WHAT'S INSIDE: Articles dealing with Inclusion & Equity

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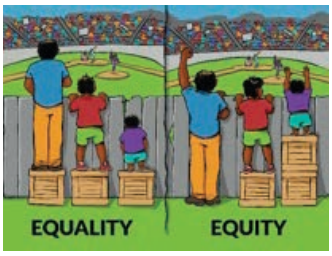
The Need for Equity in the Fight for Equality

In the United States, the civil rights movement became the catalyst for providing equal rights to all people, but especially to people of color. Though trodden with racial discourse, America in the 1960s was willing to take a hard look at itself and address sensitive issues related to discrimination and bigotry. Outcomes from this movement included the Civil Rights Act of 1964, the end of Jim Crow laws, and school desegregation. African Americans also acquired voting rights that were once denied to them.



*Interaction Institute for Social Change
Artist: Angus Maguire.

No one will dispute that the United States accomplished a lot in terms of equality during the 1960s; however, in the 21st century we still find ourselves dealing with the racial juggernauts of the past. For example, African American males are still being incarcerated at a disproportionate rate, and the gentrification of communities of color within major U.S. cities is becoming frighteningly commonplace. One might ask: Why aren't we further along in our quest for equality? Perhaps one answer is that we, as a country, should have considered how equity affects equal rights.

Equality and *equity* are terms that are often used interchangeably, but their meanings are different. Equality addresses sameness, whereas equity addresses fairness. Equality without equity inevitably leaves someone at a disadvantage, as the illustration shows.

This annual bulletin will discuss why equity matters in addressing racism and the other "isms" that we face. It also considers prevalent societal disparities and explores what can be done to make sure that fairness is applied cross culturally. Finally, one will find articles that consider ways to incorporate inclusion practices so that marginalized people can be protected and heard.

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Addiction to Activism: Recovery Is the Thing

Donald McDonald, MSW

The American Society of Addiction Medicine (ASAM) recently revealed its strategic plan for 2018 through 2021 in which it strengthens its focus on the *full* spectrum of addiction care: prevention, treatment, remission, and *recovery*. The inclusion of recovery as the ultimate potential within the addiction spectrum, distinct from remission, affirms what many have known for decades: Recovery can mean more than the absence of problematic alcohol and drug use from an otherwise unchanged life. This inclusion also arguably marked the most significant development in addiction treatment philosophy since ASAM defined addiction as a primary chronic disease of the brain in 2011. We learned in *The Surgeon General's Report on Alcohol, Drugs & Health* (2016) that every dollar invested in treatment and recovery saves $4 in health care costs and $7 in criminal justice costs. Such an inarguably rich return on investment *ought* to prompt an immediate transition from systems of punishment to systems of care. It has not. Even more, an additional return on investment exists when we get *better than well*. I am living proof. On October 12, 2019, I will celebrate 15 years of continuous recovery. Life keeps getting better.

Return on Investment

Historically, little has been known about recovery from addiction. In fact, sustained recovery as the desired outcome of addiction treatment has largely remained an afterthought. In response to a call for recovery focused research, Faces and Voices of Recovery, the national recovery advocacy organization, in collaboration with Dr. Alexandre Laudet, conducted the first nationwide survey to document the benefits of recovery for individuals, families, and communities. The key findings of the *Life in Recovery* survey (Laudet, 2013) involve dramatic improvements in all areas of life: healthier/better financial and family life, higher civic engagement, dramatic decreases in public health and safety risks, and significant increases in employment and work. Specifically, when comparing recovery experiences with those of an active substance use disorder, the survey found:

- Paying bills on time and paying back personal debt increases by 50 percent
- Fifty percent more people pay taxes when in recovery

- Planning for the future (e.g., saving for retirement) increases nearly threefold
- Involvement in domestic violence (as victim or perpetrator) decreases dramatically
- Participation in family activities increases by 50 percent
- Volunteering in the community increases nearly threefold
- Voting increases significantly
- Frequent utilization of costly emergency room departments decreases tenfold
- The percentage of uninsured persons decreases by half
- Reports of untreated emotional/mental health problems decrease more than fourfold
- Involvement in illegal acts and involvement with the criminal justice system (e.g., arrests, incarceration, DWIs) decreases about tenfold
- Steady employment increases by more than 50 percent
- Twice as many people further their education or training
- Twice as many people start their own businesses

Sensible approaches to substance use will not only save billions of tax dollars; the concurrent benefits of recovery could create cohorts of nearly model Americans—some may even say great Americans.

That Escalated Quickly

It's not stigma; it's discrimination. We may be experiencing the deadliest public health crisis in American history. More than 70,000 Americans died from drug overdoses in 2017, including from illicit drugs and prescription opioids—a twofold increase in a decade. That's 192 deaths per day. That number increases to 433 when we factor in alcohol-related mortality. That's the equivalent of a jumbo jet full of our fellow citizens bursting into flames every single day. While these startling statistics urge public health officials to use the E word, (epidemic), I must remind social workers that "there is nothing new under the sun." Although the current opioid epidemic is measured in a staggering loss of life, social workers are no strangers to the negative outcomes that result from inappropriately responding to addiction—overflowing prisons and jails have been the metric for failure for decades.

More than three decades of Just Say No and a failed war on drugs hasn't been beneficial: One in seven of us will experience a substance use disorder in our lifetime, and only one in 10 will have access to specialized care. Compare that 10 percent access to the roughly 80 percent access we have to the specialized care appropriate to treat other chronic illnesses such as asthma, hypertension, and diabetes. We have an 11-year-old medical civil rights law, Mental Health Parity and Addiction Equity, that is not adequately enforced in any state—despite our current health crisis. Additionally, most states refuse to expand Medicaid, while they continue to introduce more punitive legislation, further isolating people who use drugs. We know how to reduce unintentional drug-related death. We know what causes addiction. We know how to prevent adolescent alcohol and drug use. We know how to treat addiction. We know people recover. The only question which remains unanswered is: Where is the outrage? Social workers have a responsibility to insist on equity for all people, including people who use drugs. This is a civil rights issue. We ought to be angry.

Harnessed Anger and Clear Direction

Watching a groundbreaking documentary film in MSW school, The Anonymous People (2013) by Greg Williams, changed my life. I clearly heard Stacia Murphy, then interim executive director of The Alcohol Council of New York, casually say, "Advocacy is about anger." After watching the film, I was angry—most of the time. I had a new lens, one unobstructed by internalized stigma. When I learned of persons in recovery being denied by employers or landlords or schools, exasperation brought tears. When I witnessed people seeking recovery being turned away by treatment providers because they became symptomatic, indignation turned to rage. When I truly discovered the depth of discrimination against people living with mental and substance use disorders, I was outraged. Before this liberating moment, my shame kept me from getting angry because I couldn't believe our people deserved anything better. Many of us continue to feel this way.

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Instead of seething in isolation, I learned how to affirm my recovery status with pride, using language provided by a new recovery movement. I studied up on recovery advocacy (the writings of William L. White), which help craft the intentional and impactful words I chose to make change. I joined the national recovery movement—a vanguard of citizens affected by addiction and mobilized by recovery—raising our voices to eliminate stigma and ask for what we deserve. I volunteered with a grassroots recovery community organization engaging in purposive change activities (education, advocacy, support) with the goal of a more just social order. I empowered others to speak for changes on their own behalf (messaging training, coaching, stigma elimination). I worked at a residential recovery program that offered services on demand, free of charge, for those who needed them most and had the least. I stuck with the winners, and life took on new meaning.

Demanding What We Deserve

Throughout the course of your work, everyone you encounter experiencing mental and substance use disorders has the potential to get well—then to get better than well. I didn't get this well because I wanted it more than others—or because I worked harder than others—or because I am special. I am Donald McDonald, MSW, because I had immediate access to adequate and appropriate treatment, robust recovery support services in my community, and the unrestrained opportunity to chase my dreams. I was afforded these opportunities through dumb luck and privilege—and my share of hard work. Don't leave recovery to luck. Don't sit by while we write another chapter in our great American history of institutional oppression and systemic discrimination. Demand what your people deserve. Become a recovery activist.

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Organizational Efforts to Cultivate Equity and Inclusion in Child Welfare

Sharon Kollar, LMSW

Child welfare cases that involve children and families of color are more likely to be reported, investigated, screened-in for services, have substantiated reports of maltreatment, and be recommended for out-of-home placements than cases involving white families (Child Welfare Information Gateway, 2016). These racial disparities have existed in the child welfare system for decades. At the same time, child welfare leaders at all levels agree that every child, youth, and family deserve effective supports and services that meet their unique needs. All who work in child welfare have an ethical and legal responsibility to cultivate equity and inclusion and to eliminate disproportionality and disparities for those we serve.

The ethical responsibility for working toward equity is rooted in the core social work principle of social justice. The NASW *Code of Ethics* requires social workers to challenge social injustice and work to change society with and on behalf of vulnerable and oppressed individuals and groups (NASW, 2017). The *Code* states that our change efforts must focus on promoting "sensitivity to and knowledge about oppression and cultural and ethnic diversity." It also specifies that "ensuring access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people" are obligatory social work responsibilities. Therefore, all social workers are obligated to reduce inequities related to ethnicity, tribal status, sexual orientation and gender identity, and other identities and circumstances.

Title VI of the Civil Rights Act of 1964 protects people of every race, color, and national origin from discrimination in programs, activities, and services administered by child welfare agencies (U.S. Department of Health and Human Services, 2019). While it may be obvious that intentional discrimination falls under this statute, the act also necessitates that policies and procedures that have a discriminatory impact on individuals because of their race, color, or national origin are against the law, even if such policies and procedures appear to be neutral. This includes, but is not limited to, criteria for accessing services, methods of administering programs, and environmental conditions.

