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OF THE NEW YORK CITY CHAPTER

National Association of Social Workers

NASW

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Chapter Staff Member Christina (Nzinga) Reid Works After Work

Launching a Non-Profit Called "Black Diaries" to Examine the Context of People's Lives

Editor's Note: *Currents asked the Chapter's Program Manager for Continuing Education, Christina (Nzinga) Reid, to submit an article about the work that she and her colleague are doing to focus on the lives of people in the African diaspora. Given the Chapter's priority of focusing on the many dimensions of racism, diversity and intersectionality in American society and New York City, Christina's work is innovative, inspirational, and unique. We encourage you to check out her website, Black Diaries.org, after reading this article.*

Christina (Nzinga) Reid with the co-founder of Black Diaries Tyrone (Ty) *Nero*

New York-based Black Diaries: You Don't Know My Story provides an outlet for people of color to share personal narratives for community building through social media commentaries, town hall meetings, and community organizing projects. Based on the idea that people are experts of their own lives, Black Diaries narrative approach to counseling and community organizing focuses on the voices of individuals, not just their circumstances.

Its founders, both social workers, view the non-profit (Black Diaries) as a catalyst for social change amplifying and unifying the once silenced voices of the marginalized into a mighty mobilized force through personal accounts. These collections of "diaries," or interviews, seek to examine the broader context of lives resulting from the African diaspora.

Black Diaries mission, consequently, is to engage healing-stream narratives contrary to the stories about Blacks told negatively from media outlets and research that fuels stereotypes that are cast onto this community. Believing that systemic oppression can be overcome through the marriage of education and social action, Black Diaries therefore aims to:

- Create and/or enhance community among individuals of color domestically and globally.
- Focus on community empowerment thereby enabling more people of color - specifically residents in low-income environments - to actively participate in the decision-making process that affects their neighborhoods.

- Inform the public to challenge racial stereotypes in hopes of ending discrimination and systemic oppression of minorities by unveiling its negative impact.
- Ensure the social equality of all citizens.

In April of 2015 during a string of protests known as the "The Baltimore Uprising," Black Diaries organizers took a team of social workers on multiple trips to Baltimore, Md. to engage in narrative therapy with demonstrators. The team desired to give voice to the various crossroads and intersections that resulted in the protest and some riots. They listened as community members shared accounts of racism, systemic oppression, and multi-generational poverty; a recurring theme in the lives of far too many Blacks and people of color.

Children from a small orphanage in Port Au Prince, Haiti recounted similar stories during an international trip by Black Diaries last year in expressing their lives. Using their narrative framework, the Black Diaries team focused on how the children perceived themselves and interpreted their experiences, which is foundational in the formulation of the Black identity.

Black Diaries team and children from a small orphanage in Port Au Prince, Haiti. Click here to view video of the trip.

The heart and soul of this organization are its creators Christina (Nzinga) Wilkerson Reid and Tyrone (Ty) Nero, graduates of Columbia University School of Social Work 2014. The pair established Black Diaries in 2014 while graduate students at the Columbia University after witnessing many minority students facing micro-aggressions and isolating times during matriculation. The cohorts asked students and alumni to advise incoming Black students entering a predominantly White college. The responses led to a "video diary" chronicling first-hand experiences of the advisers. The project -- Columbia Diaries: A Black Students Survival Guide --included noteworthy observations by scholar, Dr. Carl Hart, a neuropsychopharmacologist at Columbia University.

Reid and Nero have similar life experiences as African Americans reared in single-parent homes located in low-income communities. Their own experiences demonstrate an overcoming spirit. In 2011, while a student at the University of Southern California, Christina Reid fell victim to gun violence; wounded in her left hand attempting to push a friend out the trajectory of a bullet when a dispute escalated between two strangers. Despite her injuries, she suppressed the other victim's bleeding chest and administered CPR. Her lifesaving action earned a "Community Hero" award presented by LAPD Chief of Police Charlie Beck in January 2012. More importantly, this event set the stage for her devotion to social work. She would go on to graduate as the Valedictorian of the Black graduating class due to her GPA combined with her community service involvement.

Ty Nero has worked in social services since 1989 guided by life experiences for his passion in this field. Nero's mother died of AIDS at the age of 42. He suddenly became the guardian of five brothers and sisters at the age of 19. To support himself, and his family, Nero joined the Air Force devoting a decade to military service, which sparked interest in psychology and social work. Nero is a noted disabled veteran in tuned with the complexities of working with Black and African American individuals and families. As a civilian, he has worked in the fields of foster care, residential treatment center care, New York City Housing, financial management and AIDS Advocacy.

As a team, Reid and Nero understand first-hand the concepts of class differences in socioeconomic status, the intricacies of Marx's conflict theory of class struggle, and the reproduction of poverty. Their social work backgrounds formulate their identities, which birth Black Diaries. They are currently holding multiple events around the New York City area, including a book reading and discussion of "My Father is In Prison" by Patrick Baker at Harlem Nights on June 18, 2016.

More information about this organization can be found by visiting www.blackdiaries.org.

NASW NEW YORK CITY CHAPTER
National Association of Social Workers

June 17, 2016

NASW-NYC joins with the Latinx* and LGBTQ Community in Mourning Victims of Orlando Shooting and Calls for Gun Control

The Sexual Orientation Gender Identity and Expression (SOGIE) Collective, Coalition on Race, Diversity and Intersectionality (CRDI) and Latinx Social Work Collective of the NYC Chapter of the National Association of Social Workers joins in solidarity with the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community as it mourns and honors the victims of the Orlando shooting at Pulse Nightclub, which claimed 49 lives and injured 50 others.

