003).

Stated simply, race is the word used to describe the physical characteristics of a person. These characteristics can include everything from skin color, eye color, facial structure, or hair color. This term is physiological in nature and refers to distinct populations within the larger species. Race was once a common scientific field of study. Today, however, most scientists agree that genetic differences among races do not exist which means we are all the same inside. Clearly, we all have the same make-up which consists of vitamins, minerals, water, and oxygen.

What Is Ethnicity?

Ethnicity denotes groups, such as Irish, Fijian, or Sioux, for example, that share a common identity-based ancestry, language, or culture. It is often based on religion, beliefs, and customs as well as memories of migration or colonization (Cornell & Hartmann, 2007). In scientific analysis, it can be important to distinguish between race and ethnicity. Biological anthropologist, Fatimah Jackson (2003), provides a pertinent example of cultural practices being misread as biological differences. Micro ethnic groups living in the Mississippi Delta, she writes, use sassafras in traditional cooking. Sassafras increases susceptibility to pancreatic cancer. Medical practitioners who do not carefully disaggregate cultural and biological traits might interpret a geographic cluster of pancreatic cancer as related to a genetic or racial trait when, in fact, the disease is produced by cultural practices—in this case, shared culinary habits.

Ethnicity, on the other hand, is the word used to describe the cultural identity of a person. These identities can include language, religion, nationality, ancestry, dress, and customs. The members of a particular ethnicity tend to identify with each other based on these shared cultural traits. This term is considered anthropological in nature because it is based on learned behaviors.

Difference between Race and Ethnicity

One example of the difference between these two terms can be seen by examining people who share the same

ethnicity. Two people can identify their ethnicity as American, yet their races may be black and white. Additionally, a person born of Asian descent that grew up in Germany may identify racially as Asian and ethnically as German. People who share the same race may also have distinct ethnicities. For example, people identifying as white may have German, Irish, or British ethnicity.

Socially Constructed Differences

Some researchers believe that the idea of race and ethnicity has been socially constructed. This is because their definitions change over time, based on widely accepted public opinion. Race was once believed to be due to genetic differences and biological morphologies. This belief gave way to *racism*, the idea of racial superiority and inferiority. For example, when Italian immigrants began arriving in the United States, they were not considered part of the "white race." The same is true of Irish and Eastern European immigrants. The widely accepted view that these individuals were not white led to restrictions of immigration policies upon the arrival of "non-white" immigrants. In fact, during this time, people from these areas were considered of the "Alpine" or "Mediterranean" races. Today these race categories no longer exist. Instead, due to policy changes, people from these groups began to be accepted into the wider "white" race. They are now identified as individual *ethnic groups*. This shows that, like the idea of race, the idea of ethnicity also changes over time based on widely held public opinion.

Humans vary remarkably in wealth, exposure to environmental toxins, and access to medicine. These factors can create health disparities. Krieger (2000) describes disparities that result from racial discrimination as "biological expressions of race relations." African Americans, for example, have higher rates of mortality than other racial groups for 8 of the top 10 causes of death in the U.S. (Race, Ethnicity, and Genetics Working Group, 2005). Although these disparities can be explained in part by social class, they are not reducible to class distinctions.

When we talk about power and privilege, we talk in terms of race, ethnicity, gender and class. And with good reason as these are some of the strongest cases of privilege in our culture. We also need to understand that one of the strongest aspects of power and privilege is that very often those who have it are not even aware of the extent of their privilege.

Racism and Prejudice

According to Gordon Allport, an American psychologist, ***Prejudice*** is an affective feeling toward a person or group member based solely on their group membership. The word is often used to refer to preconceived, usually unfavorable, feelings toward people or a person because of their beliefs, values, race/ethnicity, or other personal characteristics (Allport, 1979). In this case, it refers to a positive or negative evaluation of another person based on their perceived group membership.

If you open a dictionary, the definition that typically falls under "***racism***" is: a belief or doctrine that inherent differences among the various human racial groups determine cultural or individual achievement, usually involving the idea that one's own race is superior and has the right to dominate others or that a particular racial group is inferior to the others.But racism is a lot more complicated than that. Racism is a "learned" form of hate that can be unlearned. It is systemic and institutional; basically it is prejudice plus power (influence, status and authority). Laws, restrictions and other norms in our society have been created by the majority in order to create these prejudices against another, differing group. For example, these things can include: slavery, wage gap, workplace and employment discrimination, police brutality, and so on.

There are many other definitions and concepts that make up this giant, tangled web. For example, with "***white privilege***," people who are white benefit from societal structures simply by existing in them. Of course, some people do not consciously choose to benefit, but that doesn't mean there isn't a type of advantage for them. You may not hate someone for the color of his/her skin, but you may benefit from the systems that have been set up.

White privilege does not mean that white people have or grew up with everything handed to them. Being privileged does not mean someone had or has an easy life. The thing about privilege is that it can make people blind to struggles they are not aware of.

In 1989, Wellesley College professor Peggy McIntosh wrote an essay called "White Privilege: Unpacking the Invisible Knapsack." McIntosh observes that people who are white, in the U.S. are "taught to see racism only in individual acts of meanness, not in invisible systems conferring dominance on my group." To illustrate these invisible systems, McIntosh wrote a list of 26 invisible privileges whites benefit from.

> McIntosh' White Privilege Checklist: http://www.sap.mit.edu/content/pdf/white_privilege_checklist.pdf

McIntosh (1989) further describes white privilege as an "invisible package of unearned assets, which one can count on each day. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, code books, visas, clothes, tools, and blank checks."

Minority Groups

The term "**minority**" is applied to various groups who hold few or no positions of power in a given society. The term minority doesn't necessarily refer to a numeric minority. Women, for example, make up roughly half the population but are often considered a *minority group*.

Minority does not just refer to a statistical measure and can instead refer to categories of persons who hold few or no positions of social power in a given society. For example: gender and sexuality minorities, religious minorities, and people with disabilities.

Gender and Sexuality Minorities

Gender Equality Symbol

Recognition of lesbian, gay, bisexual, and transgender people as a minority group or groups has gained prominence in Western culture since the nineteenth century. The abbreviation "LGBTQ" is currently used to group these identities together. The term queer is sometimes understood as an umbrella term for all non-normative sexualities and gender expressions but does not always signify a minority; rather, as with many gay rights activists of the 1960s and 1970s, it sometimes represents an attempt to highlight sexual diversity in everyone.

There is a growing realization that sexual and gender minorities face discrimination, violence, and criminalization. For example, nearly eighty countries criminalize homosexuality in some way (Park, 2016). Cultural stigma prohibits sexual and gender minorities from reaching their full potential. ***Stigma*** is an attribute, or mark on, another person. In the context of social interaction, it is a shared belief about someone's characteristics and traits.

For example, the attribute might be wearing a turban. Many people might share a belief that a man wearing a turban is dangerous. Stigma assigns meaning to an otherwise meaningless attribute such as wearing a turban equates to certain political beliefs.

Gender minorities can be identified and grouped according to any one of the three different categories:

- People whose inter self-identity does not match gender assigned at birth
- People whose gender expression (or socially assigned gender) does not match gender assigned at birth
- People whose social expression does not conform to relevant cultural norms and expectations of gender.

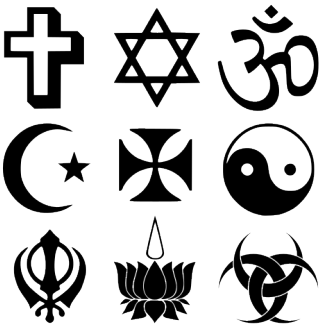
Sexual minorities can be identified and grouped according to:

- People who describe themselves using sexual minority terminology
- People whose sexual partners are the same gender, or a minority gender
- People who experience attraction to individuals of the same or a minority gender

While in most societies the numbers of men and women are roughly equal, the status of women as an oppressed group has led some, such as feminists and other participants in women's rights movements, to identify them as a minority group.

Religious Minorities

Persons belonging to religious minorities have a faith which is different from that held by the majority population or the population group that is in power. It is now accepted in many multicultural societies around the world that people should have the freedom to choose their own religion as well as including not having any religion (atheism or agnosticism), and including the right to convert from one religion to another. However, in some countries, this freedom is still either formally restricted or subject to cultural bias from the majority population.



Symbols of many different religions

For example, Burma's population is 90 percent Theravada Buddhist, a faith the government embraces and promotes over Christianity, Islam and Hinduism. Minority populations that adhere to these and other faiths are denied building permits, banned from proselytizing and pressured to convert to the majority faith. Religious groups must register with the government, and Burmese citizens must list their faith on official documents. Burma's constitution provides for limited religious freedom, but individual laws and government officials actively restrict it (U.S. Commission on International Religious Freedom, 2016).

People with Disabilities

Forms of disabilities

The disability rights movement has contributed to an understanding of people with disabilities as a minrity or a coalition of minorities who are disadvantaged by society, not just as people who are disadvantaged by their impairments. Advocates of disability rights emphasize differences in physical or psychological functioning rather than inferiority: for example, some people with autism argue for acceptance of neuro-diversity in the same way opponents of racism argue for acceptance of ethnic diversity. The deaf community is often regarded as a linguistic and cultural minority rather than a group with disabilities, and some deaf people do not see themselves as having a disability at all. Rather, they are disadvantaged by technologies and social institutions that are designed to cater to the dominant, hearing-unimpaired group.

Immigration

Immigration involves the permanent movement from one country to another. Social workers are often called upon to work with immigrants. Immigrants represent a significant portion of the U.S. population. In 2010, 40 million people (12.9%) of the total population were foreign-born (U.S. Census Bureau, 2010).

People with different national origins often find it difficult to integrate into mainstream culture, especially when language barriers exist or they experience immigration issues. Social workers play a crucial role in many immigration

cases. A social worker is often the first person people talk to about their immigration struggles. Social workers often help clients gather key evidence, write detailed evaluations, assist with citizenship or change of legal status, or are the primary contact with police officers. There is a range of immigration status which immigrant children, youth and parents may hold. Immigrants may fall into one of the following categories:

- legal permanent residents
- naturalized citizens
- refugees
- undocumented persons

Each category or status can carry different legal rights and access to services.

Asylum	Provides specific protections to individuals who have reason (e.g. political, economic, etc.) to fear returning to their native country.
Deferred Action	Provides individuals who came to the US under the age of 16, protection from CHILDHOOD ARRIVALS deportation and an opportunity to receive employment authorization to two (DACA) 2 years. At the end of the two year period, individuals may apply for renewal.
Special Immigrant	Provides lawful permanent residence to immigrant children and youth who JUVENILE STATUS (SUS) are under the jurisdiction of the juvenile court and who have not been able to reunify with their families as a result of abuse, neglect or abandonment. Timing is critical; the SUS application must be processed while the child or youth is under the jurisdiction of the court.
T-VISA	Provides immigration relief to human trafficking victims who can demonstrate they have suffered tremendous hardships. Victims must have cooperated with reasonable requests during the investigation or in the prosecution of the accused.
U-VISA	Provides temporary visas to victims of crime. Victims must possess information related to the criminal activity and must cooperate with the criminal investigation and prosecution of the accused.
VIOLENCE AGAINST	Provides an abused victim an opportunity to seek permanent residency under WOMEN ACT (VAWA) the immigration provisions of the Violence Against Women Act (VAWA). The victim is eligible if he or she experiences abuse at the hands of a US citizen or permanent resident parent or stepparent.

Source: NASW Quick Resource Guide, 2013

A large number of immigrant households are comprised of mixed-status families (Capps & Passel, 2004; Torrico, 2010) which can mean that only some family members can access public funded services. For many immigration cases, it is important that a knowledgeable social worker be involved in the process.

Cultural Competency

It is important for social workers to have an understanding of the concept of culture in order to have ***cultural competence***. This can be defined as a set of behaviors, attitudes, and policies that come together in a system, agency, or program. It can also be among individuals, enabling them to function effectively in diverse cultural interactions and similarities within, among, and between groups. Another way to describe cultural competence is a point on a continuum that represents the policies and practices of an organization, or the values and behavior of an individual which enable that organization or person to interact effectively in a culturally diverse environment. The competency of social workers is limited when they do not possess tools of acknowledgment that can affect them when working with diverse populations.

The social work profession is built upon culturally sensitive practices that advocate for social and economic justice for those who are disadvantaged, oppressed, and/or discriminated against. Standard 1.05(c) in the National Association of Social Workers' (NASW) Code of Ethics (NASW, 2008), reminds social workers of their duty to be culturally competent and to purposefully "obtain education about and seek to understand the nature of social diversity and oppression." NASW's National Committee on Racial and Ethnic Diversity (NASW, 2001) highlights this necessity by identifying standards that make up culturally competent practices, including self-awareness, cross-cultural knowledge, skills, and leadership.

Although "diversity is taking on a broader meaning to include the sociocultural experiences of people of different genders, social classes, religious and spiritual beliefs, sexual orientations, ages, and physical and mental abilities" (p. 8), the historical impact of race on American society continues to play an integral part in the development and effectiveness of culturally competent practice. Having cross cultural sensitivity and cultural competence remains challenging as the concept of culture and how it relates to individuals continues to evolve.

Social workers must possess the skills to be able to understand a broad spectrum of varying cultures and have an understanding of important and influential beliefs related to that specific culture. An informed social worker will better understand how culture and diversity may impact how we present services and treatment and what interventions could produce better outcomes for those we serve. It would be useful for a social worker to be bilingual but not required as most agencies have access to interpreters.

Ethnic and Cultural Differences

We've established that understanding and appreciating diversity are essential for social workers to practice effectively with clients. The following section discusses some of the values, beliefs, and perspectives assumed by several cultural groups in our society: Hispanic, Native Americans, African Americans, Asian Americans, and Muslim Americans.

Celebration of Hispanic American Heritage

Hispanics

As we know, no one term is acceptable to all groups of people. Hispanic and Latino/Latina have generally been used to refer to people originating in countries in which Spanish is spoken. However, we have also established that the terms refer to people originating in a wide range of places. Others prefer to be addressed by their specific countries of origin.

For example, people from Puerto Rico prefer to be addressed as Puerto Ricans. The three primary Hispanic groups in the United States in terms of size are Mexican Americans (over 66% of all Hispanics), Puerto Ricans (almost 9%), and Cuban Americans (almost 3.5%) (U.S. Census Bureau, 2010). Other groups include those from the Dominican Republic and from other countries in Central and South America (Santiag-Rivera, Arredondo, & Gallardo-Cooper, 2002). It's important not to make stereotyped assumptions about such a diverse group.

Specific variations exist within the many sub-groups; we will discuss some cultural themes important to Hispanic families in general. Hispanic heritage is rich and diverse, but the groups tend to share similarities in terms of values, beliefs, attitudes, culture, and self-perception. These include the significance of a common language, the importance of family and other support systems, spirituality, and the traditional strictness of gender roles.

The first theme important in understanding the environment for children growing up in Hispanic families is the significance of a common language. According to the Pew Research Center, almost 60% of Latinos/Latinas indicate they speak English only or speak it fluently; however, almost 32% of Latinos/Latinas indicate they speak Spanish fluently. (Krogstad, Stepler, & Lopez, 2015).

A second theme reflecting a major strength in many Hispanic families is the significance placed on relationships with nuclear and extended family, including aunts, uncles, cousins, and grandparents, as well as close friends.

A third theme characterizing many Hispanic families is the importance of spirituality and religion. Catholicism is a defining role for family and gender roles for Latino or Hispanic people.

A fourth theme often characterizing Hispanic families is the strict gender roles. This is reflected in two major concepts: *Machismo* is the idea of male "superiority" that "defines the man as provider, protector, and head of the household", *marianismo*, on the other hand, is the idea that, "after the Virgin Mary," females are valued for their "female spiritual sensitivity and self-sacrifice for the good of husband and children"??? (Santiago-Rivera, Arredondo, and Gallardo-Cooper, 2002).

For more information on Hispanic Americans: http://www.dimensionsofculture.com/2011/03/cultural-values-of-latino-patients-and-families/

End of the Line

Native Americans

In the United States, there are about 700 native groups (Indian and Eskimo) that still exist. Of that number, about 556, including some 223 village groups in Alaska, are formally recognized. (For a listing of federally recognized groups, log on to http://www.doi.gov/bia/tribes/entry.html) (Sutton, 2004).

