CHALLENGES FOR SOCIAL WORK PRACTICE WITH SEVERE MENTAL ILLNESS: RESULTS OF A NATIONAL SURVEY

Christina E. Newhill, Ph.D., LCSW, BCD

Introduction
Developing and maintaining effective services for persons with severe and persistent mental illness is a top priority for the public mental health system today (U.S. Dept. Health & Human Services, 1999; O'Neill, 2000; Winerip, 1999; NIMH, 1991; U.S. Dept. Health & Human Services, 1988). Success in reaching this goal is dependent on the ability to identify and support a cadre of professionals in the various mental health disciplines who are both willing and well-trained to work with severely ill consumers (O'Hare, 1997; Hogarty, 1991; Lefley, 1988; Anthony, Cohen & Farkas, 1988). Social workers are the primary providers of clinical services to consumers with severe mental illness, particularly in resource-poor areas (O'Neill, 1999; Werrbach & DePoy, 1993; Sands, 1991). In fact, recent federal data indicate that social workers comprise the largest group of direct services mental health professionals in the country (SAMHSA, 1998).

Because of the pivotal importance of social work service in the public mental health arena, it is critical to determine the training needs and obstacles to retention of social work practitioners in working with those consumers with the greatest mental health needs. A few studies have examined social work students' interests in and attitudes toward work with persons with severe mental illness, suggesting that students generally hold positive perceptions (Werrbach & DePoy, 1993). However, whether such positive attitudes and commitment are maintained following graduation has not yet been determined. In response to this lack of information, we conducted a national random survey of 2000 National Association of Social Workers members who identified themselves as post-M SW direct services practitioners with mental health as their primary practice area (Newhill & Korr, in press).

Methods
Respondents were identified by a computerized random selection procedure from the national NASW membership directory. Following one initial mailing in January 1997 and two follow up mailings at three week intervals, we obtained a return rate of 60 percent (1204 usable questionnaires). We defined severe and persistent mental illness as including schizophrenia, major mood disorders, obsessive-compulsive disorder, and severe personality disorders (NIMH, 1991). The survey questionnaire included both closed- and open-ended items addressing the following five research questions:

• What challenges, frustrations, obstacles, and difficulties do social workers encounter in working with consumers with severe mental illness (SM I)?
From the Chair

Welcome to the first issue of the NASW Specialty Practice Section for Mental Health. I would like to take the opportunity to introduce the Mental Health Section Committee members and briefly share our goals. All of the committee members maintain contact through e-mail and occasional conference calls. Our most important objective is to identify the needs of our members. We hope that once you read the current newsletter, you will send us your thoughts and ideas about how we can best support your professional growth and fund of knowledge. The Mental Health Section will publish two newsletters annually, including a section for members to speak on topics of concern or interest. Members are invited to submit articles to be considered for publication in the newsletter. Additionally, we hope you will take advantage of our members only Mental Health Section Web site, an important resource for information and connecting with your colleagues. We welcome your input and ideas. Please feel free to contact us by e-mail.

Sincerely,

Barbara A. Conniff, ACSW
Chair and Editor, NASW Mental Health Section
MEET THE MEMBERS OF THE MENTAL HEALTH SPECIALTY PRACTICE SECTION COMMITTEE

Barbara A. Conniff, ACSW

Barbara A. Conniff, ACSW, has been the Chief Executive Officer for Allegheny East Mental Health/Mental Retardation, a community-based mental health center in Pittsburgh, Pennsylvania, for 13 years. She and her team have successfully fostered change in the culture and practice of behavioral health services. Barbara is also the President and CEO of PACT, a private behavioral health practice owned by Allegheny East, which also manages a 52-bed inpatient Psychiatric Unit at Forbes Regional Hospital. Barbara knows how to form and sustain collaborative partnerships with other social service organizations and large health care organizations. She received her MSW in 1976 from the University of Pittsburgh and holds her ACSW credential. She has served on the Advisory Board for Carlow College, Department of Social Work for seven years and the Admissions Committee for four years. Barbara is the Chair of the NASW Mental Health specialty practice section.

