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American families struggle with a variety of needs that propel them to enlist different types of services. One in six American children live in poverty, out of which 73 percent are children of color (Children’s Defense Fund, 2021). One in six American children has experienced a traumatic event and just under 20 percent develop posttraumatic stress disorder (Kessler et al., 1995). Thirty-eight percent of American children identify as racial minorities, many of whom suffer negative health effects from experiencing racism (Comas-Díaz, 2016). Dislocation, substance abuse, violent communities, incarceration, as well as many other hardships also impact families, with many suffering multiple adversities. When children and families have numerous needs, their situations become more complex and service delivery trickier. Despite a high need for services, many families find it difficult to access the supports and services that would benefit them.

Underlying the difficulties with service access and delivery lies a variety of difficulties that vary with the types of policies and funding that govern the various programs. Some systems are disorganized because they grew in a haphazard way (e.g., the mental health system), others have been purposely structured in complex ways to keep enrollment small (for instance, Medicaid and welfare benefits), and still others have simply never been allocated sufficient funding to fulfill their mandates (school districts). Across the service sector, limited funding for programs, siloed agencies, and strict requirements for gaining services has led to a lack of integration and accessibility. Looking at examples from the mental health system, Medicaid, welfare, and schools demonstrates the difficulties involved.

From its inception, the mental health system has never been well organized, creating difficulties that have yet to be remedied. In previous centuries, individuals with psychiatric difficulties or disabilities were either cared for by family members or placed in schools and institutions that were of poor quality and sometimes inhumane. Residents experienced sexual abuse, unsanitary conditions, and were made to work without pay. In the 1970s, a series of lawsuits by parents and advocates against those schools and facilities, as well as the arrival of new drugs that could control psychiatric symptoms, forced the dismantling of the offending institutions. The resulting deinstitutionalization helped fuel new service systems that aimed to provide care in homes, schools, and the community.

While the new arrangement created a range of specialized schools and community services that greatly benefit families, community care organizations never received enough funding or attention to fully meet needs. In 1980, President Carter signed the Community Mental Health Act to finance community-based treatment facilities, but adequate resources were never allocated. In 1980, President Carter signed the Mental Health Systems Act, hoping to restructure and improve the system. Soon after, President Reagan repealed the legislation, instead funding mental health services through block grants to states. Unfortunately, block grants tend to lead to fixed funding levels that are not necessarily adjusted to inflation or increased need, forcing their value to erode over time (Center on Budget and Policy Priorities, undated). Block grants also do not mandate a certain level or type of service delivery. States thus retain significant decision-making power over their mental health systems and how much additional funding to grant them. On the one hand, the system allows states to try and meet local needs. On the other, no incentives exist to meet those needs, making service quality and access highly variable from state to state or even between counties. Other sources of revenue, such as reimbursements from insurance companies, also influence the availability of services.

Starting in 1975, a series of laws mandating educational equality for children with disabilities greatly benefit families, community care organizations never received enough funding or attention to fully meet needs. In 1963, President Kennedy signed the Community Mental Health Act to finance community-based treatment facilities, but adequate resources were never allocated. In 1980, President Carter signed the Mental Health Systems Act, hoping to restructure and improve the system. Soon after, President Reagan repealed the legislation, instead funding mental health services through block grants to states. Unfortunately, block grants tend to lead to fixed funding levels that are not necessarily adjusted to inflation or increased need, forcing their value to erode over time (Center on Budget and Policy Priorities, undated). Block grants also do not mandate a certain level or type of service delivery. States thus retain significant decision-making power over their mental health systems and how much additional funding to grant them. On the one hand, the system allows states to try and meet local needs. On the other, no incentives exist to meet those needs, making service quality and access highly variable from state to state or even between counties. Other sources of revenue, such as reimbursements from insurance companies, also influence the availability of services.

