This year marks the 50th Anniversary of the War on Poverty. The war on poverty was introduced in a State of the Union address by President Lyndon B. Johnson on January 8, 1964. Johnson was quoted as saying, “This administration today, here and now, declares unconditional war on poverty in America” and “The richest nation on earth can afford to win it.” Yet, five decades later in the United States, many demographic groups are impoverished, unemployment is at an all-time high and there are more Americans whose wages do not cover their basic survival needs. In retrospect, though Johnson may remain admired for his zealous declaration to end poverty, some wonder if he lacked the foresight to understand the complexities of penury conditions faced by people experiencing hardship.

Social workers have a long history of advocating for the underserved and underprivileged. In fact, helping people living in poverty is one of the six principles within NASW’s Code of Ethics. The Code encourages social workers to challenge social injustice and pursue social change by helping vulnerable and oppressed populations. Will we ever win the war on poverty? It is hard to answer that question. However, social workers have been and continue to be the catalysts to persons rising above dire circumstances and finding stability. Social workers will continue to address inequalities, disparities, human rights and other social issues that contribute to the reasons why poverty exist. One might say that social workers are less concerned about waging war against poverty and more concerned about effective proven resources that can be applied daily to prevent and overcome destitution and economic hopelessness.
ADMINISTRATION/SUPERVISION SPS
National Agency Accreditation:
What Is It? Why Do It?

Phyllis Marsh Brestoff, ASCN, CSWP, GMCS

The social work dictionary defines accreditation as verification that an organization such as a social agency fulfills explicit standards (Rubash, 2003). In 1997, our agency decided to obtain national accreditation as we built our model of professionally managed home care. Our clients privately pay for our services. The State of Wisconsin does not license our agency—licensed agencies primarily provide medical services paid for through Medicare and other health insurance programs. Our agency focuses on providing long-term care to medically ill or functionally challenged individuals.

We believed that seeking national accreditation would demonstrate our commitment to meeting national standards as well as help us build a sustainable business model going forward. I explored the choices available at that time: the Council on Accreditation (COA), the Joint Commission for Accreditation of Healthcare Organizations (JCAHCO), the Accreditation Commission for Home Care (ACHC), and the Community Health Accreditation Program (CHAP). We choose to seek accreditation from COA because it accredited both care management and home care services, and we felt comfortable with COA standards because of their social service—rather than medical—approach. We obtained initial accreditation from COA in 2000 and were reaccredited in 2005 and 2009.

In 2011, while beginning to plan for our next reaccreditation, we decided to explore alternatives and found out JCAHCO had become The Joint Commission (TJC). Shifting “Health Care Organizations” from its title and adding accreditation for the type of personal care services we provide along with our care management services. We sought and obtained TJC accreditation in April 2012.

Accreditation has given us not only a clear set of nationally approved standards but also the recognition as an approved vendor for many long-term care insurance policies. The majority of long-term care insurance policies require a “licensed or certified” agency—often one that is licensed by a state and certified by Medicare. We have successfully used our national accreditation as the equivalent of state licensure or certification with a number of insurance providers, and recently we have seen long-term care insurance contracts include TJC accreditation as criteria for approval of an agency as a provider. We have had long-term care insurance companies accept us as a vendor even though we are not licensed by a state or certified by Medicare.

Furthermore, accreditation has been a good marketing tool for us in assuring the public that we are providing a level of service that meets national standards. And accreditation has been a good way for us to differentiate ourselves in the marketplace from the many competing franchises, individuals, and agencies that seem to spring up daily.

Accreditation has been a big investment for us, but we believe it has proven to be a worthy strategy for business growth. Having our formal notice of accreditation, we are also required to inform our clients that they can go to the TJC Office of Quality Monitoring if they have any complaints—yet another element that assures our clients of our accountability.

If you decide to seek national accreditation, you should be prepared for an intense and costly process. Because accreditation is voluntary, it is paid for by fees from the accredited organization. These fees are generally assessed based on the volume of services provided and the gross revenue.

The key factors in obtaining certification are a careful, thorough reading of the standards, as written, and a step-by-step exercise to determine whether you are currently meeting each one, and identifying supporting evidence that you are meeting the standard. If you believe that you are not meeting a standard, then you need to figure out how to do so. It may be as simple as putting into writing your agency’s current policy, or it may be as challenging as realizing that not only do you lack a policy covering that standard, but also you don’t really know how to develop one.

One advantage of seeking accreditation in today’s world is that the majority of information and interactions are handled electronically. TJC has an excellent intranet site for those seeking accreditation, and a highly responsive, consumer-oriented structure to quickly and thoroughly answer questions. In our first accreditation efforts, back in the late 90s we had to produce a large loose-leaf notebook. Today, all of those pages are submitted in electronic files.

Of course, a key element of accreditation is a site visit by a surveyor. We had that one visit on March 13 and 14, 2012, and experienced the TJC approach to compliance—called the “tracer” methodology—firsthand. In this technique, the surveyor reviews records concerning individual clients and the staff responsible for their care. The surveyor goes into the field to meet the client in person, to observe the staff in person, and to determine whether what is written on paper is, in fact, what happens in the field.

Our surveyor told us that she “was sure that we were providing excellent service to our clients.” She also was impressed with the details in our caregiver and care manager plans of service. The State of Wisconsin does not have any complaints—yet another element that assures our clients of our accountability.

We are urging TJC to add accreditation of care management as a service to their current list of programs: home health care, hospice care, personal care and support services, clinical respiratory services, rehabilitation technology, freestanding outpatient infusion services, Durable Medical Equipment (DME), and pharmacy.

Accreditation has been a winning strategy for us, and I am happy to answer any questions about it.

Phyllis Marsh Brestoff, ASCN, CSWP, GMCS, is the Executive Director of Stowell Associates in Milwaukee. She can be contacted at pmb@stowellassociates.com.
Agency Accreditation: It? Why Do It?

Phyllis Mensh Brostoff, ASCW, CISW, CMC, is cofounder and CEO of Care Managed Homecare, a home care provider in Madison, Wisconsin. Phyllis is a social worker with extensive experience in the field of home care. She is the author of numerous articles about home care and accreditation. Phyllis has been a leader in the field of home care for many years and has served on the Board of Directors of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the Joint Commission for Accreditation of Health Care Organizations (JCAHCO). Phyllis is also a member of the American Society for Social Work (NASW) and the Wisconsin Social Work Association (WSWA). Phyllis is a sought-after speaker and is a frequent contributor to national and local publications on the topic of home care.

To find out more, you can visit Phyllis’ website at www.youandme.com or contact her at phyllisb@caremanagedhomecare.com.

REFERENCES


RESOURCES

Accreditation Commission for Health Care (ACHC) www.achc.org
Community Health Accreditation Program (CHAP) www.chap.org
Joint Accreditation for Home Care Organizations (JAHCO) www.jahco.org

To find out more, you can visit our website at www.youandme.com.
Older adults with mental health needs continue to be an underserved population. Several explanations for this situation have been cited, including reimbursement policies, lack of training, and cohort differences, which can create a therapeutic relationship. Close and caring relationships are not present to a great degree. For many older men, acknowledging an inability to express one’s feelings is more painful than the loss itself. Seeking help can undermine their learned sense of self.


types of entry issues

The older men with a history of long-standing issues. Henry is a 99-year-old German Jewish man who came to this country in 1936, but was not present to a great degree. For the sake of this article, I am arbitrarily defining “older” as 65 and above.

SEVEN MASCULINE “SCRIPTS”

Mahalik, Good, and Englar-Carlson (2003) have identified that there are seven masculine “scripts.” These scripts form a useful backdrop in formulating strategies to engage older men. The “strong and silent” script stresses the importance of being strong and unemotional. The “tough guy” builds strategies to engage older men. The “innovator” builds on his way home, but he did not stop from work, Henry saw his exhausted father. His textile mill was destroyed during Kristallnacht, and Henry’s father was badly beaten. A month later, he died in the camps. Although Henry has not achieved a life with more success or recognition, he has a lifelong commitment to remembering those who died in the camps. The multiple losses that are inevitable for many older men with end-of-life issues are more painful than the loss itself. Older men with end-of-life issues are often referred by their families because of their distressing behavior. These men generally welcome the opportunity to talk with a sympathetic neutral party who will listen, but they would be forced to label the process as psychotherapy. Sometimes, these men are devoutly religious, reticent about their past, and scared of the inevitable Day of Judgment. They don’t feel comfortable discussing these concerns with anyone else in their lives. They only know how to express their vulnerability through their masculinity (Ashworth, 2006).

Older men who are holding on to long-held beliefs are often resistant to assuming new roles and experiencing things differently for the first time. My proximity to someone with long-standing issues. Henry is a 99-year-old German Jewish man who came to this country in 1936, but was not present to a great degree. For the sake of this article, I am arbitrarily defining “older” as 65 and above.

SOME OF THE OTHERS

The older men who have chosen to go into therapy for the first time experience difficulty coping with age-related issues. Bradford is 83-year-old lawyer who still lives in the house he had built with his wife, requires a walker that does not always prevent falls, and depends on a live-in caregiver. He has been a long-time client of Bradford’s nagging sense of isolation. Despite his physical frailty and a radically reduced client load, Bradford misses being driven to his Beverly Hils office twice a week. He acknowledges that he does little more than shuffle papers around and struggle to complete a few minimal tasks. Although he calculates that maintaining his office costs him around $100,000 a year, he feels that if it were to go on, they would lose all sense of purpose. Bradford still grieves the death of the woman he met a year after his wife’s death. He tries to be a “tough guy,” misses being a “playboy,” and no longer feels like a “winner.” The doesn’t know who he is now.

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OVERCOMING RESISTANCE

In many ways, developing a therapeutic relationship with these men is no different than it is with any client. You start where the client is, you: M in your role as a facilitator, but you also balance the client as a person who has value. You express empathy and understanding. Maybe that is something more than anything else, you let them know that you are listening. Older men do present particular challenges. Psychotherapy for this cohort will hold enormous potential. It is time to explore the challenges, appreciate the strengths, and explore the benefits.

Finding a way to overcome resistance often requires creativity and humility. Employing a more conversational style helps to loosen the stigma by reducing the provider/client hierarchy and any concomitant sense of shame (Vickers, Hays, & Thompson, 2006). The main ingredients include topics in sessions that are not ordinarily fall to the therapeutic process. One can start by talking about business, the economy, and the stock market. For some older men, discussing current events is a godsend, part of the pain of their isolation is that they have no one with whom to discuss the news of the day.

...
Engaging Older Men in Psychotherapy

Some of the older men who have chosen to go into therapy for the first time experience difficulty coping with age-related issues. Bradford is an 83-year-old former police officer who retired from the police force at 65. He feels that he has no one to talk to about his feelings and that he is alone. He is too embarrassed to talk about his feelings, and he is afraid of being judged. Bradford is stuck in a cycle of isolation and loneliness. He does not explore his feelings or question his beliefs. He is afraid of being judged by others.

Bradford feels that he is a failure because of his past mistakes. He has tried to change his ways, but he has not been successful. Bradford feels that he is not good enough for anyone. He is afraid of being rejected by others. He is afraid of being judged for his past mistakes.