Gwendolyn Strong Scott, ACSE, LMSW-ACP, BCD

Gwendolyn Strong Scott, ACSE, LMSW-ACP, BCD, received her MSW from the University of Oklahoma. She currently maintains a private practice specializing in addictive disorders, women’s issues, and marriage and family therapy and is an active provider of services for several Managed Care Organizations. In addition, Gwen is an Adjunct Professor in the Social Sciences and Humanities Department at the University of Houston, Clear Lake and downtown campuses and has served as a reviewer for several textbooks on Child Development Child Psychology.

Gwen’s experience also includes management of addictive disorders programs and other mental health programs in the social services community of Houston. She has served as a consultant for the Houston area Women’s Center; and as a faculty member at the Annual Institute of Alcohol and Drug studies, sponsored by the Texas Commission on Alcohol and Drug Abuse. Gwen is the author of several articles on Substance Abuse and Domestic Violence. Gwen served as the Chair of the Houston Unit of NASW and on the NASW/Texas Chapter Board of Directors. She currently serves on the NASW Professional Development and Advocacy Committee. Gwen is a strong supporter of ethics and professionalism in the social work profession, and is very active in the community as an advocate for social work reforms.

Gail M. Johnson, MSW, LCSW

Gail M. Johnson, MSW, LCSW, is presently a Clinical Associate Professor and field liaison at the University of Wisconsin-Milwaukee. She also teaches courses on ethics and supervision within the curriculum and in the community for professionals obtaining continuing education hours. Gail received her BA in social work from the University of Wisconsin-Madison and her MSW from the University of Wisconsin-Milwaukee. She is currently past-president of NASW-WI and previously served as the South-East Branch Chair in Wisconsin. In her thirty-five years of social work, Gail has been privileged to practice in child welfare, child psychiatry, public mental health (direct and administrative) and in her own private clinic before joining the Helen Bader School of Social Welfare.

Lana Sue Ka’opua, Ph.D., ACSW

E aloha pumehana kakou. Warmest greetings and thank you for the dedicated work you do on behalf of so many. I am pleased to be a

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committee member of the Mental Health Section. My hope is that you will feel as though you can contact me with matters relevant to our Mental Health Section.

NASW. I joined NASW as a graduate student in 1980. Since then I have served in various local and national capacities. Through involvement with the national HIV Spectrum Mental Health Training and Education of Social Workers Project, I have collaborated with many fine social workers from across the county. What an invaluable opportunity to learn about our profession’s diversity, as well as our shared commitments. Equally rewarding is working our chapter board to address the five P’s: policies, politics, practice standards, professional recognition, and protection of title.

Current Work. My 22 years of mental health/health practice grounds my current work as a researcher in psychosocial oncology. As faculty at the University of Hawai‘i, Cancer Research Center, my work is aimed at developing family and community interventions to promote mental health/health among Native Hawaiians and other medically underserved groups. Na Lei Pulama (Cherish Our Beloved Ones) is a current project involving the use of orho’oponopono, an indigenous healing method to enhance coping among Native Hawaiian women newly diagnosed with breast cancer and their families. I am also involved in developing community collaborations to promote breast cancer screening among older, women associated with Hawaiian faith-based communities. As a researcher-practitioner, I believe that community partnerships strengthen the research-practice link. Please contact me at Lkaopua@crch.hawaii.edu if I may be of assistance in supporting your needs in this area.

WELCOME TO THE 21ST CENTURY!

Gwendolyn Strong Scott, ACSW, LMSW-ACP

The National Association of Social Workers closed out the 20th century in high style with the celebration of the 100th anniversary of the social work profession. Throughout 100 years of milestones, we tried to exemplify the high standards that NASW set for the Social Work Practitioner.

These standards were generally aimed at enriching and enhancing individual and group development, and alleviating adverse social and economic conditions. We worked hard to provide care for abused or neglected children; rehabilitated the physically, mentally, and emotionally challenged; and extended financial aid to the aged and those who live in poverty. Social workers were involved in treatment, counseling, and direct-service activities to help those individuals with mental and emotional disorders, to rehabilitate those with disabilities, or to provide preventive services to enhance their quality of life.

Over the last century, we saw our profession become better defined. Formerly, all philanthropic and charitable activities, including those of untrained, civic minded individuals, were regarded as social work. Such activities focused primarily on solving the immediate problems of the indigent and did little to change the conditions that caused those problems. Throughout the past century, however, social research made possible
analyses of the social and economic maladjustment’s of modern society, and the activities of social workers were coordinated to achieve the maximum benefit both for individuals in need and for the entire community.