The result of limited and decentralized funding is an uneven, disorganized, and inadequate system for serving children with mental health problems and disabilities. Demand for services far outstrip supply (Anderson et al., 2017; Marshall et al., 2017). Schools and mental health agencies often struggle to fully meet the needs of the clientele they serve. As one director of an outpatient mental health agency explained:

We have data about the ages, socioeconomics, and diagnoses of our clients, and we look at it to help determine what services to provide. But it is hard to start up new programs or treatments. A lot is guided by reimbursement. If the insurance companies won’t pay it, we can’t afford to do it. We eat some costs and do things, anyway. But all our outpatient clinics lose money. Insurance drives policy and services.

(Zilberstein, 2019, p. 35)

When programs must rely upon rigid and inadequate streams of funding, it limits how many families can be helped, and in what ways. In order to stay within budget, programs or states must cut services, install stricter eligibility restrictions, or keep waiting lists (Center on Budget and Policy Priorities, undated). As a service coordinator for DDS notes, all these resources are limited. Just think about numbers. There is only so much availability. So, often, we rely on families reaching out to us. Families are not always offered services because we can’t fund everyone and everything. Sometimes we don’t share information, if we feel that the family won’t qualify for, or be prioritized for, that service. That’s hard for us, as professionals. The answer is more funding across the human services systems. There’s just not enough. (Zilberstein, 2019, p. 34)

Another consequence is that many types of services that families might need cannot be delivered. As the outpatient director notes, we see families with intensive needs. They need a lot of support. In-home therapy is great, and I value what they do, but families sometimes need basic things. Like they could use someone in there who could be a parent advocate, or a nurse, or a PCA, or just help them go food shopping. Basic needs. But their difficulties need to be very severe to get that kind of help. (Zilberstein, 2019, p. 36)

Rigid streams of funding also tend to result in siloed, rather than integrated services. Mental health care can be accessed in different ways through community mental health centers, private practitioners, schools, the juvenile justice system, and other entities. A lack of coordination and integration of services amongst agencies complicates the delivery of services and makes it difficult to cover adequately the span of families’
needs. In the words of the outpatient director, “In the mental health field, there is no system for coordinating services at the local agency that assure that all needs and specialties are covered. We can coordinate well within our agency, but outside is harder. We don’t always know what other agencies are doing or where to send people for problems we don’t cover. And because there is little integration across agencies, there are lots of gaps in services or a family could be getting different services, which could be difficult for them.” (Zilberstein, 2019, pp. 33-34)

While some parts of the service sector are difficult to navigate because they evolved in a haphazard way, other benefits have at times been made purposefully hard to discourage use. When Arizona faced budget problems in its public health system, it reduced benefits and time limits and imposed numerous eligibility restrictions for receiving aid. As a consequence, Arizona’s Temporary Assistance for Needy Families (TANF) caseload declined nearly 80 percent between 2006 and 2017 (Floyd et al., 2018).

In 2011, Kansas implemented stricter sanctions on those not meeting welfare work requirements, causing many families to lose assistance. Four years later, approximately 70 percent of those families remained in deep poverty because they could not find steady employment that paid sufficiently (Floyd et al., 2018). For low-income families, children may be in school and have additional costs in obtaining aid can prove prohibitive and cut down on usage. One researcher found that a $10 Medicare premium could increase the number of uninsured enrollees by 15 percent of enrollees exiting the program (Dugue, 2012).

Many parents find applying for services or renewing benefits difficult, and low-income families can find the hurdles particularly steep. A Morning Consult national tracking poll (January 04-08, 2020) of 4400 adults in the general population found that 27 percent of respondents said they would find it difficult to shift their work schedule to attend a non-working meeting, 25 percent had received government documentation that they did not understand, and 31 percent had forgotten to pay a bill on time. Fifteen to 20 percent said they would have difficulty finding a needed document and nine percent reported losing important benefit forms or paperwork. High administrative and research demands, as well as the need to visit distant offices and sometimes wait in long lines proves especially daunting for families or individuals who lack stable work schedules, reliable transportation, bank accounts, or internet access. Throw in the need to apply for multiple types of benefits—welfare, housing subsidies, specialized equipment or aid for a family member with a disability, or other services—and it is easy to see how family can get overwhelmed by applications and paperwork.