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The Affordable Care Act (ACA) on addictions and substance abuse prevention and treatment services has been intimately connected with such policy initiatives of the Obama Administration as the National Drug Control Strategy 2012 (www.whitehouse.gov/ondcp/2012-national-drug-control-strategy) and the National Prevention Strategy (HHS, 2012). These are many changes in policy that can potentially expand and improve coverage, this is particularly true now that the tax penalty for some categories of the uninsured has been found constitutional (June 28, 2012). The goal is not only increased quantity and quality of treatment services that are accessible, but also improved quality of treatment based on research evidence.

Historically, in the United States, insurance coverage for mental illness and substance abuse disorders has been inferior to physical medical health coverage. The Mental Health Parity Act of 1996 (MHPA), signed by President Clinton, did not require mental health and substance abuse treatment services to be included in group health plans. It stipulated that there was no coverage in specific categories of group health care insurance, then the annual and lifetime cost limits could not be lower than what is provided for physical care. There were a number of insurance categories exempted (Tostes, 2012, pp. 476–482).

In 2008, President Bush signed the Paul Wellstone and Petro Dominican Mental Health Parity and Addiction Equity Act (MHPAEA), which regulated employer-provided insurance plans that covered more than 51 employees or exempted many of same plans as MHPA. It did not mandate that any health insurance policy offered must provide behavioral health coverage (Tostes, 2012, pp. 442–444).

“The 2008 Parity Act requires that if a plan includes MBS (Mental Health/Substance Use Disorder), then it must do so with:

- No greater financial burden (cost sharing, deductibles) than medical
- No annual or lifetime limits unless also apply to medical benefits
- Benefits not more limited than medical (number visits, frequency of treatment, etc.) – Non-quantitative treatment limits
- Out of network if medical out of network
- Transparency in medical necessity & details of care” (Colker, 2011, p. 29).

The ACA, signed into Law by President Obama, has expanded health care insurance coverage for mental illness and substance abuse disorders. It is the first time the government has mandated behavioral health coverage and, as a consequence, the act will benefit many more groups of people who currently are not covered, but not all:

- The first provision expands mental health and substance abuse parity beyond large-national groups to all qualified health-care plans that will be offered in the state and regional insurance exchanges (created by the ACA) by January 1, 2014.
- Second, it clarifies the parity acts of 1996 and 2008 to prohibit offering inferior coverage for those illnesses.
- ACA’s third provision is that mental health and substance abuse disorders are included in the identical “essential health benefits” (EHB) and after January 1, 2014, lifetime and annual costs limits will be prohibited.
- A fourth and extremely important provision is that many, if not most, insurance offerings will be required to provide coverage for mental illness and addiction treatment as part of the EHB package. All the plans being offered in the insurance exchanges are mandated to provide this coverage. Insurers of individuals and small groups must also offer the complete package. Medicaid benchmarks and benchmark equivalent plans are included in this mandate. Taken together, this group of provisions is thought to be a significant expansion of coverage for addiction and mental illness treatment (Tostes, 2012, pp. 488–489).

Group health plans that extend the day prior to President Obama’s signing the ACA into law are exempted; however, there are a number of conditions in place that could nullify these exemptions (i.e., changes in the insurance contract such as increases in co-pay or deductible). The list of qualifying conditions is extensive. It is predicted that many small and large insurers will reexamine their exemption status by the end of 2012 (Tostes, 2012, pp. 488–489).

The specifics of the EHB coverage are to be developed by the Secretary of Health and Human Services, with periodic reviews based on recommendations coming from a variety of relevant groups and stakeholders. Guidelines have been established (Tostes, 2012). As of this writing, the specifics of the EHBs have not been published. The process appears to be quite complex and attempts to take in new viewpoints, with a particular goal of finding a balance between benefits and cost.

Substance Abuse and Mental Health Services (SAMHSA) supports a shift of dollars to recovery support services that Medicaid currently considers “not medical enough” (Colker, 2011, p. 26).

“What Are Important Inputs Regarding Service Coverage?

- What services do they need? Need to identify the necessary services
- What’s the modality/setting that will work?
- What will it cost?
- What’s the modality/setting that will work?
- What does the evidence say about what works for these populations?
- How much will these individuals need?
- How well will it cost?
- What are the cost offsets to the healthcare system?” (Colker, 2011, p. 30).

At this point, a key challenge for substance use disorder services is establishing treatment programs that are more clearly evidence based, as required by J.C.H. Humphreys and McLellan (2010, p. 282)—both of whom are members of the White House Office of National Drug Control Policy—point out that “of the 30 most common chronic diseases, addiction treatment has the lowest level of scientifically supported interventions.

The Obama Administration has established an initial “pay for performance” block grant through SAMHSA to encourage states and tribes to initiate quality improvement efforts in addiction treatment, using any practice that has an evidence base and which can be monitored. If this initial grant is successful, then the program will be expanded to include more states (Humphreys and McLellan, 2010, p. 282).

This final element, incoming evidence, that the methods used are based on research, may ultimately be the key to growth in addiction treatment services—broad, more effective treatment, not just more treatment.

Richard M. Jazwinski, PhD, ACSW, LCSW

RESOURCES

SAMHSA’s national source of information about Health Care Reform (ACA)

U.S. Dept of Health and Human Services

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.SAMHSA.gov
OTHER DRUGS SPS

liable Care Act Affect
Order Treatment?

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services—better, more effective
treatment, not just more treatment.

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Fried, R. K., & Green, J. (2012). National prevention strategic
action plan for better health and reduced health care:
National, state, and community action implementation

Full Text of the Affordable Health Care Act:

American Journal of Law & Medicine, 38(4),

Addiction Drug Treat. Policy. National Drug Control

The Affordable Care Act: How it expands
coverage for those with substance health conditions:

Kaiser Family Foundation Health Reform Source

Families USA—The Voice of Health Care Consumers
www.familiesusa.org/health-reform-central

Families USA—The Voice of Health Care Consumers
www.familiesusa.org/health-reform-central

Addiction Drug Treat. Policy. National Drug Control

The 10 Essential Health Benefits Mandated by 2014

Kaiser Family Foundation Health Reform Source

Families USA—The Voice of Health Care Consumers
www.familiesusa.org/health-reform-central

The Affordable Care Act: How it expands
coverage for those with substance health conditions:

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Full Text of the Affordable Health Care Act:

American Journal of Law & Medicine, 38(4),

Addiction Drug Treat. Policy. National Drug Control

The Affordable Care Act: How it expands
coverage for those with substance health conditions:

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Addiction Drug Treat. Policy. National Drug Control

The 10 Essential Health Benefits Mandated by 2014

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CHILDREN, ADOLESCENTS, & YOUNG ADULTS SPS
Identifying, Assessing, & Helping Child & Adolescent Sex Trafficking Victims
Rebecca J. Macy, PhD, ACSW, LCSW

Given their wide range of practice settings, social work professionals are well positioned to identify and help sex trafficking victims, especially children and adolescents. These young victims are more likely to interact with social workers in child protection services, health care settings, homeless shelters and outreach services, victim advocacy agencies, juvenile justice settings, and schools. Unfortunately, their presence in everyday settings might be overlooked because the fluid, ever-changing world of sex trafficking means that many social workers lack knowledge of trafficking signs and current response strategies when victims are identified. To help address this professional knowledge gap, this article provides an overview of the current recommended best practices for identifying, assessing, and assisting child and adolescent victims of sex trafficking.

What signs indicate a child or adolescent victim is likely a victim of sex trafficking? Sex trafficking is defined as, “a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform the act has not attained 18 years of age” (U.S. Department of State, 2012, p. 8). Although the stereotypical sex trafficking victim is a young girl who was kidnapped or sold by her family and forced into sex work, social workers should use an approach consistent with the Federal government’s definition and consider anyone younger than 18 years old involved with prostitution or sex work as a sex trafficking victim. When social workers encounter such a client, that client should be treated as a trafficking victim rather than as an offender engaged in the crime of prostitution. Of course, many child or adolescent clients will not report being involved with prostitution. Social workers should be vigilant for signs that indicate a client is a trafficking victim. These fall into three categories: (1) signs related to prostitution and sexualization; (2) signs related to the client’s identity and life stability; and (3) signs of general abuse and maltreatment (A21 Campaign, n.d.; Bortel, Ellingen, Ellison, Phillips, & Thomas, 2008; U.S. Department of Education, 2009; Zimmerman & Warn, 2003).

In the first category, signs related to prostitution and sexualization, social workers should consider the possibility that their young clients are sex trafficking victims if the clients have a sketchy “boyfriend” or “girlfriend,” talk about sexual activities in a way that is not developmentally appropriate, carry around multiple keys and keys to hotel rooms, have a cell phone but few, if any, other belongings, have large amounts of cash, and have had multiple sex partners, particularly within a relatively brief period.

In the second category, signs related to difficulty in establishing the client’s true identity and indications of instability in the client’s life, social workers should consider that child or adolescent clients might be sex trafficking victims if the clients lie about their age, possess false identification or do not have control over their identifying documents (if developmentally appropriate to have such control); tell life stories with inconsistencies; have little knowledge of the local community, indicating that they have been transported from other communities; have unplanned school absences or do not attend school regularly; and do not have control over their own schedules or life activities (as developmentally appropriate).

Signs falling into the third category of signs of abuse and maltreatment include physical, emotional, and behavioral indications of victimization. Social workers should consider that child or adolescent clients might be sex trafficking victims if the clients often run away from their home or primary caregivers, have signs of physical abuse or injury (e.g., bruises, cuts, frequent sprains), are withdrawn, fearful, or depressed, appear hungry or malnourished, or appear to be addicted to substances, including prescription medications.

However, considering the implications of such signs, social workers must remain mindful that children or adolescents can display many of these signs and not be victims of sex trafficking. These same signs can also indicate other psychological problems, such as family violence. Nonetheless, if providers note these signs in child and adolescent clients, then they should follow up with the client to further assess the possibility of sex trafficking victimization.

What questions are recommended for assessing clients who might be sex trafficking victims? Before asking questions specific to sex trafficking, an important first step is to consider the client’s developmental stage, cultural background and heritage, and language (A21 Campaign, n.d.; Bortel et al., 2008; Zimmerman & Warn, 2003). This consideration will enable the social worker to ask trafficking assessment questions in a manner that is consistent with the client’s development, culture, and preferred language. Further to protect the client’s confidentiality and safety, social workers should ask trafficking assessment questions only when the client is in a private, confidential setting where he or her answers cannot be overheard by others. Once the social worker has set the context for this type of confidential assessment interview, then the assessment could include the following questions (A21 Campaign, n.d.; Bortel et al., 2008): (1) Do you stay in hotel rooms? Do you have a job? Can you leave your job if you want to? (2) Where is your home? Who lives with you? Are you afraid to leave the place? Can you leave the place? (3) Has anyone ever tried to stop you from running away by telling you something bad might happen to you? Do you have any worries or concerns about your health or any injuries that need attention or a doctor? By following these questions, social workers might then consider the likelihood of the client’s victimization status. This preliminary assessment will help the social worker determine whether a client is a sex trafficking victim or might not occur in other settings.

Using these questions as starting points, social workers will need to ask follow-up questions and probe for additional details to discover the specifics of the client’s life situation and to determine the likelihood of whether the client is a sex trafficking victim. Social workers should also be mindful that even though sex trafficking victims often endure horrific treatment, child and adolescent trafficking victims might not be forthcoming about their life circumstances if they do not feel that they have a trusting relationship and positive rapport with the social worker. Accordingly, social workers should act to establish such a relationship before asking trafficking assessment questions.