As social workers, we need to be both good practitioners and strong advocates. While efforts to cultivate equity and inclusion may start with individual actions, they must ultimately lead to systemic changes in organizational policies and procedures. Individual social workers who build their skills in culturally responsive practice can remedy disproportionality and disparities by creating a more inclusive environment for those they serve. Cultural responsiveness reflects "the idea that child welfare professionals need to identify and nurture the unique cultural strengths, beliefs, and practices of each family with whom [they] work and integrate that knowledge into the intervention approaches [they] employ" (LaLiberte, Crudo, Ombisa Skallet, & Day, 2015, p. 2). Schulman (2019) recommended an interactional model for inter- and intracultural practice in child welfare that includes: (1) tuning in to those we work with; (2) being careful about stereotypes; (3) mitigating the impact of microaggressions; and (4) continually working to address internalized biases.

The National Child Welfare Workforce Institute (NCWWI) recommended building on individual practice improvement efforts to focus on six areas of workforce and organizational action to promote equity: (1) institutional analysis; (2) agency and workforce development; (3) cross-systems and tribal partnerships; (4) agency–university partnerships; (5) data collection and analysis; and (6) sustainability (National Child Welfare Workforce Institute, 2015).

Conducting an institutional analysis helps an organization examine the factors, such as administrative practices, that contribute to disparate outcomes. This process, guided by quantitative and qualitative data approaches, identifies gaps between the intent of policies and procedures and the outcomes that result from them. For example, it can reveal that the policies, administrative procedures, job requirements, and other aspects of an agency's functioning result in worse outcomes for specific populations, despite the intention that all are served equitably.

Training and workforce development are key strategies for supporting staff at all levels. Ideally, core training, coaching, and ongoing professional development opportunities for staff would emphasize reflective practices and provide information on how racism and implicit bias affect the lives of children, families, and communities. As with other areas of practice, family and youth voice inclusion increases the effectiveness and applicability of training curricula.

Reducing disproportionality and disparities and increasing equity and inclusion cannot be done in a vacuum. Social workers in child welfare agencies can strengthen or create cross-systems and tribal partnerships to support an agency's disparity-reduction efforts. Effective child welfare leaders seek out partnerships with communities of color and engage with tribal governments around Indian Child Welfare Act, (ICWA) compliance and improving tribal community outcomes.

Strong child welfare leaders also leverage their partnerships with social work programs in colleges and universities that serve racially and ethnically diverse students, to exchange resources and implement strategies. Social work faculty can support evaluation and research activities at the agency as well as facilitate educational experiences for staff; social workers at the child welfare agency can serve as guest lecturers in social work courses to discuss the agency perspective on equity and inclusion, ensuring that program graduates understand the impacts of equitable policies and appreciate the social worker's role in improving equity and inclusion as they begin to work at an agency.

Because most agencies focus on data collection and analysis as part of their continuous quality improvement process, data must be disaggregated by race, gender, and other demographic variables to understand the effect of policies and practices at various decision points and to determine where data are missing. Additionally, because having a diverse workforce that represents the population being served is one concrete step toward an equitable and inclusive agency, workforce data must also be collected and compared to the demographic data of the client population.

Finally, as with all improvement efforts, creating structures and partnerships with community groups that provide accountability will help in the sustainability of equity work. Being explicit about the goal of achieving equity in mission and vision statements—and in communications with agency partners—will ensure that those inside and outside the agency can assist in encouraging ambitions and broad thinking about future goals and in holding each other accountable when energy wanes.

Ultimately, our goal is to guarantee that racial identity no longer predicts how someone will fare in the child welfare system (specifically in terms of assessments, service quality, and opportunities). Social work leaders at all levels of a child welfare organization can take steps toward this goal through the actions described here. We as social workers must fulfill our ethical and legal responsibility to cultivate equity and inclusion in the agencies and communities in which we work.

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Social Work's Role in Aging: An Opportunity to Promote Equity and Inclusion by Addressing Ageism

Denice Goodrich Liley, PhD, ACSW, CSW-G

Social work's call to promote equality and inclusion speaks to no greater area than that of our aging population. Today's aging population is one of the most profound and far-reaching influences in contemporary society. At no time in history have so many older adults been a part of our world. Unfortunately, attitudes, perspectives, and knowledge regarding aging do not align with the reality of many older individuals' lived experiences.

Demographics

By 2056, for the first time in U.S. history, the 65+ population will outnumber those individuals age 18 and younger (Hardy, 2014). By 2030, one in five Americans is projected to be 65 or older (Colby & Ortman, 2014). Not only is our older population increasing, it is living longer than before. The oldest old (85 years and older) is the fastest growing segment of our population (Hardy, 2014). This modern trend represents a long-term shift in the structure of our society.

The baby boomers, individuals born between 1946 and 1964, largely account for the increase in this older demographic. The first wave of baby boomers began turning 65 in 2011; the youngest of this group started turning 50 in 2014. By 2030, all baby boomers will have moved into the ranks of the older population (Colby & Ortman, 2014).

Social workers are finding that, regardless of their field of practice, they are engaging in work with older adults. For instance, social workers in school-based settings are seeing grandparents as custodial parents for their grandchildren. Older adults are present in behavioral health centers, domestic violence programs, and homeless shelters, and the prison system has a growing aging inmate population. Practice with older adults has moved beyond hospital and long-term care facilities (Youdin, 2014).

Many social workers have little gerontology education and training and may be unmotivated to engage in work with older adults (Williams, 2017). Misconceptions of aging individuals as being set in their ways and unable to change or generalizations, such as being too frail and feeble with limited capacity for engagement, fuel this lack of motivation. Also, younger workers may experience reluctance to work with older adults out of anxiety about death and illness (Williams, 2017).

Ageism

This reluctance and hesitancy to engage in work with older adults link directly to one of the last "isms"—that is, ageism. Coined by Robert Butler (1969), this term is used to describe negative attitudes toward aging. Butler defined ageism as "a process of systematic stereotyping and discrimination against people because they are old" (1987, p.22). He further delineated ageism as having three connected elements: prejudicial attitudes toward older people, old age, and the aging process; discrimination against older people; and practices and policies that perpetuate stereotypes of older people. Ageism has a direct link to the exclusion of older people and the justification of putting them on the sidelines of society (Blancato & Ponder, 2015).

Prejudice toward older people, old age, and the aging process can be seen in words that are used to describe older adults, such as geezer or codger; pejoratives of "dear" and "sweetie"; the use of elderspeak (using a childlike tone of voice and words); and the media portrayal and stereotyping of older adults as dependent or engaging in bumbling escapades. These practices reinforce a sense of lost competency and other negative outcomes as a consequence of aging.

Organizational practices perpetuate stereotypes of aging by using an individual's age as a category for possible concern rather than looking at the individual older adult's functionality. Discriminatory practices—such as 65 is the appropriate age to retire—are common in the workforce. Individuals may wish to continue working beyond age 65 or may need the income that work provides, yet often these individuals are viewed as no longer current with

workforce trends or as holding a younger person back by keeping their positions.

Older people may even try to distance themselves from being old and stay middle age by claiming to be younger or not acknowledging their age. Consider, for example, the mantra "60 is the new 40." Older adults internalize the negative, ageist stereotypes, and often suffer low self-esteem. Moreover, health outcomes of older adults are negatively impacted by ageism (Allen, 2014).

Ageism is unique, as it is based on another person's chronological age. Unlike other forms of prejudice and stereotypes rooted in gender or race, ageism occurs in later life and is not part of one's lived experience. Everyone will encounter ageism unless death occurs early in life.

Aging Today

The last life stage is now the most extended single life stage that most individuals will live. We have limited demarcation for this time of life. It is not realistic to assume that a 65-year-old person is the same as a 90-year-old person. Both are grouped as "older adults." Who would compare a 10-year-old and a 35-year-old? Older adults, as a group, vary significantly regarding health, financial situation, and functional status (Lindland et al., 2015).

The U.S. Census groups older adults into three subcategories: (1) the "young-old," individuals who are 65 to 74 years of age; (2) the "old," individuals who are 75 to 84 years of age; and (3) the "oldest-old," individuals who are age 85 and older (Ortman et al., 2014). Older adults vary greatly within each of these subcategories. As one expert explained, "A pessimist might see a financially dependent frail woman living alone with five chronic illnesses, and an optimist might see a healthy, very attractive 70-year-old woman playing tennis." Both exist (Lindland et al., 2015). Older adults are a highly heterogeneous group.

The number of older Americans is increasing along with their life expectancy (Lindland et al., 2015). This increase has meant more years of productive life. The Nation Health Interview Survey found that three-fourths (76 percent) of those age 65 and older assessed their own health as being "good, very good, or excellent" (Federal Inter-agency Forum on Aging Related Statistics, 2012). And given their impact on social values, sexual orientation, and ethnic biases in their youth, the baby boomers are not just aging but have the potential to redefine the process (Youdin, 2014).

Conclusion

For most people, a long life is accompanied by a trajectory of extended good health and productivity. Social work education must expand to meet the needs of practitioners who seek evidence-based education to guide their work with older adults. Within the generalist social work education, curriculum enriched aging content should be expanded. For practicing social workers, relevant continuing education offerings should be provided.

Social work advocacy for equity and inclusion of older adults can help to reframe our understanding of older Americans so that aging is understood as both a personal and a shared opportunity. Such reframing can assist with reducing ageism so that older Americans are viewed as central rather than marginalized societal members. The aging of the American population is not a passing trend; it is a permanent and unprecedented shift to our demographic structure. Social work's commitment to service, social justice, dignity and worth of the individual, integrity, and competence puts social workers in an excellent position to help eradicate ageism.