For parents of children with disabilities or behavioral difficulties who may also need to obtain services from a variety of agencies, the child welfare system is often outpatient mental health, occupational or speech therapy, the Department of Social Services (DSS), the Department of Mental Health (DMH), or welfare and housing, among others. This fragmentation and decentralization of the service sector can be complex and time consuming. As a service coordinator for DDS notes, “For this, you’ve got to apply in this avenue, and apply here, and apply here. As opposed to, ‘Here are all your needs.’ A lot of what DDS does is to help families navigate the system, assist them with getting applications, and letting them know about different opportunities to get involved in a complicated process. Who is funding what, and providing what, is confusing for families.” (Zilberstein, 2019, p. 33)

The amount of research, time required to submit applications, and ongoing need to coordinate with numerous providers takes a toll. Studies indicate that families of children with special needs face managing the service sector arduous (Blum, 2015; Marshall et al., 2017; Zilberstein, 2019). Time lags between referrals and receipt of services, understanding eligibility requirements, communicating misunderstandings, and the requirement to meet with and coordinate numerous different providers and satisfy their demands for information can overwhelm families amongst other reasons given. As one parent described, “My husband has dyslexia. When we went to IEP meetings, they started throwing out all of these terms and scores, and he felt like his head would explode.” (Zeitlin, 2019, p. 174)

Because the child welfare system tends to focus its interventions on parenting education and counseling, rather than addressing poverty, the system tends to perpetuate structural inequities, especially amongst families of color who are disproportionally poor.

Race-based biases also impact what services are delivered and how. CULTURED views of how emotions should be expressed and handled limits accurate diagnosis (Alegria et al., 2010). Often the distress of Asian Americans is overlooked (Sue et al., 2012), while black and Latinx youths are over-diagnosed with conduct disorders for the same difficulties for which their white peers receive diagnoses of ADHD or depression (Eaton et al., 2016). In addition, black youths are more likely to get diverted into punitive rather than ameliorative interventions. In school assessments, black students more often than white receive labels of Emotionally Disturbed (ED), a diagnosis denoting behavioral problems, rather than Learning Disabled (LD), which focuses on intellectual needs, again impacting the types of services they receive (Mandell et al., 2008).

In the child welfare system, similar types of disproportionality exist that negatively affect families and communities of color. Black and Native American children are overrepresented in child welfare along the child welfare continuum: from black and Native American families being reported and investigated for abuse and neglect, to being placed out-of-home more often, and to experiencing longer stays in foster care (Barbarin, 2020; Pyce et al., 2019; Summers, 2015). In 2014, thirty-two percent of children in foster care were black, compared to the rates in the general population of only 16 percent (Summers, 2015). Underpinning these inequities are professional biases in decision-making, higher rates of economic disadvantage and structural racial barriers to increased scrutiny of minority populations, systemic biases towards punitive rather than ameliorative interventions, and a dearth of culturally competent services. Because the child welfare system tends to focus its interventions on parenting education and counseling, rather than addressing poverty, the system tends to perpetuate structural inequities, especially amongst families of color who are disproportionally poor (Duvv & Metzger, 2010). Most families enter the child welfare system because of neglect, not abuse, and a high proportion tend to be impoverished (IOM & NRC, 2014). Despite the system’s emphasis on counseling and education, extensive evidence suggests that when poverty and parental stress decline, children’s outcomes improve at a far quicker rate (Eaton et al., 2016). Moving a family to a better neighborhood, reducing housing, utility bills, and other financial assistance predicts decreased maltreatment (Cancian et al., 2013; Mandell & Pelton, 2015). More funding for early childhood education or school also results in improved outcomes (Chetty et al., 2016). Unfortunately, such therapies are rarely available in today’s service environment. As a service provider with the Department of Children and Families in San Francisco notes, “As a worker, there aren’t enough resources, so you are always making these very tough decisions, because you can’t really do as much as you want. We can actually become too a tone of thing to afford to get them therapy to adjust to the idea of not having a house. So that’s what you get.” (Zilberstein, 2019, p. 4)