Each Native American group has always had a name for itself – a name that often translates to something like "The People." However, groups have often been known to the outside world by other names (i.e. American Indian, Native American, and First Nation's Peoples) (Weaver, 2008). Whenever possible, it's best to identify the participants' specific group. As part of their increasing pride and power, many groups are trying to revive their original names and asking

that these be used instead of other names. For example, the Chippewa, Ottawa, and Potawatomi want to be called Anishinaabe ("The People from Above").

Several themes characterize many Native American people. These include the importance of extended family and respect for older adults, noninterference, harmony with nature, the concept of time, and spirituality.

As with Hispanic people, family ties including those with extended family, are very important. The sense of self is secondary compared to that of the family and of the tribe. It is tradition to consult tribal leaders, elders, and spiritual leaders when conflicts emerge. It is also very common to have extended family members living together in one household.

Children receive supervision and instruction not only from their parents but also from relatives of several generations. In the Anishinaabe culture, it is the aunts and uncles who provide the discipline. The idea is that parents love their children and do not have the capability to see the "naughty" in their children. Aunts and uncles, who also love the children, have the ability to recognize when a child needs guidance and are obligated to provide it.

A second significant concept in Native American culture involves the emphasis on noninterference. The highest form of respect for another person is respecting their natural right to self-determination. For example, Native parents use noncoercive parenting styles that encourage the child's self-determination. Unlike many other cultures, it is not uncommon to see children running around during religious ceremonies instead of sitting and paying attention. The hope is that the children will pick up on different things, said and done, and someday decide to participate.

A third theme that characterizes Native American culture is that of harmony with nature. Western culture generally tends to measure its advancement by the distance it places between itself and nature. In contrast, Native cultures tend to view greater closeness to the natural world and its cycles as a measure of significant achievement.

A fourth concept basic to Native people's lives, and related to harmony with nature, is the concept of time, often termed "Indian Time". Time is considered an aspect of nature which flows along with life. It is not something that should take precedence over relationships. It is more important to have human relationships rather than to be punctual. The idea is that it will happen when it is supposed to, not because of a certain time.

For more information on Native Americans: http://pluralism.org/religions/native-american-traditions/

The flag of the US and Ghana

African Americans

There are about 41.8 million African Americans in the United States (U.S. Census Bureau, 2010). African Americans, like other racial, cultural, and ethnic groups, reflect great diversity. Despite this diversity four general commonalities exist: importance of extended family, role flexibility, high respect for older adults, and strong religious beliefs and a close relationship with the church.

Like Hispanic and Native Americans, extended family ties are very important for African American families. Often children are raised not only by the nuclear family consisting of parents and children but also by extended family members (Martin, 1980). Children often receive nurture and support from multiple caring family members, who also provide each other with mutual aid.

A second theme characterizing African American families is role flexibility. Often time's mothers play both roles of

mother and father (Barbarin, 1983). Older children are also accustomed to being the parent figure so that the parents can work. Sometimes older African American children drop out of school so they can go to work and help their families financially.

A third theme common among African American families is respect for older adults. Older adults are held in high regard. It is a belief that older adults should be provided in home care by their children.

A fourth theme in African American life involves strong religious beliefs and a close relationship with the church. Many African American families consider the church to be a part of the extended family. Religion is considered to be what contributed to their resilience, their survival of slavery, and their ability to overcome struggles.

For more information on African Americans: African Americans in U.S. History in Context

Painted Indian Elephant Figurines

Asian Americans

In 2001, Asian Americans in the United States numbered more than 12.5 million and represented more than thirty different nationalities and ethnic groups, including Samoan, Tongan, Guamanian, and native Hawaiian from the Pacific Islands; Lao, Hmong, Mien, Vietnamese, Cambodian, Thai, Burmese, Malay, and Filipinos from Southeast Asia; Pakistani, Bangladeshi, Indian, and Sri Lankan from South Asia; Afghani and Iranian from Central Asia; and Korean, Japanese, and Chinese from East Asia. In 2000, the three largest Asian nationalities in the United States were Chinese, Filipinos, and Asian Indians. The diversity of Asian Americans, in terms of their various languages, cultures, and histories, is remarkable (Kiang, 2017). Obviously, there is a huge variation among these groups despite the fact that they are clustered under the same umbrella term *Asian Americans*.

All U.S. Asians –17,320,856

Chinese	4,010,114
Filipino	3,416,840
Indian	3,183,063
Vietnamese	1,737,433
Korean	1,706,822
Japanese	1,304,286
Pakistani	409,163
Cambodian	276,667
Hmong	260,073
Thai	237,583
Laotian	232,130
Bangladeshi	147,300
Burmese	100,200
Indonesian	95,270
Nepalese	59,490
Sri Lankan	45,381
Malaysian	26,179
Bhutanese	19,439
Mongolian	18,344
Okinawan	11,326

Source: *The Asian Population: 2010*, U.S. Census Bureau, Retrieved March 2012

Four themes tend to be similar throughout the diverse groups. These include family as the primary unit and individuality as secondary in importance, interdependence among family, filial piety, and their involvement in patriarchal hierarchy.

Like previous cultures discussed, Asian families stand out for their strong emphasis on family. More than half (54%) say that having a successful marriage is one of the most important things in life. Two-thirds of Asian-American adults (67%) say that being a good parent is one of the most important things in life (Pew Research Survey, 2012). Their living arrangements align with these values.

A second theme, related to the significance of the family, involves interdependence. For example, they are more likely than the general public to live in multi-generational family households. Some 28% live with at least two adult

generations under the same roof. This is slightly more than the share of African-Americans and Hispanics who live in such households.

A third theme concerns a strong sense of *filial piety*—"a devotion to and compliance with parental and familial authority, to the point of sacrificing individual desires and ambitions." About two-thirds say parents should have a lot or some influence in choosing one's profession (66%) and spouse (61%) (Pew Research Survey, 2012).

A fourth theme characterizing many Asian American families involves the vertical family structure of patriarchal lineage and hierarchal relationships. This is common in traditional Asian-American families, but there is diversity in practice across cultures. Based on the teachings of Confucius, responsibility moves from father to son, elder brother to younger brother, and husband to wife. Women are expected to be passive, and nurture the well-being of the family. A mother forms a close bond with her children, favoring her eldest son over her husband.

For more information on Asian Americans: http://www.asian-nation.org

Muslim-American Flag

Muslim Americans

Since the U.S. Census Bureau does not ask questions about religion, there is no official government count of the U.S. Muslim population. It has been estimated, by Pew Research, in 2015 that there were 3.3 million Muslims of all ages in the United States. Islam is the second largest religion in the world and third largest in the United States (Lipka, 2017). As a social worker, it is likely that you will work with an individual who identifies as a Muslim.

It is important to understand that, unlike the previous cultures discussed, we are attempting to give a brief overview of the religion Islam and not the people. Like any religious group, religious beliefs and practices of Muslims vary depending on many factors including where they live. Each of these cultures practices Islam to a different degree just as many Christians practice their religion at different degrees. For example, a Muslim individual from Saudi Arabia may be very strict with the way that women should dress while an individual from Turkey may be more relaxed.

Social values are divided into three groups: necessities (*dharuriyyat*); convenience (*hajiat*); and refinements (*kamaliat*). Human basic values consist of life (al nafs), reason (al'aql), descent (nasab), property (al mal) and religion (al din) (Akunduz, 2002). Islam protects these primary human values and prohibits any violation of them.

Muslims around the world are almost universally united by a belief in one God and the Prophet Muhammad, and the practice of certain religious rituals.

For a brief introduction to Islam go to: http://www.islamicity.com/mosque/Intro_Islam.htm

Islam emphasizes practice as well as belief. Law rather than theology is the central religious discipline and locus for defining the path of Islam and preserving its way of life.

The essential duties of all Muslims, the Five Pillars (Bala, 2017), are:

- The Shahadah (Witness)
- The Salat (Prayer)
- The Zakat (Alms)
- The Sawm or Siyam (Fasting)

- The Hajj (Pilgrimage)

Islam law states there is no god but God and Muhammad is the messenger of God (Shahadah), worship or prayer should occur five times daily with community prayers at the mosque on Fridays (salat), charity (zakah), fasting during the month of Ramadan(siyam), and pilgrimage (hajj) to Mecca at least once in a lifetime. Jihad, or struggle in the way of God, is sometimes considered the sixth pillar. Jihad includes both internal spiritual struggles and external war waged in defense of the Muslim community (Bala, 2017).

Women are the dominant players in family and home. Men are considered to be the economic providers. Women are expected to cover their bodies, except their hands and faces, in front of men other than than their brothers, husbands, fathers and sons. This is an expression of modesty so as not to sexually provoke or invite unacceptable sexual behavior.

Of course, any discussion of these general cultural themes of values and behaviors is just that—general. Actual practices vary dramatically from one ethnic group to another and from one family to another. It's important not to make assumptions about an individual's values and expectations simply because that person belongs to a different group.

For more information on Muslim Americans: https://www.cfr.org/backgrounder/muslims-united-states

Case Study: Lia Lee

This true story involves the life of Lia Lee, a Hmong child who is epileptic, which was made famous by the author Anne Fadiman in her book "The Spirit Catches You and You Fall Down". Lia began having epileptic seizures when she was about three months old. The Hmong regard this disease with ambivalence. They acknowledge that it is potentially dangerous and life threatening, but they also consider it to be an illness of some distinction, an illness in which a healing spirit enters the body. The Hmong saw it as divine, because many of their shamans (spiritual leaders) were afflicted with it.

Over the first few months of her life, Lia had over twenty seizures which made her parents (Foua-mother and Nao Kao-father) take her to the emergency room. There was obviously a great difference between American doctors and Hmong shamans. A shaman might spend eight hours in a Hmong home while an American doctor demanded the patient come to the hospital where the doctor might only see him for twenty minutes. Shamans could render an immediate diagnosis while the doctors had to run many tests and then sometimes didn't know what was wrong anyway. Shamans never undressed their patients while doctors, on the other hand, put their hands and fingers into body orifices. Most significantly, shamans knew you had to treat the soul as well as the body unlike American doctors.

Besides the differences between doctors and shamans, there was a feeling among the Hmong that doctors' procedures were actually more likely to threaten their health than to restore it. For example, the Hmong believe that there is only a finite amount of blood in the body, and doctors are continually taking it. Hmong people believe that when they are unconscious, their souls are at large, so anesthesia may lead to illness or death. Surgery is taboo and so are autopsies and embalming for the Hmong. The only form of medical treatment that was gratefully accepted by the Hmong was antibiotics. They had no fear of needles and frequently practiced dermal treatments like acupuncture, massage, pinching, scraping the skin, heating a cup to the skin or even burning the skin. The fact that epilepsy has a divine nature to them and the fact that the doctors see it only as a disease to be either cured or controlled foreshadows problems yet to come between the two cultures.

The greatest problem, for both the Lees and the hospital, was Lia's medication. Most of the time, she was on a combination of several different medications. By the time she was four, she had changed prescriptions 23 times.

Add to this the fact that Lia's parents were illiterate in both English and Hmong; they often forgot what the doctors told them. The doctors never assumed anything other than that the Lees would give Lia her medicines properly, but time soon proved that Lia's mother especially was either confused or lying about how she administered the medicines. This is where the hospital social worker (Jeanine Hilt) initially stepped in to help. Jeanine worked with the Lee family to simplify the medication regimen.

Later, the Lee's had come to the conclusion that the medicines were causing the seizures and fever therefore, they refused the medications. The nurses soon come to the realization that the Lees were non-compliant. Due to the parent's non-compliance, the doctor felt he had no choice but to refer Lia's case to the health department and child protective services. He recommended she be placed in a foster home so that compliance of medications could be obtained. The Superior Court of the State of California immediately acted upon his request and declared that Lia should be removed from the custody of her parents.

Months later, with the efforts of social worker Jeanine, Lia is reunited with her family. The family is overjoyed to have her home again. However, the celebratory mood soon began to dissipate as the Lees realized that Lia had been returned to them in damaged condition. She didn't know people she had known before, and she could speak very little. From their perspective, the courts and the foster care system had made her sicker, but of course, the doctors felt it was due to the damage done when the Lees failed to comply with their orders. As a result of Lia's condition, the Lees stepped up her traditional medicine.

Lia's family spent large amounts of their money on such things as amulets. They tried every known cure in their medical library even to the point of changing Lia's name to Kou on the premise that the *dab* (spirit) that stole her soul would be tricked into thinking she was someone else, and the soul could return. They even took her to a shaman in Minnesota for help.

The doctors would have been surprised to learn that the Hmong actually took their children's health seriously since they so readily spurned American care. At the hospital, Lia's case metastasized into a mass of complaints that grew angrier with each passing year. Especially the nurses were angry that the Lees were so ungrateful for the $250,000 worth of care they received for free. They were angry that the Lees had been noncompliant and believed that Lia did not need to be in the state she was in. They believed the Lees just hadn't given her the medication.

Lia's brain impairment is never resolved and she eventually becomes vegetative for the rest of her life. Lia is taken home by her parents to be loved and cared for by them. The doctors in Merced and other medical communities begin to realize that understanding the cultural differences of an immigrant must be considered when treating them as patients. However, in the end, the doctors still believe that the bottom line means save the patient's life while the Hmong believed that it was the patient' soul.

When the author of the book asked why the doctors never asked the Hmong how they treated their illnesses, he replied that because they dressed in American clothing, had American driver's licenses and shopped in supermarkets, it never occurred to the medical staff that they might practice unconventional healing arts. Jeanine Hilt was the only one who ever asked the Lees how they were treating Lia's developmental delays. She is the only person who fought against the medical establishment on Lia's behalf. She had simplified Lia' medication regimen, secured them their disability money and advocated to the courts for her return home and she never described them as closemouthed and dim.

Case study from: Fadiman, A. (1997). *The Spirit Catches You and YouFall Down*. New York: Farrar, Straus and Giroux

Summary

Being culturally competent and having cross-cultural awareness is an ongoing process. It is helpful in understanding the circumstances and social issues from a client's perspective. Competency is also important as social workers must attend to their own perspectives about their own cultural identity and how the client may view us. The need to assess all aspects of a client's belief system, values, and how they view themselves within their own culture is as important as assessing their whole bio-psychosocial history. By having some understanding of and sensitivity to other cultures means that we can also help others learn about different views and perspectives. Most importantly, we can dispel any generalizations or myths about a certain culture. With better insight we can appropriately match client's needs in respect to resources and services.

A social worker's aim is to advance social justice, equality and to end discrimination. In many ways, it has been observed, that a person's or group's culture has played a large part of many incidents of inequality and disenfranchisement in the past, both in our country's history and across the globe. One of our most important goals is to be the voice of our client(s) whether it is for an individual, a group, a neighborhood, or organization, in order to make sure that their rights are not violated and they are treated with dignity and respect. Learning to deal with how and what types of social issues regarding injustices exist, will help when we are dealing with real life discrimination and inequality that occurs and may be affecting our clients. By understanding and identifying social injustice and inequality, we can offset mechanisms of oppression and how they work.

Having cross cultural sensitivity and cultural competence remains challenging as the concept of culture and how it relates to individuals continues to evolve. Social workers must possess the skills to be able to understand a broad spectrum of varying cultures and have an understanding of important and influential beliefs related to that specific culture. An informed social worker will better understand how culture and diversity may impact how we present services and treatment and what interventions could produce better outcomes for those we serve.

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Appendix A - Community Resources

Community Resources

The following resources are community partners with the Human Services program at the College of DuPage. These materials are protected by copyright unless otherwise noted and for information purposes only. Please visit these websites for the most current information.

https://www.raygraham.org/

Our Life-Changing Story

Founded in 1950, Ray Graham Association serves nearly 2,000 people with disabilities and employ about nearly 350 people. Ray Graham enriches lives by empowering those we support and those who care for them to reach, grow, and achieve. Thank you for being a part of this life-saving and life-giving mission.