What immediate services should social workers offer when they identify victims of sex trafficking? Social workers are required to report sex trafficking victims to child protective services (CPS, Polaris Project, 2010). Therefore, social workers should help the client develop an immediate safety plan to ensure the client’s well-being while child protection and anti-trafficking services are being put into place.

Social workers should be mindful that determining whether a client is a sex trafficking victim might not occur in other settings. Likewise, making a clear determination of a client’s victimization status might not be straightforwardly accomplished with multiple interviews. Accordingly, readers are encouraged to work through the topic of sex trafficking, as we as consult with community and national resources (e.g., CPS, Polaris Project) in advance of such interviews. In this manner, they can be prepared to ensure that they are as well trained as possible to conduct the interviews in such examinations, and to help clients with safety planning strategies.

CONCLUSION
Perhaps the most pressing aspect of sex trafficking is its ability to thrive in ordinary settings and remain undetected by many social work professionals. Readers should be mindful that the strategies provided in this article have not been tested empirically and that anti-trafficking services are needed and developing. Thus, the practices presented here are likely to evolve and extend as new strategies are developed and research is conducted. Nonetheless, these recommendations provide social workers with a starting place for helping the youngest and most vulnerable victims of the horrors of human sex trafficking.
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Using these questions as starting points, social workers will need to ask follow-up questions and probe for additional details to discover the specifics of the trafficking events, motivations, and to determine the likelihood of whether the client is a sex trafficking victim. Social workers should also be mindful that even though sex trafficking victims often experience horrific trauma, child and adolescent trafficking victims might not be forthcoming about their life circumstances if they do not feel that they have a treating relationship and positive rapport with the social workers. According, social workers should aim to establish such a relationship before asking trafficking assessment questions.

What immediate services should social workers offer when they identify victims of sex trafficking? Social workers are required to report sex trafficking victims to child protective services (CPS, Polaris Project, 2010).

Thus, once a social worker has determined that a child or adolescent is a sex trafficking victim, the social worker should contact the local child protection hotline. Social workers are encouraged to contact the National Human Trafficking Resource Center hotline (888-373-7888) for further information about sex trafficking and how to help victims. The Polaris Project (polarscope-ng.org/index.php) provides this resource hotline so that service providers can connect with anti-trafficking services in their communities as well as support training, technical assistance, and anti-trafficking information. Equally important, social workers should help the client develop an immediate safety plan to ensure the client’s well-being while child protection and anti-trafficking services are being put into place.

Social workers should be mindful that determining whether a client is a sex trafficking victim might not occur in one interview or conversation. Likewise, making a clear determination of a client’s victimization status might not be straightforwardly accomplished even with multiple interviews. Accordingly, readers are encouraged to set training on the topic of sex trafficking, as well as consult with community and national resources (e.g., CPS, Polaris Project) in advance of such interviews to ensure that they are as well trained as possible to conduct the interviews, make such assessments, and to help clients with safety planning strategies.

CONCLUSION

Perhaps the most pervasive aspect of sex trafficking is its ability to override ordinary settings and remain undetected by many social work professionals. Readers should be mindful that the strategies provided in this article have not been empirically examined and that anti-trafficking services are novel and developing. Thus, the practices presented here are likely to evolve and emerge as new strategies are developed and research is conducted. Nonetheless, these recommendations provide social workers with a starting point for helping the youngest and most vulnerable victims of the horrors of human sex trafficking.

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RESPONSE TO MINORITY OVERREPRESENTATION

Judge Regina Walter • Carol J. Harper, BSW, MPA

Sometime in 1995, after three years serving as a juvenile magistrate, I announced that the population of El Paso County, Colorado, was one-third white, one-third black, and one-third Hispanic. A friend suggested that I check my facts and asked that I “had been on the bench too long.” In reality, in 1990, less than 20 percent of the total population of El Paso County was comprised of people of color, not the population I saw daily in my courtroom was more than 60 percent minority. Until that time, I was completely unaware that minority overrepresentation (MOR) existed in the court system or that it existed within the public child welfare system. I was equally ignorant of the data that showed children of color often experienced poorer educational outcomes.

Twenty-three years later, sadly, MOR still permeates the juvenile justice, education, child welfare, and criminal justice systems, however, public systems and private organizations in El Paso County, Colorado, that are served by the Fourth Judicial District have actively attempted to correct the problem, and with the definitions that provide a framework for looking at the issue. Hill (2006) defined disproportionality as the level at which groups of children are present in the child welfare system at a higher or lower percentage or rate than they are present in the general population. He developed a “disproportionality index.” An index is calculated by taking the proportion of children in a given race and dividing it by the proportion of the child population for that same racial group for the given county region, or state. This calculation leads to ratio scores. The score ranging from 0.00 to 0.99 are indicative of underrepresentation; scores of 1.0 indicate no disproportionality; and scores of 1.5 and greater indicate overrepresentation. Thus, in a community where 40 percent of the children entering foster care are African American, and 20 percent of the child population are African American, the disproportionality index would be 2.0. This means that African American children are represented twice as often as foster care as they are in the general population. Scores can be calculated for foster care, child care, out-of-home care, or any type of care.

Table 1 provides data on the existence of MOR nationally and locally, provide a complex and nuanced picture of racial disparities. Based on a review of the research, McCarthy, president and CEO for Anne Casey (2011) made the following observations: “Relative to white children, kids of color are more likely to drift in care, less likely to be reconnected with families, more likely to experience group care, less likely to find a permanent family, and more likely to have poor educational, social, behavioral, and other outcomes. It is no surprise that they are less prepared to succeed in life. It’s fair to say that these disparities in outcomes line up all too well with the disparities in outcomes seen in other areas, such as poverty, housing, employment, and the criminal justice system.”

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Research has revealed that disproportionality can be the result of intentional bias, however, more often, it stems from unintentional individual and professional bias, or lack of knowledge, through practice and policy decisions that yield unintentional side effects and from institutional, economic, and geographic structures that reduce access to needed services. A review of the literature also reveals the complex nature of MOR. For example, MOR analysis ideally considers the relationship of poverty, age of the children, and race/ethnicity when it comes to incidents of child maltreatment and race of being case. The National Incidence Studies (NIS) examined the relationship of children in families with annual incomes below $15,000 were 22 times more likely to experience harm. Bureau and colleagues (2008) found that lower-income families, often families of color, are more likely to have their children removed from their homes than are families with more resources. Using data from the National Survey of Child and Adolescent Well-Being study, Adams and Boozma (2009) found that younger Hispanic children were more likely to be placed in out-of-home care than were their older counterparts. These results suggest that such factors as poverty and age have an impact on the level of disproportionality and disparate outcomes. Thus, current evidence provides an important as well as a complex and nuanced picture of racial disparities.

Table 1: Disproportionality Index of Children in Foster Care National

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<th>African American</th>
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A review of national educational outcomes from the 2009-2010 school year revealed that 87 percent of what students graduating from high school within four years of entering ninth grade as compared to 71 percent of Latino, 67 percent of Native American, and 66 percent of black students (Stillwell & Sable, 2013). In fact, in 2010 not until the 2010 school year that the national graduation rate for black males was more than 50 percent (Stillwell & Sable, 2013). The 2012 graduation data from the Colorado Department of Education reveal that the most populous school district in El Paso County has significant disparity graduation rates by race. Colorado Springs School District 11 had graduation rates as follows: 70 percent of white students graduated within 4 years as compared to 84 percent of Latino students, 46 percent of black students, and 45 percent of Native American students. In contrast, 73 percent of Asian students graduated within four years (Colorado Department of Education, 2013).

A contributing factor to the lower graduation rate among black student may be the disproportionate application of school discipline. During the 2009-2010 school year, one in every six black student was suspended from school, as compared to one in 14 Latin students, and one in 20 white students (American Council on Education, 2011). Further analysis revealed that black students are three times more likely to be suspended than their white peers as compared to 39 percent of black children and 31 percent of Latino children (U.S. Department of Commerce, Bureau of the Census, 2010).

Unfortunately, living in poverty is often a predictor for school failure, with 22 percent of children who live in poverty not graduating from high school. Communities, 94 percent of individuals who have never experienced poverty will graduate (Anne Casey Foundation, 2011).

A look at the poverty statistics for the state of Colorado demonstrates that they are comparable to national results: 9 percent of white children live in poverty as compared to 37 percent of black children and 31 percent of Latino children (U.S. Department of Commerce, Bureau of the Census). In fact, it was not until the 2010 school year that the national graduation rate for black males was more than 50 percent (Stillwell & Sable, 2013). The 2012 graduation data from the Colorado Department of Education reveal that the most populous school district in El Paso County has significant disparity graduation rates by race. Colorado Springs School District 11 had graduation rates as follows: 70 percent of white students graduated within 4 years as compared to 84 percent of Latino students, 46 percent of black students, and 45 percent of Native American students. In contrast, 73 percent of Asian students graduated within four years (Colorado Department of Education, 2013).

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of Color Summit: A Local Overrepresentation

Reanalysis and the Negative Impacts

Hispanic children were more likely to be placed in out-of-home care than were their white counterparts. These results suggest that such factors as poverty and age have an impact on the level of disproportionality and disparate outcomes. Thus, current evidence provides an important assessment of the complex and nuanced picture of racial disproportionality.

Based on a review of the research, Patrick McCarville, president and CEO for Annie Casey (2011) makes the following observations: “Relates to white children, kids of color are more likely to drift in care, less likely to be reunited with families, more likely to experience group care, less likely to find a permanent family, and more likely to have poor educational, social, behavioral, and other outcomes. It is not surprising that they are less prepared to succeed in life. It’s fair to see that these disparities in outcomes line up all too well with the disparities in outcomes seen in other areas, such as poverty, housing, employment, and the criminal justice system.”

Research suggests that disproportionality can be the result of unintentional bias; however, more often, it stems from unacknowledged individual and professional bias, lack of knowledge, through practice and policy decisions that yield unintentional side effects and from social, economic, and geographic situations that reduce access to needed services.

A review of the literature also reveals the complex nature of MOR. For example, MOR analysis should consider the relationship of poverty, age of the child, and race/ethnicity when it comes to incidents of child maltreatment and out of home care. The National Incidence Study (NIS) examined the incidence of child maltreatment and the rate of out of home care. Both children and families from rural areas with annual incomes below $15,000 were twice as likely to experience harm. Researchers found that lower-income families, often families of color, are more likely to have their children removed from their homes than are families with more resources. Using data from the National Survey of Child and Adolescent Well-Being study, Alcina and Rosenthal (2009) found that younger Hispanic children were more likely to be placed in out-of-home care than were their white counterparts. These results suggest that such factors as poverty and age have an impact on the level of disproportionality and disparate outcomes. Thus, current evidence provides an important assessment of the complex and nuanced picture of racial disproportionality.

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WHAT DOES CURRENT RESEARCH REVEAL?

National statistics for 2010 to 2011 indicate that 33 percent of white, 35 percent of black, and 33 percent of Latino individuals experienced poverty in the United States (Kaiser Family Foundation, 2011).