As a consequence, poor families and families of color can find themselves caught in cycles of disadvantage. Parents of color can also experience microaggressions that deter them from participating in many different types of services. Microaggressions are “unconsciously delivered negative or dismissive looks, gestures, and tones…. [that] impact performance… by sapping the psychic and spiritual energy of recipients and by creating a sense of threat.” (Cooper et al., 2017, p. 275). When Posey-Maddix (2017) studied black families living in a predominantly white Wisconsin suburb, only two of the fifty-six parents in the study recounted no episodes of microaggressions in their children’s lives. Families described receiving stances and comments about how they looked, found their perspectives overlooked, were assumed to be poor, urban, and not involved with their children’s education and viewed as threatening and criminal. Many felt discouraged from participating in school activities, which inadvertently reinforced racial stereotypes. “As the narrator…” wanted a bad brush in another study, “is you people don’t care. You people aren’t good parents. You are not involved enough in your children’s lives” (Zilberstein, 2019, p. 131).

Blum’s (2015) study of mothers with children with disabilities similarly found a difference in how white, middle class families versus families that were low-income or of color experienced the service sector. White, middle class mothers faced stigma and isolation from their communities, whereas poorer families and those from racial minorities experienced more communal acceptance but greater professional judgment. School personnel and poor professional judgment of mothers of color and those who were low-income for not doing enough to help their special needs children. Professionals were also more likely to report marginalized families to authorities when they appeared to be “gaming the system,” such as “welfare queens,” rather than addressing poverty, the system tends to perpetuate structural inequities, especially amongst families of color who are disproportionally poor.

Problems with the Service Sector

Part of the reason America has never established an organized, unbiased and fair social welfare system stems from deeply rooted cultural ideologies that influence socio-political trends and institutions of helping. An underclass of poor workers and indentured servants have labored on America’s soil since its founding.
have never been granted much means for upward mobility (Isenberg, 2016). Discrimination against non-white residents began with the taking of Native American lands, the institutionalization of over two hundred years of slavery, and subsequent laws that discriminated against blacks in housing, education, labor, law, and other domains. Despite policies that clearly disadvantage certain segments of the population, American social work has shown remarkable ability to persevere and overcome all odds (Isenberg, 2016). In fact, Americans tend to prioritize individual liberty and self-reliance more than their European counterparts, who place a higher value on state intervention to ensure no one is in need (Pew Research Center, 2015). The differing attitudes can be traced into immigrant parent’s roots, and the supports towns offers families are stinger and harder to access than in other wealthy nations, with the gap growing larger in the last half century (Edin & Shaefer, 2016; Lindert & Williamson, 2016). While after the devastation of the Great Depression (1929 – 1933), the government showed greater interest in providing citizens a safety net, the twin emphases of individualism and resilience have increased in American discourse over the last 50 years, along with economic policies favoring the free market and private sector over government programs. The Social Security Act of 1935 established a safety net that grew to aid many people, including the elderly, unemployed, poor, individuals with disabilities, and veterans. Public benefits peaked in the 1970s, after which a stalling American economy led to weakening the efforts at the federal government level. By the 1980s, neoliberal philosophies became prominent and promoted the idea that success derived from individual choice and effort, rather than social or public benefit.

Most psychotherapists do not have sufficient training in advocacy and other forms of intervention that could be used to help clients gain the material and environmental supports they need.

President Reagan popularized the term “welfare queen” during his 1976 presidential campaign as he strove to undermine support for public programs. Under his administration, the social safety net underwent significant change, the field has increasingly turned towards micro interventions aimed at helping individuals. In 2017, 92 percent of MSW graduates reported working directly with individuals, families, or groups rather than with communities or in public policy, advocacy, or administration, up from 85 percent just two years earlier (Mattocks, 2018; Salsberg et al., 2018). While direct service provides many benefits, other important needs, as will be discussed, are not being met through community investments and policy reforms.