Our Purpose-Driven Mission

Thanks to your continued support, Ray Graham Association provides a loving community, stability, and personal care, for nearly 2,000 people with disabilities. Our goal is to empower people to:

- **Reach their potential** by providing access to therapeutic programs, recreation, and family support resources.
- **Grow their future** through neighborhood living, life-skills training, and employment opportunities.
- **Achieve their goals** by pursuing personalized plans with measurable actions and results.

Our Ground-Breaking Namesake

J. Ray Graham (1898-1961) was a lifelong public servant. He was an educator, administrator, and superintendent for various Illinois school districts before being appointed the first Director of Special Education in the state. Innovative and pioneering, he advocated for people with disabilities as an expert lecturer in the field.

Our Person-Centered Ethos

Ray Graham Association believes in a person-centered approach to care and community. We provide people with

disabilities and their families an array of services that cater to their individual needs, strengths, and dreams. Putting people first leads to a happier and healthier community.

Title VI Non-Discrimination

Ray Graham Association complies with Title VI of the Civil Rights Act of 1964 which states, "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The final Title VI Program can be found here, which includes an explanation of the complaint and appeal process.

Ray Graham Association
901 Warrenville Road, Suite 500
Lisle, IL 60532
Call Us: 630-620-2222

https://www.serenityhouse.com/

Alcohol & Drug Substance Abuse Treatment Center

For over 30 years, Serenity House has consistently and successfully met the increasing demands for substance abuse treatment through our full continuum of care that includes Adult and Adolescent Outpatient and Intensive Outpatient services, DUI, as well as our Halfway Houses and Recovery Homes. Our Halfway House services are unique in DuPage County as we remain the only facility of its kind offering a 90-day Extended Residential Care Treatment Program specific to assisting individuals recovering from substance abuse. Our programs provide a holistic approach that focuses on integrating men and women back into their surroundings as self-sufficient, productive members of their communities while improving the quality of life for their families.

Serenity House began as a four-bed cottage in 1985. Today, we host a current capacity of 107 beds in our men's and women's residential programs and over 200 individuals in our outpatient programs. Through the years, treatment has developed into a broad range of interventions and now includes individual counseling, group counseling, family support including family nights, and sober fun activities.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/exploringhumanservices/?p=142#oembed-1

630-620-6616

891 S. Rohlwing Rd.
Addison, IL 60101

https://teenparentconnection.org/

Teen Parent Connection is a nonprofit agency serving teen parents in DuPage County as they navigate the challenges of both parenthood and adolescence. In addition, we offer school-based pregnancy prevention education programs in both middle schools and high schools to help reduce the risk of teen pregnancy. We are a staff, board, and community dedicated to empowering young families and creating the best possible start for young mothers, young fathers, and their babies.

OUR HISTORY

Led by Jeanne Altendorf-McLennan, a registered nurse who was Prenatal Services Coordinator at Hinsdale Family Medicine Center, a group of dedicated founders established Teen Parent Connection (formerly Greater DuPage MYM) in June 1985. Their purpose was to provide adolescent parents with parenting education, support, and resources to improve the outcomes for young parents and their children. Teen Parent Connection is currently the only agency in DuPage County providing comprehensive programs and services related to teen pregnancy and parenting.

OUR MISSION

The mission of our organization is "*to serve the community through education on the realities and responsibilities of teenage pregnancy and through long-term assistance to adolescent parents for their development of self-esteem, parenting skills, and empowerment towards self-sufficiency.*" The primary goal of the organization is to provide services that will prevent child abuse and neglect among this at-risk population.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://cod.pressbooks.pub/exploringhumanservices/?p=142#oembed-2

475 Taft Avenue
Glen Ellyn, IL 60137
Tel: (630) 790-8433
Fax: (630) 790-4530
info@teenparentconnection.org

YWCA Logo

https://www.ywca.org/

About YWCA Metropolitan Chicago

Founded in 1876, YWCA Metropolitan Chicago is a social enterprise committed to eliminating racism, empowering women, and promoting peace, justice, freedom, and dignity for all. As a leading association among a national network of more than 200 YWCAs, YWCA Metropolitan Chicago impacts tens of thousands of women and families annually through comprehensive human services provided across the region. YWCA Metropolitan Chicago is a leading service provider in the areas of sexual violence support services, early childhood and child care provider services, family support services, youth STEM programming, and economic empowerment services. Located in the third-largest American city with the third-highest percentage of women in the U.S., YWCA Metropolitan Chicago serves as a national incubator for innovative programming, outreach and engagement strategies. Contributing to our diverse and balanced economy, YWCA Metropolitan Chicago is working at the individual and systems levels to create an inclusive marketplace where everyone thrives. The organization is also an active member of many national, state, county and city-level coalitions, representing the interests of and advocating for policies that positively affect women and families.

347 S. Gladstone, Aurora, IL
Aurora, IL 60506
630-299-2282

One N. LaSalle, Suite 1150
Chicago, IL 60602-4039
312-372-6600

Appendix B - Codes of Ethics

I. Code of Ethics – Human Services

The National Organization for Human Services (NOHS) is a nonprofit organization representing Human Service practitioners, educators, students and future Human Service Professionals. NOHS works to support all Human Service Professionals in our primary purpose to assist individuals and communities to function as effectively as possible in all major domains of living (https://www.nationalhumanservices.org/what-is-human-services).

Ethical Standards for Human Service Professionals

National Organization for Human Services Adopted 2015

Preamble

Human services is a profession developed in response to the direction of human needs and human problems in the 1960's. Characterized by an appreciation of human beings in all of their diversity, human services offers assistance to its clients within the context of their communities and environments. Human service professionals and those who educate them promote and encourage the unique values and characteristics of human services. In so doing, human service professionals uphold the integrity and ethics of the profession, promote client and community well-being, and enhance their own professional growth.

The fundamental values of the human services profession include respecting the dignity and welfare of all people; promoting self-determination; honoring cultural diversity; advocating for social justice; and acting with integrity, honesty, genuineness and objectivity.

Human service professionals consider these standards in ethical and professional decision making. Conflicts may exist between this code and laws, workplace policies, cultural practices, credentialing boards, and personal beliefs. Ethical-decision making processes should be employed to assure careful choices. Although ethical codes are not legal documents, they may be used to address issues related to the behavior of human service professionals.

Persons who use this code include members of the National Organization for Human Services, students in relevant academic degree programs, faculty in those same programs, researchers, administrators, and professionals in community agencies who identify with the profession of human services. The ethical standards are organized in sections around those persons to whom ethical practice should be applied.

Responsibility to Clients

STANDARD 1 Human service professionals recognize and build on client and community strengths.

STANDARD 2 Human service professionals obtain informed consent to provide services to clients at the beginning of the helping relationship. Clients should be informed that they may withdraw consent at any time except where denied by court order and should be able to ask questions before agreeing to the services. Clients who are unable to give consent

should have those who are legally able to give consent for them review an informed consent statement and provide appropriate consent.

STANDARD 3 Human service professionals protect the client's right to privacy and confidentiality except when such confidentiality would cause serious harm to the client or others, when agency guidelines state otherwise, or under other stated conditions (e.g., local, state, or federal laws). Human service professionals inform clients of the limits of confidentiality prior to the onset of the helping relationship.

STANDARD 4 If it is suspected that danger or harm may occur to the client or to others as a result of a client's behavior, the human service professional acts in an appropriate and professional manner to protect the safety of those individuals. This may involve, but is not limited to, seeking consultation, supervision, and/or breaking the confidentiality of the relationship.

STANDARD 5 Human service professionals recognize that multiple relationships may increase the risk of harm to or exploitation of clients and may impair their professional judgment. When it is not feasible to avoid dual or multiple relationships, human service professionals should consider whether the professional relationship should avoided or curtailed.

STANDARD 6 Sexual or romantic relationships with current clients are prohibited. Before engaging in sexual or romantic relationships with former clients, friends, or family members of former clients, human service professionals carefully evaluate potential exploitation or harm and refrain from entering into such a relationship.

STANDARD 7 Human service professionals ensure that their values or biases are not imposed upon their clients.

STANDARD 8 Human service professionals protect the integrity, safety, and security of client records. Client information in written or electronic form that is shared with other professionals must have the client's prior written consent except in the course of professional supervision or when legally obliged or permitted to share such information.

STANDARD 9 When providing services through the use of technology, human service professionals take precautions to ensure and maintain confidentiality and comply with all relevant laws and requirements regarding storing, transmitting, and retrieving data. In addition, human service professionals ensure that clients are aware of any issues and concerns related to confidentiality, service issues, and how technology might negatively or positively impact the helping relationship.

Responsibility to the Public and Society

STANDARD 10 Human service professionals provide services without discrimination or preference in regards to age, ethnicity, culture, race, ability, gender, language preference, religion, sexual orientation, socioeconomic status, nationality, or other historically oppressed groups.

STANDARD 11 Human service professionals are knowledgeable about their cultures and communities within which they practice. They are aware of multiculturalism in society and its impact on the community as well as individuals within the community. They respect the cultures and beliefs of individuals and groups.

STANDARD 12 Human service professionals are aware of local, state, and federal laws. They advocate for change in regulations and statutes when such legislation conflicts with ethical guidelines and/or client rights. Where laws are harmful to individuals, groups, or communities, human service professionals consider the conflict between the values of obeying the law and the values of serving people and may decide to initiate social action.

STANDARD 13 Human service professionals stay informed about current social issues as they affect clients and communities. If appropriate to the helping relationship, they share this information with clients, groups and communities as part of their work.

STANDARD 14 Human service professionals are aware of social and political issues that differentially affect clients from diverse backgrounds.

STANDARD 15 Human service professionals provide a mechanism for identifying client needs and assets, calling attention to these needs and assets, and assisting in planning and mobilizing to advocate for those needs at the individual, community, and societal level when appropriate to the goals of the relationship.

STANDARD 16 Human service professionals advocate for social justice and seek to eliminate oppression. They raise awareness of underserved population in their communities and with the legislative system.

STANDARD 17 Human service professionals accurately represent their qualifications to the public. This includes, but is not limited to, their abilities, training, education, credentials, academic endeavors, and areas of expertise. They avoid the appearance of misrepresentation or impropriety and take immediate steps to correct it if it occurs.

STANDARD 18 Human service professionals describe the effectiveness of treatment programs, interventions and treatments, and/or techniques accurately, supported by data whenever possible.

Responsibility to Colleagues

STANDARD 19 Human service professionals avoid duplicating another professional's helping relationship with a client. They consult with other professionals who are assisting the client in a different type of relationship when it is in the best interest of the client to do so. In addition, human services professionals seek ways to actively collaborate and coordinate with other professionals when appropriate.

STANDARD 20 When human service professionals have a conflict with a colleague, they first seeks out the colleague in an attempt to manage the problem. If this effort fails, the professional then seeks the assistance of supervisors, consultants, or other professionals in efforts to address the conflict.

STANDARD 21 Human service professionals respond appropriately to unethical and problematic behavior of colleagues. Usually this means initially talking directly with the colleague and if no satisfactory resolution is achieved, reporting the colleague's behavior to supervisory or administrative staff.

STANDARD 22 All consultations between human service professionals are kept private, unless to do so would result in harm to clients or communities.

Responsibility to Employers

STANDARD 23 To the extent possible, human service professionals adhere to commitments made to their employers.

STANDARD 24 Human service professionals participate in efforts to establish and maintain employment conditions which are conducive to high quality client services. Whenever possible, they assist in evaluating the effectiveness of the agency through reliable and valid assessment measures.

STANDARD 25 When a conflict arises between fulfilling the responsibility to the employer and the responsibility to the client, human service professionals work with all involved to manage the conflict.

Responsibility to the Profession

STANDARD 26 Human service professionals seek the training, experience, education and supervision necessary to ensure their effectiveness in working with culturally diverse individuals based on age, ethnicity, culture, race, ability, gender, language preference, religion, sexual orientation, socioeconomic status, nationality, or other historically oppressive groups. In addition, they will strive to increase their competence in methods which are known to be the best fit for the population(s) with whom they work.

STANDARD 27 Human service professionals know the limit and scope of their professional knowledge and offer services only within their knowledge, skill base, and scope of practice.

STANDARD 28 Human service professionals seek appropriate consultation and supervision to assist in decision-making when there are legal, ethical or other dilemmas.

STANDARD 29 Human service professionals promote cooperation among related disciplines to foster professional growth and to optimize the impact of inter-professional collaboration on clients at all levels.

STANDARD 30 Human service professionals promote the continuing development of their profession. They encourage membership in professional associations, support research endeavors, foster educational advancement, advocate for appropriate legislative actions, and participate in other related professional activities.

STANDARD 31 Human service professionals continually seek out new and effective approaches to enhance their professional abilities and use techniques that are conceptually or evidence based. When practicing techniques that are experimental or new, they inform clients of the status of such techniques as well as the possible risks.

STANDARD 32 Human service professionals conduct research that adheres to all ethical principles, institutional standards, and scientific rigor. Such research takes into consideration cross-cultural bias and is reported in a manner that addressed any limitations.

STANDARD 33 Human service professionals make careful decisions about disclosing personal information while using

social media, knowing that they reflect the profession of human services. In addition, they consider how their public conduct may reflect on themselves and their profession.

Responsibility to Self

STANDARD 34 Human service professionals are aware of their own cultural backgrounds, beliefs, values, and biases. They recognize the potential impact of their backgrounds on their relationships with others and work diligently to provide culturally competent service to all of their clients.

STANDARD 35 Human service professionals strive to develop and maintain healthy personal growth to ensure that they are capable of giving optimal services to clients. When they find that they are physically, emotionally, psychologically, or otherwise not able to offer such services, they identify alternative services for clients.

STANDARD 36 Human service professionals hold a commitment to lifelong learning and continually advance their knowledge and skills to serve clients more effectively.

Responsibility to Students

STANDARD 37 Human service educators develop and implement culturally sensitive knowledge, awareness, and teaching methodologies.

STANDARD 38 Human service educators are committed to the principles of access and inclusion and take all available and applicable steps to make education available to differently- abled students.

STANDARD 39 Human service educators demonstrate high standards of scholarship in their scholarship, pedagogy, and professional service and stay current in the field by being members of their professional associations, attending workshops and conferences, and reviewing and/or conducting research.

STANDARD 40 Human service educators recognize and acknowledge the contributions of students to the work of the educator in such activities as case material, grants, workshops, research, publications, and other related activities.

STANDARD 41 Human service educators monitor students' field experiences to ensure the quality of the placement site, supervisory experience, and learning experience towards the goals of personal, professional, academic, career, and civic development. When students experience potentially harmful events during field placements, educators provide reasonable investigation and response as necessary to safeguard the student.

STANDARD 42 Human service educators establish and uphold appropriate guidelines concerning student disclosure of sensitive/personal information which includes letting students have fair warning of any self-disclosure activities, allowing students to opt-out of in-depth self- disclosure activities when feasible, and ensuring that a mechanism is available to discuss and process such activities as needed.

STANDARD 43 Human service educators are aware that in their relationships with students, power and status are unequal. Human service educators are responsible to clearly define and maintain ethical and professional relationships with student; avoid conduct that is demeaning, embarrassing or exploitative of students; and always strive to treat students fairly, equally and without discrimination.

STANDARD 44 Human service educators ensure students are familiar with, informed by, and accountable to the ethical standards and policies put forth by their program/department, the course syllabus/instructor, their advisor(s), and the Ethical Standards of Human Service Professionals.

II. Code of Ethics – NASW

> Social Work Mission: "To enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (Cournoyer, 2011, p. 160).

Ethics

Social work is considered a helping profession. Like many other helping professions such as nursing, counseling, teaching, and psychiatry, social work has ethical guidelines that help direct us in our work. Social workers are a vital membesr of the helping community and can be seen assisting many other helping professions (Cournoyer, 2011). Helping professions address a multitude of problems or dilemmas often involving a person's physical, mental, social, intellectual, and spiritual well-being.

Therefore, as a social worker in the helping profession, you are responsible for many legal and important decisions. Often these decisions involve ethical choices in the best interest of clients' lives. These decisions can be extremely difficult and emotionally charged and they may not always be the choices you are comfortable making.