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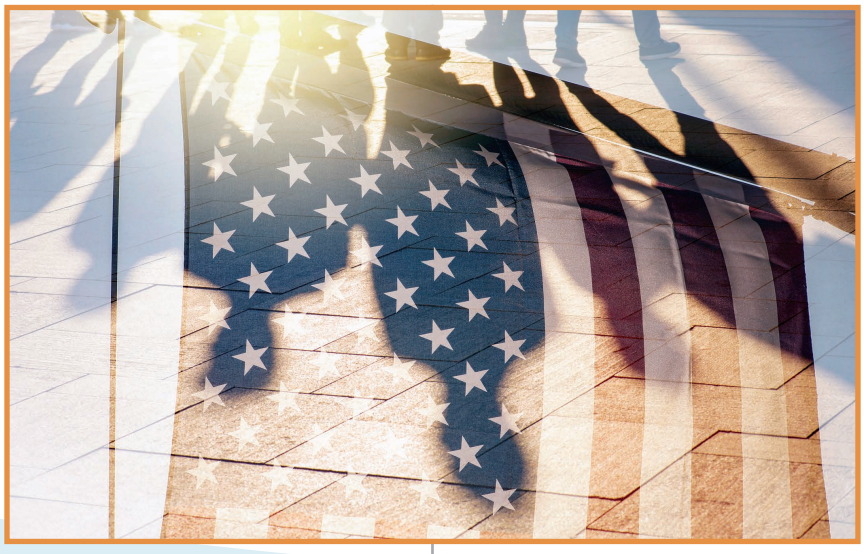
Using Political Views to Help Clients Promote Equity and Inclusion in Social Work Private Practice

Dionne M. Brown-Bushrod, MSW, LCSW-C, CFSW

This country's ideals and practices weaved patterns that go in opposite directions: a curvy route to freedom and a straight line to oppression. Inlaid in the quilt of the American ideal is the "imagined nation" of its founders, who focused on one race and one class. Slowly, via legal and constitutional challenges and amendments, the founders and the men who came after them had to give other races and classes access to democratic rights. Every person has the right to start each day with a feeling of fairness (equity) and belonging (inclusion).



Politics are practices that inform and influence how a society governs; they can determine how groups of people are seen by others and how an individual can view his or her levels of opportunity, engagement, and success. When social workers assess the value that clients assign to themselves, feelings of equity and inclusion must be examined. Where do clients feel less equal, and where are they left out? Their answers reveal self-worth, and the absence of self-worth can lead to feelings of oppression. The oppressed are individuals who feel left out, who are constantly trying to understand who they are and who society says they are. When the oppressed know they are oppressed, they may engage in a righteous fight for justice.

In his book, March: Book One, Congressman John Lewis retold seminal moments that led to his fights for justice. His demand for justice began at a young age on his family's farm. Justice remained at the forefront for Lewis throughout his adolescence, which was shaped by his faith and his exposure to nonviolent protests. Today, thanks to opportunity, resiliency, and a strong sense of self, Lewis keeps rising to fight for social justice despite fearful and oppressive forces. Social work circles would view him as having cultivated stamina and resiliency.

Beat down by circumstances, some oppressed may lack consistent stamina and resiliency, and many may lack energy for a "righteous fight." With each disappointment, their strife for justice for self and society becomes clouded by a pervasive wave of disconnect and loss. They've repeatedly been faced with diminished opportunity by living in opportunity deserts and by being surrounded by inherited terror: systematic practices that can confine generations of marginalized communities through restricting access and thereby decreasing hope. Because our country promotes the ideal of defeating the odds, the oppressed blame themselves for their shortcomings, and this blame may lead them to seek a social worker in private practice. They come presenting complaints of depression, anxiety, addiction, psychosis, grief, etc. They feel the world gave them a bad break. They must have missed something. They surmise a good life is intended for everyone but them.

In Kirsten Havig's 2010 dissertation, "Empowerment for Social Justice: A Grounded Theory Study of Social Work Field Instruction Strategies," she highlighted literature that points to "self-efficacy, voice, access to choices, and decision-making power" as elements for social justice. These same elements are necessary for self-empowerment. Disempowerment can lead to depression.

Mood symptoms viewed through the lens of mental health are pathologies of mind and life functioning. Social workers know that mood issues can be manifestations of the mind, body,

soul, and circumstances, leading a client to feel that he or she doesn't have value and a sense of self-worth. Eddie Glaude Jr., author of Democracy in Black: How Race Still Enslaves the American Soul, wrote that the oppressed can experience a value gap—some people matter more than others. The idea of supremacy "is in our national DNA." For the oppressed a question remains: How do they rise above a national sentiment that says they don't have value?

Havig explained that a structural approach allows for a look at the client's issues in a broad environmental context that includes oppressive and privileging forces and their consequences. The political process of inequality and exclusion can be intentional. The client is not imagining or overselling his or her victimization. The structural approach can also illustrate that self-worth is suffocated by disenfranchisement that diminishes personal empowerment, which interrupts the client's ability to look critically at the world and promote self-esteem, self-determination, and a sense of responsibility, productivity, assertiveness, and hope (Havig, 2010).

To resuscitate the client's self-worth, the treatment process must include an empowerment aspect. Empowerment theory brings solutions to problems by erecting the client as the primary agent of change, through raising awareness, confronting the oppression, and designing solutions.

Havig's research offers a road map for infusing the treatment process with empowerment practices under the arc of politics, and the process can be guided by the following eight essential methods:

- Assess the client's ability to respond to change. Determine the pace of the client's readiness for treatment.
- Help the client determine his or her sense of relatedness to relationships and his or her communities.
- Help the client practice the ability to advocate for self by helping him or her to cultivate his or her "voice."
- Role model and promote self-efficacy for the client.
- Help the client sustain an internal locus of control in frustrating and oppressive situations.
- Encourage the client's personal power development.
- Help the client research access to choices that will stabilize or increase his or her quality of life.
- Help the client defend his or her right to decide what is appropriate for him or her.

Weaving political identity into the therapeutic process can reveal that a client's disconnection in society is a phenomenon that is not just in his or her mind, and by doing so, clients are released from feeling that they are unlucky souls who make bad choices. What is true about the sometimes-irrational messages in anxiety and depression is also true about helping the client to find fairness and belonging: deal with facts, not feelings. Depression might lead the client to believe he or she is worthless and helpless, and it might bring about a feeling of hopelessness. The social worker in private practice must help the client realize that he or she has value. Society may say that oppressed individuals are less valuable; by challenging oppression and promoting equity and inclusion, the social worker in private practice is able to reflect otherwise to the client.

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Managing the Emotions of Equity Work: Moving Beyond Shame, Blame, and Guilt

Jenny Andersen, LCSW

People who are members of privileged groups may experience a range of emotions when confronted with the negative experiences of people of color, LGBTQ individuals, immigrants, people with disabilities, and others. They may feel shame, blame themselves or others, or feel guilty. When someone is experiencing any or a combination of those emotions, the work of social justice cannot move forward. This article seeks to address the emotions frequently experienced by people in privileged identity groups—white, straight, cisgender, and so on—and provide social workers with action items for moving through those emotions to most effectively engage in equity work.

We as social workers were called to this profession because of our strong values regarding justice. In fact, social justice is the second value given in the National Association of Social Workers *Code of Ethics* (2017). Social work and social justice are intrinsically tied to our core personal beliefs. For those social workers who have dedicated their practice to equity work, that call is even greater. When social workers from privileged groups begin to study equity work and learn that they have been complicit in social and political systems that perpetuate racism, homophobia, transphobia, and so on, they can experience defensiveness, shame, blame, and guilt. These feelings can happen when we are concerned for how we might be devalued by others, especially by our closest social groups (Snyzer, et al 2016). If we have made our livelihoods out of a dedication to social justice, it follows that we would experience shame when we are first being exposed to how we may have benefited from privilege or been complacent in systemic oppression.

Imagine, for example, a white social worker. This social worker signed up for an antiracist workshop. During the presentation, this social worker notices himself becoming upset. Perhaps he feels defensive about what the presenter is saying or thinks that the presenter is generalizing. This social worker is a "nice person," not "a racist."

Does that sound familiar? Maybe it has been your own experience, or maybe you are working with a client or colleague who has had this experience. It is an understandable reaction. We can have empathy for people in that situation—even if it is us. But as we know from our work, this reaction is not helpful. If we allow ourselves to get caught up in these thoughts, we miss the presentation we wanted to attend. Instead, consider the following: There's no room for shame in the revolution.

Social workers attend presentations on equity because they know the work of equity is not yet complete. Social workers feel compelled to learn more. We cannot change instances where we have been complicit in the past, but, by being open to the experiences of people who are different from us, to data and research that we might not have seen before, and to new theories and practice, social workers commit themselves to moving in a more equitable direction.

But maybe a reminder of why we participate is not enough, and we still notice those feelings arising and distracting us. We can navigate those feelings through mindfulness and cognitive behavioral skills. In mindfulness, we seek first to become aware of our thoughts. We can notice when the mind wanders from the presentation or an emotion arises, without judging the thought or emotion (Tlaka, 2019). We can simply label it as "thought" or "emotion" and bring ourselves back to the present by focusing on our

body in the chair and the presenter's words. As many times as it takes, we can practice bringing ourselves back to the present moment. We can even write down these thoughts or feelings to process later. When the presentation is finished, we can explore what caused those thoughts and emotions to bubble up. But if we allow our thoughts to distract us, we will miss the very workshop we were excited to attend.

From a cognitive behavioral perspective, we should remember that our thoughts often create our own distress. Did the presenter walk up to a white audience member and call him or her a racist? Did a facilitator say that all straight people are personally to blame for violence against the LGBTQ community? If not, perhaps we are experiencing a cognitive distortion (Thinking About Thinking [PDF]. (n.d.)). As with mindfulness, it is helpful to be aware of our thoughts; then we can label our cognitive distortions. If we can use cognitive behavioral therapy skills to interrupt feelings and thoughts before they turn into actions, we have "more room" to be open to learning from others.