The chapter expresses sincere condolences to the families and loved ones of the victims and calls for the tragedy to be identified as what it is, a hate crime against the LGBTQ community. The erasure of the Latinx and LGBTQ community cannot continue and social workers are called now – more than ever – to take a stance against gun violence which claims the lives of so many in this country.

Last year, the National Association of Social Workers released recommendations on addressing racism, gun violence and mental illness and they can be found here: http://www.socialworkblog.org/advocacy/2015/06/6628/. The NYC Chapter echoes these recommendations and the call for chapters and social workers to organize in an intentional manner to stop the violence, particularly violence aimed at those most vulnerable: LGBTQ communities of color.

The NYC Chapter joins with other organizations and groups in expressing that tragedies of violence cannot be alleviated by more violence. Attempts have been and will be made by political interest groups to promote Islamophobia. These efforts perpetuate violence targeted at the Muslim community and should not be sanctioned by those who are called to protect the inherent worth and dignity of peoples.

In addition, attention must be paid to the role of mass media and its responsibility in condemning further violence against LGBTQ and communities of color rather than perpetuating it. At such a painful and traumatizing time, communities need to remain unified and committed to the prevention of more violence. Social workers can use the tools and resources of the profession to address gun violence in their respective localities and municipalities. Please refer to the article, "An Easy Guide to Contacting Your Elected Representatives About Gun Control" by Nicole Silverberg, which can be found at: http://www.huffingtonpost.com/nicole-silverberg/guide-elected-representatives-gun-control_b_8708154.html.

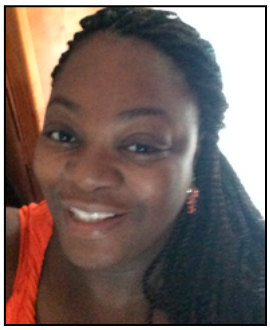
Finally, and very importantly, we ask that you all take care of yourselves during this time. Violence targets us

differently and it affects us all. We encourage you to reach out to colleagues, be kind and patient with yourselves and one another. This is a very delicate time. We remain committed to empowering social workers to create change in the world.

*Latinx, pronounced "La-teen-ex," includes the numerous people of Latin American descent whose gender identities fluctuate along different points of the spectrum.

Rest In Peace:

Stanley Almodovar III, 23 years old
Amanda Alvear, 25 years old
Oscar A Aracena-Montero, 26 years old
Rodolfo Ayala-Ayala, 33 years old
Antonio Davon Brown, 29 years old
Darryl Roman Burt II, 29 years old
Angel L. Candelario-Padro, 28 years old
Juan Chevez-Martinez, 25 years old
Luis Daniel Conde, 39 years old
Cory James Connell, 21 years old
Tevin Eugene Crosby, 25 years old
Deonka Deidra Drayton, 32 years old
Simon Adrian Carrillo Fernandez, 31 years old
Leroy Valentin Fernandez, 25 years old
Mercedez Marisol Flores, 26 years old
Peter O. Gonzalez-Cruz, 22 years old
Juan Ramon Guerrero, 22 years old
Paul Terrell Henry, 41 years old
Frank Hernandez, 27 years old
Miguel Angel Honorato, 30 years old
Javier Jorge-Reyes, 40 years old
Jason Benjamin Josaphat, 19 years old
Eddie Jamoldroy Justice, 30 years old
Anthony Luis Laureanodisla, 25 years old
Christopher Andrew Leinonen, 32 years old
Alejandro Barrios Martinez, 21 years old
Brenda Lee Marquez McCool, 49 years old
Gilberto Ramon Silva Menendez, 25 years old
Kimberly Morris, 37 years old
Akyra Monet Murray, 18 years old
Luis Omar Ocasio-Capo, 20 years old
Geraldo A. Ortiz-Jimenez, 25 years old
Eric Ivan Ortiz-Rivera, 36 years old
Joel Rayon Paniagua, 32 years old
Jean Carlos Mendez Perez, 35 years old
Enrique L. Rios, Jr., 25 years old
Jean C. Nives Rodriguez, 27 years old
Xavier Emmanuel Serrano Rosado, 35 years old
Christopher Joseph Sanfeliz, 24 years old
Yilmary Rodriguez Solivan, 24 years old
Edward Sotomayor Jr., 34 years old
Shane Evan Tomlinson, 33 years old
Martin Benitez Torres, 33 years old
Jonathan Antonio Camuy Vega, 24 years old
Juan P. Rivera Velazquez, 37 years old
Luis S. Vielma, 22 years old
Franky Jimmy Dejesus Velazquez, 50 years old
Luis Daniel Wilson-Leon, 37 years old
Jerald Arthur Wright, 31 years old



Using Cognitive Behavioral Therapy with Children and Families

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Cognitive Behavioral Therapy (CBT) is a model of psychotherapy treatment that focuses on the interconnected relationships between thoughts, feelings and behaviors. It has been demonstrated to be effective in the treatment of numerous mental health issues such as depression, anxiety, and substance use. It is also effective in addressing multiple family relational issues.

CBT has been shown to be effective in family work when it is inclusive of the needs of each family member and the family as a whole. There are three important factors that need addressing before implementing CBT with families. First, the time frame of services needs to be considered. CBT is effective for short-term services ranging from three months to a year. The time frame of services will facilitate the clinician and family in developing meaningful goals and interventions. For example, a time frame of three months may not be a realistic period for achieving a family goal of fighting cessation among children, if the children fight every day. However, it is realistic to have a reduction of every day fighting to 3-4 times a week for that time frame.