The National Association of Social Work (NASW) Code of Ethics serves as guidelines for professional practice. It is relevant to all social workers, social work students, and social work educators regardless of their specific duties or settings. One should certainly use and become familiar with this website as a guide for learning about the Code of Ethics.

> The NASW Code of Ethics can be found at https://www.socialworkers.org/pubs/code/default.asp

To be an ethical and professional social worker one must have a thorough understanding of the Code of Ethics and the legal obligations social workers are responsible for (Cournoyer, 2011). When encountering specific dilemmas, you as a social worker are responsible for knowing what ethical principle or value best applies to that situation. You must also be able to think critically to determine the best outcome for all parties involved (Woodcock, 2011).

The purpose of this chapter is to provide you with a brief understanding of the NASW Code of Ethics as you begin your journey through a social work program. This chapter is designed to help explore and provide a base understanding of these terms and overall principles. The goal is to prepare you for future courses and your future career so you are familiar with the general concepts. You will continue to explore the NASW Code of Ethics throughout your education, and will become much more applicable through continuing courses. **(keywords: ethics, values, obligations and duties)**

Establishment of the Code of Ethics

Social work is grounded on the concepts of social justice and fairness and the idea that all people should be treated equally. Clearly, when looking at the history of our nation, not all people have been treated equally. In the nineteenth century, social work became known as the calling that responded to the needs of vulnerable populations and those living in poverty. Through the rise of settlement houses and charity organization societies in the twentieth century and during the Great Depression, social workers promoted and provided new ways to address structural problems (Reamer, 2006)

As social work endeavored to gain recognition as a profession, the need arose for a formal code of ethics. While there were many social workers who helped pave the way, Mary Richmond is considered to be one of the most important. In 1920, Mary Richmond provided an experimental Code of Ethics which served as a base for many other social workers seeking social justice, equality, and fairness for vulnerable and oppressed populations (Reamer, 2006).

Richmond's Code of Ethics served as a guide to the first edition of the NASW Code of Ethics which was constructed in October of 1960. This document, developed by the NASW's Delegate Assembly of the National Association of Social Workers, officially defined the ***duties and obligations*** for which a social worker is responsible. The 1960 edition defined fourteen responsibilities social workers were obligated to fulfill based on the mission of social work, and even included a discrimination clause. With the first revision in place the social work profession established a sense of professionalism.

Mary Richmond

Mary Richmond, a significant person in establishing social work as a profession.

For more information on Mary Richmond, see http://socialwelfare.library.vcu.edu/social-work/richmond-mary

The NASW Code of Ethics continues to be updated. Many significant revisions have been created as the needs of the increasingly diverse population social workers serve continue to change. Shortly after the publishing of the 1960 Code of Ethics, social workers became concerned with the Code's suggestions for handling ethical dilemmas. In an effort to address these concerns, a task force was established to revise the original Code of Ethics (Reamer, 2006). In 1979, the NASW Delegate Assembly continued to work on the revisions as needed. It was not until the 1990's when the NASW Code of Ethics was significantly modified again.

During the 1990's the Code of Ethics had several impactful changes that were centered on the relationship between clients and social workers (Reamer, 2006). The profession began to stress the importance of maintaining professional boundaries with clients as social workers started to become more involved in clients' lives. Five new principles were also included in the Code of Ethics that were centered on social work impairment and dual relationships. This lead to a major revision due to the profession's developing understanding of ethical issues previously not addressed resulting in the public and media paying more attention to the NASW Code of Ethics.

In 2008, a major advancement occurred which incorporated the terms sexual orientation, gender identity, and immigration status into the non-discrimination standards in the Code of Ethics. This was a significant update because

for a long period of time these groups of people have been heavily discriminated against in the United States and throughout the world.

Provided is a link with all updated changes: https://www.socialworkers.org/nasw/ethics/ethicshistory.asp

Overview of NASW Code of Ethics: Four Sections

The NASW Code of Ethics consists of four sections:

- Preamble
- Purpose of the NASW Code of Ethics
- Ethical Principles
- Ethical Standards

(Woodcock, 2011).

Ethics highlighted

The first section, the preamble, is intended to outline Social Work's mission and core values while the second section provides a purpose and overview of the NASW Code of Ethics and how to handle or deal with ethical dilemmas (Woodcock, 2011). The third section, which is labeled Ethical Principles, helps define ethical principles based on Social Work's six core values. Finally, the fourth section provides detailed ethical standards for which social workers are held accountable. It is important that as future social workers you are familiar with all four sections as they are intended to serve as guidelines for practice.

Preamble

Social Work's mission is "to enhance human well-being and help meet the basic human needs of all people, with attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (Cournoyer, 2011, p. 160). With this mission, social workers should have a clear indication of what is expected when entering the field and practicing as a social worker. The six core values of Social Work are derived from the mission statement. These values will be further discussed in the chapter, but keep in mind the preamble section is rooted in these values.

Social workers should take pride in their work as they are seeking to improve the lives of others, and enhance the well-being of society. It is important to recognize social work's primary mission, but as social workers you will also need to best represent the agency or organization you are working for. Every agency or organization will have their own guidelines or rules; it is then your responsibility to incorporate those guidelines along with the NASW Code of Ethics. Social workers have many different roles and can be found in many areas of work, but the primary goal is to endorse social justice (Woodcock, 2011).

Purpose of the NASW Code of Ethics

The purpose of the NASW Code of Ethics is to hold social workers to a high standard of professionalism.

The NASW *Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.

4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

(NASW, 2008)

The NASW Code of Ethics cannot guarantee all ethical behavior, therefore it is up to you as a social worker to follow the Code of Ethics and best represent the profession. Become familiar with the Code of Ethics and continue to stay familiarized with them even beyond your education. There are going to be times when you as a social worker will not be sure what to do or what decision to make. This can be very frustrating. The Code of Ethics are intended to guide you through the process of difficult decision making so that you do come to the correct or best conclusion. Working closely with a supervisor will also be important.

When making ethical decisions where there is no clear answer on what to do, it becomes a difficult process. The simple answer is not always going to be present. Later in this chapter we will discuss ethical dilemmas, but remember to let the six core values, the NASW mission statement, and the Code of Ethics guide you in selecting the appropriate choice.

Ethical Principles

The ethical principles are based on the six core values of social work. These six values are important for all social workers to recognize and apply to their practice. They should help direct you in all ethical decisions or dilemmas you encounter. Social workers should also be conscientious of these values when working with clients, talking with co-workers, writing grants, or any other role a social worker performs, even if an ethical dilemma does not present itself. During your education, these six values will become much more significant than you may have imagined. You will learn true definitions of these terms and how to apply them to your practice.

> How do you define value? What are important values in your life?

Today the term value is used in a variety of ways with many meanings. In the field of social work the six core values provide a framework for us that are connected in three important ways. First, the six core values have a direct relationship with clients, colleagues, and members of the broader society. Secondly, these six values derive from social works overall mission statement, and lastly, these six values relate to the resolution of ethical dilemmas and interventions that social workers use in their work (Reamer, 2006).

The six core values of social work are listed as:

- Service
- Social Justice
- Dignity and Worth of a Person
- Importance of Human Relationships
- Integrity
- Competence

Service

One of social work's primary goals is to help people who are in need and to address social problems (Cournoyer, 2011). This value defines what social workers should be responsible for and the dedication to their job. As a social worker, you are encouraged to volunteer your time and professional skills with no expectation of significant financial return (Reamer, 2011). Social workers need to be dedicated to their delivery of services and be fully committed to assisting to a client's needs.

Social Justice

Social Justice is a significant value for all social workers, as we seek to promote equality for all people. This is often done by advocating for fair laws or policies, on behalf of clients (Cournoyer, 2011). When promoting social justice, social workers have a specific focus on vulnerable and oppressed individuals or groups of people (Reamer, 2006).

Dignity and Worth of a Person

As a social worker, you must respect that individuals come from a variety of different backgrounds and cultures and that all people deserve to be treated with respect. Social workers should certainly support equality without assigning levels of worth to an individual or group and it is important to honor in the uniqueness of all individuals. Social workers should also be consistent with all values, ethical principles, and ethical standards of the profession when working with clients (Reamer, 2006). As social workers, one of your duties is to help others find their worth as a person.

Importance of Human Relationships

While recognizing the worth of all individuals, social workers should also respect the relationship of humans as they are important for change or working through dilemmas (Reamer, 2011). Social workers should work to strengthen relationships among people of all backgrounds. Relationships are a key in being successful in the field and promoting all ethics and values.

Integrity

Integrity is a significant value as it underlines the trustworthy manner all social workers should demonstrate. Social workers should be honest, responsible, and promote the ethical practices to the fullest (Reamer, 2006). You should also be aware of the profession's mission, vision, values, and ethical standards and apply them in a consistent manner as well as promote all ethical practices for any agency they are affiliated with. Social workers should take pride in their work.

Competence

Social workers should frequently enhance their professional knowledge and skills. As a social worker, it is important to continue to strive to best serve clients and represent the profession. Social workers must be competent in their practice and also know when they do not have the knowledge base or skill set, and therefore must refer out for services.

Ethical Standards

The ethical standards of social work consist of six important criteria for which all social workers are held responsible. They are social workers' ethical responsibilities:

- To clients
- To colleagues
- In practice settings
- As professionals
- To the social work profession
- To broader society

This link from the NASW website specifically lists all ethical standards under the six criteria: https://www.socialworkers.org/pubs/code/code.asp

Common ethical violations to be aware of consist of the following:

- Sexual activity with clients and colleagues
- Dual relationship
- Boundary violations
- Failure to seek supervision
- Failure to use practice skills
- Fraudulent behavior
- Premature termination
- Inadequate provisions for case transfer or referral
- Failure to discuss policies as part of informed consent with clients

(Cournoyer, 2011)

Summary

The NASW Code of Ethics is a living document and will continue to be adjusted as new developments and issues arise. Therefore, as a social worker, you are responsible to stay updated on all changes that are made and apply them to your practice. The Code of Ethics enforces the belief that the public will not be taken advantage of by the work of social workers for their own benefit and that clients will be treated fairly.

Legal Duties/Obligations

Another critical role of becoming a social worker is the legal obligations or duties you are responsible for. These duties are very serious and all social workers must abide by them. These duties or obligations consist of the:

- Duty to maintain confidentiality
- Duty to report
- Duty to inform
- Duty to respect privacy
- Duty to warn and protect

Duty to Maintain Confidentiality

Another important term in this chapter is the term confidentiality. Confidentiality, is extremely important for social workers as they have a **duty to maintain confidentiality** with all clients and the conversations they have with them. The term confidentiality indicates that any information shared by a client or pertaining to a client will not be shared with third parties (Cournoyer, 2011). It must remain between the social worker and the client. If confidentiality is broken, it can be a serious violation.

When meeting with clients for the first time it is mandatory to inform the client of their rights of confidentiality. No matter who is trying to seek information about a client you are working with, you must follow your duty to maintain confidentiality. Even if a client is deceased, you as the social worker are still obligated to protect the information you have obtained. Social workers should not only protect the information gained from clients, but they should also respect information shared by colleagues.

An important confidentiality law that you are likely to encounter as a social worker is the U.S. Health Insurance Portability and Accountability Act (HIPAA) which is commonly found in the health profession. HIPAA assures that client information will remain private and between them and the professional, and includes provisions for the protection of health information, records, or other information (Cournoyer, 2011). If a client wishes to give consent for their information to be shared, then they will be asked to sign a release form provided by the social worker giving permission to share that information.

Duty to Report

There are times when a social worker is required to break the confidentiality rule. These circumstances are the only time that a social worker is legally obligated to breach confidentiality agreements and must be taken very serious. This is known as **duty to report**. As a social worker, you are a *mandated reporter* and have a legal obligation to report to the designated authority if a client disclosed any of the following:

- they are going to harm or kill another person or indications of outrages against humanity
- abuse or neglect of a child, disabled person or senior citizen
- have a plan to commit suicide and admit to wanting to commit suicide

(Cournoyer, 2011)

For example, if a client discloses they have or plan to abuse a child or if a person's life is at imminent risk, then you are required to act. These are the times when confidentiality agreements are broken and the social worker must report to a supervisor or the proper authority, so the authority can take further action. If not reported, the social worker can face serious legal offenses. Upon taking a job and throughout your education you will learn who the proper person or agency is that you should report to.

At times, it may be difficult to determine if you should report or not report. This can be known as an ethical dilemma. Throughout your education you will better learn about the times when you as a social worker will be required to breach confidentiality. For now it is extremely important to understand that as a social worker there are times when it is necessary to report.

Duty to Inform

Another important duty you will be obligated to abide by is **duty to inform**. As a social worker, you are required to educate clients concerning the scope of your services. This consists of informing the client about confidentiality, duty to report, but also the cost, length of treatment, risks, alternative services and anything else your agency requires (Cournoyer, 2011). When you are hired by an agency they will certainly walk you through the steps of your duty to inform and what they require, but it is your obligation as a social worker to best inform the client of your role. This is often completed early in the process when you are first meeting with a client.

If you are taking any actions regarding the care of client, it is your job to inform them and consult with the client first. It is best to inform the client in advance and have informed consent. Not informing a client of your role can be a form of malpractice.

Duty to Respect Privacy

When becoming a social worker, it is extremely important to follow your **duty to respect the privacy** of the people you serve and work with. As a social worker, you should protect all information obtained during services and respect the client's right to privacy. Privacy differs from confidentiality because it refers to the client's right to choose what to share and what to not share with a social worker. Social workers must respect that there may be things the client does not wish to disclose and we must not force them to do so.

Often social workers help or assist people during vulnerable times and become a part of many people's lives. As a social worker, it is your duty to respect the relationship you have with clients and to not intrude on their lives outside of your sessions. For example, if you are working in a small town and run into a client you regularly meet with at the grocery store it is in your best interest as a social worker to respect the privacy of that individual and not approach them. Nor should you approach them and begin talking about what you previously talked about during one of your sessions together. You should discuss these possibilities with your client so they are aware of how you will react to them if you meet them in a public setting.

Duty to Warn and Protect.

Another duty social workers take on is the responsibility to warn potential victims a client may harm (Cournoyer, 2011). Along with many other helping professions a social worker is obligated to act to insure that anybody who may be in danger is aware of the possible danger. Therefore, as a social worker you must take serious action in deciding if a client is serious about harming another person. This is a great example of an ethical dilemma, deciding if the client is serious

and has intent. If they do, then you are obligated to **warn and protect**. It is best to consult with a supervisor if there is any indication a client has stated he or she is going to act out and kill or harm another individual.

Case Study: Tarasoff v. Regents of the University of California

A case to be familiar with is the well-known *Tarasoff v. Regents of the University of California* case that helped ensure helping professions become obligated to act and protect the lives of third parties. Tatiana Tarasoff was a student studying at the University of California Berkley who met a fellow student named Prosenjit Poddar. The two briefly shared a romantic interaction, but Tarasoff decided to inform Poddar she wanted to date other men.

Afterward, Poddar became aggravated by this and he decided to see a psychologist by the name of Dr. Lawrence Moore. During sessions with Dr. Moore, Poddar mentioned that he intended to harm and kill Tatiana Tarasoff. After receiving a mental health diagnosis and held for a short time, Poddar was released and later killed Tatiana Tarasoff. At no point did Dr. Lawrence inform Tatiana or her parents of the possible danger Poddar had disclosed. After the murder of Tatiana Tarasoff, her parents brought the case against the Regents, in which the Supreme Court ruled that mental health professionals have a duty to protect individuals of a third party who may be threatened or at harm by a client, in which now is known as duty to warn and protect.

From (Dolgoff, Harrington, & Loewenberg, 2009).

Malpractice

Malpractice definition image

Another key term to be aware of related to the NASW Code of Ethics is **malpractice**. Malpractice can be defined as a form of negligence which occurs when a licensed social worker is not consistent with the professions' Code of Ethics, standards of care, and is negligent to his or her legal duties and obligations (Reamer, 2006). Often this involves poor delivery of services or a social worker failing to meet the standard of care at his or her agency.