Now, as we move forward into the 21st century, the mental health profession will face many new challenges—challenges brought about by social reforms resulting from proponents of social legislation; managed care companies, as they become more actively involved in how social work services are delivered; and through an increase in activities of social planners conducting research and helping to develop meaningful social welfare policy.

We will continue to be employed in family service agencies, medical and psychiatric hospitals and clinics, public agencies, substance abuse treatment facilities, and industrial settings. Social workers will provide services through such agencies as the United Way and its affiliated agencies, YMCA, YWCA, and the American Red Cross. The Council on Social Work Education will continue its important work to accredit schools of social work to train students in collaboration with social work agencies, and to obtain supervised experience in actual professional practice concurrent with their academic work. At the national level, the Association will continue its effort to provide emphatic leadership and direction for the coordination of social work policy. Mental health professionals will enhance their skills, effectiveness, and productivity through continuing education.

As strong advocates of professional ethics, we must maintain a high standard of professionalism. My charge to you is that as we continue into the new millennium, each of you becomes familiar with the ethical responsibilities of our profession as it relates to all aspects of mental health service delivery. My challenge to you is that clients’ self-determination, the protection of human life, and enhancing the quality of life become three values to which social workers become committed. How social workers deal with these issues will provide us with our greatest ethical and professional challenges.

Finally, in order for us to be successful in this new millennium, we must be totally committed. Our commitment must include:

• Competent delivery of services;
• Licensing;
• Adherence to the NASW Code of Ethics and accompanying standards;
• Involvement in professional organizations;
• Involvement in civic and community mental health organizations; and
• Active political involvement: Knowing who our congressional representatives are and how they stand on issues that are relevant to our profession as well as to the people we serve.

I hope that you are as excited about our future as I am.

Gwendolyn Strong Scott, ACSW, LMSW-ACP BCD, is an adjunct professor in the Social Sciences and Humanities Department at the University of Houston and a private practitioner specializing in addictive disorders, women’s issues and marriage and family therapy. She can be reached at gwenscottmsw@msn.com.

The NASW Code of Ethics and Standards are available online at www.socialworkers.org.
HEALTH AND MENTAL HEALTH SCREENING OF CAREGIVERS OF DISABLED AND CHRONICALLY ILL COMMUNITY DWELLING ELDERLY: IMPLICATIONS FOR SOCIAL WORKERS

Goldie Kadushin, MSW, PhD

Introduction
Decreasing mortality rates and the ageing of the Baby Boom generation—those seventy-five million babies born in the United States between 1946 and 1964 (Hobbs & Damon, 1996)—are projected to double the number of persons age 65 and older by the middle of the next century. As age increases so does the probability of having multiple chronic conditions.

Elderly individuals experiencing chronic conditions are also likely to experience functional limitations or difficulty performing personal care and home management tasks (Hobbs & Damon, 1996). Of those individuals age 65 and older, 16.5 million or 50 percent were classified as disabled by the U.S. Census Bureau Survey of Income and Program participation in 1999 (U.S. Department of Health & Human Services, 2001). As a result of these trends, and the fact that the disabled community-dwelling elderly receive the majority of their assistance from informal caregivers, increasing numbers of middle-aged adults are likely to be providing more physically and psychologically demanding care to surviving relatives for a longer period of time than previous generations (Hobbs & Damon, 1996).

Caregiving can be defined as informal or unpaid care activities that exceed the normative and customary care that comprise the routine obligations and social expectations between family member or friends (Kramer & Thompson, 2002). The influence of caregiving on the individual is referred to as “burden.” Although there is no standard definition of burden, it generally includes the emotional, psychological, physical, and financial impact of caregiving on the individual as well as the subjective appraisal of how the performance of these tasks affects the life of the caregiver (Kane & Kane, 2000).

The development of burden is explained through the application of stress-coping models of caregiving. These models suggest that if an environmental event is appraised as threatening and there is a lack of resources to reduce the threat, there is an increased likelihood of negative outcomes such as caregiver burden. The stress-process model is based on the concept of stress “proliferation,” or the spread of stress from care provision to other areas of life (e.g., work, family relations, finances, and mental health) (Kane & Kane, 2000).