Finally, we should remember that it is not the responsibility of people of color, LGBTQ individuals, immigrants, people with disabilities, and others to talk about their sometimes-traumatic experience of living while marginalized in this country. That is called tone policing, and it refers to focusing on one speaking the "right way" about their experiences instead of focusing on their message (Wheeler, 2018). This happens frequently in equity work: "Well, if they weren't so angry," "I think this is all just divisive," or "She's too loud." It is a way to derail equity work. As social workers, we have been trained to create space for others to emote, and this training is useful in our equity work. By empathizing about the traumatic lived experiences of people of color, LGBTQ individuals, immigrants, people with disabilities, and others, we can hold space for their emotions and stay focused on our shared goal to move forward with a more just and equitable practice and world.

Ultimately, if people who experience privilege are committed to equity work, they must be willing to manage the emotions that come from that work—and stay engaged. As social workers, we have the skills and training to do this and support others in their journeys of equity work as well.

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Changing the Policy on Separating Families: A Challenge for Social Work Administrators


Larry Breitenstein, MSW, PhD • Nancy Miringoff, LMSW, ACSW

The current treatment of immigrant and refugee families should deeply trouble everyone, but particularly those of us in human services. As the media has reported, children have been separated from and denied access to their families; they are being kept in tents and fenced detention centers by providers who may not be licensed in their respective state. Medical care has not always been provided as needed; family records have not been kept, making reunifications difficult; and a reported six children have died while in U.S. custody (Jacobs, 2019).

Administrators and supervisors regularly challenge policymakers on the best way to serve our constituents, but today it seems we see family separations purposely structured to disrupt and disregard long-standing children and family policies intended to ensure human safety, protection, and well-being. This runs contrary to the decades of policies designed to support the preference for keeping families together, the most recent example being President Trump's signing of the Family First Prevention Services Act (Pecora et al., 2019). The core value that government should support the child remaining with his or her family is as old as almost every living American.

Consider, for example, that the first White House Conference on Children, convened in January 1909, proclaimed the standards for keeping dependent children with their families; the preference of families over orphanages; the need to address the causes of dependency; and the need to provide dependent care, when necessary, in a familial setting, with education, health care, and maintained records (Hart et al., 1909).

The standards from this first White House Conference, and federal policy created and implemented over this and the past century, support the family as the preferable institution for child rearing, even when child dependency is an issue. The Child Abuse and Treatment Act of 1974 and the Indian Child Welfare Act in 1978 provided funding, educational

materials, and/or rights to families. The Adoption Assistance and Child Welfare Act of 1980, the Personal Responsibility and Work Opportunity Reconciliation Act, the Adoption and Safe Families Act of 2008, the Keeping Children and Families Safe Act, the Adoption Incentive Program, the Fostering Connections to Success and Increasing Adoptions Act, and countless other pieces of federal and companion state legislation were designed to strengthen families through services, funding, and legal rights. Most recently, the Family First Prevention Services Act, signed by President Trump, gives states flexibility in moving funds to evidenced-based prevention services to keep children safe within their families (Pecora et al., 2019). Today the Children's Bureau lists as part of its vision, to help "state and territorial public child welfare agencies and their partners become prevention-focused systems that prioritize the importance of families, prevent unnecessary removals, and achieve safety, permanency, and well-being for the children, youth, and families they serve" (U.S. DHHS, 2019).

The administration's "zero tolerance" immigration policy, implemented in spring 2018, undercuts that same value espoused in the Family First Preservation Act. It dismisses a century of policy supporting families, by separating refugee children as a perceived deterrent to seeking shelter in the United States. Some would argue that public safety, immigration, and/or refugee threats take precedence over existing policy, but this sentiment ignores other existing federal policies that support keeping refugee families intact (U.S. DHHS, 2012). Simply stated, the U.S. policy is to support the family unit when possible and oppose unnecessary removals or separations.

Public opinion is opposed to separating families at the border. An NPR/PBS NewsHour/Marist Poll taken in

December 2018 found that 52 percent of American adults disapproved of President Trump's handling of immigration policy, while 54 percent of American adults disapproved of President Trump's handling of the reuniting of immigrant children who were separated from their parents at the border (NPR/Marist Poll, 2018). Similarly, a different poll also found that two-thirds of American adults opposed separating families at the border (CBS, 2018).

Today, administrators in human services, particularly those involved with dependent children, find themselves in an uncomfortable position. Under current federal policies, no agency or state child welfare program can operate without adequate medical care, recordkeeping, family visitation, family reunification, and the investigation of child deaths. The "zero tolerance" policies for refugees and asylum seekers run counter to the intent of established U.S. family policy, dependent childcare policy, immigrant and refugee policies, public opinion, and American values confirmed well over 100 years ago.

Immigration was not discussed as a reason for the child dependency problems in 1909. More typical were the suggestions and comments like those of Jane Adams, a founder of the social work profession, who even then recognized the need for systems and legislative changes to prevent dependency in the first place (Adams, 1909).

Today, social work administrators and supervisors find themselves at a point in history where their practice of inclusion and equity for children and families are challenged by a policy that goes against decades of established values and standards. Poor immigration and refugee decisions are causing real harm to families and sending a message that undermines a century of policy and system building designed to care for dependent children (Yee & Jordon, 2018).

For a century, U.S. policy has focused on the best ways to support families. In 2019, America should not be revisiting the question of whether the family is the best place for the child.

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Justice Works: The Cornerstone Framework at the Intersection of Social Work Practice

Alexis Jemal, JD, PhD, LCSW

Social work and the courts are intimately connected. Social work pertains to humans and human relations. Humans have rights and much of the law dictates human interactions. Laws are one unique facet of human existence that separates humans from other animals: Humans are not solely controlled by biology and instinct, but by our agreements and a sense of justice.

> We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness. (U.S., 1776)

Social work facilitates equitable access to inalienable human rights. Injustice is a broad term that encompasses inequity, unfair treatment, and denial or violation of human rights, and it can manifest as social, economic, environmental, or political, or some hybrid (Dylan & Coates, 2012). Systems of injustice are interacting, mutually constitutive, and reinforcing, such that injustice in one system threatens the health of other systems (Jemal, 2018). These unhealthy dynamics of injustice, which take the form of thoughts, attitudes, behaviors, decisions, and policies, create a process that systematically produces outcomes that perpetuate inequity (i.e., oppression and privilege; Jemal, 2018). To understand these processes and outcomes of inequity, one must explore disparities at the intersections of class, race, ethnicity, and gender at the local, regional, national, and global levels on issues related to the just distributions of and access to resources, opportunity, and power (Jemal, 2018).

The root of oppression is press, which means to be caught between interrelated forces or barriers that jointly restrict mobility (Jemal, 2018). Oppression within multiple systems or institutions denies a person's individuality, identity, and independence to freely advance one's full potential as an individual and contributor to society (Gee & Ford, 2011). Specifically, oppression prevents members of oppressed groups from meeting their hierarchical needs and thus relegates them to a dehumanized life experience. These ideas are easily demonstrated within the structure and institutions of American society. Every U.S. institution and system—for example, education, criminal justice, economic, housing, political, health—are interdependent forces such that those who occupy a substandard position in one system will likely be locked in an equivalent position in other systems. In other words, oppression is interlocking.

Oppression overlaps multiple intersecting social constructs: sexuality, race, gender, ability, and class. These varying degrees of intersecting socially constructed identities make for real-life consequences and differences for those occupying these identities. When social identities come into play, they bring their respective "-ism": racism, sexism, heterosexism, classism, and so on. Although people are trained to identify oppression at the individual level and within interpersonal experiences, "-isms" are a systematic, group-based phenomenon—meaning, simply belonging to a specific group places a person at greater odds of experiencing forms of systematic

disadvantage (oppression) or systematic advantage (privilege), regardless of individual identity or merit.

In addition to these intersections, there are intersections at the corners of social work practice that require more exploration—for example, the intersection of victim–offenders and social workers as clients. Many social workers could operate as credible messengers because their personal histories place them in the seat of the client. Accepting the idea that we are our clients and that those overlapping experiences that shape who we are cannot fit neatly into boxes on intake forms would help develop empathy, which undergirds a broader understanding of equity. Empathy provides X-ray vision to see inside how people are hurting from inequity. For example, racial oppression is pervasive in American society, yet it is purposefully hidden and thus must be studied in ways that make it visible.

The U.S. education system sometimes systematically denies equal access and opportunity to persons of color, especially those who are poor. Nationwide, in the 2011–2012 academic year, high school graduation rates for black, Hispanic, and white students were 68 percent, 76 percent, and 85 percent, respectively (NCES, 2015). Additionally, black students are suspended and expelled at a rate three times greater than that of white students (U.S. Department of Education, 2014). Substandard education perpetuates the lack of proportionate representation of people of color in higher education at staff, student, faculty, and administrative levels. Disparities similar to those of suspension rates are illustrated by the overrepresentation of youth of color in the child welfare system (Boyd, 2014) and the juvenile/criminal justice system (Amurao, 2013). Although African Americans are approximately 13 percent of the U.S. population (U.S. Census Bureau, 2010), they represent 59 percent of the prison population (U.S. Department of Justice, 2014). Because African Americans are incarcerated at higher rates than those of whites, the influence of a criminal record on employment is confounded with race. Even without the help of the criminal justice system, racism is rampant in hiring practices and employment. In February 2014, the unemployment rate for African Americans was 8.8 percent as compared with 3.9 percent for white Americans (U.S. Bureau of Labor Statistics, 2016). People of color continue to be underrepresented in managerial and administrative positions and paid less than white employees for the same work. Thus, racism in the employment sector negatively affects economic mobility.