Another factor to be considered when applying CBT with families and children is consistency and buy in. The family (children and parents) need to want to give CBT a try and should be willing to attend sessions regularly.

A cornerstone of CBT effectiveness is repetitive practice outside of session in the form of homework. If the family is not attending sessions regularly nor practicing new behaviors or cognitive skills on their own, then it is difficult to achieve set goals within the time frame of services.

Finally, the developmental age of the child(ren) is important when utilizing CBT. The clinician needs to be cognizant of when a behavioral intervention may be warranted. Children under the age of 11 are in the concrete operational phase of their cognitive development and may not be able to fully participate or understand cognitive interventions.

Assessment of the presenting issue is as important as family buy in and commitment in CBT. When assessing the issues that bring a family into treatment, it is important to determine the baseline in order to set meaningful goals with the family and develop effective interventions. The baseline assessment should focus on the frequency (how often is the situation or behavior occurring), duration (how long (timing) is the situation or behavior occurring) and intensity (how severe (magnitude) is the situation or behavior). Furthermore, the focus should not be on a specific child's behavior but on all members of the family to avert anyone feeling targeted.

For example, a parent may state: *the problem is my Child A does not come home on time from school; skips school and has a bad attitude*. It is important to partialize each of these issue by asking how often does A come home late? (Frequency) How late does A come home? (Duration) and how does A behave/react to coming home late? (Intensity). After you get a sense of the severity of the "coming home late" issue then you can move on to the "skipping school" issue and apply the same process. As part of assessing the baseline of the presenting problem, it is also important to inquire from *Child A*

what he/she thinks the issue is, and how the parent acts or reacts. This is essential to facilitating an intervention plan that is inclusive of the Parent and *Child A*. For example, *Child A* may say: *I come home 15 minutes late and my mother/father starts screaming and threatening me with punishment before I can explain what happened*.

Your baseline assessment of frequency, duration and intensity may include how often do you come home late? How often does your parent scream or threaten? How long does it last? How are you feeling when your parent is screaming? You may also ask the parent if he or she agrees that he/she screams and threatens, how he/she is feeling in that moment when A comes home late. It is critical for the clinician to assess each family members perspective of the presenting issue(s) in order to have a contextual baseline for each family member. Partializing each issue allows the clinician to manage concerns coming from multiple viewpoints and have a sense of what the actual baseline is.

Note, even with the best assessment skills, clinicians may still have a fuzzy baseline picture as families sometimes struggle with determining accurate frequency, duration and intensity of situations. Oftentimes, they simply want a resolution to the struggle/issue and find the assessment process frustrating especially when seeking assistance in the midst of an active crisis. Nevertheless, it is important to try and get a sense of the baseline of the main issues of focus from each family member.

Beyond assessing the baseline of the presenting issue, it is important to assess external and internal environmental related factors such as where (school, home, community) behaviors occur; with whom (friends, families, authority figures) it occurs; how family members are reacting to behavior(s); what is the person feeling before, during and after the behavior is occurring; and finally, what the person affected by the behavior is thinking before and after the behavior occurs.

Goal setting is an integral part of creating a behavior change plan in CBT. The clinician can begin to set goals when a thorough assessment of the baseline and context of the presenting issue(s) has been conducted. The goals you develop will determine the intervention you implement thus, goals need to be related to the presenting issue, and they need to be clear and measurable in CBT. In setting goals in CBT with families, it is important that you try not setting more than 2-4 goals for a short-term intervention program. The clinician must be flexible about changing goals when necessary. Most importantly, make sure each family member is invested in the goals that have been set. To formalize the family's goal, you may contract with each member and provide a copy of the identified goals to each member thus, reinforcing buy in.

The intervention phase in CBT begins when goals are formalized. Effective interventions are often aligned closely with goals that were derived from the assessment process. Common interventions in CBT with family focuses on developing or enhancing communication, anger management, coping, problem solving, negotiating, conflict management and resolution skills. Some effective cognitive and behavior interventions are positive reinforcements, time outs, response cost, token economy, positive self-talk, affirmations and cognitive restructuring. During the intervention phase, the family is provided with opportunities to learn and practice new skills individually and together. Families are given homework on a regular basis to reinforce what's learned and in an effort towards goal achievement.

Social workers working with children and families often deal with a myriad of complicated issues such as familial relational problems, mental health issues, poverty, and childhood developmental issues. Addressing these issues while attending to the well being of all those involved requires identifying and utilizing effective interventions. CBT is an effective model of choice, facilitating a collaborative relationship with all family members whilst providing interventions suitable for children and adults.

Immigrant Experience and Cultural Competence in Delivering Educational and Human Services

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For some time now, both in the human services and higher education there has been a demand for cultural competence, yet the elements of cultural competence have not been clearly defined. In addition, there has not been a standard formula for developing a culturally competent system of care nor teaching. Cultural Competence as a concept or movement emerged in response to concerns that certain populations, including immigrants were underserved. In human services, it evolved as a model consisting of cultural awareness, cultural sensitivity, knowledge acquisition and skill development.