As the number of community-dwelling disabled elderly individuals continues to grow and increasing numbers of individuals assume the caregiving role, social workers in all practice settings will require the ability to screen individuals who are at high risk for the development of caregiver burden and negative mental health outcomes arising from burden.

The following discussion reviews research published within the last ten years (1992-2002) that examines factors associated with caregiver burden and depression among caregivers of the community-dwelling chronically ill or disabled elderly (individuals age 50+) residing in the United States. Research examining caregiver burden and depression among caregivers of individuals with Alzheimer’s disease and dementia is excluded because the amount of research on this topic is beyond the scope of this review and because this literature has been analyzed in other publications (Schulz, 2000).
Burden

Background variables

Background or contextual variables may influence the appraisals of caregiving demands. Kinship status is associated with levels of caregiver burden. Wives and daughters are at higher risk of caregiver burden than other relatives. Wives, compared to husbands, are more involved in the caregiving role and are more likely to restrict their social and personal lives to provide caregiving than husbands (Bookwala & Schulz, 2000; Mui, 1995b). Adult daughters experience higher levels of burden than other relatives, including spouses, because they experience a high level of stress in attempting to balance caregiving commitments with family roles, work roles, and personal life (Faison, Faria, & Frank, 1999; Ingersoll-Dayton, Starrels, & Dowler, 1996; McKinlay, Crawford & Tennstedt, 1995; Mui, 1995a; Seltzer & Li, 1996).

Caregivers who report poorer physical health experienced higher levels of burden (Bookwala & Schulz, 1998; Bull, M aruyama & Luo, 1995; Fredman, Daly & Lazur, 1995; Fredman & Daly, 1997; Mui, 1995b; Mui & Morrow-Howell, 1993) in all studies that measured this variable with one exception (Dorfman, Holmes & Berlin, 1996).

There is no consistent empirical evidence supporting an association between race/ethnicity and caregiver burden among caregivers of impaired elders (Fredman et al., 1995; Mui, 1995a; Ory, Hoffman, Yee, Tennstedt & Schulz 1997; Phillips, Komnenich, Kileen & Rusnak, 2000). Future research is needed to develop standardized measures that capture ethnic differences in the experience of caregiver burden (Calderon & Tennstedt, 1998).

Primary objective stressors

Primary objective stressors refer to the impact of the care recipient’s illness on the caregiver. Higher levels of patient physical impairment (e.g., ADL/IADL impairment) were positively associated with burden in eight studies (Bookwala & Schulz, 1998; Browning & Schirrman, 1994; Bull et al., 1995; Dorfman, Holmes & Berlin, 1996; Faison et al., 1999; Fredman et al., 1995; Martian Ritter & Deimin, 1996) and had no relationship to burden in three studies that measured this variable (Bull, M aruyama & Luo, 1997; Mui, 1995a, Seltzer & Li, 1996). Patient problem behaviors resulting from cognitive impairment (e.g., asking repetitive questions, swearing, falling down, agitation, wandering) were positively associated with burden in all studies that examined this variable (Bookwala & Schulz, 1998; Browning & Schirrman, 1994; Lawrence, Tennstedt & Assmann, 1998; Mui, 1995a; Mui, 1995b; Reidel, Fredman, & Langenberg, 1998; Seltzer & Li, 1996).

Primary subjective stressors

Primary subjective stressors refer to the caregiver’s appraisal of caregiving demands. The caregivers’ appraisal of the level of elder disability may influence the level of caregiver involvement in caregiving. Significantly, the level of caregiving involvement (hours spent on caregiving and/or amount of task assistance provided) is positively associated with levels of burden in all studies that measured this variable (Bookwala & Schulz, 2000; Bull et al., 1997; Dwyer, Lee & Jankowski, 1994; Fredman et al., 1995; Kramer & Kipnis, 1995; Mastrian et al., 1996; McKinlay et al., 1995; Ory et al., 1999; Reidel et al., 1998).

Research also documents a significant negative association between levels of burden and the quality of the relationship with the

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care recipient among spouses such that high levels of burden are associated with impairment in relationship quality, suggesting that the strain of caregiving may impair the feelings of closeness between spouses (Bookwala & Schulz, 2000; Mui, 1995a; Mui, 1995b; Mui & Morrow-Howell, 1995; Spaid & Barusch, 1994).