Employment and housing discrimination affect where someone can call home. Studies have found that black borrowers are denied loans, pay higher interest rates than comparable white borrowers, are targeted by financial companies for risky investments, and are victimized by predatory lending schemes (Cheng, Lin, & Liu, 2015). These racially motivated, recycled strategies that dispossess people of color from the land are related to gerrymandering districts that disenfranchise people of color in the political process, resulting in gross underrepresentation in federal and local elective and appointed positions. Consequently, legislation affecting the masses is produced by nonrepresentative political and legislative institutions.

Inequalities within multiple systems intersect to affect the health of racial minorities. Income and education factors, which occur along racial and ethnic lines, are significant predictors of health status, the ability to access high-quality health care, the use of preventive services, and longer life. Racial and ethnic minorities experience disparities across a significant number of health status measures, indicators, and outcomes from infant mortality to cancer (Gee & Ford, 2011), even when controlling for age and income. An example of the debilitating nature of occupying two oppressed identities is black women have a higher prevalence than women of other races/ethnicities in almost every health indicator from heart disease and associated issues (e.g., stroke, hypertension) to cancer, to maternal mortality (Gee & Ford, 2011).

Social work should bring to light the purposefully hidden systemic and sociostructural factors at the root of these racial disparities. For example, racial disparities in health are perpetuated by inadequate housing, poor access to nutrition, neighborhood segregation, community violence, lack of green space, neglect of public services such as sanitation, toxic segregation, environmental racism, and other health hazards and environmental factors within communities (Dylan & Coates, 2011). Health disparities also result from failures within the health care system, such as lack of access to quality care (Gee & Ford, 2011). For example, black and white women are equally likely to have a mammogram; however, health care professionals are less likely to adequately communicate the screening results to their black patients (Jemal, 2018).

Racist incidents such as discrimination and harassment have been identified as a chronic stressor or trauma that lead to negative short- and long-term psychological and physical consequences (Gee & Ford, 2011). The cyclical nature of the downward spiral of oppression indicates how oppression is both a process and an outcome. As a process, oppression is the way in which disadvantage produced by institutions, created by the dominant group, is visited on individuals or a group of people deemed inferior based on some inherent characteristic (e.g., social economic status, (SES) sexuality, race, gender), regardless of individual merit. The process is manifested through the beliefs, attitudes, and behaviors of individuals and groups, which are grounded and reinforced by societal and cultural norms and codified in the formal and informal laws and policies of our institutions. Oppression as an outcome is the actual disadvantage that results from these processes. These injurious outcomes of oppression—including socioeconomic disparities, racial inequalities within the criminal justice system, adverse health outcomes, multigenerational poverty, family disruption, and drugs within communities—could be considered forms of structural violence.

Dr. Martin Luther King (1958) recognized the interplay of social injustice processes and outcomes. He stated, "There must be a rhythmic alteration between attacking the causes and healing the effects" (p. 224). Such solutions must encompass a social justice orientation that emphasizes societal concerns of equity and justice, self-determination, interdependence, and social responsibility. As such, social justice is a philosophical response to structural violence, as it responds to the physical, emotional, and psychological harm resulting from exploitive and unjust social, political, economic, and environmental systems (Jemal, 2017).

Although social work aligns itself with a social justice orientation and the person-in-environment perspective—a holistic framework that considers personal and structural challenges underlying the presenting problem—traditional theoretical and treatment approaches focus on individual change and fail to address historical and structural contexts. To assess and act on the individual level and not the systemic influences is one of the paramount tools of oppression and equates to structural violence condoned by the dominant culture. Moreover, social work has an ethical and professional mandate to address systemic inequity: How do we reconcile the field's values with the actions of the profession?

The field must undergo its own truth and reconciliation process. Even though justice is on our side, as social workers we recognize that we are also products of this society. That is why we make sure that the methods we use in our struggles are transforming ourselves as well as our opponents into better human beings. (Boggs, 2012, p. 100). Social workers should meet the field of social work where it's at in its level of transformative potential development. Transformative potential is a strategy for addressing inequity within our personal lives, professional workspaces, and the world. Critical transformative potential is about information, inspiration, innovation, and involvement, all of which begin with "I." Consequently, the first step in promoting equity is self-awareness and self-work to examine and address one's own internalized oppression, privilege, prejudices, biases, and discriminatory behavior.

Critical transformative potential (CTP) development has four components: critical consciousness, accountability/responsibility, efficacy, and action. Critical transformative consciousness (CTC) develops awareness of the intersection and interaction of systems, levels, and personal identities with special attention to the intersection of oppressed identities, the interaction of micro and macro contexts, and the importance of historical reference. CTC makes the invisible visible by spotlighting the role that macro systems (i.e., culture, norms, mores, laws) play within micro contexts and the cyclical relationship between the public and private sphere— such that private troubles become public issues. History provides pertinent context for understanding current relationships and events. History, like a poisonous tree, has roots and its fruits have seeds. For transformative accountability and responsibility, social workers must take responsibility and remain accountable for the way in which our field and our professional duties have currently and historically perpetuated inequity. Part of the responsibility of the social work profession is to raise the critical consciousness level of self, others, colleagues, and clients. For transformative efficacy, we need to innovate and imagine ways to engage that advance our value, capacity, and effectiveness as creative social problem solvers.

Lastly, transformative action requires collaboration with—and not for—those who are most affected by the oppression. For action, it is helpful to keep in mind that there are only two types of action: anti-oppressive/anti-privilege action or oppressive/privileging action. If you're not helping to break down barriers, then you're helping to reinforce them. Inaction is a way of being complicit with the inequitable status quo—and what we permit, we promote. This professional duty requires social workers to get comfortable with the discomfort of facilitating difficult conversations about inequity and systemic violence. Courage and honest dialogue with openminded listening are required to step up and out of inequity. The development of CTP allows social workers to identify the similarities that exist within our lives across time, space, and experiences while also interrogating the injustices upon which this country was founded. CTP pushes the field to reach its full potential as a collective, active, dynamic force for our collective liberation.

Justice is at the intersection of all social work practice; just practice is the cornerstone of social work. Rather than adding social justice modules to social work courses, practice, and theory like a seasoning to flavor our daily grind, justice should be the core of our work such that it is completely integrated with social work knowledge and all practice areas from child welfare to aging. Social work practice includes everything a social worker may do—for example, research, community organizing, clinical practice, management, and advocacy. A justice orientation is inclusive, as it demands practice to bridge the pseudo micro, meso, macro divide. As such, social work practice must be multisystemic (e.g., criminal justice, education, health), multilevel (e.g., micro, mezzo, macro), and multi-issue (e.g., substance use, domestic violence, poverty). It should not be possible for social work to not address issues of oppression or privilege. In other words, if a practitioner purports to do social work that does not address issues of inequity, then that work is not social work; it is something else. It seems that fighting injustice exhibited through exploitation, marginalization, powerlessness, and violence should be executed by all social workers as part of what we do and who we are, regardless of our practice area or specialization. Social justice is the work; just how we do it—be it clinical practice, community organizing, or advocacy—may differ. As such, social workers can unite under the banner of social worker, and then, for example, we can identify as social workers who do clinical practice rather than clinical social workers.

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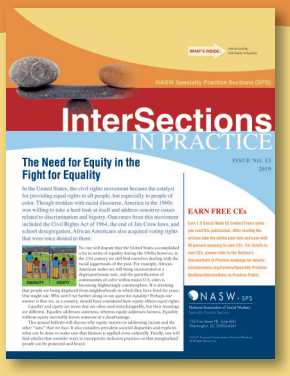

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Indeed, in light of its long history of social activism, social work is well positioned to address colonizing practices and to play an active role in the deconstruction of white supremacy and oppression. Instead of calling out social workers with limited CTC who respond to Black Lives Matter with chants of "All lives matter" or "Blue lives matter," we can call in those social workers to do the CTC work needed, so that perhaps one day the killing of black people will be as criminally prosecuted as the killing of white people. Oppression is about limited possibilities. Social work practice reveals possibility, and the revelation of possibility is the foundation of hope. Social workers are in the business of creating hope for justice. As such, justice works as an organizing framework to promote equity at the many intersections within the field of social work.

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A Social-Justice Focused Recommendation for Addressing Recovery Among Persons Experiencing Homelessness

Karen Bullock, PhD • David Fitzpatrick

Substance abuse is a significant problem in society overall and particularly in homeless populations (Tucker, Wenzel, Golinelli, Zhou, & Green, 2011). While traditional recovery programs may not be best suited for homeless populations, social, peer-led recovery programs have proven to work well. Many states have declared an opioid epidemic, and social workers are expected to bear the brunt of service provision as (arguably) the largest professional of mental health providers (NASW, n.d.). Some researchers have been exploring new ways to improve on existing interventions (Fitzpatrick, Hall, & Bullock, 2018), such as those that fall into the category of social recovery programs, because they have proven to be effective with persons experiencing homelessness and substance use problems.

Substance abuse treatment among underserved populations has been investigated extensively. An important underserved population is those who are transiently or chronically homeless. Although 235,823 homeless individuals were admitted to treatment programs in the United States in 2009, research findings suggest that services are still lacking for substance abuse treatment overall and particularly among homeless populations (Tucker et al., 2011). Some may consider the homeless population to be beyond hope and feel the solution is to occasionally make a small donation to a homeless person holding a sign, but this is not the case: Extensive research has indicated that hope exists for those affected by homelessness and that they can be rehabilitated and go on to live productive lives (Maguire, Sheahan, & White, 2012).

Traditionally, professional-led programs have not always been best suited for culturally diverse populations (Guerrero, Song, Henwood, Kong, & Kim, 2018), including homeless populations. Based on practice experience in local/statewide programs that work with homeless populations in North Carolina (Triangle Area), peer-led, social rehabilitation programs have proven to be a better match for addressing the needs of diverse client groups, because many of them report a lack for trust in formal providers in conventional recovery and mental health service systems. In addition, research has shown social rehabilitation programs are often more cost effectively than traditional programs (Kelly & White, 2011).