A review of the disproportionality index for the state of Colorado demonstrates that they are comparable to national results: 2.5 percent of white children are represented twice as often in foster care as they are in the general population. Scores can be calculated for various purposes (for example, entering care, exiting care, or remaining in care). One would use available census data for child population and the number of children in the child welfare system (by race), available from the Adoption and Foster Care Analysis and Reporting System (AFCARS). Table 1 provides disproportionality data for several groups for both 2000 and 2011 (National Council of Juvenile and Family Court Judges, 2013).

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A contributing factor to the lower graduation rate among black students may be the disproportionate application of school discipline. During the 2009–2010 school year, one in every six black students was suspended from school, as compared to one in 14 Latino students, and one in 20 white students (American Council on Education, 2011). Further analysis revealed that black males are three times more likely to be suspended than their white peers (American Council on Education, 2011). Evidence suggests that school discipline often pushes children out of school; a disproportionately large number of them are children of color, according to The Urgency of Now (2013). The report cited the results of several studies that showed that students who have experienced at least one suspension are more likely to leave school before the tenth grade than are students who have never been suspended.

A review of literature on MOR within the child welfare system reveals the following:

• **Overall, children of color have higher rates of open cases in the child welfare system.** According to the United States Department of Health and Human Services Administration for Children and Families, in 2009, 87 percent of confirmed unique victims were one of these three races or ethnicities: African American (22.3 percent), Hispanic (20.7 percent), and white (44 percent). However, victims that were African American, African American Indian or Alaska Native, and mixed race had the highest rates of victimization at 15.3, 11.6, and 12.4, respectively, per 1,000 children in the population of the same race or ethnicity.

• **Families of color receive fewer services.** Families of color across the nation have been found to be less likely to have contact with a child welfare social worker and to receive a full complement of services, including ancillary support and specialized treatment (Lobbe et al., 2006). Research also indicates that all racial groups—African American families are least likely to receive family preservation services and to experience reunification (U.S. Government Accountability Office, 2007).

• **Black and Native American children enter foster care at higher rates than do white children.** Although white children account for 79.9 percent of the national population, they comprised only 44 percent of children who entered care and 40 percent of the foster care population in fiscal year 2008. Meanwhile, that same year, African American children made up only 15 percent of the national child population, yet they comprised 26 percent of children who entered care as well as 31 percent of the foster care population. In addition, American Indian children made up 1.3 percent of the national child population, yet they comprised 2...
percent of children who entered care and lived in the foster care population (U.S. Census Bureau, 2006; U.S. Department of Health and Human Services, 2009).

- Children of color have longer lengths of stay in the system without permanence.
- Nationwide, according to the National Study of Protective, Preventive and Reunification Services (NSPPRS) findings indicate that African American children are nearly four times less likely to be reunified with their families than are white children (Hill, 2006). For example, African American children living in Illinois are more likely to stay in care than are children of other races and ethnicities (Rolick & Toto, 2001). This trend, seen in many other states, may be the result of several factors, including a decreased likelihood of both reunification and adoption for children of color (that is, African American) when compared with their white counterparts (Borth, 2005; Bowman et al., 2009; Texas Department of Family and Protective Services, 2010; Tennessee Health and Human Services Commission and Department of Family and Protective Services, 2006). In Texas, exits from kinship care are slower for both African American and Hispanic children than they are for white children (Texas Health and Human Services Commission Department of Family and Protective Services, 2006).

While the research regarding the relationship between poverty and education, and poverty and child welfare, is substantial, the disproportionate involvement of individuals of color in the juvenile/criminal justice system is also staggering. Nationwide, according to Puzzanchera and Kang (2013), of the approximately 871,000 youth/year appearing in juvenile court in 2010, for issues of delinquency, truancy, and other status offenses, 51 percent were black even though blacks represented only 14 percent of the total U.S. population. Puzzanchera and Kang (2013) also found that 56 percent of the 2010 juvenile court participants were minority youth. The table below (from the OMNI Report: Disproportionate Minority Contact within Colorado’s 4th Judicial District—Preliminary Report of Data and Potential Redirection Strategies [2011], from a study contracted for and by Colorado’s Fourth Judicial District, demonstrates the racial disparity within the particular juvenile justice system (El Paso and Teller counties, Colorado).

As Table 2 highlights, higher percentages of both Black and Hispanic providers are isolated and in detention than are white juveniles.

Data available from the Bureau of Justice Statistics (2011) for the criminal justice system also revealed similar patterns of minority overrepresentation. Seventeen percent of all incarcerated adults are persons of color. Currently, in the United States, there are 2.3 million adults in federal or state prisons. Of these incarcerated, the ratio of black inmates is 5.4 to every white inmate. The ratio of Latino inmates to white inmates is 0.8 to one. Similarly, the ratio in Colorado is a ratio of 6.6 Black inmates and 2 Latino inmates to every white inmate.

Even though the MOR issue is complex and additional research is required to refine our understanding of causal factors and the interconnections between and among various issues, the reality is that the phenomenon exists in our jurisdiction and has been demonstrated repeatedly. As a result, practitioners and decision makers in El Paso County felt they could not wait to act any longer, and we continue that effort to this day. We have data that document the inside of our system. As we write this article, 64 percent of the 29 of the 45 youth in the local detention center—non-white children of color (Harrison, 2013). There are 329 children of color that are in the juvenile system, 47 percent of our total population in out-of-home care (Carwood, 2013). The 2013 standardout scores indicate that 364 youth of color are reading below the third-grade level in our most populous school district. These children accounted for 61 percent of all third grade students not reading at grade level in Colorado Springs School District 11 (Colorado Department of Education, 2013).

HISTORICAL REVIEW OF EL PASO COUNTY’S ATTEMPTS TO CORRECT MOR

Like most communities, we started with conducting assessments and studies. Tracking and quantifying the MOR problem within El Paso County, which is served by the Fourth Judicial District, has taken place on a recurring basis since 1991. The first examination of the disproportionate representation of youth of color in detention was conducted and reported in the Fourth Judicial District Long Term Detention Needs Report. It was followed, in 1993, by a study completed by the Office of Juvenile Justice and Delinquency Prevention through the Colorado Division of Criminal Justice (DCJ). The purpose of that study was to determine whether MOR existed in those separate jurisdictions within the state of Colorado and to examine if necessary to 1997 the Center for Community Development and Design at the University of Colorado, Colorado Springs, was commissioned to identify the stages at which MOR exists and to report its findings in Disproportionate Minority Youth Contact: An Examination of the Fourth Judicial District. The 1997 report was followed by a 2004 report titled Disproportionate Minority Contact/Confimation: The Juvenile Justice System, El Paso County, funded by DCJ. Finally, in 2013, DCJ funded another study to examine the nature of youth across patterns within the state and provided the contact/confirment template. This report was titled OMNI: Disproportionate Minority Contact for Youth at the Point of Arrest in Colorado: Measurement, Monitoring, and Developing at that point and in Colorado. Every one of these studies demonstrated the existence and extent of MOR. The county/supervision’s response to the MOR findings from each of these studies varied; however, at every stage of the process, we struggled with the question “What do we do?” and “Is this making a difference?” One such response, in 1993, was the creation of the National Disproportionate Minority Confinement Taskforce, whose mission was to “audit...disproportionate minority confinement by directing research and implementing prevention and intervention efforts which address the causes of over representation for youth of color in the juvenile justice system.”

The jurisdiction received funding from DCJ to implement two intervention programs. Step-down grants (funded from 1999 to 1997) were provided for Ways One and Two to Tarrant Academies, two community-based agencies, to provide “mandated training” for youth of color and to provide an alternative to suspension and expulsion. DCJ also provided technical assistance to the Taskforce in the form of cultural competency training for the entire juvenile justice bench as well as a separate training for the juvenile court to include attorney, probation officer, public defenders, and members of the Department of Human Services who served delinquent youth. In addition, DCJ funded, in whole or in part, seven Train the Trainer sessions between 1997 and 2002. Each week long training session provided participants with the skills to, in turn, give four to eight hour training sessions for their organizations and for other organizations. Diversity training was delivered to several systems and organizations within El Paso County and throughout the state of Colorado. At one point, every juvenile branch employee in the state received the training. The Children’s Defense Fund also used this training. The culmination of this effort was the creation of a training manual in 2002, at the expense of DCJ.

In 2002-2003, the Fourth Judicial District was selected to serve as a model court by the National Council of Juvenile and Family Court Judges. Our mandate included addressing MOR in the child welfare system, as part of a national mandate for all model courts. Ultimately, in 2005, the Minority Overrepresentation Committee of the Model Court (now called the Best Practices Council) and the Taskforce continued efforts after we learned that we all too often dismiss the same families and children across systems. Under the auspices of the model court, concerted efforts were made to involve the neighborhoods from which many of the children were entering either by the child welfare and juvenile justice system. An initial approach involved forming parent/caregiver groups (meeting with mothers at each community’s student’s backpack), businesses, educators, and the faith community. However, and unfortunately, only one parent, one church, and a business showed up. The event was a failure except to the extent that it changed the focus. The next endeavor was to increase our emphasis on tracking down those in order to involve them in case plans in dependency and neglect cases and to enhance efforts to access kin in foster care. We also decided to “deep dive” like the Department of Human Services to determine what was wrong with our intervention. Why were children of color aging out of the foster care system without permanence or a disproportionate ratio? Why were the incarcerated in the Division of Youth Corrections at a rate that was higher than that of their white counterparts? What we discovered was that the data in our files was so rife with errors or missing information, it was often impossible to determine the race and ethnicity of a child or parent. We ultimately abandoned “deep mining” project with a recommender that data collection be improved.

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ON LESSONS LEARNED: EDUCATION AND CHILDREN OF COLOR SUMMIT

In 2007, as a result of our research findings, and our determination to make a difference—combined with further work at not having a tangible project—the Minority Overrepresentation Committee of the Best Practices Court decided to adopt a shared new approach to address the issue of MOR across our systems.

The approach focused on ensuring that children and youth have support to successfully achieve educational milestones, which are key to acquiring poverty and “our systems.” We also had the goal to encourage all youth to pursue higher educations, to support teacher to be successful educators, and to educate parents on what to take to be college ready and to hold their child and your child school accountable. As a result the first Educating Children of Color Summit took place in January 2008. The summit’s mission is to “achieve the cradle-to-prison pipeline for child of color, and children in poverty, through education.” Approximately 100 educators, students, parents, and juvenile justice and child welfare professionals attended the first event.
Like most communities do, we started with conducting inventories and studies. Stratifying and quantifying the MOR problem within El Paso County, which is served by the Fourth Judicial District, has taken place on a recurring basis since 1991. The first examination of the disproportionate representation of youth of color in detention was conducted and reported in the Fourth Judicial District Long Term Detention Needs Report. It was followed, in 1993, by a study completed by the Office of Juvenile Justice and Delinquency Prevention through the Colorado Division of Criminal Justice (DCJ). The purpose of that study was to determine whether MOR existed in those separate jurisdictions within the state of Colorado and to intervene if necessary. In 1997 the Center for Community Development and Design at the University of Colorado, Colorado Springs, was commissioned to identify the stages at which MOR exists and to report its findings on Disproportionate Minority Youth Contact: An Examination of the Fourth Judicial District. The 1997 report was followed by a 2004 report titled Disproportionate Minority Youth Contact/Confinement: The Juvenile Justice System, El Paso County, Colorado. Funded by DCJ, Finally, in 2011, DCJ funded another study to examine the nature of youth arrest patterns within the state and provided an address for the issues identified. This report was titled GRMI Disproportionate Minority Youth Contact for Youth at the Point of Arrest in Colorado: Measurement, Monitoring, and Trend Analysis. Of particular note, this report refuted the 1997 data and instead reported that the Child Welfare System, as part of a national mandatory pool of data, was the primary source of data. The results of this report were the creation of a training manual in 2002, at the request of the Colorado Springs School District, that was used to train parents/caregivers (sending the child welfare and juvenile justice system without permanence at a disproportionate rate). We discovered that the data in our file was so rife with errors or missing information, it was often impossible to determine the race and/or ethnicity of a child or parent. We ultimately abandoned that “deep mining” project with a recommendation that data collection be improved.