Malpractice is one reason why social workers need to be conscious of the Code of Ethics and make sure they are doing everything ethically correct. Malpractice lawsuits are common among many helping professions, not just social work, but due to the nature of and intimacy of social workers' roles it is extremely important to best represent the NASW Code of Ethics. If not, serious consequences can follow.

Three common forms of malpractice include:

- Malfeasance: when the social worker intentionally engages in practice known to be harmful
- Misfeasance: when the social worker makes a mistake in the application of an acceptable practice
- Nonfeasance: when the social worker fails to apply standard and acceptable practice if the circumstances include such practice

(Cournoyer, 2011).

Clearly, malpractice can occur even if one intentionally or unintentionally is aware of the wrongdoing. For example, a genuine mistake social workers make is simply forgetting to obtain a client's consent before sharing confidential records with third parties. This alone can lead to serious civil lawsuits and can jeopardize your social work license. When these mistakes occur, the social worker does not intend to provide harm, but due to the many responsibilities social workers have it is easy to forget and unintentionally make this mistake (Reamer, 2006).

Some common examples of malpractice include the following (Reamer, 2006; Cournoyer, 2011):

- Failure to report abuse of neglect of a child
- Failure to consult or refer other health professionals
- Failure to prevent a client from committing suicide
- Failure to warn or protect third parties of harm or abuse
- Failure to diagnose or incorrectly diagnosis for treatment
- Failure to provide treatment without consent
- Failure to renew their social work license
- Inappropriate or inaccurate billing of services
- Breach of confidentiality, even if the client is deceased
- Being sexually involved with a client
- Professional incompetence

It is your job as a social worker to know exactly what kinds of unethical behavior or misconduct result in malpractice. Simply acting inconsistent with the professions standard of care can place you in a civil lawsuit you may have never thought possible (Reamer, 2006). As a practicing social worker, it is important to have insurance coverage to protect you in case of a lawsuit. You will often be covered by your agency, and the NASW also provides legal coverage to social workers.

Ethical Dilemmas

Discussed earlier, as a social worker you are likely to face a situation where there is no clear answer or a time when you as a social worker are forced to choose between two or more decisions, but contradictory decisions with often undesirable outcomes for one or more persons (Dolgoff, Harrington, & Loewenberg, 2009). These are known as ethical dilemmas.

Dilemmas will occur often and you must be prepared to handle them. Whether you are working with individual clients, families, small groups, or community organizations in policy and planning, administration, or research and evaluation there will be ethical decisions/dilemmas along the way (Reamer, 2006).

Some social workers are uncomfortable with making difficult ethical decisions and ignore them while other social workers have no problem making a difficult decision (Dolgoff, Harrington, & Loewenberg, 2009). Ethical dilemmas are often known as the grey area of social work. Therefore, as a social worker, you must know yourself very well; be conscious of the Code of Ethics and let it guide you in making these decisions.

Some common ethical dilemmas include:

- Confidentiality and privacy issues
- Divided loyalties
- Professional boundaries with clients (this is a common and one of the most difficult dilemmas)
- Delivery of services
- When to terminate services
- Budget cuts (administration positions)

- Hiring and firing of staff members (administration positions)
- Conflicts of interest
- Relationship between professional and personal values

(Reamer, 2006)

Discussion Question: Why are professional boundaries so important?

There are many tips and suggestions for ethical problem solving, Dolgoff, Harrington, & Lowewenberg (2009) suggest considering the following when making ethical decisions:

- Who is my client?
- What obligations do I owe my client?
- Do I have professional obligations to people other than my clients? If so what are my obligations?
- What are my own personal values? Are these values compatible with the professions six core values?
- What are my ethical priorities when these value sets are not identical?
- What is the ethical way to respond when I have conflicting professional responsibilities to different people?

Often social workers are alone when they must make difficult choices and can't always seek supervision right away. Therefore, you must be prepared to handle these situations on your own. After encountering an ethical decision alone, it is still a great idea to seek supervision afterward and talk the process over with a supervisor.

Social workers are encouraged to adopt this model; it is very helpful when struggling with ethical dilemmas, (Cournoyer, 2011; Congress, 2000, p. 10):

ETHIC Model of Decision Making
E—Examine relevant personal, societal, agency, client, and professional values
T—Think about what ethical standard of the NASW Code of Ethics applies, as well as relevant laws and case decisions
H—Hypothesize about possible consequences of different decisions
I—Identify who will benefit and who will be harmed
C—Consult with supervisor and colleagues about the most ethical choice

The following are great examples of ethical decisions you may encounter. Use these dilemmas as practice to work through a situation (Dolgoff, Harrington, & Loewenberg, 2009):

- A client tells you that he intends to embezzle funds from his employer. (What do you do?)
- A client who is HIV positive tells you that he has unprotected sex with his partners because he does

not want his partners to know about his medical condition. (What do you do?)

- You discover that another social worker knows about a child abuse situation and has not yet reported the case to Child Protective Services (CPS), which is required by law. (What do you do?)
- You are a medical social worker and a surgeon at a children's hospital strongly recommends that a child have surgery. The parents of the child refuse to consent with the surgery due to the complications and risks. The surgeon asks you to convince the parents to agree to let him operate regardless of the parents' concerns. (What do you do?)
- A client has disclosed he is very angry with his cousin and wants to hurt him. (Do you breach confidentiality?)
- A previous client of mine has passed away, is it okay to talk about what that client has disclosed?

Summary

The NASW Code of Ethics does not list any value or ethic as more important than the next; you must consider all values and ethics as equal. To be a professional social worker you should be well acquainted with the Social Work Code of Ethics along with the six core values. Mentioned earlier, it is necessary to be familiar with the Code of Ethics to be an ethical social worker and to able to work with clients (Cournoyer, 2011). The NASW Code of Ethics is not something to take lightly and as you advance through your social work education these values and ethics will become much more ingrained. Having a copy of the NASW Code of Ethics with you or in your office is certainly a useful idea. Keep in mind that simply forgetting or unintentionally providing a standard of care can result in a malpractice lawsuit.

Ethical decision-making takes skill and practice, and is a never-ending process (Reamer, 2006). The more you prepare yourself, know yourself, and follow the Code of Ethics the greater skill you will obtain as a professional social worker (Cournoyer, 2011). There will always be ethical dilemmas during your career no matter the setting of your work. It is important to treat each dilemma as its own by using the suggested tips. Consulting with a supervisor before or after an ethical dilemma is a great suggestion. Supervisors are there to help and support you through difficult times.

Remember the Code of Ethics and values originated from the idea that all people are equal and deserving of the same entitlements. As a social worker, you are responsible for continuing and promoting social justice. In addition, you should always apply the ethical standards and legal duties to your work.

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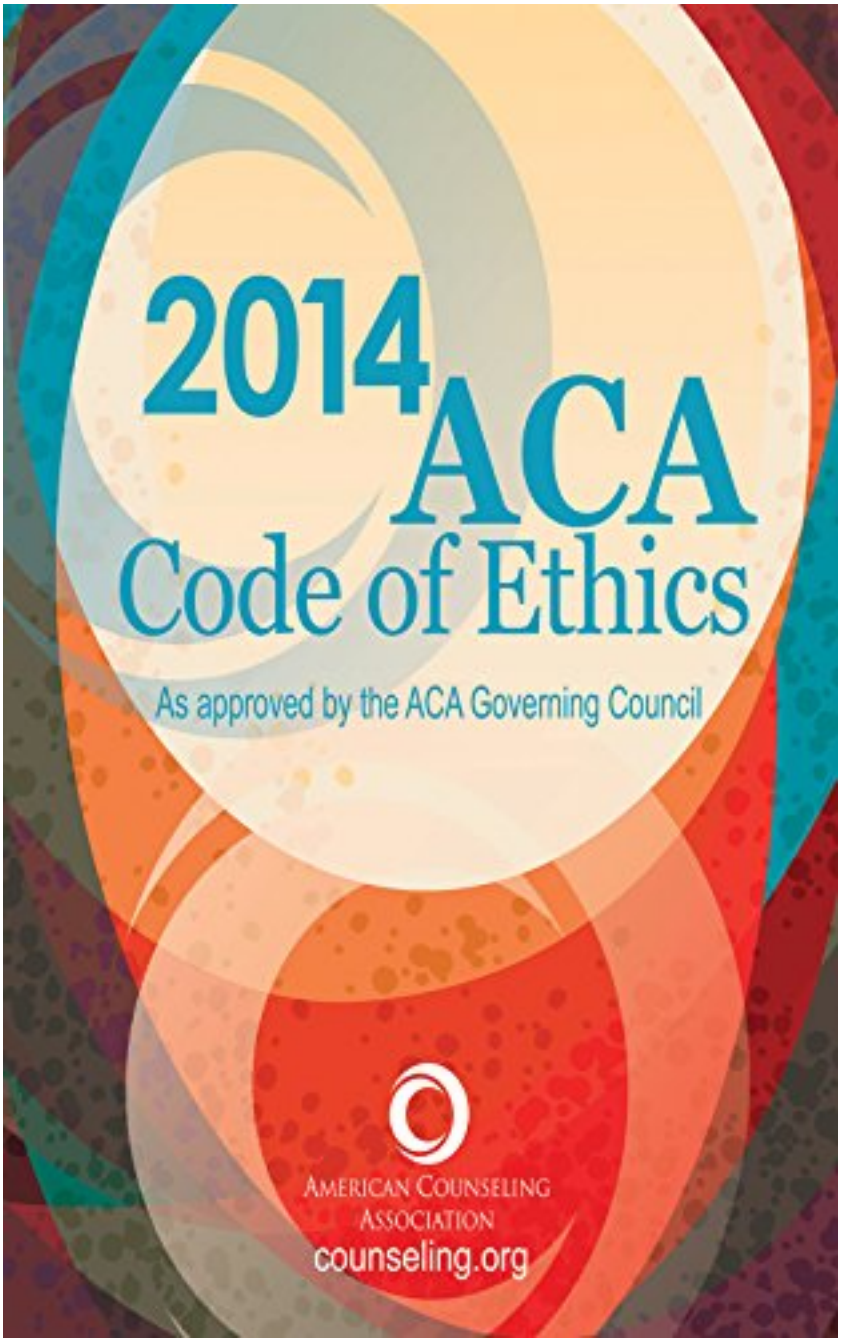
III. Code of Ethics – American Counseling Association

As approved by the ACA Governing Council https://www.counseling.org/resources/aca-code-of-ethics.pdf

The American Counseling Association is a not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association exclusively representing professional counselors in various practice settings.



Mission

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity.

Contents

ACA Code of Ethics Preamble

The American Counseling Association (ACA) is an educational, scientific, and professional organization whose members work in a variety of settings and serve in multiple capacities. Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Professional values are an important way of living out an ethical commitment. The following are core professional values of the counseling profession:

1. enhancing human development throughout the life span;
2. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;
3. promoting social justice;
4. safeguarding the integrity of the counselor–client relationship; and
5. practicing in a competent and ethical manner.

These professional values provide a conceptual basis for the ethical principles enumerated below. These principles are the foundation for ethical behavior and decision making. The fundamental principles of professional ethical behavior are

- *autonomy*, or fostering the right to control the direction of one's life;
- *nonmaleficence*, or avoiding actions that cause harm;
- *beneficence*, or working for the good of the individual and society by promoting mental health and well-being;
- *justice*, or treating individuals equitably and fostering fairness and equality;
- *fidelity*, or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships; and
- *veracity*, or dealing truthfully with individuals with whom counselors come into professional contact.

ACA *Code of Ethics* Purpose

The ACA *Code of Ethics* serves six main purposes:

1. The *Code* sets forth the ethical obligations of ACA members and provides guidance intended to inform the ethical practice of professional counselors.
2. The *Code* identifies ethical considerations relevant to professional counselors and counselors-in-training.
3. The *Code* enables the association to clarify for current and prospective members, and for those served by members, the nature of the ethical responsibilities held in common by its members.
4. The *Code* serves as an ethical guide designed to assist members in constructing a course of action that best serves those utilizing counseling services and establishes expectations of conduct with a primary emphasis on the role of the professional counselor.
5. The *Code* helps to support the mission of ACA.
6. The standards contained in this *Code* serve as the basis for processing inquiries and ethics complaints concerning ACA members.

The ACA *Code of Ethics* contains nine main sections that ad- dress the following areas:

Section A: The Counseling Relationship
Section B: Confidentiality and Privacy
Section C: Professional Responsibility
Section D: Relationships With Other Professionals
Section E: Evaluation, Assessment, and Interpretation
Section F: Supervision, Training, and Teaching
Section G: Research and Publication
Section H: Distance Counseling, Technology, and Social Media
Section I: Resolving Ethical Issues

Each section of the ACA *Code of Ethics* begins with an introduction. The introduction to each section describes the ethical behavior and responsibility to which counselors aspire. The introductions help set the tone for each particular sec- tion and provide a starting point that invites reflection on the ethical standards contained in each part of the ACA *Code of Ethics*. The standards outline professional responsibilities and provide direction for fulfilling those ethical responsibilities.

When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process, consulting available resources as needed. Counselors acknowledge that resolving ethical issues is a process; ethical reasoning includes consideration of professional values, professional ethical principles, and ethical standards.

Counselors' actions should be consistent with the spirit as well as the letter of these ethical standards. No specific ethical decision-making model is always most effective, so counselors are expected to use a credible model of decision making that can bear public scrutiny of its applica- tion. Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors work collaboratively with clients to make decisions that promote clients' growth and development. A breach of the standards and principles provided herein does not neces- sarily constitute legal liability or violation of the law; such action is established in legal and judicial proceedings.

The glossary at the end of the *Code* provides a concise description of some of the terms used in the ACA *Code of Ethics*.

Section A The Counseling Relationship

Introduction

Counselors facilitate client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relation- ships. Trust is the cornerstone of the counseling relationship, and counselors have the

responsibility to respect and safeguard the client's right to privacy and confidentiality. Counselors actively attempt to understand the diverse cul- tural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the coun- seling process. Additionally, counselors are encouraged to contribute to society by devoting a portion of their profes- sional activities for little or no financial return (*pro bono publico*).

A.1. Client Welfare

A.1.a. Primary Responsibility The primary responsibility of counsel- ors is to respect the dignity and promote the welfare of clients.

A.1.b. Records and

Documentation Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely docu- mentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects cli- ent progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies.

A.1.c. Counseling Plans Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients regularly re- view and revise counseling plans to assess their continued viability and effectiveness, respecting clients' free- dom of choice.

A.1.d. Support Network Involvement

Counselors recognize that support networks hold various meanings in the lives of clients and consider en- listing the support, understanding, and involvement of others (e.g., reli- gious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

A.2. Informed Consent in the Counseling Relationship

A.2.a. Informed Consent

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to re- view in writing and verbally with cli- ents the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

A.2.b. Types of Information Needed

Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the follow- ing: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of

services; the counselor's qualifications, credentials, relevant experience, and approach to counseling; continuation of services upon the incapacitation or death of the counselor; the role of technol- ogy; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis and the intended use of tests and reports. Additionally, counselors inform clients about fees and billing arrangements, including procedures for nonpayment of fees. Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality changes and to be advised of the consequences of such refusal.

A.2.c. Developmental and Cultural Sensitivity

Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language that counselors use, counselors provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, coun- selors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

A.2.d. Inability to Give Consent When counseling minors, incapaci- tated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capac- ity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

A.2.e. Mandated Clients

Counselors discuss the required limitations to confidentiality when working with clients who have been mandated for counseling services. Counselors also explain what type of information and with whom that information is shared prior to the beginning of counseling. The client may choose to refuse services. In this case, counselors will, to the best of their ability, discuss with the client the potential consequences of refusing counseling services.

A.3. Clients Served by Others

When counselors learn that their clients are in a professional relationship with other mental health professionals, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm

Counselors act to avoid harming their clients, trainees, and research par- ticipants and to minimize or to remedy unavoidable or unanticipated harm.

A.4.b. Personal Values

Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, train- ees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.5. Prohibited Noncounseling Roles and Relationships

A.5.a. Sexual and/or

Romantic Relationships Prohibited

Sexual and/or romantic counselor– client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in- person and electronic interactions or relationships.