Recently, increased focus and research effort have been given to programs implementing a set of guiding principles rather than a framework limited to professional-led programs. This shift will aid in decreasing the burden faced by agencies that employ clinical social workers. We know that not all interventions will work effectively for all people; therefore, we need a plethora of options available to us to increase the likelihood that we, as interventionists, will be well equipped (Kelly & White, 2011). Moreover, long-term, social recovery programs for homeless clients, which implement such guided principles, need further research. The degree to which these programs can help individuals achieve their goals of sobriety, affordable housing, and a healthy lifestyle is paramount.

While no agreement has been reached about whether substance abuse causes homelessness or vice versa, the two health concerns tend to coexist (Fitzpatrick, Hall, & Bullock, 2018). The development of effective interventions for homeless populations is especially important because there is a prevalence of alcohol abuse and drug abuse in various subpopulations (Guerrero et al., 2018) that, when left untreated, leads to greater risk of incarceration and death from untreated chronic illnesses (U.S. Department of Health & Human Services (2018). Some of the most notable research

findings in this area suggest that substance abuse treatment can be effective and lead to sustained recovery in homeless individuals (Scott & Dennis, 2011); substance-abusing homeless populations are underserved and often overlooked by treatment programs and outreach efforts (Maguire, Sheahan, & White, 2012); substance abuse treatment programs should consider targeted interventions to engage and retain homeless clients; and recommendations for effective engagement and retention of homeless individuals in treatment include providing housing and case management (Maguire, Sheahan, & White, 2012).

Summary Recommendations

Social recovery models and programs are those that use peers rather than professional staff members to design and deliver detoxification and recovery programs. Social recovery programs are often viewed as being a sobriety program for those on a budget or without insurance; to a certain extent, this is true. The cost of delivery for social recovery programs is considerably lower than that of those employing clinical professionals and medical staff members (Baker et al., 2019). Often, social substance abuse treatment programs are provided at minimal or no cost to clients. Despite the lower cost of service, investigators have found these recovery programs to be as effective as those that use the medical model and professional staff members (Maguire, Sheahan, & White, 2012). Social programs deliver content that successfully equips clients with the tools needed for extended recovery and may be better suited to certain clients who have experienced high-severity substance abuse problems or who have been homeless. A social work, strength-based recommendation is to create policies and effective programs derived from culturally competent, evidenced-based theories, skills, knowledge, and awareness. Assessing and understanding the ability and capacity of clients to build and sustain strong peer-led social support systems during and after treatment are essential to the success of this and other interventions that espouse a social justice frame and lens. We conclude with an adaptation of the Addiction Recovery Management (ARM) framework (Kelly & White, 2011; Scott & Dennis, 2011):

- Physical environment—culturally reflective and representative at all levels
- Interventionist—self-determining, peer versus hierarchical treatment planning and goal setting
- Basis of authority—experiential versus professional
- View of recovery—consumer/client versus staff driven
- Governance—empowerment versus delegation
- Community orientation—engagement versus involvement

Conclusion

In the spirit of the mantra "I am my brother/sister's keeper," it really does take a village to effectively integrate the professional and the social recovery models. Nonetheless, we need as many tools as we can fit into our "toolbox" for success if we are to combat addiction and help individuals and groups restore their mental and physical health. This article serves to promote further discussion and research of the factors affecting recovery from substance use issues in homeless populations.

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Health Social Workers as Powerful Tools for Policy Advocacy

Megan Owens, MSW

Advocacy is ingrained in the social work profession. Health social workers advocate for their clients at hospitals, outpatient clinics, and numerous other health care facilities. They help their clients access affordable health care, food, and mental and behavioral health services. They continuously fight for their clients to receive equitable treatment and services; however, advocating for clients goes beyond micro-level practice. Social workers can and should be advocating for health policy at the local, state, and federal levels. Policy significantly affects client populations, and the influence is not always as apparent as the daily struggles facing them. Policy dictates the operation of different departments, businesses, and entities; the rights of individuals and groups; and the budgets for grants, programs, and departments. These policies inform how health social workers help their clients, which services are provided, and whether these workers have access to the necessary funding to operate their programs.

Engagement in policy advocacy is one of the core competencies of practicing social workers, yet within the field, clinical practice dominates. Even though social workers are highly knowledgeable about myriad issues facing vulnerable populations in our country, there needs to be more practitioners who are engaged in advocacy and policy work at the professional level. In 2016, only 3 percent of social workers were employed in civic, social advocacy organizations and grant-making and giving services—a slight increase from 2014, when 2.4 percent of social workers reported employment in these areas (Data USA, 2016).

Why do social workers engage less often in policy practice than in micro practice? One factor is the educational emphasis on clinical practice in schools of social work. Although all programs teach policy and macro courses per NASW requirements, the programs often put a heavier focus on micro practice and employ fewer instructors who have macro backgrounds and training (Wilson, 2015). Another factor is that many social workers do not have time for additional advocacy work outside their time-consuming micro-practice jobs. In a 2015 survey, about 70 percent of respondents indicated time constraints as the primary factor for not engaging in macro practice (Wilson, 2015). A third factor is the gender confidence gap. Studies have found that women more often than men underestimate their abilities and expertise (Sakowitz, 2018; Zenger, 2018). Social work is a field pioneered and championed by women, and 80.5 percent of social workers are female (Data USA, 2016). Female social workers feeling unqualified or underestimating their knowledge and skills could lead to less engagement in policy, because they may think they lack the expertise necessary to meaningfully influence policy development. However, social workers can help connect real people's experiences to legislation and provide context for policymakers.

Lawmakers come from diverse backgrounds, and they often rely on experts in the field to provide them with information about how legislation affects different populations. Social workers are incredibly knowledgeable about the issues that face vulnerable populations; they know which interventions and programs effective and what resources are needed to have a lasting impact on their client population. Additionally, social workers have skills that translate easily into the policy world. Interpersonal and relationship-building skills are necessary for working with lawmakers and other key stakeholders. To influence policy, a relationship with the lawmaker must be formed and maintained, and

social workers have the perfect skillset to connect a lawmaker's values with one of their client's stories or a piece of policy. Health social workers must engage in policy advocacy because many of the populations with whom they work cannot advocate for themselves, whether because of insufficient resources, poor health, competing demands, or a lack of understanding of the political system. They rely on social workers to provide policy advocacy when they cannot.

Techniques for effective advocacy for health social workers and others:

- **Create opportunities for clients to meet with legislators or other key stakeholders.** Social workers often have the connections, means, and ability to organize lobby days or events that connect their clients to policymakers. These events could be in-district meetings or town halls, or an invitation to a legislator to tour an agency and meet directly with clients.
- **Testify at hearings.** Testifying before policymakers is an important intervention point when advocating for or against a specific policy. However, social workers who want to testify should first check with their supervisors and refer to employment policies, to ensure their department or agency does not prohibit policy advocacy on the job. They may be able to testify for informational purposes only or as an individual not associated with a specific department or agency.
- **Call, e-mail, or visit representatives.** Lawmakers value their constituents' perspectives and input, and direct communication can be an effective way to advocate. Although it is important to express the social work perspective at the federal level, it can be even more important to social workers' clients to advocate at the state or local levels, as state legislation and local policies often have a more direct and immediate effect on clients' health and well-being.
- **Join a local advocacy group that has already organized policy efforts.** Many existing organizations advocate locally, statewide, and federally. Many local groups target health issues such as affordable and quality health care, increased funding to clinics that serve low-income individuals, and access to healthy food. By joining their efforts, social workers can be part of a coordinated effort to effect policy in their state or community.
- **Pitching stories to media.** The media is another outlet to reach lawmakers. Most policymakers consume media from their area; profiles on clients or letters to the editor can highlight a perspective that many lawmakers may not have.
- **Focus on building relationships.** Similar to working with client populations, social workers in the policy arena must build relationships with lawmakers. First, they should find out what communication style works best for which lawmaker—personal stories or facts, e-mail or in-person communication, and so on—and use it to make an introduction. Then, they can offer to help a lawmaker get support for legislation he or she filed that aligns with social work values.

In addition to the strategies described above, the figure titled "How a Bill Becomes a Law in the Missouri House of Representatives" highlights key opportunities for health social workers and others to make a difference via state-level advocacy in Missouri. While specific processes vary among states and differ at the local, state, and federal levels, the figure can serve as a starting point for social workers interested in identifying opportunities to shape policy in their area of practice. As is clear in the figure, opportunities abound for social workers to advocate for policies that result in healthier individuals, families, and communities.