Reciprocity provided by the care recipient in the form of emotional support or task exchanges (baby sitting, companionship, help with household chores) has been associated with lower levels of caregiver burden (Dorfman et al., 1996; Dwyer, Lee & Jankowski, 1994; Ingersoll-Dayton, Starrels, & Dowler, 1996; Wright & Aquilino, 1998). Reciprocation of help by the care recipient may communicate empathy, affection, and appreciation of the caregiver's efforts and so may contribute to adaptation of the caregiver's role (Dorfman et al., 1996).

An outcome that has been less frequently documented is a positive appraisal of the caregiving experience. The research of Kinney, Stephens, Franks and Norris (1996) and Reidel et al., (1998) suggests the importance of an awareness of the caregiver's perception of satisfaction and rewards in providing care so that strengths can be identified and validated (Kramer, 1997).

Mental Health Outcomes

Depression is the mental health outcome most frequently measured in the caregiving research. The proportion of caregivers to the community dwelling elderly experiencing clinical depression is estimated to range from one quarter to one third (Li et al., 1999; Tennstedt, Cafferata & Sullivan, 1992). Depression levels among these caregivers is higher than levels of comparable community samples, but lower than depression levels for Alzheimer's caregivers or psychiatric outpatients (Tennstedt et al., 1992; Toseland, Blanchard, & MccAllion, 1995).

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Background variables

With regard to contextual variables, levels of caregiver depression are positively associated with gender (female) (Bookwala & Schulz,
2000; Tennstedt et al., 1992; Tower, Kasl & Moritz, 1997); age (younger caregivers) (Schwarz & Roberts, 2000; Li et al., 1997); poorer health (Raveis, Karus & Siegel, 1998; Tennstedt et al., 1992; Li et al., 1997); and negatively associated with levels of education (Raveis et al., 1998; Li et al., 1999).

Primary objective stressors
In several studies, higher levels of elder disability were associated with more caregiver strain, which in turn was associated with higher levels of depression (Bookwala & Schulz, 2000; Beach, Schulz, Yee & Jackson, 2000; Yates et al., 1999). One study found a positive association between care recipient problem behaviors and caregiver depression (Bookwala & Schulz, 2000).

Primary subjective stressors
Research reveals a strong positive association between various measures of caregiver burden or strain and caregiver depression (Chang et al., 1998; Lawrence et al., 1998; Noonan & Tennsted, 1997; Raveis et al., 1998; Schwarz et al., 2000; Tennsted et al., 1992; Wallhagen, 1992). However, an increase in the amount of help provided with caregiving tasks has also been related to decreased depression, possibly because a caregiver may derive some mental health benefit from helping a parent or spouse in need (Raveis et al., 1998; Beach et al., 2000). These findings suggest that involvement in caregiving may have both positive and negative effects on mental health.

Mediators and moderators
Mediators and moderators of the relationship between stressors and depression include quality of the relationship, social support, sense of mastery, and use of coping strategies. Quality of the relationship between caregiver and care recipient is an important mediator of the relationship between care recipient cognitive impairment and resulting problem behaviors and caregiver depression (Bookwala & Schulz, 2000; Chang et al., 1998; Lawrence et al., 1998; Townsend & Franks, 1995; Williamson et al., 2001; Yates et al., 1999). Caregivers of elders with cognitive impairments and problem behaviors are more likely to have a poor relationship with the elder and therefore experience higher levels of depression.

One explanation for these inconsistent findings is that the effects of support are not uniform, but are influenced by the fit between the type of stress, the type of support, and the context (Li et al., 1997). There is no consistent evidence that formal or informal support mediates the effect of caregiving stress on depression (Yates et al., 1993; Tennstedt et al., 1992), or that it moderates it (Schwarz et al., 2000).

Caregiver sense of mastery (Fingerman et al., 1996; Li et al., 1999) and use of problem-focused coping (Li et al., 1999) has been associated with decreased levels of depression among caregivers.