In higher education, the idea of instituting cultural competence took the form of the development of diversity policy, often through Affirmative Action Committees. In 2001, the NASW (National Association of Social Workers) 10 standards of cultural competence describe an array of knowledge, skills, and expected behaviors that demonstrates the ability to function effectively with diverse groups. The cultural competence movement further grew by addressing the social context of diversity, racism, homophobia, discrimination, and oppression, including ethnic, gender, and sexual oriented groups and social and economic justice concerns (NASW Cultural Standards PDF, 2015). As we deliberate these issues, however, we must apply them to both the recipients of service and providers of service.

In this regard, the New York State Agency for Children's Services established the Racial Equity Cultural Competency Committee. The goal is to eliminate poor outcomes (disproportionality and disparity) for families of diverse populations, including immigrant families, within the child welfare system. It also focuses on the development of a racial equity impact assessment tool for child care practitioners, welfare policy analysts, and administrators to help reduce institutional racism (NYS Office of Children and Family Services, 2013).

With the continuous increase in the number of immigrant groups utilizing social services and attending educational institutions there is a growing need to address the issues and concerns of this group (Matthews, 2014; Voices of New York, 2016). In response to this need, this writer believes that one of our challenges as educators is to use mentoring/teaching strategies and activities that enhance students' (transformative) learning process so they develop integrative knowledge about themselves and others in a multicultural society, from different perspectives. This is at the core of cultural competence.

In working with immigrants, whether in human services or educational setting, it is important to understand that the transitional experiences impact their adaptation and aspects of their culture may enhance or preclude their full participation in various social institutions, including social service and education. Many newly arrived immigrants (or transnationals, a term used in contemporary literature on immigrants) may not have a good command of the English language. Nor are they acculturated to many of the customs and norms of the host society.

Consequently, it is often difficult for some of them to fully comprehend available social services, or to access and navigate such services efficiently. They may not be able to adequately give informed consent or participate as partners in setting goals and working toward change. Is an agency or educational institution deemed culturally incompetent if it does not have interpreters or staff of the same ethnic group/cultural background as the client/student? In response to this question, within the context of higher education systems and human service delivery, it is important to understand the immigration experience characterized by the processes of encounter, interaction and exchange. Paternalism, patronizing, xenophobia as well as accommodation are other elements to be considered in this process.

Recognizing the hegemony of racism and ethnic disparity that are embedded in the structures of the United States and the dilemma these forces create for some immigrants, it is assumed that they enter a society that is more prosperous than the ones they left behind, but they also join the ranks of America's most frequently oppressed groups. Having come from societies where people like themselves are in the majority, their newly realized identity and racial and ethnic divisions they encounter do not escape their attention. Their 'otherness' becomes pronounced in various social situations.

In light of the above, in thinking about cultural competence as it relates to immigrants and other populations, these issues must be considered. There are several definitions of cultural competence. One that I find useful is: "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, et. al. 1989). Such a definition captures critical dynamics of intervention within educational and human services. It also highlights the importance of organizational collaboration and change agents' understanding the needs of culturally different groups in effectuating meaningful change. Such understanding is critical to the work of groups such as the Coalition of Race, Diversity and Intersectionality (CRDI), which would be instrumental in fostering cultural awareness and effective intervention.

I will close by raising a few questions that Social Work and other faculty members need to think about. Assuming that faculty believe that a culturally competent system of delivering educational services is important, should colleges and universities develop a more robust culturally competent way of providing educational services? What form should this take? Should it be imbedded in the information we disseminate (historical contexts and facts regarding contemporary issues across Disciplines)? What about the methods involved in providing such information? What really constitutes a culturally incompetent system of education? How do educators, practitioners, Para-professionals and other support staff learn about different cultures and the most effective ways of applying that knowledge in the delivery of educational/social services? Is the current institutional Diversity Training effective? How do we respond to students whose perspective on issues such as race relations, political ideology and the impact of globalization differs from ours? How do you respond in a classroom setting when there are intense debates among students about these issues, while sustaining a positive learning environment? How do you deal with a situation in which a student openly disrespects another's culture, gender orientation, religious belief, ethnicity or country of origin?

Finally, it is assumed that in higher education, 'academic excellence' is and should be one of the principle goals. However, 'academic excellence' should not be measured only in terms of scholarship or mastery of subject matter, but it must include the ability to address diversity issues, social justice, human rights and equity.

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Voices of New York (2016, May 13). Showcasing the best of community and ethnic media. Source: Manhattan Times.


Sarah Strole


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Using Ourselves in Clinical Trauma Work

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Social work is fundamentally about relationships. While the importance of relationality is widely acknowledged— we might call it an alliance with the client, or engagement—it is less widely understood how to build a strong client/therapist relationship. We argue this process is fundamentally about the use of self, and further argue this use of self is especially critical when working with clients who have experienced chronic trauma.

The use of self exists on a spectrum. It can, and should, look different depending on the client, therapist, and situation. Use of self might mean playing a game with a child, or responding to a question regarding personal preference. It might mean not responding to a question and explaining directly why you are choosing to not respond. This guidance may feel frustratingly vague, but there is no prescription. Social workers must use their assessment skills, professional judgment, and active feedback from the client. It takes a lot of courage to enter a space requiring subjective decision-making particularly when traditional education has advised therapists to follow the Freudian model of revealing as little of themselves as possible to clients.

Freud hypothesized that therapists needed to remain unknown in order for clients to project unconscious drives, beliefs, and fears onto the therapist, allowing for the content to be processed and resolved. Freud also wanted to protect against clients censoring content. Freud's rationale makes sense in some cases, but there are significant exceptions. For clients who have experienced trauma, the content impairing functioning is typically not in the unconscious. Remaining opaque to clients is also unrealistic in an era where information can be found at the click of a computer key. Even before the age of the internet, clients were able to discern much about our history, our preferences, and our values, simply based on our appearance. The question, then, is not whether use of self is important; it is how to use ourselves in service to our clients.