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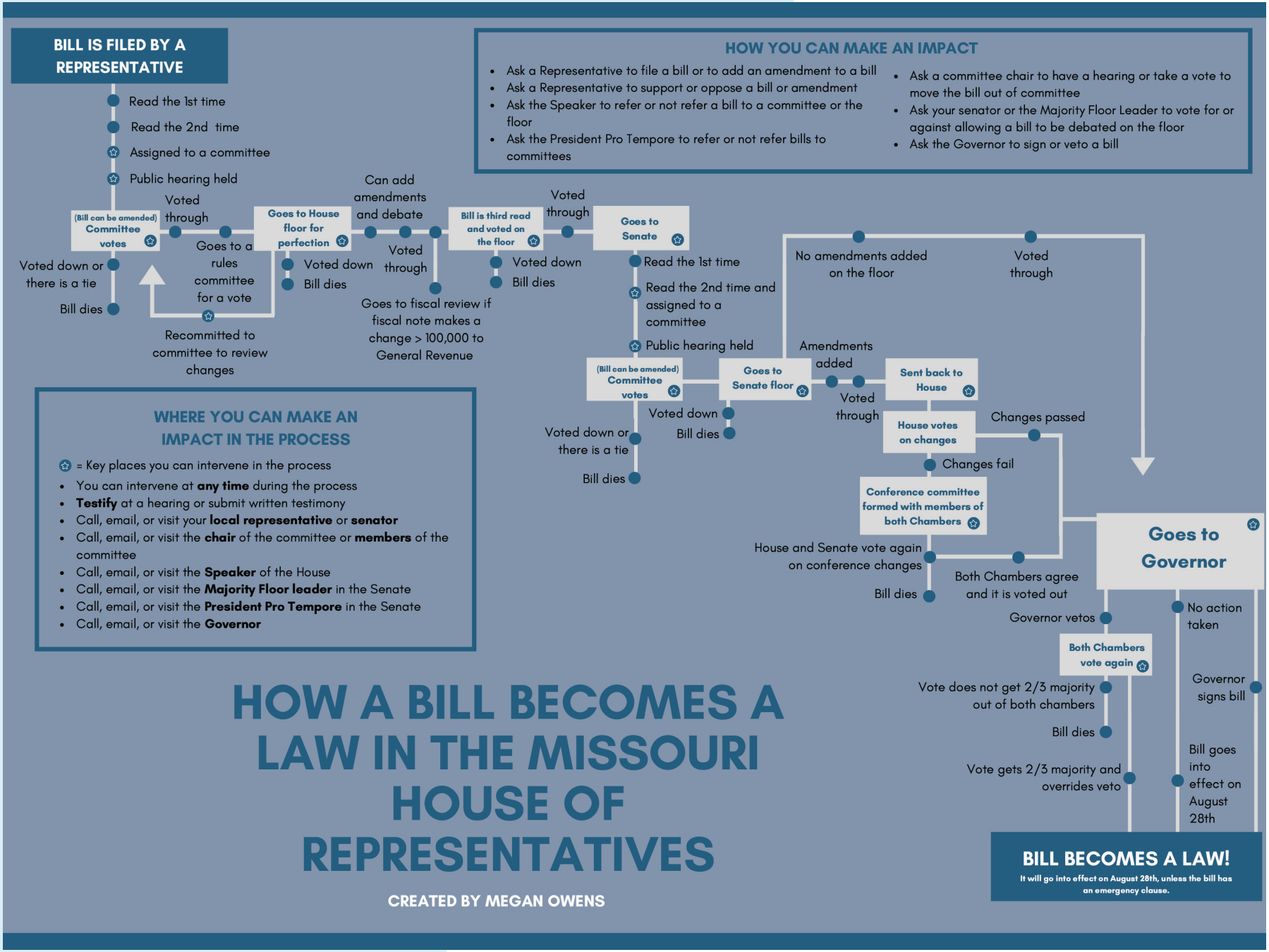
BILL IS FILED BY A REPRESENTATIVE
Read the 1st time
Read the 2nd time
Assigned to a committee
Public hearing held
(Bill can be amended) Committee votes
Voted through
Voted down or there is a tie
Bill dies
Goes to a rules committee for a vote
Recommitted to committee to review changes
Goes to House floor for perfection
Voted down
Bill dies
Can add amendments and debate
Voted through
Goes to fiscal review if fiscal note makes a change > 100,000 to General Revenue
Bill is third read and voted on the floor
Voted down
Bill dies
Voted through
Goes to Senate
Read the 1st time
Read the 2nd time and assigned to a committee
Public hearing held
(Bill can be amended) Committee votes
Voted down or there is a tie
Bill dies
Voted down
Bill dies
Goes to Senate floor
No amendments added on the floor
Voted through
Amendments added
Voted through
Sent back to House
House votes on changes
Changes passed
Changes fail
Conference committee formed with members of both Chambers
House and Senate vote again on conference changes
Bill dies
Both Chambers agree and it is voted out
Goes to Governor
Governor vetos
Both Chambers vote again
Vote does not get 2/3 majority out of both chambers
Bill dies
Vote gets 2/3 majority and overrides veto
No action taken
Governor signs bill
Bill goes into effect on August 28th
BILL BECOMES A LAW!
It will go into effect on August 28th, unless the bill has an emergency clause.
HOW YOU CAN MAKE AN IMPACT
Ask a Representative to file a bill or to add an amendment to a bill
Ask a Representative to support or oppose a bill or amendment
Ask the Speaker to refer or not refer a bill to a committee or the floor
Ask the President Pro Tempore to refer or not refer bills to committees
Ask a committee chair to have a hearing or take a vote to move the bill out of committee
Ask your senator or the Majority Floor Leader to vote for or against allowing a bill to be debated on the floor
Ask the Governor to sign or veto a bill
WHERE YOU CAN MAKE AN IMPACT IN THE PROCESS
= Key places you can intervene in the process
You can intervene at any time during the process
Testify at a hearing or submit written testimony
Call, email, or visit your local representative or senator
Call, email, or visit the chair of the committee or members of the committee
Call, email, or visit the Speaker of the House
Call, email, or visit the Majority Floor leader in the Senate
Call, email, or visit the President Pro Tempore in the Senate
Call, email, or visit the Governor
HOW A BILL BECOMES A LAW IN THE MISSOURI HOUSE OF REPRESENTATIVES
CREATED BY MEGAN OWENS

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A Trauma-Informed Approach to Supporting Immigrant Students and Families in Schools

Leticia Villarreal Sosa, PhD, LCSW

> The greatest hope for traumatized, abused, and neglected children is to receive a good education in schools where they are seen and known, where they learn to regulate themselves, and where they can develop a sense of agency. At their best, schools can function as islands of safety in a chaotic world (Van der Kolk, 2014, p. 353).

Van der Kolk's words ring true more than ever for undocumented and second-generation immigrant children in today's chaotic and traumatic world. Recent policy decisions by the Trump administration to separate children from their parents at the border has placed the trauma inflicted on these children and families—as well as the human rights violations of these acts—at the forefront of national and international conversations. For immigrant families with mixed immigration status, particularly individuals from Latin America, the potential for family separations from detentions and deportations has been a consistent experience and fear. Approximately half a million U.S. citizen children experienced the detention or deportation of a parent during the two-year period of 2011 to 2013, and an increasing number of health care providers report symptoms of "toxic stress" such as depression and anxiety due to fear that a family member will be deported (American Immigration Council, 2018). Furthermore, the Pew Research Center estimated that in 2014 about 3.9 million school children, many of whom were U.S. citizens, had at least one unauthorized immigrant parent (Passel & Cohn, 2016). Given these numbers, the potential impact of the current anti-immigrant climate, and levels of detentions and deportations, schools across the U.S. must address the needs of and support these children.

Undoubtedly, these forced separations of children from their families—either at the border or from detentions and deportations—are traumatic events. The adverse effects of trauma on children's mental health and functioning in the school setting materializes in student attendance, academic achievement, concentration, memory, sleep, and behavior (American Immigration Council, 2018). Although social workers and the media have had conversations about the impact of developmental trauma, there is a form of trauma that has been perpetuated in this case that has not been discussed: historical or identity trauma. This article will discuss the impact of this developmental and historical (identity) trauma inflicted on communities, and it will address how we, as school social workers, can respond to and support children and families affected by these events and the ongoing political climate. We must remember that all immigrants and second-generation youths who feel targeted by the xenophobic and anti-immigrant climate are affected, not just those who are undocumented. Families, communities, and children do not need to have directly experienced the family separations, detentions, and deportations to feel the traumatic effects of this chaotic and hostile moment or to experience the intergenerational transmission of the trauma that parents or caregivers may have experienced.

Complex Trauma

It has been well reported in the media (e.g., Healy, 2018; Miller, 2018) that the recent separations of families at the border are traumatic experiences for children, affecting both attachment and emotional regulation and having the potential for lifelong effects. What has been less often reported in the media, but documented in the research literature, are the parent and child separations that have already occurred because of detentions and deportations. In fact, these family separations combined with the anti-immigrant climate have created fear about potential family separations, which affects the mental health of immigrant and second-generation children. One of the consequences of these family separations and the anti-immigrant climate is the development of complex trauma owing to two different processes. Complex trauma is defined as "traumatic attachment that is life- or self-threatening, sexually violating, or otherwise emotionally overwhelming, abandoning, or personally castigating or negating, and involves events and experiences

that alter the development of the self by requiring survival to take precedence over normal psychobiological development" (Courtois & Ford, 2016, p. 25).

Among the four types of trauma that Courtois and Ford discussed (2016), two are particularly relevant to immigrant and second-generation children, although these types are not often addressed: Type III and Type IV trauma. Of the various immigrant groups, the Latinx community is most often subjected to discrimination surrounding immigration status (Pew Hispanic Center, 2010). This discrimination has only increased, as a political discourse specifically labeling Mexicans and Central Americans as criminals has entered the mainstream. Latinx families continue to experience fear, discrimination, and oppressive conditions, and the effects are magnified for those in mixed-status households. In this atmosphere of xenophobia and hate, Latinx children's development is compromised by what Kira (2010) refers to as Type III or Type IV trauma. Type III trauma refers to trauma inflicted on a person based on his or her identity. Type IV trauma refers to trauma inflicted based on community membership. This trauma can manifest itself in two ways: through an act, such as the separation of children from their families, or through daily microaggressions (Courtois & Ford, 2016), such as the climate many children experienced in the aftermath of the Trump election. Many children repeatedly had their citizenship interrogated and heard messages questioning the worth of people who are undocumented (Ayón, 2016; Costello, 2016). These family separations did not occur in an apolitical vacuum and are directly targeted at particular immigrant groups. Type III or Type IV traumas are also considered "historical trauma." This phrase refers to events that target an entire community, such as the mass immigration raids of present day or the forced deportation of Mexican Americans (of whom more than half were U.S.-born citizens) in the 1930s. These events become cumulative group trauma that is passed on across generations (Estrada, 2009).