Conclusions
In summary, caregivers who are female, younger, in poor health, and who provide care to more impaired care recipients are at high risk of experiencing caregiver burden and depression. Caregiver burden is strongly related to depression since burden suggests a negative appraisal of the caregiving situation involving feelings of loss and overload. The quality of the relationship with the care recipient, the provision of appropriate informal support, and a sense of mastery mediates and/or moderates the influence of the stress of caregiving on burden and depression. While caregiving more frequently results in negative outcomes, among some individuals caregiving may be rewarding, or associated with positive consequences for mental health, or both.

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MENTAL HEALTH NEWS AND RESOURCES

The President’s New Freedom Commission on Mental Health was established by Executive Order 13263 on April 29, 2002. The commission is tasked with making recommendations to improve the U.S. mental health service system for adults with serious mental illness and for children with serious emotional disturbances. The commission will accomplish this by reviewing both public and private sectors to identify policies that could be implemented by federal, state and local governments to maximize existing resources, to improve coordination of treatments and services, and to promote a full life in the community for people with mental illness. The commission’s recommendations will be presented in its final report, which is scheduled to be released in April or May of this year. The final report will be posted on the commission’s Web site at www.MentalHealthCommission.gov. The commission’s final recommendations will not likely include a call for more funding for mental health services, but will instead focus on enhancing existing services and programs that are working well and reducing regulatory barriers. The commission’s interim report, which described the public mental health system as “in shambles” is also available on the Web site as is additional information about the commission.

SAMHSA’s Center for Mental Health Services (CMHS), Office of Organization and Financing, regularly compiles state and national news on current information and emerging trends in public sector behavioral healthcare services in Behavioral Health Headlines. These editions contain abstracts articles from over 150 newspapers and describe new national reports on public sector behavioral healthcare services. Behavioral Health Headlines is available on the web at: www.samhsa.gov/sbhh/viewcurrent.asp. The database can be searched by state, issue, date, or keyword.

The Open Society Institute’s Project on Death in America has awarded NASW a grant to increase social workers’ knowledge in palliative care, end-of-life care and grief work. NASW’s Executive Director, Dr. Elizabeth J. Clark, will serve as the project director. Dr. Clark has experience in research, education and practice in health, oncology social work, and loss and grief care. NASW will develop social work end-of-life care practice standards; disseminate the standards widely through the NASW Web site, Specialty Practice Sections and chapters; develop a continuing education course based on these standards; and draft a policy statement for consideration at the 2005 Delegate Assembly.

WINNING TAG LINE

The winning tag line for the Mental Health Section is: New Perspectives

Thanks to all the participants who voted!
• What are social workers’ attitudes toward practice with consumers with SMI?
• What are the greatest sources of satisfaction and reward for social workers who work with consumers with severe mental illness? What aspects of practice with consumers with SMI are least satisfying professionally and personally?
• What knowledge and skills do social work students need for practice with persons with severe mental illness today and in the future?
• What unique contributions can social workers provide for consumers with SMI?

Findings

The sample was predominantly female (80 percent) and Caucasian (94 percent) with a mean age of 49. On average, respondents had 20 years of practice experience, with an average of over ten years of experience with severely mentally ill consumers. Over 90 percent reported that their main practice function was direct services.

A primary research goal for the study was to identify the challenges, frustrations, obstacles, and difficulties that social workers encounter in working with consumers with severe mental illness. Such identification could suggest areas that must be addressed by public mental health policy makers if we want to succeed in recruiting and retraining professionals for public mental health services. The survey respondents reported essentially two categories of challenges: (1) challenges related to the consumers themselves, and (2) challenges related to “the system.” Below is a summary of what was reported.

Challenges related to consumers:

• When consumers violate personal boundaries via manipulative behavior, trying to merge with their social worker, when they’re intrusive;
• Consumers with personality disorders who cause constant disruption, do not benefit much from treatment, do not take responsibility for their behavior;
• Consumers who abuse substances;
• Slow progress; when treatments do not seem to work; and dealing with chronic illness;
• When consumers decompensate, fail treatment, leave treatment, are no-shows, or are difficult to engage in treatment;
• When consumers are not compliant with treatment, (e.g. consumers who go off their medication repeatedly or need repeated hospitalization);
• Working with consumers who threaten staff, potentially violent consumers, and consumers who cause worry about personal safety; and
• Negative family issues; for example, unrealistic family expectations.