A.5.b. Previous Sexual and/or Romantic Relationships

Counselors are prohibited from engag- ing in counseling relationships with persons with whom they have had a previous sexual and/or romantic relationship.

A.5.c. Sexual and/or Romantic Relationships With Former Clients

Sexual and/or romantic counselor– client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships. Counsel- ors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship.

A.5.d. Friends or Family Members

Counselors are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective.

A.5.e. Personal Virtual Relationships With Current Clients

Counselors are prohibited from engaging in a personal virtual re- lationship with individuals with whom they have a current counseling relationship (e.g., through social and other media).

A.6. Managing and Maintaining Boundaries and Professional Relationships

A.6.a. Previous Relationships

Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a pro- fessional association, organization, or community. When counselors accept these clients, they take appropriate pro- fessional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs.

A.6.b. Extending Counseling Boundaries

Counselors consider the risks and benefits of extending current counsel- ing relationships beyond conventional parameters. Examples include attend- ing a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consul- tation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs.

A.6.c. Documenting Boundary Extensions

If counselors extend boundaries as described in A.6.a. and A.6.b., they must officially document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. When un- intentional harm occurs to the client or former client, or to an individual

significantly involved with the client or former client, the counselor must show evidence of an attempt to remedy such harm.

A.6.d. Role Changes in the Professional Relationship

When counselors change a role from the original or most recent contracted relationship, they obtain informed consent from the client and explain the client's right to refuse services related to the change. Examples of role changes include, but are not limited to

1. changing from individual to re- lationship or family counseling, or vice versa;
2. changing from an evaluative role to a therapeutic role, or vice versa; and

3. changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, therapeutic) of counselor role changes.

A.6.e. Nonprofessional Interactions

or Relationships (Other Than Sexual or Romantic Interactions or Relationships)

Counselors avoid entering into non- professional relationships with former clients, their romantic partners, or their family members when the interaction is potentially harmful to the client. This applies to both in-person and electronic interactions or relationships.

A.7. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.7.a. Advocacy

When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.

A.7.b. Confidentiality and Advocacy

Counselors obtain client consent prior to engaging in advocacy efforts on be- half of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

A.8. Multiple Clients

When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform poten- tially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately.

A.9. Group Work

A.9.a. Screening

Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select

members whose needs and goals are compatible with the goals of the group, who will not impede the group process, and whose well-being will not be jeop- ardized by the group experience.

A.9.b. Protecting Clients

In a group setting, counselors take rea- sonable precautions to protect clients from physical, emotional, or psychological trauma.

A.10. Fees and Business Practices

A.10.a. Self-Referral

Counselors working in an organization (e.g., school, agency, institution) that provides counseling services do not refer clients to their private practice unless the policies of a particular orga- nization make explicit provisions for self-referrals. In such instances, the cli- ents must be informed of other options open to them should they seek private counseling services.

A.10.b. Unacceptable Business Practices

Counselors do not participate in fee splitting, nor do they give or receive commissions, rebates, or any other form of remuneration when referring clients for professional services.

A.10.c. Establishing Fees

In establishing fees for professional counseling services, counselors con- sider the financial status of clients and locality. If a counselor's usual fees cre- ate undue hardship for the client, the counselor may adjust fees, when legally permissible, or assist the client in locat- ing comparable, affordable services.

A.10.d. Nonpayment of Fees

If counselors intend to use collection agencies or take legal measures to col-

lect fees from clients who do not pay for services as agreed upon, they include such information in their informed consent documents and also inform clients in a timely fashion of intended actions and offer clients the opportunity to make payment.

A.10.e. Bartering

Counselors may barter only if the bar- tering does not result in exploitation or harm, if the client requests it, and if

such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

A.10.f. Receiving Gifts Counselors understand the challenges of accepting gifts from clients and rec- ognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

A.11. Termination and Referral

A.11.a. Competence Within Termination and Referral

If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counsel- ors discontinue the relationship.

A.11.b. Values Within

Termination and Referral Counselors refrain from referring pro- spective and current clients based solely on the counselor's personally held val- ues, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.11.c. Appropriate Termination Counselors terminate a counseling re- lationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is

being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the cli- ent has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pretermination counseling and recommend other service providers when necessary.

A.11.d. Appropriate Transfer of Services

When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

A.12. Abandonment and Client Neglect

Counselors do not abandon or neglect

clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when neces- sary, during interruptions such as vaca- tions, illness, and following termination.

Section B Confidentiality and Privacy

Introduction

Counselors recognize that trust is a cor- nerstone of the counseling relationship. Counselors aspire to earn the trust of cli- ents by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confi- dentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations

Counselors maintain awareness and sen- sitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongo- ing discussions with clients as to how, when, and with whom information is to be shared.

B.1.b. Respect for Privacy

Counselors respect the privacy of prospective and current clients. Coun- selors request private information from clients only when it is beneficial to the counseling process.

B.1.c. Respect for

Confidentiality

Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.

B.1.d. Explanation of

Limitations

At initiation and throughout the counsel- ing process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confiden- tiality must be breached.

B.2. Exceptions

B.2.a. Serious and Foreseeable Harm and Legal Requirements

The general requirement that counsel- ors keep information confidential does not apply when disclosure is required

to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be re- vealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues.

B.2.b. Confidentiality Regarding End-of-Life Decisions

Counselors who provide services to terminally ill individuals who are con- sidering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or super- vision from appropriate professional and legal parties.

B.2.c. Contagious, Life- Threatening Diseases

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclos- ing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of con- tracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party. Counselors adhere to relevant state laws concern- ing disclosure about disease status.

B.2.d. Court-Ordered Disclosure When ordered by a court to release confidential or privileged information without a client's permission, coun- selors seek to obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible because of po- tential harm to the client or counseling relationship.

B.2.e. Minimal Disclosure

To the extent possible, clients are informed before confidential infor- mation is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential infor- mation, only essential information is revealed.

B.3. Information Shared With Others

B.3.a. Subordinates

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordi- nates, including employees, supervisees, students, clerical assistants, and volunteers.

B.3.b. Interdisciplinary Teams When services provided to the client involve participation by an interdisci- plinary or treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

B.3.c. Confidential Settings Counselors discuss confidential infor- mation only in settings in which they can reasonably ensure client privacy.

B.3.d. Third-Party Payers

Counselors disclose information to third-party payers only when clients have authorized such disclosure.

B.3.e. Transmitting Confidential Information

Counselors take precautions to ensure the confidentiality of all information transmitted through the use of any medium.

B.3.f. Deceased Clients Counselors protect the confidentiality of deceased clients, consistent with le- gal requirements and the documented preferences of the client.

B.4. Groups and Families

B.4.a. Group Work

In group work, counselors clearly explain the importance and param- eters of confidentiality for the specific group.

B.4.b. Couples and Family Counseling

In couples and family counseling, coun- selors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties regarding the confidentiality of informa- tion. In the absence of an agreement to the contrary, the couple or family is considered to be the client.

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of informa- tion received—in any medium—in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

B.5.b. Responsibility to Parents and Legal Guardians

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the coun- seling relationship, consistent with cur- rent legal and custodial arrangements. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians regarding the wel- fare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relation- ships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information

When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take appropriate measures to safeguard client confi- dentiality.

B.6. Records and Documentation

B.6.a. Creating and Maintaining Records and Documentation

Counselors create and maintain records and documentation necessary for ren- dering professional services.

B.6.b. Confidentiality of Records and Documentation

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.

B.6.c. Permission to Record Counselors obtain permission from cli- ents prior to recording sessions through electronic or other means.

B.6.d. Permission to Observe Counselors obtain permission from cli- ents prior to allowing any person to ob- serve counseling sessions, review session transcripts, or view recordings of sessions with supervisors, faculty, peers, or others within the training environment.

B.6.e. Client Access

Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the records in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that relate directly to them and do not include confidential information related to any other client.

B.6.f. Assistance With Records When clients request access to their re- cords, counselors provide assistance and consultation in interpreting counseling records.

B.6.g. Disclosure or Transfer

Unless exceptions to confidentiality exist, counselors obtain written permis- sion from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

B.6.h. Storage and Disposal After Termination

Counselors store records following ter- mination of services to ensure reasonable future access, maintain records in accordance with federal and state laws and statutes such as licensure laws and policies governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. Counselors apply careful discretion and deliberation before destroying records that may be needed by a court of law, such as notes on child abuse, suicide, sexual harassment, or violence.

B.6.i. Reasonable Precautions Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and ap- point a records custodian when identi- fied as appropriate.

B.7. Case Consultation

B.7.a. Respect for Privacy

Information shared in a consulting relationship is discussed for profes- sional purposes only. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

B.7.b. Disclosure of

Confidential Information When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation.

Section C Professional Responsibility

Introduction

Counselors aspire to open, honest, and accurate communication in deal- ing with the public and other profes- sionals. Counselors facilitate access to counseling services, and they practice in a nondiscriminatory manner within the boundaries of professional and personal competence; they also have a responsibility to abide by the ACA *Code of Ethics*. Counselors actively participate in local, state, and national associations that foster the develop- ment and improvement of counseling. Counselors are expected to advocate to promote changes at the individual, group, institutional, and societal lev- els that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being of- fered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous re-

search methodologies. Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (*pro bono publico*). In addition, counselors engage in

self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1. Knowledge of and Compliance With Standards

Counselors have a responsibility to

read, understand, and follow the ACA *Code of Ethics* and adhere to applicable laws and regulations.

C.2. Professional Competence

C.2.a. Boundaries of

Competence

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropri- ate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

C.2.b. New Specialty Areas of Practice

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.

C.2.c. Qualified for Employment Counselors accept employment only for positions for which they are quali- fied given their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional coun- seling positions only individuals who are qualified and competent for those positions.

C.2.d. Monitor Effectiveness Counselors continually monitor their effec- tiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors.

C.2.e. Consultations on Ethical Obligations

Counselors take reasonable steps to consult with other counselors, the ACA Ethics and Professional Standards Department, or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education Counselors recognize the need for con- tinuing education to acquire and main- tain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed re- garding best practices for working with diverse populations.

C.2.g. Impairment

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impair- ment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when war- ranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

C.2.h. Counselor Incapacitation, Death, Retirement, or Termination of Practice

Counselors prepare a plan for the trans- fer of clients and the dissemination of records to an identified colleague or records custodian in the case of the counselor's incapacitation, death, retire- ment, or termination of practice.

C.3. Advertising and Soliciting Clients

C.3.a. Accurate Advertising When advertising or otherwise rep- resenting their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

C.3.b. Testimonials

Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial.

C.3.c. Statements by Others When feasible, counselors make reason- able efforts to ensure that statements made by others about them or about the counseling profession are accurate.

C.3.d. Recruiting Through Employment

Counselors do not use their places of employment or institutional affiliation to recruit clients, supervisors, or consultees for their private practices.

C.3.e. Products and Training Advertisements

Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices.

C.3.f. Promoting to Those Served Counselors do not use counseling, teaching, training, or supervisory rela- tionships to promote their products or training events in a manner that is de- ceptive or would exert undue influence on

individuals who may be vulnerable. However, counselor educators may adopt textbooks they have authored for instructional purposes.

C.4. Professional Qualifications

C.4.a. Accurate Representation Counselors claim or imply only profes- sional qualifications actually completed and correct any known misrepresenta- tions of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training.

C.4.b. Credentials

Counselors claim only licenses or certifica- tions that are current and in good standing.

C.4.c. Educational Degrees Counselors clearly differentiate be- tween earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence

Counselors clearly state their highest earned degree in counseling or a closely related field. Counselors do not imply doctoral-level competence when pos- sessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counsel- ing or a related field. Counselors do not use "ABD" (all but dissertation) or other such terms to imply competency.

C.4.e. Accreditation Status

Counselors accurately represent the accreditation status of their degree pro- gram and college/university.

C.4.f. Professional Membership Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of ACA must clearly differentiate be- tween professional membership, which implies the possession of at least a mas- ter's degree in counseling, and regular membership, which is open to indi- viduals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

C.5. Nondiscrimination

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/ partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law.

C.6. Public Responsibility

C.6.a. Sexual Harassment Counselors do not engage in or condone sexual harassment. Sexual harassment can consist of a single intense or severe act, or multiple persistent or pervasive acts.

C.6.b. Reports to Third Parties Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others.

C.6.c. Media Presentations

When counselors provide advice or com- ment by means of public lectures, dem- onstrations, radio or television programs, recordings, technology-based applica- tions, printed articles, mailed material, or other media, they take reasonable precautions to ensure that

1. the statements are based on ap- propriate professional counsel- ing literature and practice,
2. the statements are otherwise consistent with the *ACA Code of Ethics*, and

3. the recipients of the information are not encouraged to infer that a professional counseling relation- ship has been established.

C.6.d. Exploitation of Others Counselors do not exploit others in their professional relationships.

C.6.e. Contributing to the Public Good

(Pro Bono Publico) Counselors make a reasonable effort to provide services to the public for which there is little or no financial return (e.g., speaking to groups, shar- ing professional information, offering reduced fees).

C.7. Treatment Modalities

C.7.a. Scientific Basis for Treatment

When providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation.

C.7.b. Development and Innovation

When counselors use developing or innovative techniques/procedures/ modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/ modalities. Counselors work to minimize any potential risks or harm when using these techniques/procedures/modalities.

C.7.c. Harmful Practices Counselors do not use techniques/pro- cedures/modalities when substantial evidence suggests harm, even if such services are requested.

C.8. Responsibility to Other Professionals

C.8.a. Personal Public Statements

When making personal statements in a public context, counselors clarify that they are speaking from their personal perspec- tives and that they are not speaking on behalf of all counselors or the profession.

Section D Relationships With Other Professionals

Introduction

Professional counselors recognize that the quality of their interactions

with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relation- ships and systems of communication with colleagues to enhance services to clients.

D.1. Relationships With Colleagues, Employers, and Employees

D.1.a. Different Approaches Counselors are respectful of approaches that are grounded in theory and/or have an empirical or scientific founda- tion but may differ from their own. Counselors acknowledge the expertise of other professional groups and are respectful of their practices.

D.1.b. Forming Relationships

Counselors work to develop and strengthen relationships with col- leagues from other disciplines to best serve clients.

D.1.c. Interdisciplinary Teamwork

Counselors who are members of in- terdisciplinary teams delivering mul- tifaceted services to clients remain focused on how to best serve clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counsel- ing profession and those of colleagues from other disciplines.

D.1.d. Establishing

Professional and Ethical Obligations

Counselors who are members of inter- disciplinary teams work together with team members to clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

D.1.e. Confidentiality

When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative pro- ceedings, they clarify role expectations and the parameters of confidentiality with their colleagues.

D.1.f. Personnel Selection and Assignment

When counselors are in a position requiring personnel selection and/or assigning of responsibilities to others, they select competent staff and assign responsibilities compatible with their skills and experiences.

D.1.g. Employer Policies

The acceptance of employment in an agency or institution implies that counsel- ors are in agreement with its general poli- cies and principles. Counselors strive to reach agreement with employers regard- ing acceptable standards of client care and professional conduct that allow for changes in institutional policy conducive to the growth and development of clients.

D.1.h. Negative Conditions Counselors alert their employers of inap- propriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such poli- cies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be af- fected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

D.1.i. Protection From Punitive Action

Counselors do not harass a colleague or employee or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practices.

D.2. Provision of Consultation Services

D.2.a. Consultant Competency Counselors take reasonable steps to ensure that they have the appropri- ate resources and competencies when providing consultation services. Coun- selors provide appropriate referral resources when requested or needed.

D.2.b. Informed Consent in Formal Consultation

When providing formal consultation services, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality.

Section E Evaluation, Assessment and Interpretation

Introduction

Counselors use assessment as one com- ponent of the counseling process, taking into account the clients' personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using ap- propriate educational, mental health, psychological, and career assessments.