There is a fear that relationality exists only at the polarities: either the therapist is opaque, or they dominate each session with their own views and stories. There is a middle ground where useful and healthy relationality lies, and each therapist will find a different middle ground. In order to find this middle ground ethically and successfully, social workers first have to be self-aware with a good understanding of what emotions are at play and where sensitivities exist. Second, social workers must have a good awareness of the client, staying attuned to how the client is feeling. This can be as simple as asking directly how they are feeling or providing them with some educated guesses on how you imagine they might be feeling. Finally, therapists need an accurate assessment of their relationship with the client. How has your client been presenting? Have there been any large changes in your client's presentation? How long have you been working with your client? Is the client currently in crisis?

Alongside these guidelines, keep in mind the same interpersonal skills clinicians teach clients are used to build relationships with clients: clear expression of emotions and needs, empathetic responses, and appropriate self-disclosure.[1] We encourage social workers to respond authentically and honestly to

clients, modeling emotional expression and awareness, as well as curiosity regarding the client's concerns, needs, thoughts and feelings.[2] The therapist demonstrates how the client impacts the therapist, and redefines both therapist and client as equal and dynamic agents in the therapeutic process. This is particularly important with clients who present with poor interpersonal skills and a flattened affect, as is typical in clients who have experienced chronic trauma. In being willing to have emotional responses and model appropriate responses, therapists help clients with restricted emotions develop confidence in the ability to not only modulate the intensity of reactions as they see fit, but also that it is possible to have emotional reactions and still remain in relationship with another person.

Relationality enhances cultural competence and client agency. It reduces the inherent power dynamic between therapist and client, giving the client more control. For chronic trauma, the foremost issue is not anxiety provoked by triggers, but rather the stress of the unpredictable and uncontrollable. Allowing the client access to information about the therapist permits the client to assess the therapist and to use that information to calibrate their own reactions and choices, reducing client risk and anxiety. Honestly acknowledging and discussing your personal culture removes the stigma from the conversation, and when you ask about your client's culture, positions the client to be the expert.

Obviously, there are many traps therapists can fall into when using themselves more relationally. One of the most common traps is over-sharing. In this instance, a social worker fails to identify how, or even if, what they are saying is helpful to the client. While this is a very common trap, it is also easily solved. Check in with your client. Ask if your client is interested in hearing what you want to say. Remember your client is alive and has agency; they are usually able to say what they want or don't want.

Therapists also can run the risk of sharing inappropriate information. But what may be over-sharing in one situation might be necessary in another. Typically sharing with a client that a family member is sick would not be appropriate. But if, because of illness, a therapist will take a significant amount of time off, it might be appropriate to share that information. Again, there is an easy solution: ask yourself the purpose of what you are saying and ask the client if it is helpful for them.

Another common trap is assuming social worker feelings and beliefs are the same as their client. This looks like a therapist who fails to check in to see how the client is feeling,or a therapist who demands the client conform to therapist expectations. It could also look like a therapist who fails to acknowledge the unique expertise their client may have, re-teaching clients skills they already possess.

A final big trap clinicians can fall into is blurred social boundaries, particularly with the ubiquity of social media. This can happen when clinicians conflate authenticity, transparency, and relationality for friendship. We are still providing a professional service, and those boundaries should be clearly discussed and understood. Since boundaries are important in all relationships, having these conversations with our clients can help clients learn and practice this skill.

All evidence-based practices emphasize the therapeutic alliance, what we call relationality, as critical towards therapeutic efficacy. We argue that the authentic use of self is critical in building relationality, particularly when working with clients coming from traumatic and chronically traumatized backgrounds. Social workers are particularly well trained to draw upon client strengths to build a more effective therapeutic relationship, and to make professional determinations on when and what levels of self-disclosure are in service to their clients.

(Endnotes)
1 Glenn M. Callaghan, 'Functional Assessment of Skills for Interpersonal Therapists: The FASIT System,' Behavior Analyst Today 7, no. 3 (2006); D. Watts-Jones, 'Location of Self: Opening the Door to Dialogue on Intersectionality in the Therapy Process,' Family process 49, no. 3 (2010).

2 Constance J. Dalenberg, 'On Building a Science of Common Factors in Trauma Therapy,' Journal of Trauma & Dissociation 15, no. 4 (2014); Lucia Haene et al., 'Voices of Dialogue and Directivity in Family Therapy with Refugees: Evolving Ideas About Dialogical Refugee Care,' Family process 51, no. 3 (2012).

Addressing the Increasing Incident of Suicide

Designing Systematic, Multi-Dimensional Approaches to Suicide Prevention

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Suicide is a known nation public health problem and the national is currently experiencing, often double digit, increases in suicide rates in most states around the country.

Provider training, depression screening, and means restriction are all simple steps that any organization can undertake. However, implementing one screening or integrating one component of care is not enough; organizations need to design systematic, multi-dimensional approaches to suicide prevention. The implementation of a multimodal approach can dramatically improve the ability of providers to both identify and treat patients at risk for suicide, ultimately saving lives.

One of the first suicide prevention activities should be the systematic training of all clinicians in Assessing and Managing Suicide Risk (AMSR) and all staff, clinical support, and administrative staff, in SafeTALK. AMSR and SafeTALK are both evidence based trainings.