Our Current Approach, Based on Lessons Learned: Educating Children of Color Summer In 2007, as a model of our current findings, and our determination to make a difference—confronted with former or at having a tangible project—the Minority Overrepresentation Committee of the Best Practices Committee of the Minnesota Overrepresentation Committee of the Model Court (now called the Best Practices Court) and the Texas Association of Criminal Defense Lawyers, we launched our summer school program. In 2002–2003, the Fourth Judicial District was selected to serve as a model site by the National Council of Juvenile and Family Court Judges. Our mandate included addressing MOR in the child welfare system, as part of a national effort for all model courts. Ultimately, in 2005, the Minority Overrepresentation Committee of the Model Court (now called the Best Practices Court) and the Juvenile and Family Court Judges. Our mandate included addressing MOR in the child welfare system, as part of a national effort for all model courts. Ultimately, in 2005, the Minority Overrepresentation Committee of the Model Court (now called the Best Practices Court) and the Child Welfare and Juvenile Justice Committees of the Colorado Springs School District and the Colorado Springs Police Department have partnered in an effort to address the issue of MOR at the local level. The approach focused on ensuring that children and youth have support to successfully achieve educational milestones, which are key to escaping poverty and “our systems.” We made a goal to encourage all youth to pursue higher education, to support teachers to be successful educators, and to educate parents on what it takes to be college-ready and to hold your child and your school accountable. An Effie, the First Educating Children of Color Summer Summit took place in January 2008. The summit’s mission is to “infuse the cradle-to-prison pipeline for children of color, and children in poverty, through education.” Approximately 150 educators, parents, students, and juvenile justice and child welfare professionals attended the first summit.

Over the past six years, attendance has increased dramatically. In January 2013, we had 900 attendees, 500 of whom were youth, at the one-day summit. At the first summit, all participants attended the same session; at the 2013 summit, participants could select from approximately 60 sessions, including “Street Law to Law School” (youth) and “American Promise: A National Effort to Advance Black Male Achievement” (professionals and parents). The topics for youth included everything from financial aid to crime same investigations. Over the years, we have grown to 3,630 in-student scholarships to support access to higher education as well as 16 laptops.

In conjunction with the 2013 summit, ACT prep classes were offered to youth and a Diversity University was offered to professionals. The first ACT session began post-summit in January 2013 and continued through that April. The Diversity University, a five-course series, took place the week of July 22–26, 2013, when educators were not in school. Thirty participants attended the training that included educators, youth corrections officers, counselors, Department of Human Services (DHS) social workers, a researcher, the director of a not-for-profit for at-risk girls, and a county attorney who prosecutes child welfare cases. Like the original Train the Trainers, the Diversity University is designed to help individuals and organizations to leverage their power to address the problem by offering their work environments, and, ultimately, train others. Although teachers were not present, a dedicated effort to advance Black Male Achievement (professionals and parents) worked to provide social workers, the director of a not-for-profit for at-risk girls, and a county attorney who prosecutes child welfare cases. The original Train the Trainers, the Diversity University is designed to help individuals and organizations to leverage their power to address the problem by offering their work environments, and, ultimately, train others. Although teachers were not present, a dedicated effort to advance Black Male Achievement (professionals and parents) worked to provide social workers, the director of a not-for-profit for at-risk girls, and a county attorney who prosecutes child welfare cases.
As a jurisdiction, we have not yet been able to formulate and fund an evidence-based implementation that can definitively document that our efforts result in a decrease in the social determinants of achievement gap, a reduction of the number of children aging out of foster care, or a reduction in disproportionate confinement. But, our numbers are improving.

The youth and families of color who stand before us in our courts, who are reported to the child welfare system, and who struggle to meet educational standards are looking to us. We all have an ongoing responsibility to continue and refine our efforts to ensure educational attainment, a permanent loving home, and a life free of poverty and criminal activity for every youth.

Judge Regina Walter was appointed to the county court bench in August 2009. Prior to her appointment, she was a prosecutor in the Fourth Judicial District for 21 years. Previously, she was a deputy public defender with the Colorado State Public Defender’s Office. Judge Walter created the Fourth Judicial District’s Family Treatment Drug Court. She is a former chair of the Fourth Judicial District’s Best Practices Project. Since then she has been a member of the Marquette Disproportionality Workgroup at the Best Practices Council. Carol Walters can be reached at regina.walter@judicial.state.co.us.

The Colorado Department of Education’s website is https://www.cde.edu/.

Carol has her own independent consultant business, Social Visions. Carol is a member of the National Congress of Black Women. Carol is a member of the National Association of Social Work. Child Welfare League of America.


Gad L. Mayer, MPH, has more than 30 years of experience in research, evaluation, program implementation, curriculum development, professional development, and policy development in the areas of health, education, and social services, having worked in more than 30 states, the District of Columbia, and numerous countries within the United States. Carol Walters is a member of the National Association of Social Workers, Child Welfare League of America. The Order of the State United, Social Welfare, and Other Diverse Features Found in the United States—An Analysis of American Families and Children in the 21st Century, May 2010.


National Resource Center for Permanency and Family Connections: www.hunter.cuny.edu/socwork/nrcfcpp/.


Puzzanchera, C., & Kang, W. (2013). "Easy access to information they are given. Clients need to be given the order written on a prescription pad and handed to the client with only a written explanation of how to prepare? If it were important, then my provider must follow specific directions in order to prepare for them. Were those directions explained clearly to the client, or was the order written on a prescription pad and handed to the client with an oral explanation of how to prepare? Wren worked on a variety of medical and social services to clients and to remove children. Child Welfare, 82(1), 133–141.


HEALTH SPS

Health Literacy for Social Workers

A Cross-Cultural Approach

Robin Lennox-Dearing, PhD, MSW

Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and utilizes, the worth and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation, and other diverse factors found in individuals.—NASW, 2005 (p. 8)

Social workers help their clients function within their social environments, but addressing the medical environment—even though it is a part of a client’s social environment—can be very overwhelming and not to be understood. Nobody wants to be the person who doesn’t get it.

Another example of a client’s unfamiliarity with medical terminology is when they do not understand their medications’ names or know why they have been prescribed. Medications go by several names—generic name and possible several brand names. So, when clients see multiple physicians, they are prescribed a medication of the same type of one they are already taking resulting in an unintended double dose which may have critical results. Simplifying health care information into nonscientific terms may not be enough; clients need to understand their health care made as well as the steps to improve their health.

For a client who is unfamiliar with language, customs, and culture of medicine, the medical environment could deter
HEALTH SPS
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Social workers have skills in cultural awareness and cultural competence, in which social work practice respectfully responds to, and alleviates, the north and dignity of people of all cultures, languages, classes, ethnic backgrounds, abilities, religions, sexual orientation, and other diverse features found in individuals. "NASW, 2005 (p. 8)

Simplifying health care information is written at a tenth-grade reading level or above, client from seeking services unless absolutely necessary. The ability to navigate the health care environment successfully is called health literacy. Healthy People 2020, an initiative of the U.S. Department of Health and Human Services that provides science-based, near-term national objectives for improving the health of all Americans, defines health literacy as, "to the degree an individual has the ability to obtain, communicate, and navigate within. Providers must follow specific directives in order to prepare for them. Those directions explained clearly to the client, or was the order written on a prescription pad and handed to the client with understanding explanation of how to prepare for them. Another example of a client’s misunderstanding with medical terminology is when they do not understand their medications’ names or know why they’ve been prescribed. Medications go by several names—a generic name and possibly several brand names. So, what does multiplicity of names, which may have critical differences resulting in an unmeasured double dose which may have critical differences. Simplifying health care information into nonmedical terms may not be enough; clients need to understand their health care needs as well as the steps to improve their health. Social workers help their clients function in today’s busy practice environment, understanding the decision to provide education to those deemed to be mistreated children. Child Welfare, 55(2), 138-148.

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Medical social workers address health literacy issues on a daily basis. They maneuver within the medical environment between the clients and the medical staff. As primary professionals, social workers can use their cross-cultural skills to bridge cultural gaps between clients and the medical environment (NASW, 2007). Social workers ensure clients have all the information needed to make informed decisions about their health.

The basic values of social work are particularly applicable to health literacy concerns—such as recognizing the difficulty that clients have been acknowledged. In the provision of services. Social workers address health literacy in a variety of ways, from their own cultural dimensions to their work with clients in the medical environment. Social workers understand the importance of cross-cultural skills and their role in ensuring clients have all the information needed to make informed decisions about their health.

Social workers understand that clients have different health literacy levels, and they work to ensure clients have all the information needed to make informed decisions about their health. Social workers also ensure that clients have all the information needed to make informed decisions about their health. Social workers understand that clients have different health literacy levels, and they work to ensure clients have all the information needed to make informed decisions about their health. Social workers also ensure that clients have all the information needed to make informed decisions about their health. Social workers understand that clients have different health literacy levels, and they work to ensure clients have all the information needed to make informed decisions about their health.
Mental Health SPS

Addressing Hyperarousal in Trauma Work
Xue Yang, LCSW

Understanding the biological nature of trauma and how to help clients manage emotional dysregulation is significant for social workers. The body is the container for the trauma and has a built-in alarm system similar to alarm systems installed in our homes.

One of the main components to this alarm system is the autonomic nervous system (ANS), specifically, the sympathetic nervous system and parasympathetic nervous system. One can consider the brain as the command center, so when the ANS sends a signal to the brain, the brain then makes the decision. This process happens almost instantaneously, more quickly than the blink of an eye.

The DSM-IV-TR (2000) defines posttraumatic stress disorder (PTSD) as “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving actual or threatened death or serious injury, or a threat to one’s own physical integrity; or reexperiencing an event that involves death, injury, or threat to one’s own physical integrity; or witnessing in one’s own person the death, injury, or threat of death, injury, or tolerate to one’s own physical integrity. The symptom of reexperiencing the traumatic event can manifest as traumatic dreams, intrusive memories, and thoughts or images of the original trauma.

RESEARCH

Effective Communication Tools for Health Care Professionals

A free online learning experience designed to help health care professionals improve their patient communication skills, increase knowledge and confidence so they can effectively communicate with patients, and improve patient centered communication practices.

www emo cone ctedcmmsfor health provi ders/Quick Guide to Health Literacy

The goal is to provide a brief and easy reference for nurses for health literacy and provide their clients’ care at a professional and personal level.