E.1. General

E.1.a. Assessment

The primary purpose of educational, mental health, psychological, and career assessment is to gather information regarding the client for a variety of purposes, including, but not limited to, client decision making, treatment planning, and forensic proceedings. As- sessment may include both qualitative and quantitative methodologies.

E.1.b. Client Welfare

Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information pro- vided. They respect the client's right to know the results, the interpretations made, and the bases for counselors' conclusions and recommendations.

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence Counselors use only those testing and as- sessment services for which they have been trained and are competent. Counselors using technology-assisted test interpreta- tions are trained in the construct being measured and the specific instrument being used prior to using its technology- based application. Counselors take reason- able measures to ensure the proper use of assessment techniques by persons under their supervision.

E.2.b. Appropriate Use

Counselors are responsible for the appropriate application, scoring, inter- pretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

E.2.c. Decisions Based on Results

Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thor- ough understanding of psychometrics.

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by po- tential recipients. The explanation will be given in terms and language that the client (or other legally authorized person on behalf of the client) can understand.

E.3.b. Recipients of Results Counselors consider the client's and/ or examinee's welfare, explicit under- standings, and prior agreements in de- termining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group as- sessment results.

E.4. Release of Data to Qualified Personnel

Counselors release assessment data in

which the client is identified only with the consent of the client or the client's legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data.

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interviews) used to determine client care (e.g., locus of treatment, type of treatment, recommended follow-up) are carefully selected and appropri- ately used.

E.5.b. Cultural Sensitivity

Counselors recognize that culture affects the manner in which clients' problems are defined and experienced. Clients' socioeconomic and cultural experiences are considered when diag- nosing mental disorders.

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology

Counselors recognize historical and so- cial prejudices in the misdiagnosis and

pathologizing of certain individuals and groups and strive to become aware of and address such biases in themselves or others.

E.5.d. Refraining From Diagnosis

Counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Counselors carefully consider both the positive and negative implications of a diagnosis.

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments

Counselors carefully consider the validity, reliability, psychometric limi- tations, and appropriateness of instru- ments when selecting assessments and, when possible, use multiple forms of assessment, data, and/or instruments in forming conclusions, diagnoses, or recommendations.

E.6.b. Referral Information

If a client is referred to a third party for assessment, the counselor provides specific referral questions and suf- ficient objective data about the client to ensure that appropriate assessment instruments are utilized.

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions

Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the admin- istration, those conditions are noted in interpretation, and the results may be designated as invalid or of question- able validity.

E.7.b. Provision of Favorable Conditions

Counselors provide an appropriate environment for the administration of assessments (e.g., privacy, comfort, freedom from distraction).

E.7.c. Technological

Administration

Counselors ensure that technologi- cally administered assessments func- tion properly and provide clients with accurate results.

E.7.d. Unsupervised

Assessments

Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring, counselors do not permit unsupervised use.

E.8. Multicultural Issues/ Diversity in Assessment

Counselors select and use with cau-

tion assessment techniques normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language pref- erence, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpre- tation, and they place test results in proper perspective with other relevant factors.

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting

When counselors report assessment re- sults, they consider the client's personal and cultural background, the level of the client's understanding of the results, and the impact of the results on the client. In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or inappropriateness of the norms for the person tested.

E.9.b. Instruments With Insufficient Empirical Data

Counselors exercise caution when interpreting the results of instruments not having sufficient empirical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee. Counselors qualify any conclusions, di- agnoses, or recommendations made that are based on assessments or instruments with questionable validity or reliability.

E.9.c. Assessment Services Counselors who provide assessment, scoring, and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applica- tions of the procedures and any special qualifications applicable to their use. At all times, counselors maintain their ethical responsibility to those being assessed.

E.10. Assessment Security

Counselors maintain the integrity and security of tests and assessments consistent with legal and contractual obligations. Counselors do not appro- priate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Assessment and Outdated Results

Counselors do not use data or results

from assessments that are obsolete or outdated for the current purpose (e.g., noncurrent versions of assessments/ instruments). Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

E.12. Assessment

Construction

Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of assess- ment techniques.

E.13. Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a. Primary Obligations When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evalua- tion, which may include examination of the individual and/or review of records. Counselors form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

E.13.b. Consent for Evaluation

Individuals being evaluated are in- formed in writing that the relationship is for the purposes of an evaluation and is not therapeutic in nature, and enti- ties or individuals who will receive the evaluation report are identified. Coun- selors who perform forensic evalua- tions obtain written consent from those being evaluated or from their legal representative unless a court orders evaluations to be conducted without the written consent of the individuals being evaluated. When children or adults who lack the capacity to give voluntary consent are being evaluated, informed written consent is obtained from a parent or guardian.

E.13.c. Client Evaluation Prohibited

Counselors do not evaluate current or former clients, clients' romantic partners, or clients' family members for forensic purposes. Counselors do not counsel individuals they are evaluating.

E.13.d. Avoid Potentially Harmful Relationships

Counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with family members, romantic part- ners, and close friends of individuals they are evaluating or have evaluated in the past.

Section F Supervision, Training, and Teaching

Introduction

Counselor supervisors, trainers, and educators aspire to foster meaningful and respectful professional relation- ships and to maintain appropriate boundaries with supervisees and students in both face-to-face and elec- tronic formats.

They have theoretical and pedagogical foundations for their work; have knowledge of supervision models; and aim to be fair, accurate, and honest in their assessments of counselors, students, and supervisees.

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare

A primary obligation of counseling supervisors is to monitor the services provided by supervisees. Counseling supervisors monitor client welfare and supervisee performance and profes- sional development. To fulfill these obligations, supervisors meet regularly with supervisees to review the super- visees' work and help them become prepared to serve a range of diverse clients. Supervisees have a responsibil- ity to understand and follow the ACA *Code of Ethics*.

F.1.b. Counselor Credentials Counseling supervisors work to ensure that supervisees communicate their

qualifications to render services to their clients.

F.1.c. Informed Consent and Client Rights

Supervisors make supervisees aware of client rights, including the protection of client privacy and confidentiality in the counseling relationship. Supervis- ees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidential- ity. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be stored, transmitted, or otherwise reviewed.

F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation Prior to offering supervision services, counselors are trained in supervision methods and techniques. Counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervi- sion topics and skills.

F.2.b. Multicultural Issues/ Diversity in Supervision

Counseling supervisors are aware of and address the role of multiculturalism/ diversity in the supervisory relationship.

F.2.c. Online Supervision

When using technology in supervision, counselor supervisors are competent in the use of those technologies. Supervi- sors take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means.

F.3. Supervisory Relationship

F.3.a. Extending Conventional Supervisory Relationships

Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Supervisors con- sider the risks and benefits of extend- ing current supervisory relationships in any form beyond conventional parameters. In extending these bound- aries, supervisors take appropriate professional precautions to ensure that judgment is not impaired and that no harm occurs.

F.3.b. Sexual Relationships Sexual or romantic interactions or rela- tionships with current supervisees are prohibited. This prohibition applies to

both in-person and electronic interac- tions or relationships.

F.3.c. Sexual Harassment Counseling supervisors do not con- done or subject supervisees to sexual harassment.

F.3.d. Friends or Family Members

Supervisors are prohibited from engag- ing in supervisory relationships with individuals with whom they have an inability to remain objective.

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision

Supervisors are responsible for incor- porating into their supervision the principles of informed consent and participation. Supervisors inform su- pervisees of the policies and procedures to which supervisors are to adhere and the mechanisms for due process appeal of individual supervisor actions. The issues unique to the use of distance supervision are to be included in the documentation as necessary.

F.4.b. Emergencies and Absences

Supervisors establish and communi- cate to supervisees procedures for con- tacting supervisors or, in their absence, alternative on-call supervisors to assist in handling crises.

F.4.c. Standards for Supervisees Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities.

F.4.d. Termination of the Supervisory Relationship

Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Rea- sons for

considering termination are discussed, and both parties work to resolve differences. When termination is warranted, supervisors make appro- priate referrals to possible alternative supervisors.

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities Students and supervisees have a re- sponsibility to understand and follow the ACA *Code of Ethics*. Students and supervisees have the same obligation to clients as those required of professional counselors.

F.5.b. Impairment

Students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They notify their faculty and/or supervi- sors and seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

F.5.c. Professional Disclosure Before providing counseling services, students and supervisees disclose their status as supervisees and explain how this status affects the limits of confidentiality. Supervisors ensure that clients are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and super- visees obtain client permission before they use any information concerning the counseling relationship in the training process.

F.6. Counseling Supervision Evaluation, Remediation, and Endorsement

F.6.a. Evaluation

Supervisors document and provide supervisees with ongoing feedback regarding their performance and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.6.b. Gatekeeping and Remediation

Through initial and ongoing evalua- tion, supervisors are aware of super- visee limitations that might impede performance. Supervisors assist su- pervisees in securing remedial assis- tance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credential- ing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions.

F.6.c. Counseling for

Supervisees

If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Su-

pervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning.

F.6.d. Endorsements

Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or train- ing program only when they believe that supervisees are qualified for the endorsement. Regardless of qualifi- cations, supervisors do not endorse supervisees whom they believe to be impaired in any way that would inter- fere with the performance of the duties associated with the endorsement.

F.7. Responsibilities of Counselor Educators

F.7.a. Counselor Educators Counselor educators who are respon- sible for developing, implementing, and supervising educational programs are skilled as teachers and practitio- ners. They are knowledgeable regard- ing the ethical, legal, and regulatory aspects of the profession; are skilled in applying that knowledge; and make students and supervisees aware of their responsibilities. Whether in traditional, hybrid, and/or online formats, counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior.

F.7.b. Counselor Educator Competence

Counselors who function as counselor educators or supervisors provide in- struction within their areas of knowl- edge and competence and provide instruction based on current informa- tion and knowledge available in the profession. When using technology to deliver instruction, counselor educators develop competence in the use of the technology.

F.7.c. Infusing Multicultural Issues/Diversity

Counselor educators infuse material related to multiculturalism/diver- sity into all courses and workshops for the development of professional counselors.

F.7.d. Integration of Study and Practice

In traditional, hybrid, and/or online formats, counselor educators establish education and training programs that integrate academic study and super- vised practice.

F.7.e. Teaching Ethics Throughout the program, counselor educators ensure that students are aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum.

F.7.f. Use of Case Examples

The use of client, student, or supervisee information for the purposes of case ex- amples in a lecture or classroom setting is permissible only when (a) the client, student, or supervisee has reviewed the material and agreed to its presentation or (b) the information has been suf- ficiently modified to obscure identity.

F.7.g. Student-to-Student Supervision and Instruction

When students function in the role of counselor educators or supervisors, they understand that they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselor educators make every effort to ensure that the rights of students are not compromised when their peers lead experiential counseling activities in tra- ditional, hybrid, and/or online formats (e.g., counseling groups, skills classes, clinical supervision).

F.7.h. Innovative Theories and Techniques

Counselor educators promote the use of techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific founda- tion. When counselor educators discuss developing or innovative techniques/ procedures/modalities, they explain the potential risks, benefits, and ethical con- siderations of using such techniques/ procedures/modalities.

F.7.i. Field Placements

Counselor educators develop clear policies and provide direct assistance within their training programs regard- ing appropriate field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision in the formats in which services are provided and inform site supervisors of their professional and ethical responsibilities in this role.

F.8. Student Welfare

F.8.a. Program Information and Orientation

Counselor educators recognize that program orientation is a developmen- tal process that begins upon students' initial contact with the counselor educa- tion program and continues throughout the educational and clinical training of students. Counselor education fac- ulty provide prospective and current students with information about the counselor education program's expecta- tions, including

1. the values and ethical principles of the profession;
2. the type and level of skill and knowledge acquisition required for successful completion of the training;
3. technology requirements;
4. program training goals, objectives, and mission, and subject matter to be covered;
5. bases for evaluation;
6. training components that encour- age self-growth or self-disclosure as part of the training process;
7. the type of supervision settings and requirements of the sites for required clinical field experiences;
8. student and supervisor evalua- tion and dismissal policies and procedures; and
9. up-to-date employment pros- pects for graduates.

F.8.b. Student Career Advising Counselor educators provide career advisement for their students and make them aware of opportunities in the field.

F.8.c. Self-Growth Experiences Self-growth is an expected component of counselor education. Counselor edu-

cators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform stu- dents that they have a right to decide what information will be shared or withheld in class.

F.8.d. Addressing Personal Concerns

Counselor educators may require stu- dents to address any personal concerns that have the potential to affect professional competency.

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students Counselor educators clearly state to stu- dents, prior to and throughout the train- ing program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clini- cal competencies. Counselor educators provide students with ongoing feedback regarding their performance throughout the training program.

F.9.b. Limitations

Counselor educators, through ongoing evaluation, are aware of and address the inability of some students to achieve counseling competencies. Counselor educators do the following:

1. assist students in securing reme- dial assistance when needed,
2. seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. ensure that students have recourse in a timely manner to address decisions requiring them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures.

F.9.c. Counseling for Students

If students request counseling, or if counseling services are suggested as part of a remediation process, counselor educators assist students in identifying appropriate services.

F.10. Roles and Relationships Between Counselor Educators and Students

F.10.a. Sexual or Romantic Relationships

Counselor educators are prohibited from sexual or romantic interactions or relationships with students currently enrolled in a counseling or related pro- gram and over whom they have power and authority. This prohibition applies to both in-person and electronic interac- tions or relationships.

F.10.b. Sexual Harassment Counselor educators do not condone or subject students to sexual harassment.

F.10.c. Relationships With Former Students

Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty

members discuss with former students potential risks when they consider engaging in social, sexual, or other intimate relationships.

F.10.d. Nonacademic

Relationships

Counselor educators avoid nonacademic relationships with students in which there is a risk of potential harm to the student or which may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisor placement.

F.10.e. Counseling Services

Counselor educators do not serve as counselors to students currently enrolled in a counseling or related pro- gram and over whom they have power and authority.

F.10.f. Extending Educator– Student Boundaries

Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe that a nonprofessional relation- ship with a student may be potentially beneficial to the student, they take pre- cautions similar to those taken by counselors when working with clients. Examples of potentially beneficial in- teractions or relationships include, but are not limited to, attending a formal ceremony; conducting hospital visits; providing support during a stressful event; or maintaining mutual mem- bership in a professional association, organization, or community. Coun- selor educators discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relation- ships with students should be time limited and/or context specific and initiated with student consent.F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs

F.11.a. Faculty Diversity

Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing the diverse cultures and types of abili- ties that students bring to the training experience. Counselor educators pro- vide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice.

Section G Research and Publication

Introduction

Counselors who conduct research are encouraged to contribute to the knowl- edge base of the profession and promote a clearer understanding of the condi- tions that lead to a healthy and more just society. Counselors support the efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implement- ing research.

G.1. Research Responsibilities

G.1.a. Conducting Research Counselors plan, design, conduct, and report research in a manner that is con- sistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research.

G.1.b. Confidentiality in Research

Counselors are responsible for under- standing and adhering to state, federal, agency, or institutional policies or appli- cable guidelines regarding confidential- ity in their research practices.

G.1.c. Independent Researchers When counselors conduct independent research and do not have access to an institutional review board, they are bound to the same ethical principles and

federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.

G.1.d. Deviation From Standard Practice

Counselors seek consultation and ob- serve stringent safeguards to protect the rights of research participants when research indicates that a deviation from standard or acceptable practices may be necessary.

G.1.e. Precautions to

Avoid Injury

Counselors who conduct research are responsible for their participants' wel- fare throughout the research process and should take reasonable precautions to avoid causing emotional, physical, or social harm to participants.

G.1.f. Principal Researcher Responsibility

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

G.2. Rights of Research Participants

G.2.a. Informed Consent in Research

Individuals have the right to decline requests to become research partici- pants. In seeking consent, counselors use language that

1. accurately explains the purpose and procedures to be followed;
2. identifies any procedures that are experimental or relatively untried;
3. describes any attendant discom- forts, risks, and potential power differentials between researchers and participants;
4. describes any benefits or changes in individuals or organizations that might reasonably be expected;
5. discloses appropriate alternative procedures that would be advan- tageous for participants;
6. offers to answer any inquiries concerning the procedures;
7. describes any limitations on confidentiality;
8. describes the format and potential target audiences for the dissemi- nation of research findings; and
9. instructs participants that they are free to withdraw their con- sent and discontinue participa- tion in the project at any time, without penalty.