These challenges clearly indicate the need for appropriate training. Working with consumers with severe mental illness requires a different set of expectations and different approaches to treatment than treatment for less severe disorders. Targeted SMI training can enable the practitioner to meet the challenges such consumers present with competence and, ultimately, enhance the probability of a successful outcome.

Challenges related to the system:

• High case loads, too many duties not associated with direct consumer care such as administrative duties, excessive paperwork, etc.;

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• Problems with colleagues including: those who focus on pathology only; those who do not act professionally; those who do not support one another; those who engage in poor management and/or supervision; or those who evidence incompetence that is not resolved;

• Problems dealing with systems other than mental health, e.g. dealing with the legal system, the drug/alcohol system, etc.;

• Continued stigma toward consumers, lack of community acceptance of mentally ill consumers, private mental health providers’ negative attitudes toward severely ill consumers; and

• Burn out; having to be available regardless of personal needs for space; consumers constantly in crisis and needing support off hours.

These system challenges are not easily solved. Some may be overcome through a systematic overhaul of the fragmented community mental health service system, while others require the enlightenment and education of the public about mental health issues and mental illness. Leadership from social work supervisors and managers, however, can begin the process of change. This change must begin at the top—from agency directors, and county and state policy makers.

We also asked respondents to rate on a five-point scale 12 items relating to potential frustrations in practice with SMI consumers. The highest mean scores (indicating the most frustration) were given to managed care regulations (M =4.6) and difficulty in obtaining community resources (M =4.11), both systems’ problems. In contrast, the lowest ratings were given to consumer characteristics: passivity, dependency, and bizarre behavior (M =2.58); and failure of consumers to improve and/or stabilize (M =2.68). Clearly the systems’ problems were viewed as the most burdensome.

At the conclusion of the questionnaire, we asked respondents an open-ended question about what unique contributions they thought social workers could make for consumers with severe mental illness. In spite of all of the challenges noted by the survey respondents, many were very articulate about the special contributions that social workers could make to public mental health practice. The following are some of their thoughts:

• “Social workers are unique in their ability to bridge the gap between the institution and the community, to advocate for individuals. Social workers have a knowledge base that includes understanding of the person as well as the interface with the community and community resources.”

• “Sometimes I see social workers as being the ‘explainers’—what the doctor said to the consumer, what community mental health would like to have done, what meds worked before, where would you like to live, this is what your family worries about, etc. Sometimes I think we’re the only ones who listen!”

In summary, our data suggest that social workers in mental health continue to be committed to working with and providing the best service to those consumers who are most in need, i.e. consumers with severe mental illness. Social workers have not abandoned their mission, as some have suggested (Specht & Courtney, 1994), but continue to forge ahead in spite of sometimes overwhelming systems’ obstacles to accomplishing their mission. Our results make us feel proud of our profession and its continued commitment to serving those members of society who are most in need.

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References


HIPAA HIGHLIGHTS FOR SOCIAL WORKERS

We encourage you to visit NASW’s new online resource center, HIPAA Highlights for Social Workers available at www.socialworkers.org/hipaa. Check the Web site regularly for new information as it is added. Features of this Web site include: a general overview of HIPAA; online privacy training courses for CE credit; sample forms and policies; links to NASW HIPAA practice updates, legal analysis and guidelines; NASW slide show on the HIPAA Privacy Rule; FAQs about the Electronic Transactions Standards and Code Sets; links to helpful government resources such as the Covered Entity Decision Tool (how to determine whether you are a “covered entity” under HIPAA); and links to the text of the HIPAA Privacy Rule.
ARTICLE SUBMISSION GUIDELINES

• Articles must be submitted to the section’s editors at bconniff@aemhmr.org and amj@uwm.edu.

• Articles must be submitted by the author in a format that is suitable for printing in the newsletter. While the section editor and the NASW staff editor will review the document, the author is expected to submit the article in a format that does not require major content and grammatical revisions.

• Articles should be no more than three single-spaced pages.

• In-text citations with page numbers must be listed in the reference list when a direct quote is included.

• A short biography (included at the end of the article) should indicate the authors name, degree, certifications, affiliations, and e-mail address.

• Articles must be submitted in Microsoft Word format.