Health Literacy Online

It is research based on tools developed by the US Office of Disease Prevention and Health Promotion (ODPP) to assess, train, and evaluate health literacy in the United States. It offers a way to access the HS and is available online. The tool is available online for free at www.healthliteracy.org.

NLM Standards for Cultural Competence in Social Work Practice


Lennon-Dearing, PhD, MSW, is an assistant professor at the University of Washington, Seattle, Washington, Department of Social Work. She is a licensed social worker and licensed counselor.

REFERENCES


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To understand why people who have suffered from trauma might be in a constant state of hyperarousal, we need to understand how the brain and the nervous system work. The brain can be fundamentally altered at or before these stages:

1. The amygdala, the front part of the brain that manages emotions and responses to acute stressors.
2. The hippocampus, the brain’s memory center.
3. The prefrontal cortex, the brain’s executive center.

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2. The hippocampus, the brain’s memory center.
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from the nervous system to the brain. Of course, this is a very simplified way of explaining what goes on in the brain. In the case of a house on fire: Panic! Get out! Of course, to do this requires the involvement of the autonomic nervous system (ANS) and the parasympathetic nervous system (PNS). As one goes from the emergency work of Peter A. Levine, PhD, Stephen Porges, MD, and many others from various fields can take place, and breathing is deep and relaxed (The Human Body Atlas, 2000, Porges, 2011).

We can now see this information to help our clients learn skills to regulate their hyperarousal states, thanks to the work of Peter A. Levine, PhD, Stephen Porges, MD, Jack Panksepp, PhD, and many others from various fields who have been studying and reporting on the body and the mind, and how they work together.

Pendulation is a concept from Levine’s work on somatic experiencing that describes how humans can actually swing from the lightfright mode to a more restful mood using the understanding that the SNS and PNS can pendulate out of high arousal activation. The SNS can be activated, this can cause the heart to quicken, the mouth to dry up, pupils to dilate, and limbs to tense in preparation for fighting or running. The PNS is activated when we are at rest and feel safe because there is no threat detected in the environment. The PNS conserves energy, digestion can take place, and breathing is deep and relaxed (The Human Body Atlas, 2000, Porges, 2011).

How does the work? Let us say that a client is working with a client who appears to be at a normal state of rest, but as the client begins telling her or his story, it is obvious that breathing is becoming shallow, his or her eyes are darting around more, and speech is getting faster. This is a person whose nervous system has been activated. The normal resting heart rate of an adult ranges from 60 to 100 beats a minute. When the heart rate goes to 100 and above, the body goes into “fight or flight,” and the parasympathetic nervous system (PNS) begins to process information as if there is a tiger in the room. The eyes dart around looking for dangers, the heart beats faster, breathing becomes shallow, the pupils constrict so that vision is more narrowly focused, and the mind’s goal is to find the danger and a path of escape; any words spoken to the person at this point will likely be experienced as an attack (Levine, 1997, 2005).

We can help clients out of this state of hypervigilance by teaching the client how to pendulate his or her nervous system. I do this with my clients by saying, “I can see how this is becoming difficult for you. Would you like to learn a skill that will help you manage what’s happening at this very moment?” The personal experience, I have not had anyone turn on the brain because most people who have suffered traumatic events in their lives have struggled with their hyperaroused state for years.

In this state, most people don’t understand what’s happening to them, and they feel out of control, unable to control their inability to affect different behaviors, and even that there is something dreadfully wrong with them. Once I have the client’s attention, I can gently guide her to turn her focus away from her panic by focusing her mind and attention on the furniture she is sitting on, the cushion that is supporting her, the chair she is sitting on, the weight of the shoes she has on her feet. Describing the client’s attention to the same outside the window or a picture on the wall, or simply having the client begin describing the house will affect the pendulation process.

Please suggest that the client describe to you in detail what they are looking at, what they are feeling in their feet or their legs, for example. This will help the client to actively engage his or her thoughts with the new elements. This process will move the client from the sympathetic to the parasympathetic state (Levine, 1997, 2005).

(A note here would be helpful about using the word “body” in trauma work. People can escape an unescapable situation by dissociating. At the moment of the trauma, the body is experienced as an unsafe place. When helping your clients with pendulation, language is important. Focusing the client’s attention on the external sensations such as the chair or the view outside the window brings them to a more neutral place. Even the word “body” can be triggering to many people.)

As the client becomes more engaged in the new stimuli, they will feel like they are not alone, and the therapist will notice the level of activation decreasing. Once the client breathes in a big sigh of relief or lets out a yawn and his or her breathing slows down, the client will have moved to a more restful place. This tool can be used over and over again to help clients pendulate out of high around activation to a more restful place or homeostasis.

Xian Yang, LCSW operates in private practice and now is a member of the National Health Specialty Practice Set fering trauma.

REFERENCES


PRIVATE PRACTICE SPS

Social Media Ethics in Social Work
Julie de Azevedo Hanks, MSW, LCSW, BCD

The Internet and social media offer social workers unprecedented opportunities to educate communities, to advocate for disadvantaged populations, to raise awareness about their private practice and professional services, and to establish themselves as experts in their specialty areas. Because people search online for health-related information, developing a strong online presence is increasingly important for social workers in private practice.

One aspect of developing an online presence is through social media. Although social media sites were often originally seen as “kid’s stuff,” that is no longer the case. For the first time in history, more than half of adults in the United States—65 percent—report using social networking sites like Facebook, Twitter, LinkedIn, and others. Even though these numbers are continuing to grow, many social workers remain uncertain about how to use and embrace social media as a valid professional activity. Fear regarding breaches of client confidentiality, potential dual relationships, and maintaining personal privacy are often cited as reasons for the hesitation. Professional associations struggle to provide guidelines about how to ethically respond to specific technology issues because technology changes so quickly, such as San Francisco psychologist Kirk Dolaison, but that doesn’t seem to be the existing rules don’t seem to apply in the digital world. Without clear guidelines for social media use, social workers and other mental health professionals are encouraged to engage in ongoing discussions about policy guidelines and use their own professional judgment in order to apply the current Code of Ethics in the digital world.

Social workers who blog, post on Facebook, or use Twitter, Pinterest, or any other social media should be deliberate in their behavior—mindful of the possible effects their online behavior may have on their clients and their careers.

Engaging in meaningful and ethical social media activities can further the advancement of the core social work values: service to people in need, promotion of social justice, adherence to the dignity and worth of each person, education on the importance of human relationships, demonstration of integrity and trustworthiness in online behavior, and demonstration of a commitment to professional competence (NASW, 1999). Here are some suggested guidelines to help social workers engage in ethical social media use.

There’s no such thing as absolute privacy or anonymity. Privacy breaches in large corporations or agencies are frequently reported in the news, and they show that no matter how vigilantly you safeguard digital information, leaks can happen. The only way to guarantee your online privacy is to refrain from posting anything online. Because opting-out of the digital world is rarely an option, it’s important to be mindful that your online activities, including social media, can have the potential to be seen by others.

Be transparent in social media use. There are many personal and professional uses for social media. Clarifying your purpose and your goals can help you make informed decisions about your digital presence.
2. The Internet and social media offer social workers unprecedented opportunities to educate communities, advocate for disadvantaged populations, and reach audiences about their private practice and professional services, and to establish themselves as experts in their specialty areas. Because people search online for health-related information, developing a strong online presence is increasingly important for social workers in private practice.

One aspect of developing an online presence is through social media. Although social media sites were often originally seen as “kid’s stuff,” that is no longer the case. For the first time in history, more than half of adults in the United States—45 percent—report using social networking sites like Facebook, Twitter, LinkedIn, and others. Even though these numbers are encouraging to clients, many social workers are confused about high arousal activation or to a more restful place. This tool can be quickly guide her to take her focus or thoughts with the new stimuli. This process will move the client from the sympathetic state to the parasympathetic state (Lavina, 1997, 2005).

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As the client becomes more engaged in the new attack, they will feel and the therapist will notice the level of activation decreasing. Once the client breaches a big sigh of relief or looks out a window and has her breathing slows down, the client will have moved to a more restful place. This tool can be used over and over again to help clients pendulate out of high arousal activation to a more restful place or homeostasis.

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Engaging in meaningful and ethical social media activities can further the advancement of the core values service to people in need, promotion of social justice, affirmation of the dignity and worth of each person, education on the importance of human relationships, demonstration of integrity and stewardship in our online behavior, and demonstration of a commitment to professional competence (NASW, 1999). Here are suggested guidelines to help social workers engage in ethical social media use.

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Be intentional in social media use. There are many personal and professional uses for social media:

- Clarifying your purpose and your goals for engaging in each social networking activity is an important part of ethical social media use. What is your goal in setting up this account? What kinds of information do you want to share? Who are you trying to reach with this account? Developing a clear rationale and specific goals for engaging in personal and professional social media activities will help you gain the goals you set for yourself.

Private Practice SPS

Social Media Ethics in Social Work Practice

Julie de Andrade Hanks, MSW, LCSW, RCD

The Internet and social media offer social workers unprecedented opportunities to educate communities, advocate for disadvantaged populations, and reach audiences about their private practice and professional services, and to establish themselves as experts in their specialty areas. Because people search online for health-related information, developing a strong online presence is increasingly important for social workers in private practice.

One aspect of developing an online presence is through social media. Although social media sites were often originally seen as “kid’s stuff,” that is no longer the case. For the first time in history, more than half of adults in the United States—45 percent—report using social networking sites like Facebook, Twitter, LinkedIn, and others. Even though these numbers are encouraging to clients, many social workers are confused about high arousal activation or to a more restful place. This tool can be quickly guide her to take her focus or thoughts with the new stimuli. This process will move the client from the sympathetic state to the parasympathetic state (Lavina, 1997, 2005).

(A note here would be helpful about using the word “body” in trauma work. People can escape an inescapable situation by dissociating. At the moment of the trauma, the body is experienced as an unsafe place. When helping your clients with pendulation, language is important. Focusing the client’s attention on external sensations such as the chair or the view outside the window brings them to a more neutral place. Even the word “body” can be triggering to many people.)

As the client becomes more engaged in the new attack, they will feel and the therapist will notice the level of activation decreasing. Once the client breaches a big sigh of relief or looks out a window and has her breathing slows down, the client will have moved to a more restful place. This tool can be used over and over again to help clients pendulate out of high arousal activation to a more restful place or homeostasis.

Engaging in meaningful and ethical social media activities can further the advancement of the core values service to people in need, promotion of social justice, affirmation of the dignity and worth of each person, education on the importance of human relationships, demonstration of integrity and stewardship in our online behavior, and demonstration of a commitment to professional competence (NASW, 1999). Here are suggested guidelines to help social workers engage in ethical social media use.

There’s no such thing as absolute privacy or anonymity. Privacy breaches in large corporations or agencies are frequently reported in the news, and they show that no matter how vigilant you safeguard digital information, leaks can happen. The only way to guarantee your online privacy is to refrain from posting anything online. Because opting out of the digital world is rarely an option, it’s important to be mindful that your online activities, including social media, have the potential to be seen by others.

Be intentional in social media use. There are many personal and professional uses for social media:

- Clarifying your purpose and your goals for engaging in each social networking activity is an important part of ethical social media use. What is your goal in setting up this account? What kinds of information do you want to share? Who are you trying to reach with this account? Developing a clear rationale and specific goals for engaging in personal and professional social media activities will help you gain the goals you set for yourself.