G.2.b. Student/Supervisee Participation

Researchers who involve students or supervisees in research make clear to them that the decision regarding participation in research activities does not affect their academic standing or supervisory relationship. Students or supervisees who choose not to partici- pate in research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.c. Client Participation Counselors conducting research involv- ing clients make clear in the informed consent process that clients are free to choose whether to participate in re- search activities. Counselors take neces- sary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.d. Confidentiality of Information

Information obtained about research participants during the course of re- search is confidential. Procedures are implemented to protect confidentiality.

G.2.e. Persons Not

Capable of Giving Informed Consent

When a research participant is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the ap- propriate consent of a legally authorized person.

G.2.f. Commitments to Participants

Counselors take reasonable measures to honor all commitments to research participants.

G.2.g. Explanations After Data Collection

After data are collected, counselors provide participants with full clarifi- cation of the nature of the study to re- move any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding infor- mation, counselors take reasonable measures to avoid causing harm.

G.2.h. Informing Sponsors

Counselors inform sponsors, insti- tutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.i. Research Records Custodian

As appropriate, researchers prepare and disseminate to an identified colleague or records custodian a plan for the transfer of research data in the case of their inca- pacitation, retirement, or death.

G.3. Managing and Maintaining Boundaries

G.3.a. Extending Researcher– Participant Boundaries

Researchers consider the risks and ben- efits of extending current research rela- tionships beyond conventional parameters. When a nonresearch interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated con- sequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant, the researcher must show evidence of an attempt to remedy such harm.

G.3.b. Relationships With Research Participants

Sexual or romantic counselor–research participant interactions or relationships with current research participants are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

G.3.c. Sexual Harassment and Research Participants

Researchers do not condone or subject re- search participants to sexual harassment.

G.4. Reporting Results

G.4.a. Accurate Results Counselors plan, conduct, and report research accurately. Counselors do not engage in misleading or fraudulent re- search, distort data, misrepresent data, or deliberately bias their results. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors

If counselors discover significant errors in their published research, they take

reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

G.4.d. Identity of Participants Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self- identify their involvement in research studies, researchers take active steps to ensure that data are adapted/ changed to protect the identity and welfare of all parties and that discus- sion of results does not cause harm to participants.

G.4.e. Replication Studies Counselors are obligated to make available sufficient original research information to qualified professionals who may wish to replicate or extend the study.

G.5. Publications and Presentations

G.5.a. Use of Case Examples

The use of participants', clients', stu- dents', or supervisees' information for the purpose of case examples in a presentation or publication is permis- sible only when (a) participants, clients, students, or supervisees have reviewed the material and agreed to its presenta- tion or publication or (b) the informa- tion has been sufficiently modified to obscure identity.

G.5.b. Plagiarism

Counselors do not plagiarize; that is, they do not present another person's work as their own.

G.5.c. Acknowledging Previous Work

In publications and presentations, counselors acknowledge and give rec- ognition to previous work on the topic by others or self.

G.5.d. Contributors

Counselors give credit through joint authorship, acknowledgment, foot- note statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contribu- tor is listed first, and minor technical or professional contributions are ac- knowledged in notes or introductory statements.

G.5.e. Agreement of

Contributors

Counselors who conduct joint research with colleagues or students/supervi- sors establish agreements in advance re- garding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research Manuscripts or professional presen- tations in any medium that are sub- stantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permis- sion and list the student as lead author.

G.5.g. Duplicate Submissions Counselors submit manuscripts for con- sideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in one journal or published work are not submitted for publication to another publisher with- out acknowledgment and permission from the original publisher.

G.5.h. Professional Review Counselors who review material sub- mitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors make publication decisions based on valid and defensible standards. Coun- selors review article submissions in a timely manner and based on their scope and competency in research methodolo- gies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review ma- terials that are within their scope of competency and avoid personal biases.

Section H Distance Counseling, Technology, and Social Media

Introduction

Counselors understand that the profes- sion of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to bet- ter serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the

additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

H.1. Knowledge and Legal Considerations

H.1.a. Knowledge and Competency

Counselors who engage in the use of distance counseling, technology, and/ or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

H.1.b. Laws and Statutes Counselors who engage in the use of dis- tance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the coun- selor's practicing location and the client's place of residence. Counselors ensure that their clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries.

H.2. Informed Consent and Security

H.2.a. Informed Consent and Disclosure

Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/ or social media, are addressed in the informed consent process:

- distance counseling credentials, physical location of practice, and contact information;
- risks and benefits of engaging in the use of distance counseling, technology, and/or social media;
- possibility of technology failure and alternate methods of service delivery;
- anticipated response time;
- emergency procedures to follow when the counselor is not available;
- time zone differences;
- cultural and/or language differ- ences that may affect delivery of services;
- possible denial of insurance benefits; and
- social media policy.

H.2.b. Confidentiality

Maintained by the Counselor

Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employ- ees, information technologists).

H.2.c. Acknowledgment of Limitations

Counselors inform clients about the inherent limits of confidentiality when using technology. Counselors urge clients to be aware of authorized and/ or unauthorized access to information disclosed using this medium in the counseling process.

H.2.d. Security

Counselors use current encryption stan- dards within their websites and/or tech- nology-based communications that meet applicable legal requirements. Counselors take reasonable precautions to ensure the confidentiality of information transmitted through any electronic means.

H.3. Client Verification

Counselors who engage in the use of distance counseling, technology, and/ or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics, or other nondescript identifiers.

H.4. Distance Counseling Relationship

H.4.a. Benefits and Limitations Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, so- cial media and Internet-based applications and other audio and/or video communi- cation, or data storage devices or media.

H.4.b. Professional

Boundaries in Distance Counseling

Counselors understand the necessity of maintaining a professional relationship with their clients. Counselors discuss and establish professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, times when not ap- propriate to use).

H.4.c. Technology-Assisted Services

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible mis- conceptions, discover appropriate use, and assess subsequent steps.

H.4.d. Effectiveness of Services When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face-to-face. If the counselor is not able to provide face-to-face services (e.g., lives in another state), the coun- selor assists the client in identifying appropriate services.

H.4.e. Access

Counselors provide information to clients regarding reasonable access to pertinent applications when providing technology-assisted services.

H.4.f. Communication Differences in Electronic Media

Counselors consider the differences be- tween face-to-face and electronic com- munication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

H.5. Records and

Web Maintenance

H.5.a. Records

Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electroni- cally. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

H.5.b. Client Rights

Counselors who offer distance counseling services and/or maintain a professional website provide electronic links to rel- evant licensure and professional certifica- tion boards to protect consumer and client rights and address ethical concerns.

H.5.c. Electronic Links Counselors regularly ensure that elec- tronic links are working and are profes- sionally appropriate.

H.5.d. Multicultural and Disability Considerations

Counselors who maintain websites provide accessibility to persons with disabilities. They provide translation ca-

pabilities for clients who have a different primary language, when feasible. Coun- selors acknowledge the imperfect nature of such translations and accessibilities.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distin- guish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public

Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

Section I Resolving Ethical Issues

Introduction

Professional counselors behave in an ethical and legal manner. They are aware that client welfare and trust in

the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that standards are upheld. Counselors strive to resolve ethical dilemmas with direct and open commu- nication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work and engage in ongoing professional development regarding current topics in ethical and legal issues in counseling. Counselors become familiar with the ACA Policy and Procedures for Processing Com- plaints of Ethical Violations1 and use it as a reference for assisting in the enforcement of the ACA *Code of Ethics*.

I.1. Standards and the Law

I.1.a. Knowledge

Counselors know and understand the ACA *Code of Ethics* and other applicable ethics codes from professional organizations or certification and licensure bod- ies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

I.1.b. Ethical Decision Making When counselors are faced with an eth- ical dilemma, they use and document, as appropriate, an ethical decision- making model that may include, but is not limited to, consultation; consid- eration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the cir- cumstances and welfare of all involved.

I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other gov-

erning legal authority, counselors make known their commitment to the ACA *Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be re- solved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other govern- ing legal authority.

I.2. Suspected Violations

I.2.a. Informal Resolution

When counselors have reason to believe that another counselor is violating or has violated an ethical standard and substan- tial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible, provided such action does not violate confidential- ity rights that may be involved.

I.2.b. Reporting Ethical Violations

If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not ap- propriate for informal resolution or is not resolved properly, counselors take fur- ther action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or ap- propriate institutional authorities. The confidentiality rights of clients should be considered in all actions. This standard does not apply when counselors have been retained to review the work of another counselor whose professional conduct is in question (e.g., consultation, expert testimony).

I.2.c. Consultation

When uncertain about whether a particular situation or course of ac- tion may be in violation of the ACA *Code of Ethics*, counselors consult with other counselors who are knowledge- able about ethics and the ACA *Code of Ethics*, with colleagues, or with appropriate authorities, such as the ACA Ethics and Professional Stan- dards Department.

I.2.d. Organizational Conflicts

If the demands of an organization with which counselors are affiliated pose a conflict with the ACA *Code of Ethics*, counselors specify the nature of such conflicts and express to their supervi- sors or other responsible officials their commitment to the ACA *Code of Ethics* and, when possible, work through the appropriate channels to address the situation.

I.2.e. Unwarranted Complaints Counselors do not initiate, participate in, or encourage the filing of ethics com- plaints that are retaliatory in nature or are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

I.2.f. Unfair Discrimination Against Complainants and Respondents

Counselors do not deny individuals employment, advancement, admission to academic or other programs, tenure, or promotion based solely on their having made or their being the subject of an ethics complaint. This does not preclude taking action based on the outcome of such proceedings or con- sidering other appropriate information.

I.3. Cooperation With Ethics Committees

Counselors assist in the process of enforcing the ACA *Code of Ethics*. Counselors cooperate with investiga- tions, proceedings, and requirements of the ACA Ethics Committee or eth- ics committees of other duly consti- tuted associations or boards having jurisdiction over those charged with a violation.

1 See the American Counseling Association web site at http://www.counseling.org/knowledge-center/ethics

Glossary of Terms

Abandonment – the inappropriate ending or arbitrary ter- mination of a counseling relationship that puts the client at risk.

Advocacy – promotion of the well-being of individuals, groups, and the counseling profession within systems and organiza- tions. Advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development.

Assent – to demonstrate agreement when a person is oth- erwise not capable or competent to give formal consent (e.g., informed consent) to a counseling service or plan.

Assessment – the process of collecting in-depth information about a person in order to develop a comprehensive plan that will guide the collaborative counseling and service provision process.

Bartering – accepting goods or services from clients in ex- change for counseling services.

Client – an individual seeking or referred to the professional services of a counselor.

Confidentiality – the ethical duty of counselors to protect a client's identity, identifying characteristics, and private communications.

Consultation – a professional relationship that may include, but is not limited to, seeking advice, information, and/ or testimony.

Counseling – a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Counselor Educator – a professional counselor engaged primarily in developing, implementing, and supervising the educational preparation of professional counselors.

Counselor Supervisor – a professional counselor who en- gages in a formal relationship with a practicing counselor or counselor-in-training for the purpose of overseeing that individual's counseling work or clinical skill development.

Culture – membership in a socially constructed way of liv- ing, which incorporates collective values, beliefs, norms, boundaries, and lifestyles that are cocreated with others who share similar worldviews comprising biological, psychosocial, historical, psychological, and other factors.

Discrimination – the prejudicial treatment of an individual or group based on their actual or perceived membershipin a particular group, class, or category.

Distance Counseling – The provision of counseling services by means other than face-to-face meetings, usually with the aid of technology.

Diversity – the similarities and differences that occur within and across cultures, and the intersection of cultural and social identities.

Documents – any written, digital, audio, visual, or artistic recording of the work within the counseling relationship between counselor and client.

Encryption – process of encoding information in such a way that limits access to authorized users.

Examinee – a recipient of any professional counseling ser- vice that includes educational, psychological, and career appraisal, using qualitative or quantitative techniques.

Exploitation – actions and/or behaviors that take advantage of another for one's own benefit or gain.

Fee Splitting – the payment or acceptance of fees for client referrals (e.g., percentage of fee paid for rent, referral fees). **Forensic Evaluation –** the process of forming professional opin- ions for court or other legal proceedings, based on professional knowledge and expertise, and supported by appropriate data.

Gatekeeping – the initial and ongoing academic, skill, and dispositional assessment of students' competency for professional practice, including remediation and termination as appropriate.

Impairment – a significantly diminished capacity to perform professional functions.

Incapacitation – an inability to perform professional functions.

Informed Consent – a process of information sharing as- sociated with possible actions clients may choose to take, aimed at assisting clients in acquiring a full appreciation and understanding of the facts and implications of a given action or actions.

Instrument – a tool, developed using accepted research practices, that measures the presence and strength of a specified construct or constructs.

Interdisciplinary Teams – teams of professionals serving clients that may include individuals who may not share counselors' responsibilities regarding confidentiality.

Minors – generally, persons under the age of 18 years, un- less otherwise designated by statute or regulation. In some jurisdictions, minors may have the right to consent to counseling without consent of the parent or guardian.

Multicultural/Diversity Competence – counselors' cul- tural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and cli- ent groups.

Multicultural/Diversity Counseling – counseling that recog- nizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts.

Personal Virtual Relationship – engaging in a relationship via technology and/or social media that blurs the profes-

sional boundary (e.g., friending on social networking sites); using personal accounts as the connection point for the virtual relationship.

Privacy – the right of an individual to keep oneself and one's personal information free from unauthorized disclosure.

Privilege – a legal term denoting the protection of confidential information in a legal proceeding (e.g., subpoena, deposition, testimony).

***Pro bono publico* –** contributing to society by devoting a por- tion of professional activities for little or no financial return (e.g., speaking to groups, sharing professional information, offering reduced fees).

Professional Virtual Relationship – using technology and/ or social media in a professional manner and maintaining appropriate professional boundaries; using business accounts that cannot be linked back to personal accounts as the connection point for the virtual relationship (e.g., a business page versus a personal profile).

Records – all information or documents, in any medium, that the counselor keeps about the client, excluding personal and psychotherapy notes.

Records of an Artistic Nature – products created by the client as part of the counseling process.

Records Custodian – a professional colleague who agrees to serve as the caretaker of client records for another mental health professional.

Self-Growth – a process of self-examination and challeng- ing of a counselor's assumptions to enhance professional effectiveness.

Serious and Foreseeable – when a reasonable counselor can anticipate significant and harmful possible conse- quences.

Sexual Harassment – sexual solicitation, physical advances, or verbal/nonverbal conduct that is sexual in nature; oc- curs in connection with professional activities or roles; is unwelcome, offensive, or creates a hostile workplace or learning environment; and/or is sufficiently severe or intense to be perceived as harassment by a reason- able person.

Social Justice – the promotion of equity for all people and groups for the purpose of ending oppression and injustice affecting clients, students, counselors, families, communi- ties, schools, workplaces, governments, and other social and institutional systems.

Social Media – technology-based forms of communica- tion of ideas, beliefs, personal histories, etc. (e.g., social networking sites, blogs).

Student – an individual engaged in formal graduate-level counselor education.

Supervisee – a professional counselor or counselor-in-train- ing whose counseling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional.

Supervision – a process in which one individual, usually a senior member of a given profession designated as the supervisor, engages in a collaborative relationship with another individual or group, usually a junior member(s) of a given profession designated as the supervisee(s) in order to (a) promote the growth and development of the supervisee(s), (b) protect the welfare of the clients seen by the supervisee(s), and (c) evaluate the performance of the supervisee(s).

Supervisor – counselors who are trained to oversee the profes- sional clinical work of counselors and counselors-in-training. **Teaching –** all activities engaged in as part of a formal edu- cational program that is designed to lead to a graduate

degree in counseling.

Training – the instruction and practice of skills related to the counseling profession. Training contributes to the ongoing proficiency of students and professional counselors.

Virtual Relationship – a non–face-to-face relationship (e.g., through social media).

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