Patients should be screened at least annually using a tool such as the Patient Health Questionnaire 2 (PHQ-2) (12) and 9 (PHQ-9) item screening instruments. Patients who endorse suicidality during this screen are then assessed for suicidal thoughts and behaviors using the Columbia Suicide Severity Rating Scale (C-SSRS) Screener or similar tool. A formal risk assessment is made, means restriction counseling is provided, and a safety plan is completed. Clinicians then systematically reassess patients for suicidality and needs at every visit. If the patient is at imminent risk for suicide, as evidenced by active suicidal thoughts or suicidal preparatory behaviors, the patient is also added to a registry, high risk list, pathway or other similar organizational process. It is critical for organizations to have a process to track and monitor their patient population at risk for suicide.

Following a suicide related event, an organization should be committed to learning from each individual attempt and completed suicide and use this information to improve clinical protocols and design new policies. Everyone in the organization must understand suicide prevention as their responsibility.

Organizations need to develop a multi-modal approach that accurately identifies, tracks and treats at-risk patients using evidence based practices, and reinforce these initiatives routinely in clinical care and administrative processes. If we act now, we can change the face of suicide prevention and save lives.

Welcome New Staff Member

Shari Jones Joins Chapter Staff as Events Coordinator

Shari Jones, NASW-NYC Program and Events Coordinator and student at Fordham University Graduate School of Social Service.

I first became acquainted with the NASW-NYC Chapter through my position as the Membership Associate (MA), which is a chapter role for selected students to help with students to help with student recruitment in each school. As an MA I was charged- along with peers from other schools of social work in the city- to galvanize students on our respective campuses and make them aware of the chapter's offerings. This included speaking at new student orientations and hosting/attending monthly events in collaboration with Fordham University- where I am a
second year part-time MSW student.

During my MA tenure, I was hired as the Program and Events Coordinator at the chapter. I recently wrapped the coordination of my first event- the 48th Annual Addictions Institute. In collaboration with the AI Planning Committee and other chapter staff, we successfully contributed to the continuing education and professional growth of close to 500 social workers specializing in addictions.

I look forward to contributing to the NASW-NYC chapter and its members through coordination of the Annual Meeting, Leadership Awards Dinner and the annual CE conference. I also look forward to growing professionally as a student of social work and personally as I prepare to become a first time mother in the Fall.

Please stop by and say hello when you visit the office!

NASW NEW YORK CITY CHAPTER
National Association of Social Workers

2016 Legislative Session Report

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NASW-NYC Chapter 2016 Legislative Session Report

As a representative of the NASW New York State and New York City Chapters, Carreau Consulting continues to move the organizations' policy agenda forward, strategically align the Chapters' legislative priorities, maintain a high level of visibility at the Capitol, and work in collaboration with a number of strategic partners.

While our legislative work continues throughout the year, the pace of such work accelerates in January as the formal session begins. The official first day of session was January 6, followed by the Governors State of the State Address/Executive Budget Proposal on January 13, 2016, budget negotiations commenced throughout March and then, after a legislative recess in April, the remainder of session focused on non-fiscal issues. As such, NASW members have had representation each and every day at the Capitol that is proactive on a broad range of identified priority issues as well as responsive to legislative initiatives posing a threat to the field of social work. For purposes of this report, the work is broken into three headings: Career Protection, Workforce Development, and Social Justice.

CAREER PROTECTION

Social Work Licensure Exemption

Prior to last year's budget negotiations, the Chapters worked with impacted agencies, key legislators and their staff, the Executive team and partner organizations to craft language that would lead to the long overdue implementation of the social work licensure statute originally passed in 2002. While stakeholders were engaged in the process all fall, the impacted agencies could not reach a consensus on the best route. As a result, language was included in the Governors Executive Budget proposal to simply extend the exemption for another five years. Such an outright continuation was unacceptable to the Chapters and as such, we continued to work with key members of the legislature, the Governors staff, impacted agencies and stakeholders on language that would mitigate concerns, maintain a standard threshold of education and experience required to deliver social work services, and provide clarifying language for tasks not requiring a license. The negotiations went down to the wire and though we were close to brokering an accord, we all felt additional time was needed. As a result, we agreed to a two-year extension and the Governor's assemblage of a work group (immediately following passage of the budget) to include the NASW Chapters, the Society for Clinical Social Work, the NYS Deans Association, key legislative and State Education Department staff, impacted agencies and stakeholders. In early June, the Governor's staff, as representatives for the impacted agencies, took the first step in the process of crating a document that outlines their areas of concern and need for further clarification. We have offered initial feedback on such document and will be convening a number of internal roundtables over the summer and early fall — with the intention of drafting a final implementation bill to be advanced early in the 2017 session.

Expansion of Service Delivery Options

The Chapters have worked to advance a bill that adds Licensed Clinical Social Workers to the list of qualified mental health care providers authorized to deliver mental health services under the state's Workers' Compensation program. While we were successful in passing the bill through both houses in 2014, the Governor vetoed the bill later in the year (along with two other similar bills). Neither the veto message, nor the Governor's Counsel cited philosophical opposition to the concept of adding LCSWs, but instead, opposition to "piece meal solutions" to a system in need of comprehensive reforms.