Separate personal and professional social media accounts.

After you’ve developed a clear intention for your social media usage, create separate personal and professional accounts and profiles. For example, on Facebook, once you set up a personal profile, you can set up a separate professional business page for your private practice. Separating accounts into personal and professional helps protect your personal information and helps establish your professional online presence.

Stay informed about privacy settings.

Familiarize yourself with the privacy settings for each social media account and check frequently for updates. Privacy settings are not static, and may change over time. Use the highest level of privacy settings on your personal accounts in order to protect your personal information. For professional

privacy settings, the more informed you are about the specifics of your privacy settings, the more effective you’ll be in protecting your personal information.
accounts, use privacy settings on the lowest level so that more people can find your private practice/business information.

Be cautious when posting about work on social media. Every social worker has difficult days, but venting on social media is not the best venue for processing challenging work situations. In addition to being cautious about posting about your personal responses to work, never post information about clients, period. The well-being of clients and respect for the therapist-client relationship should guide your social media activities.

Develop a social media policy for your practice. Developing a social media policy for your private practice is an excellent way to clarify for yourself and for your clients what you do and how you will be engaging professionally in social media. Components of a social media policy may include information about branding, following, interactives, business review sites, location-based services, use of search engine, and preferred method of communication (Kolmes, 2010).

Social workers need not be reluctant to engage in social media as professionals—as long as they are aware of how to protect their own and their clients' privacy, to protect the client-therapist relationship, to be intentional in social media activities, and to develop a comprehensive social media policy.

Social Media by the Numbers:

- Facebook: 1.35 billion users
- Twitter: 330 million total users
- LinkedIn: 400 million users
- Instagram: 200 million users
- Pinterest: 200 million users
- Google+ : 120 million users
- YouTube: 1 billion users

Julie de Avennes, RN, MS, LCSE, RDN, is a member of the Promote Practice Speaking Practice Section serving committee. She is the owner and executive director of Maruthi Health Family Services. She can be contacted by e-mail at julie.deavenes@maruthihealth.com

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School Social Work SPS

Eating Disorders in Schools

Lynn Bye, PhD • Bridget Nines

School social workers are typically called to be advanced generalists, and responding to eating disorders should be among their many competencies. School social workers and support staff must be aware of the common signs of eating disorders and take precautions to protect the students in their schools. Eating disorders can present serious physical and emotional obstacles to learning. They also have the highest mortality rate among all mental disorders (Galton, 2009; Keel & Herzog, 2004). According to the South Carolina Department of Mental Health, 93 percent of the individuals with eating disorders are between the ages of 12 and 23 (South Carolina Department of Mental Health, 2004)—a statistic that verified students' higher risk for eating disorders. Therefore, such disorders should be a particular area of concern for school social workers.

Eating disorders can be easily overlooked because of many misconceptions about them. Disordered eating symptoms are typically identified in white, adolescent girls; however, eating disorders, such as anorexia nervosa and bulimia nervosa, are mental disorders that are found in people of all races and ages (National Eating Disorders Association, 2005). Eating disorders are not gender selective; neither is it true to believe a male or female cannot have an eating disorder (Galton, 2009; Keel & Herzog, 2004).

Many factors contribute to developing an eating disorder. Students may feel pressure from the media to be thin, have a genetic predisposition, learn behaviors from friends or family, suffer from a high volume of stress, experience a traumatic event, or desire control or influence over aspects of their lives (Galton, 2009; Keel & Herzog, 2004). Eating disorders are not gender selective; neither is it true to believe a male or female cannot have an eating disorder (Galton, 2009; Keel & Herzog, 2004).

Schools and other public community programs have the power to treat eating disorders (Lee, 2007). A school should be a safe environment where students feel comfortable about their cultural identities, religion, and appearances. Schools must provide students with a solution of health and wellness programs, because a solid education in health will support life-long wellness. Arial, physical education programs to athletic, skills that can take away on the build endurance, strength, and flexibility. Furthermore, after-school programs such as hobby groups or intramural

NATIONAL ASSOCIATION OF SOCIAL WORKERS 2014 NATIONAL CONFERENCE

JOIN US IN WASHINGTON, DC FOR NASW’S 2014 LEADERSHIP CONFERENCE. This is no ordinary conference. Some of the brightest leaders on the Waldorf of social work are coming. Network with 2,000 colleagues and earn up to 25 CEUs.

LEARN & BE INSPIRED BY THE KEYNOTE SPEAKERS:


STEVE PEMBERTON: Chief diversity officer and divisional vice president at Wegmans. Fortune magazine put him on their list of the “Top 20 Chief Diversity Officers” in corporate America.

ROBERT REICH: Economic analyst, professor, and commentator. Reich was Secretary of Labor during the Clinton Administration. Time magazine named him one of the 10 most effective cabinet secretaries of the 20th century.

What to look for:

- Odd eating habits–restrictive, selective, refusal
- Fasting or dieting
- Declining academic performance
- Enlarged bathroom mirrors
- Poor concentration
- Chronic fatigue
- Frequent bathroom visits
- Fasting or dieting
- Preoccupation with food
- Mood changes, depression
- Rapid or cyclic weight change
- Eating alone
- Odd eating habits–restrictive, selective, refusal
- Declining academic performance
- Enlarged bathroom mirrors
- Poor concentration
- Chronic fatigue
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SCHOOL SOCIAL WORK SPS

Eating Disorders in Schools

Lynn Bye, PhD • Bridget Nines

School social workers are typically called to be advanced generalists, and responding to eating disorders should be among their many competencies. School social workers and support staff must be aware of the common signs of eating disorders and take precautions to protect the students in their schools. Eating disorders can present serious physical and emotional obstacles to learning. They also have the highest mortality rate among all mental disorders (Galton, 2009; Keel & Herzog, 2004). According to the South Carolina Department of Mental Health, 93 percent of the individuals with eating disorders are between the ages of 12 and 23 (South Carolina Department of Mental Health, 2004)—a statistic that verified students’ higher risk for eating disorders. Therefore, such disorders should be a particular area of concern for school social workers.

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The screening could include questions about other mental health disorders, such as depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, substance abuse, and physical and sexual abuse. Such questions are important because eating disorders have high comorbidity with other mental disorders (Riddle, 2011; Poirier et al., 2008). Survey results will direct an appropriate response, using the three-tier model. A small number of students may need more intensive assessment related to referrals to mental health care. Other may benefit from group discussions on how to handle stress, choose healthy foods and portion sizes, and create exercise plans (Collaghan, 2004; Passi et al., 2008; O’Shea, 2008).

Schools and other public community programs have the power to treat eating disorders (Lee, 2007). A school should be a safe environment where students feel comfortable about their cultural identities, religion, and appearances. Schools must provide students with a solution of health and wellness programs, because a solid education in health will support life-long wellness. Arial, physical education programs to athletic, skills that can take away on the build endurance, strength, and flexibility. Furthermore, after-school programs such as hobby groups or intramural
Media by the Numbers: People of All Races and Ages (National Eating Disorders Association, 2004).


School Social Work SPS

Eating Disorders in Schools

Lynn By, PhD • Bridget Hines

Social workers in schools are typically called to be advocates of all students, to identify eating disorders and respond to such disorders. Eating disorders can be easily overlooked because of many misconceptions about them. Disordered eating symptoms are typically identified with obesity, adolescent girls; however, eating disorders, such as anorexia nervosa and bulimia nervosa, are mental disorders that are found in people of all ages and races (National Eating Disorders Association, 2003). Eating disorders are not gender specific, but rather common to persons of either gender (Galen, 2009; Keel & Hering, 2004).

Many factors contribute to developing an eating disorder. Students may feel pressure from the media to be thin, have a genetic predisposition, learn behaviors from family or friends, suffer from a high volume of stress, experience a traumatic event, or develop control or perfection in their lives (Kane, 2007). Eating Disorders Association, 2004). Whatever the factor or combination of factors, the disease community members itself in abnormal eating behaviors, fear of gaining weight, irregular exercise or purging habits, and a distorted body image (American Psychiatric Association, 2000).

What to look for:

• Eating alone
• Drinking excessive water
• Rapid or cyclic weight change
• Mood changes, depression
• Odd eating habits—contractive, selective, refusals
• Fasting or slaving
• Declining academic performance
• Frequent bathroom visits
• Post concussive
• Chronic fatigue
• Preoccupation with food
• Dieting

A good first step toward confronting eating disorders in schools is to determine the scope of the problem within the student population. Screen for disordered eating behaviors with such tools as the body mass index (BMI) calculator, the Eating Attitudes Test, the Questionnaires of Influences of the Aesthetic Beauty Model, the Questionnaire of Nutrition, the Clinical Eating Disorder Rating Instrument, or the Eating Disorder Examination (Shepherd, 2008, Bardick et al., 2008). The screening could include questions about other mental health disorders, such as depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, substance abuse, and physical and sexual abuse. Such questions are important because eating disorders have high comorbidity with other mental disorders (Renfrew, 2011; Pisetsky et al., 2008). Survey results will direct the appropriate response, using the three-step model. A small number of students may need immediate assessment and referrals to mental health care. Others may benefit from group discussion on how to handle stress, choose healthy foods and portion, and create exercise plans (Callaghan, 2004, Fadij et al., 2008; O’Dera, 2000).

Schools and other public community programs have the power to treat eating disorders (Lau, 2007). A school should be a safe environment where students feel comfortable about their cultures, identities, religions, and appearance. Schools must provide, students with a selection of healthy foods at affordable prices, because a solid education in health will support long life health. Also, physical education programs teach athletic skills that can reduce stress and build endurance, strength, and flexibility. Furthermore, after-school programs—such as hobby groups or intramural sports teams—help support a positive atmosphere and demonstrate the school’s commitment to healthy living. 

Besides health and physical education, as integrated overall curriculum can highlight the importance of holistic health in everyday lessons (O’Dera & Maloney, 2000). For example, science teachers can explain how the human body uses energy to function. Social studies teachers can encourage students to research and critically think about new topics in health, such as sustainable farming and organic foods. Art teachers can give students avenues to express their emotions in creative projects or to reflect on what is truly beautiful. Social workers can work alongside these instructors in their incorporate healthy life skills into lessons; however, social workers and educators should be careful to avoid a specific discussion on symptoms of eating disorders—such as symptoms during or after eating techniques—because such information can trigger the mechanics of eating disorders might trigger copies of anorexia (Bardick et al., 2008; Reardon, 2013). A collaborative effort will provide the greatest defense against eating disorders.
Students with eating disorders need particular attention. School social workers are challenged to take the leadership role in intervention and to reach those students who are at high risk for developing a long-term, dangerous mental health disorder.

Lynn Bye, PhD, is an associate professor in the HPW program at the University of Minnesota—Duluth. She worked for seven years as a school social worker and has conducted research with children and youth on obesity and mental health. Lynn is a graduate student in the University of Minnesota—Duluth's School of Social Work. She teaches several courses in the health-promoting schools framework.

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PREVENTION AND CARE

It is imperative that individuals who are at risk for eating disorders receive appropriate intervention. This can be accomplished through a variety of means, including individual and group therapy, family therapy, and medication management. In addition, schools and communities can play a crucial role in identifying and addressing eating disorders. By implementing prevention programs and providing resources for individuals at risk, schools can help mitigate the potential negative consequences of these disorders.