School Social Workers Addressing Trauma

Given the complex nature of trauma and traumatic events faced by immigrant and second-generation youths, school social workers can play an important role in ensuring their psychological and emotional safety in the school setting. School-based interventions must include prevention and intervention efforts at the Tier 1 level that address discrimination in both child-to-child and teacher-to-child interactions. These interventions could include activities that increase awareness about diversity and equity, support teachers to build relationships with immigrant parents, and consider the overall school climate toward immigrant and second-generation youths. Connecting parents and children to advocacy efforts and community-based supports are also important, as trauma inflicted on an entire group or community is often best supported by addressing these issues as a community in addition to individual-level support. Children and adolescents may feel a sense of empowerment by participating in advocacy efforts, enhancing their resiliency in the face of adversity, particularly at a time of extreme powerlessness, discrimination, and loss.

Given the lack of access to mental health services for the undocumented community, the school social worker may be one of the few mental health service providers available to immigrant and second-generation families. Fear may also prevent mixed-status or undocumented families from seeking community services; thus, the provision of Tier 2 or Tier 3 services may be essential services that school social workers provide to immigrant and second-generation youths. We, as social workers engaged in this mental health work, must understand youth behavior in a racialized and trauma-informed context. We can support schools to respond to immigrant and second-generation youths in ways that honor this context—rather than in ways that treat them as the potential "criminal" or "gang banger"—and create awareness of biases toward immigrant and second-generation youths that manifest themselves in inequitable discipline practices. As a school social worker, I had several experiences where the very same behavior was responded to or interpreted differently depending on the race, immigration and/or generational status, class, and gender of the student. Thus, one youth's quiet demeanor was seen as "polite," while another's was seen as "withdrawn" and "disengaged." As stated by Menakem (2017), trauma work needs to be contextualized within a reality of white supremacy and how this lives in the bodies of both people of color and white people as somatic neurobiological responses and long-term health issues. To be effective in this work, social workers must challenge themselves to do their own work on trauma awareness and racial justice.

Interventions at all levels need to recognize that trauma lives in the body, and we must provide opportunities for children to develop somatic awareness and process trauma. In addition to using sensory and body awareness approaches in our individual and group work, we must also advocate for maintaining or reinstating much needed physical education and recess in our schools (Menakem, 2017; Van der Kolk, 2014). One of the most critical aspects of any approach is what is often called a "relational" approach. In other words, any intervention—when provided by caring and supportive adults who show "empathy, self-awareness, compassion, and positive regard" (Courtois & Ford, 2016, p. viii)—will be more effective, independent of empirically tested, evidence-based practices.

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Separating Immigrant Children From Families: The Need for a Coordinated Social Work Response to This Human Rights Crisis


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In May 2018, Catalina, a three-year-old girl from Honduras, crossed the border in Laredo, Texas, with her father, mother, and nine-month-old brother. There, her family was apprehended, and Catalina was removed from her mother's arms. Her mother and brother were detained together, but her father was separated from his wife and children and detained at the Rio Grande Detention Center. Shortly after being taken from her family, Catalina was placed in a short-term foster care program run by Lutheran Immigration and Refugee Service (LIRS). When Catalina arrived, she was noticeably affected by her separation from her family; while trying to tell her story, Catalina cried and was upset. Multiple attempts were made to reach Catalina's father in the detention facility, but the facility's staff would not connect the case manager to Catalina's father.

While in foster care, Catalina has been engaged in play therapy. Although initially reluctant to attend, she has started engaging with the therapist. However, during one session, she broke down crying while sharing a horrific event she witnessed: her grandmother's murder by a police officer.

In early June, Catalina's mother and brother were released, and they made contact with the LIRS short-term foster care staff, who facilitated a video call between mother and daughter. Catalina sobbed throughout the call and stated she wanted to be with her mom. After the call ended and Catalina began to play in the sand tray, she turned to the therapist, asked about her father, and began to cry again. She begged to be with her parents. To help Catalina cope with being separated from her family, her foster parents are learning relaxation techniques. Although Catalina enjoys playing with her infant foster sister and cries less at bedtime, she cannot comprehend why she was taken from her family. She frequently asks to go home to her family. At this time, Catalina remains in the LIRS short-term foster care program until the reunification process is successfully facilitated.

Catalina is just one of more than 2,342 children estimated to have been separated from their parents at the U.S. border during the period of May 5 through June 9, 2018, as a result of the Trump administration's "zero tolerance" policy, according to Customs and Border Protection (CBP; Kates, 2018). This includes "tender-age" children—those under the age of five—who have now spent months separated from their parents. Some have taken their first steps and spoken their first words in a federal immigration detention center (Bowden, 2018).

On May 7, 2018, former Attorney General Jeff Sessions announced that any border crosser who does not present at an official port of entry will be apprehended and prosecuted. He stated further, "If you are smuggling a child, then we will prosecute you, and that child will be separated from you as required by law. If you don't like that, then don't smuggle children over our border." This effectively meant that all parents detained at the border would face prosecution, spend time in federal jail, and be separated from any accompanying children, who would then be sent to a shelter if an adult

sponsor or family member was not available (Barajas, 2018). This "zero tolerance" policy seems to be rooted in a "migration deterrence approach," first articulated in March 2017 by then Secretary of Homeland Security John Kelly to CNN. It has since been walked back due to significant backlash (Diaz, 2018). Advocates have long called into question the morality, ethics, and even legality of separating children from their parents as a measure to deter further immigration.

Stemming from the claim that U.S. borders are under siege and that unauthorized border crossings have surged, the Trump administration has called for various immigration enforcement policies, including the construction of a wall at the U.S.-Mexico border. However, data from the nonpartisan Migration Policy Institute (MPI) indicates a "downward trend" in migration over the past 18 years, with an increased proportion of migrants traveling as families or as unaccompanied minors in 2017 and 2018. MPI reports that 36 percent of those who have been apprehended in fiscal year (FY) 2018 are either families or unaccompanied children, compared with only 10 percent of those who were apprehended in FY 2012 (Bolter & Meissner, 2018). For these families—many from the Northern Triangle of Honduras, Guatemala, and El Salvador—migration to the United States is an untenable choice between enduring violence, poverty, and persecution in their countries of origin or crossing the border and risking separation from their children (Carcamo, 2018). The cruelty of separating children from mothers and fathers, many of whom have already experienced significant trauma and hardship, as a tactic to deter migration is breathtaking. Moreover, challenging the Trump administration's claim that migrants seeking asylum will not be detained if they present themselves at an official port of entry, reporters and advocates indicate that CBP officials are indeed turning away asylum seekers at ports of entry and have even been found physically stopping migrants from setting foot on U.S. soil (Lind, 2018; Moore, 2018). While CBP states that these actions result from a lack of capacity to process migrants, advocates have called out the legality of such actions in accordance with federal and international asylum law (Amnesty International, 2017).

Amid rising public outrage, largely due to the efforts of immigrant rights' advocates to shed light on this human rights crisis, President Donald Trump signed an executive order on June 20, 2018, to end the separation of children from their parents when detained for crossing the U.S.-Mexico border. On June 26, 2018, Dana Sabraw, a U.S. district judge from California, called for separated children younger than age five to be reunited with their parents within 14 days and all separated children to be reunited within 30 days. Judge Sabraw referred to the government's family separation policy as "brutal, offensive," and contrary to "traditional notions of fair play and decency" (Tchekmedyian & Davis, 2018).

Though families had started to be reunified, since that time questions still remain as to whether all reunifications will be possible and on what timeline. President Trump's executive order may have shifted the crisis into another form: while ending child separation, the order called for indefinite family detention and the modification of the Flores agreement, which determines standards of care for immigrant minors in federal custody.

Video footage shot by activists of these reunions have shown some joyful and emotional moments between parent and child, but some have also revealed the heavy toll of family separation, showing children who are emotionally withdrawn.

Reports from released children indicate unsanitary conditions in ill-equipped facilities, including a previously closed office building in a strip mall in Phoenix where children were reported to bathe themselves in sinks; many there were exposed to lice, chicken pox, and bed bugs (Bogado, 2018; Gross, 2018). For children housed in short-term foster care, reports from foster parents indicate the children had suffered emotional trauma from the separation, as illustrated in the case of Catalina and in a New York Times article about José, a five-year-old boy separated from his father, whose only consolation from his grief was a hand-drawn picture of his father (Jordan, 2018). Even in shelters such as Southwest Key, a nonprofit that advocates have validated in the past for being a more "humane, culturally sensitive alternative to for-profit and government-run facilities," reports indicate that workers are undertrained, overworked, and overwhelmed (Surana & Futurechi, 2018).

The National Association of Social Workers (along with other major associations, including the American Psychological Association and the American Academy of Pediatrics) has published a strong statement condemning the separation of immigrant children from their families, and recently there was a coordinated move by many deans of schools of social work to publish their own statements against such policies. However, there remains little guidance regarding the role of social workers in providing assistance through this crisis. On a Twitter chat organized by #MacroSW Collaboration, social workers discussed feeling helpless about the implications of family separation on child and adult well-being. Some felt torn about whether social workers should work in shelters and detention centers that are based on an unjust policy of family separation; others reflected that social workers can advocate within such systems for the best interests of the child, and they can offer solace as well as much needed therapeutic and mental health services.

Social workers are right to be concerned about the injustice of family separation. Child welfare research has clearly shown that child attachment is key to healthy development, and insecure attachment and trauma have a deleterious and long-term impact on a child's outcomes. Such times call for focused and coordinated efforts by social work organizations; they must set guidelines, develop organizing principles, and provide leadership for the many social workers who are ready but uncertain of how to engage in action.

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