Continued on next page

Development of such reforms were completed in late fall by the New York State Workers' Compensation Board (WCB) Business Process Re-Engineering Program—a multi-year effort to "redefine the Workers' Compensation system, improve access to quality medical care, and improve the underlying technology systems that support the organization." While the program worked toward the development standards, we continued to meet with the WCB and the Executive to advance our LCSW provider initiative. As a result, the Governor's Executive Budget proposal included expansive reform language which contained the addition of Licensed Clinical Social Workers as providers. Unfortunately, the recommended reforms in their entirety, were tabled for further negotiation. Once again, there was no opposition to adding LCSWs as providers. Once budget negotiations ceased, we again met with the WC Board. It is our understanding that they remain engaged with the Governor's staff to alter the reform recommendations, however, no final agreement was reached by session end. As a result, we are considering drafting another stand alone bill that utilizes the framework the Board and Governor's crafted.

Licensed Professions and Administration of Heroin Overdose Antidote

As part of the broad package of heroin and opioid addiction bills recently passed and signed into law, we worked with the Governor's staff and the legislature to include a provision that would allow LMSWs and LCSWs to administer the life-saving antidote to a heroin overdose. The update to our licensing statute was necessary because without it, such professions are expressly prohibited from administering drug therapy.

Persevering School Social Work Positions

The Chapters have continued to engage in issues related to school social work. Most recently, such work has focused on the proposed amendments to regulations that sought to alter the title of School Guidance Counselor to that of a much more generic term of School Counselor, and would then authorize such "School Counselors" to provide "individual" and "group" counseling — terms that connote the provision of mental health services. In response, we submitted written comments and proposed clarifying language. As a result, we participated in a State Education Department Stakeholder meeting with representatives of United Federation of Teachers, New York State United Teachers, New York State School Social Work Association, The School Psychologist Association, the Counselors Association, and key members of the Education Department's Pre K-12 Committee. Our concerns appeared to resonate (and in many instances were echoed by other participating stakeholders). We are awaiting a new draft of said proposed regulatory changes. We continued to meet with the appropriate members of the legislature and their staff throughout the session regarding our concerns. As a result, they too have been highly engaged. The issue was recently on a list of topics prioritized for further discussion by the Board of Regents.

In addition, we have led work around another school related issue: A bill was introduced in early May that sought to amend the education law, in relation to the establishment of a school certificate title for school mental health practitioners that are licensed under Article 163 of the Education Law (Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Creative Arts Therapists, and Psychoanalysts).

The New York State and City Chapters, the New York State Society for Clinical Social Work, and the New

York State School Social Workers' Association, collectively responded with a memo in opposition that articulates:

- the critical role School Social Workers serve in our educational system related to addressing the social, emotional, behavioral, and mental health needs of students that are proven barriers to student learning,
- The strong research supporting the efficaciousness of school social work interventions in improving academic and behavioral outcomes, promoting positive school climates, and providing vital student support services by maximizing school based and community resources,
- the in-depth clinical curriculum/education, experience and credentials required of School Social Workers to practice in the district and the lack of such educational or experiential content required for that of the Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Creative Arts Therapists, and Psychoanalysts.

In addition to the release of our joint memo, legislative meetings were conducted to halt progress of the bill. The bill did not pass. We expect the issue will be live in the upcoming 2017 session and as such, we will continue to represent the concerns of the social work profession.

Diagnosis

In yet another attempt to expand their scope of practice, mental health practitioners licensed under Article 163 of the Education Law had a bill introduced that would allow them to (through a pilot program) expand their scope of practice to include diagnosis in the context of the Veterans Administration and entities they contract with. Again, based on the fact that such groups have varying degrees of education and experience, not equivalent to the LCSW (the only mental health practitioner other than an MD or PhD licensed psychologist authorized to independently diagnose and treat), and are expressly prohibited from diagnosing (in their own scope of practice). We immediately met with key legislators and their staff to derail the bill. The bill did not advance.

Insurance Reimbursement

Another bill that Article 163 practitioners attempted to advance was an initiative that would require blanket health insurance policies to provide coverage for outpatient treatment by mental health practitioners licensed pursuant to Article 163 of the Education Law. As we articulated in a joint Memo of Opposition with the NYS Psychiatric Association, the NYS Society for Clinical Social Work, and the NYS Psychological Association, current law allows only for such reimbursement to practitioners holding a medical degree, a PhD in psychology, or a Licensed Clinical Social Worker-R (a master's level degree with two examinations and six years of highly prescribed supervised experience in the diagnosis and treatment of mental illnesses). Due to their limitations of their education and training, mental health practitioners are not authorized by Article 163 of the Education Law to diagnose mental illness. In addition, Article 163 stipulates, "It shall be deemed practicing outside the boundaries of his or her professional competence for a person licensed pursuant to this article, in the case of treatment of any serious mental illness, to provide any mental health service for such illness on a continuous and sustained basis without a medical evaluation of the illness by, and consultation with, a physician regarding such illness." The bill did not pass. We will, monitor its movement next session.

Limited Liability Partnerships

We continued our work on a multi-year campaign to advance legislation to allow licensed mental health professions to form limited liability corporations with other licensed providers. As such, we have a two-pronged approach. We are active members of a collation of Title VIII licensed professions seeking to advance an omnibus bill authorizing enumerated professions to form LLC's with physicians *and* any other licensed profession. In addition, we have recently had a bill introduced into the Assembly that would allow for the formation of partnerships between the professions of social work, psychology, and psychiatry. We are meeting with potential Senate sponsors. Both of these initiatives are long game uphill battles, but would be a huge opportunity for our members.