The human rights perspective provides a framework for understanding the experience of people with eating disorders. It recognizes the importance of addressing not only the individual's health needs but also the societal factors that contribute to these issues. This approach empowers individuals to reclaim their autonomy and dignity, and works to ensure that they have access to the resources and support they need to recover.

In conclusion, eating disorders are complex and multifaceted issues that require a comprehensive and holistic approach to prevention and care. By combining evidence-based treatments with human rights principles, we can work towards creating a more equitable and just society for all individuals.
Advocates of human rights, we promote belonging to every human being—human rights. Those essential rights—desired change when dealing with particular attention to empowerment enhance human well-being with work profession’s primary mission is to participation. These are the foundation of rights, self-determination, and provide modern principles in terms of people take precedence over social the principle that the rights of the universe are the tenets of human rights (NASW, 2012).

The pledge to human rights is clearly expressed in current international social work documents and codes of ethics. International associations of social work educators and practitioners endorse all United Nations human rights conventions and provide modern principles in terms of rights, self-determination, and participation. These are the foundation for strengths-based empowerment (Cemlyn, 2008). The NASW Code of Ethics Preambles tells us that the social work profession’s primary mission is to enhance human well-being with particular attention to empowerment (NASW, 2008). It is in this strengths-based empowerment that results in real and lasting change, and this is the desired change when dealing with human rights. These essential rights—belonging to every human being—empower all people and strengthens self-determination, which are the tenets of the social work profession.

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CIRCUIT COURT IN THE CRITICAL ROLE OF THE D.C. CIRCUIT COURT IN NATIONAL POLICY

The D.C. Circuit is one of twelve regional Appellate Courts that hear cases from the United States Courts of Appeals. The D.C. Circuit Court reviews cases involving constitutional questions, administrative law, and other matters of Federal importance. It is also known as the D.C. Circuit Court. The D.C. Circuit Court is widely regarded as a critically important court in the United States, next to the U.S. Supreme Court. The following statement from Sen. Patrick Leahy (D-VT) is indicative of how this particular court is viewed:

*"...the unique character of the D.C. Circuit's caseload means that it isIncluded to compare its workload to that of the other Circuits. The D.C. Circuit Court of Appeals is often considered “the second most important court in the land” because of its special jurisdiction and because of the important and complex cases that it decides. The Court reviews complicated decisions and rulings of many Federal agencies, and in recent years has handled some of the most important terrorism and enemy combatant detention cases since the attacks of September 11."

"All cases are not the same and many of the hardest, most complex and most time-consuming cases in the Nation are up at the D.C. Circuit. " (Sen. Patrick Leahy)

SOCIAL WORK & THE COURTS SPS

President Obama Nominates Three

Malvin Wilson, MBA, LCSWC

It has been widely reported that President Obama has taken the extraordinary step of nominating three individuals to fill the remaining vacancies of the U.S. Court of Appeals for the District of Columbia Circuit (also known as the D.C. Circuit Court). This step is extraordinary because:

1. There is a critical need to fill all the vacancies on this important court and
2. Submitting multiple nominations is a White House strategy to protect against filibustering against the President’s judicial nominees.

PRESIDENT OBAMA’S NOMINEES

The three nominees include highly qualified candidates who are diverse in terms of gender and ethnicity.


While the concern for the composition and completeness of filling judicial vacancies is noteworthy, why should this issue particularly interest social workers? The answer is directly linked to the National Association of Social Workers’ commitment to social justice and human rights through its strong core ethics and values.

THE CRITICAL ROLE OF THE D.C. CIRCUIT COURT IN NATIONAL POLICY

The D.C. Circuit is one of twelve regional Appellate Courts that hear cases from the United States Courts of Appeals. The D.C. Circuit Court has the authority to hear cases involving constitutional questions, administrative law, and other matters of Federal importance. It is also known as the D.C. Circuit Court. The D.C. Circuit Court reviews cases involving constitutional questions, administrative law, and other matters of Federal importance. It is also known as the D.C. Circuit Court.
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**PRESIDENT OBAMA’S NOMINEES**

The three nominees include highly qualified candidates who are diverse in terms of gender and ethnicity. The nominees are:

- **Patricia Ann Millett**, a white woman who is a prominent appeals lawyer in Washington, D.C., Carville Fleet, a white woman who is currently a highly regarded law professor at Georgetown University, and **Robert Leon Wilkins**, an African-American man who was appointed to the United States District Court for the District of Columbia in 2009. Judge Wilkins successfully argued a milestone racial profiling case (Wilkins v. Maryland) in 1994 before the U.S. Supreme Court.

**RESOURCES**

- **American Bar Association (ABA)**
  - www.abanet.org
  - An international, membership-driven organization that supports human rights learning, the framing of access and advocacy, the development of educational materials and programming, and community building through online technologies.

- **Amnesty International**
  - www.amnesty.org
  - A global movement of more than three million supporters, members, and activists in more than 150 countries and territories who campaign in defense of human rights.

- **Human Rights Watch**
  - www.hrw.org
  - An international nongovernmental organization that protects human rights through online technologies.

- **UNESCO**
  - www.unesco.org
  - A specialized agency of the United Nations (UN). Its stated purpose is to contribute to peace and security by promoting international understanding, respect for human rights, and other values.

- **Avery International**
  - www.avery.com
  - A global manufacturer of identification labels through superior design, service, and quality.

- **National Social Work**
  - www.socialworkers.org/pubs/code
  - A publication of the National Association of Social Workers.

- **NATIONAL POLICY ON HUMAN RIGHTS**
  - www.amnesty.org

- **THE CRITICAL ROLE OF THE D.C. CIRCUIT COURT**
  - www.courts.gov

- **THE AFFORDABLE CARE ACT (ACA)**
  - www.courts.gov

**SOCIAL WORK & THE COURTS SPS**

President Obama Nominates Three to DC Circuit Court: Why Should Social Workers Care?

Melvin Wilson, MBA, LCSWC

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A federal appeals court in Washington upheld the Obama administration's health care law on Tuesday in a decision written by a prominent conservative jurist. The decision came as the Supreme Court is about to consider whether to take up challenges to the Affordable Care Act, a monumental legislative achievement of the administration. Of four appeals court rulings on the health care law so far, this is the third to deal with the law on the merits, and the second that upheld the Affordable Care Act. The United States Court of Appeals for the District of Columbia Circuit in Washington issued the 37-page opinion by Judge Laurence H. Silverman. In the opinion, Judge Silverman, who was appointed by President Ronald Reagan, described the law as part of the fundamental

CONSEQUENCES OF A LACK OF IDEOLOGICAL BALANCE OF CURRENT D.C. CIRCUIT COURT

In addition to its major health care related decision, the D.C. Circuit Court has significant responsibility for deciding cases regarding the balance of powers of the branches of government and actions by federal agencies that affect our health and safety. For organizations and advocacy groups that are deeply concerned about protections and access to services for the many vulnerable individuals in our society, there is a push for rulings from the D.C. Circuit Court that are more favorable to needs of their constituents. Therefore, the ideological makeup of the court is of concern.

There is a general consensus that the D.C. Circuit Court has become more conservative due to the fact that even though the eight active judges on the D.C. Circuit Court are split between four Republican-appointed judges and four Democratic-appointed judges, all five of senior judges (who are semi-retired) are Republican-appointed (American Constitution Society, www.acslaw.org/studio/guests/2012/05/09/story-on-conservative-dc-circuit-court-nominations). All senior judges care and often do sit on the D.C. Circuit’s three-judge panels to rule on a wide range of cases.

As a result, some of recent decisions of the D.C. Circuit Court have:

• Rolled back environmental protections.
• Undermined labor rights, and
• Rolled back environmental protections.

RECENT D.C. CIRCUIT COURT RULINGS CONFLICT WITH SOCIAL WORK SPEAKS

Social Work Speaks, 2012-2014 (NASW, 2012) presents basic statements on several key legal opinions made by D.C. Circuit Court's conservative majority. Most of the court's rulings were contrary to the positions taken in Social Work Speaks. A comparison of Social Work Speaks positions of and the Court’s decisions follows:

• **Environmental Protections**: In 2012, the D.C. Circuit Court struck down an Environmental Protection Agency rule intended to control air pollution that crossed state lines. According to the EPA, in 2016 alone the rule would have prevented 13,000 to 14,000 premature deaths, 15,000 non-fatal heart attacks, and 1.8 million annual days of school and work. Social Work Speaks’ basic statement on Environmental Justice is fundamentally in opposition to the court’s position. Adverse health conditions due to air pollution disproportionately impact low-income and minority populations (News America Media, http://newsamericaonline.org/2012/11/minorities-pest-breathe-worse-air-pollution-study-finds.php). To that end, Social Work Speaks states that “Fair treatment (in environmental justice) means that no population, because of policy or economic disempowerment, is forced to bear a disproportionate burden of the negative human health or environmental effects of pollution or other environmental consequences resulted from industrial, municipal, or commercial operations…” (NASW, 2012, p.425).

• **Worker Rights and Consumer Protections**: In 2013, the Court invalidated the President’s three recess appointments to the National Labor Relations Board, under reasoning that would also invalidate an appointment to the Consumer Financial Protection Bureau. This decision was contrary to other court’s rulings and 150 years of recess appointments— including 141 such appointments during the presidencies of Barack Obama and George W. Bush alone. The Court also ruled in 2011 that an NLRB rule requiring employers to inform workers of their legal rights violates the employees’ First Amendment rights. Wall Street Reform: In 2011, the Court placed an unnecessarily high standard on the Securities and Exchange Commission and struck down a key Wall Street Reform regulation that would have made it easier for shareholders to propose their own nominees to corporate boards of directors.

• **Social Work Speaks addresses these issues in the context of Economic Justice. From an Economic Justice standpoint, the position taken by the D.C. Circuit Court’s Wall Street Reform ruling would be an anathema to social workers. Social Work Speaks refers to “America’s new economy” (NASW, 2012, p.237) as being one where there are vast economic disparities between the richest one percent of Americans and the rest of the population.

• **Health Protections**: In 2012, the Court struck down an FDA cigarette warning label regulation, citing the First Amendment rights of cigarette companies.

• On the issue of health protections, Social Work Speaks takes a broad comprehensive position on access to health care, health disparities and health policies. The FDA cigarette warning case was struck down by the D.C. Circuit Court as a preventative health issue. Social work advocates for all efforts to prevent life altering health conditions that often disproportionately impact low-income and minorities more severely than the general population.

The juxtaposition of the recent rulings of the D.C. Circuit Court on key socio-economic issues with the stated positions in Social Work Speaks is stark. The philosophy and morality of judges about major issues that impact millions of people matters. It is often the case that the functions, impact and responsibilities of the federal judiciary (including the Supreme Court) is something that falls distant to most Americans. However, social workers have a long history of placing social justice and human rights at the forefront of their professional ethos and values. The power of the D.C. Circuit Court and other of the federal courts in the judiciary is such that its rulings can either impede the advancement of social justice or become the defenders of rights of the country’s vulnerable and disempowered populations.

The White House’s nominations of Patrick Ann Miller, Cornelia Pillard, and Robert Leon Wilk would seem to be a major step forward for bringing philosophical balance to the D.C. Circuit Court of Appeals.