Health Republic

As previously reported, Health Republic, the state's largest cooperative insurer, abruptly closed its doors in November of 2015, leaving providers without reimbursement for services rendered. We immediately reached out to the Department of Financial Services and relayed details of such closure plans to our membership.

In early 2016, Carreau Consulting met with the Department of Financial Services who provided NASW-NYS with an update regarding the process of liquidation, background information leading up to the closure, and a sense of next steps. In late May, we met with the Department once again, to assess the progress and advocate for restitution for our members. As we had reported to our members in May, the liquidation process began in Supreme Court in Manhattan (hearing took place on May 10th). Under Article 74 of the insurance law, DFS applied to the court to begin an order of liquidation which authorizes the superintendent to liquidate the insurer (in this case, on the basis of insolvency). The Judge did indeed sign the orders, and as a result, DFS will continue to marshal the assets, quantify, adjudicate, and determine the equitable distribution of assets. Under Article 74, the highest priority of restitution is for the administration of the estate, and second, consumer and provider claims. A complicating factor in determining the final pot of dollars to be distributed to administrators, consumers, and providers is the federal government and their pending decision to seek or abandon dollars owed to them (CMS). While DFS ahs a verbal assurance that CMS will not seek restitution, there is no written order. Furthermore, history in other states has shown that they've sought to recover funds in similar instances. It is expected that claims and counter claims will be filed and the process will not be swift.

Many of our members received Hearing Notices in early May and as such, were directed to respond. If they have not, they should contact the court with their claims/ concerns.

Two other potential sources of funding for restitution:

- A Guaranty Fund (though not likely, despite the fact that New York is only one of ofur states without such a safety net), or
- Through the State budget process—in this year's budget there was language articulating the intent to do "something" for providers in the context of the budget, though given the uncertainty (above) a specific number was not appropriated. The language provided the Division of Budget with the authority to create a fund from which settlement dollars will be held. Once there is more clarity reading the amount—language will follow.

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Parity

NASW has a long history as a key advocate of the state's enactment and implementation of mental health parity legislation. As we celebrate the 10-year anniversary of **Timothy's Law**, we are examining the statutes implementation and as a result have grave concerns. As such, we are working with the New York State Society for Clinical Social Work, the NYS Psychiatric Association, and the NYS Psychological Association to closely examine the settlements between the Attorney General and five insurers (Cigna, Value Options, MVP, Excellus, and Emblem Health) found to be in non-compliance of Timothy's Law. We have, collectively, analyzed the settlements and as a result, drafted language to amend section 210 of the Insurance Law—to require a separate annual report card for MH and SA compliance. The bill was introduced by the Senate Mental Health Committee. This issue has both consumer protection and provider implications and will be a high priority initiative next session.

WORKFORCE DEVELOPMENT

Expansion of the Social Work Loan Forgiveness Program

For the third and final year in a three-year campaign, we have secured an additional expansion of the state's loan forgiveness program—bring the grand total of the program to just over $1.7 million for the 2017 cycle. One detail, worthy of note, revolves around process. While the legislature added the increase for the 2017 budget cycle, we will not advocate with the Davison of Budget and the Governor's staff that he "annualizes" the latest increase in his next 2017/18 executive budget proposal. He has, to date, done so two years running.

SOCIAL JUSTICE ISSUES

Juvenile Justice Reform

As a member of the Raise the Age Campaign, NASW has continued to advocate passage of an initiative to Raise the Age of criminal responsibility. While the issue gained an enormous amount of support last year, a deal could not be reached between the houses by session's end, leaving new York to be only one of two states that continues to automatically prosecute 16 and 17 year olds as adults. As an interim step, the Governor issued an Executive Order "directing the Department of Corrections and Community Supervision, in collaboration with the Office of Children and Family Services, to implement a plan to remove minors from adult prisons in the state. The plan, which was developed over the past serval months, will transfer all female youths and all medium and minimum security classified where they are currently housed, to a juvenile facility. This facility will provide specialized programs of treatment geared for younger offenders, while also ensuring the safety of staff, inmates, and the surrounding community".

The Governor again, included comprehensive language in his 2016 Executive Budget proposal to: raise the age of juvenile justice from 16 to 18; mandate parental

Continued on next page

notification upon arrest; mandate proper questioning procedures be followed when a 16- or 17-year-old is arrested; process Juvenile Delinquent cases in Family Court; process Youthful Offenders in a newly created Youth Part of Adult Court; provide for a robust array of diversion, rehabilitative, and reentry services; and provide (though limited) for opportunities of record sealing.

Unfortunately, despite non-stop lobbying efforts, weekly lobby days, and numerous press conferences, editorials, and Letters to the Editors, the legislature again failed to make a unified position. Core advocates are already recalibrating the off session and next session steps.

Conversion Therapy

NASW continues to advocate in favor of a bill that seeks to prohibit mental health professionals from engaging in sexual orientation change efforts with a patient under the age of eighteen years, and expanding the definition of professional misconduct with respect to mental health professionals. While the Governor recently prioritized the issue as well and as such, issued an Executive Order prohibiting public and private health insurers from reimbursing for such "therapies", statutory or regulatory bans must be instituted. As such, NASW continued to meet with key legislative members and their staff to advance the issue. The bill passed the Assembly, but remained in the committee in the Senate. The rationale for holding the bill in the upper house is a concern that prohibiting certain modalities of treatment, creates a slippery slope in the future. As a result, it has been recommended that we work with the State Education Department to issue guidance on the matter. Such guidance would (preferably) denote the practice as malpractice. We are currently engaging SED on the matter.

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