Changes in the profession also extend to the workplace, where higher demands, funding limitations, and policy mandates restrict what service providers can accomplish. Neoliberal ideas favoring efficiency, cost saving, and productivity have led to low pay and high caseloads, leaving little time for essential thought, learning, supervision, coordination, or going the extra yard. Furthermore, state mandates and high practice conditions and stagnant wages generate high turnover, which also hamper the ability to nurture a stable, expert, and effective workforce (Beidas et al., 2016; Edwards & Walfish, 2016; Zilberstein, 2019). Workers are expected when social workers are expected to meet the needs of families facing complex and precarious circumstances with too little time or resources (Epstein, 2019). The ability to institutionalize and more effective programs is handicapped.

As the social work field turns increasingly towards direct care and work with individuals and families, an increasing number of social workers provide psychotherapeutic services. Although psychotherapy is currently in great demand and can be quite helpful, it too, tends to have an individual focus, limiting its use. Most contemporary psychotherapeutic theories and interventions focus on how to overcome a sense of, adapt to, or overcome their circumstances and experiences through learning new skills, redefining meaning, or forming stronger connections to and gaining support from a therapist, parent, partner, or group (Holmes, 2017; Masten, 2018; Zilberstein, 2019). Although some therapists incorporate spirituality, direct help in social action, and absorb clients into their practices, in general, less consideration is given to what broader resources could be leveraged to resolve problems. Most psychotherapists do not have sufficient training in interventions of intervention that could be used to help clients gain the material and environmental supports they need (Goodman et al., 2020; Zilberstein & Popper, 2019). Yet when social workers and psychotherapists provide direct support, it not only helps clients achieve goals, but strengthens the working relationship and enables further collaboration (Goodman et al., 2020).

Individually oriented interventions such as psychotherapy may also be best matched to clients from western societies that emphasize individualization. For many cultures, healing does not occur in the private offices of practitioners but in spiritual and communal realms. Fellowship and communal efforts of emotion through prayer, singing, and praise assume therapeutic functions in the Black church (Dempsey et al., 2016). Connection to and harmony with the land and cosmology bestow comfort and resilience to the Inuit people of the Canadian Arctic (Kirmayer et al., 2011). In Japan, Nakanai counseling methods direct clients to meditate and resolve problems for help and seek care in order to reduce self-indulgence (Koeci & Kafao, 2019). Although communal resources and interventions can boost families’ well-being and reduce interventions of intervention that could be used to help them to the community investments and policy reforms.

Every day. (Medical ethicist quoted in Zilberstein, 2019, p. 36)

The Impact of Neoliberal Beliefs on Families

Neoliberal ideals about individualism and resiliency have also drifted into family domains, affecting parenting practices. Over the centuries and decades, parenting in America has increasingly child-centered and focused on methods that promote autonomy and achievement in children, traits favored in neoliberal environments, where children are seen as assets of economic justice market jobs. (Dening, 2015; Greenfield, 2016). Child-focused parenting favors affective parent-child interactions, discipline through reasoning and explanation, providing choices, supporting child assertiveness, and providing opportunities to learn and practice a wide range of cognitive and social skills. More active involvement of parents is required in this type of parenting than has typically occurred in other cultures or in historical eras (Quinn & Mageo, 2013). In fact, it does not reflect parenting styles or family structures seen in most parts of the world, or even within different societies within the United States, earning it the designation WEIRD (western, educated, industrialized, rich, and democratic) by a group of psychologists (Henrich et al., 2010). Time, knowledge, and resources are also needed for its full implementation. For parents of special needs children, the pressure can lead to herculean efforts to do more and more;

What is striking is how relentless it was, how many different sources of expertise they sought. The mothers might find someone who is helpful, but they couldn’t stop, they had to keep going, had to keep thinking of someone more, another piece, another kind of specialist, or a more accurate diagnosis. They continually wondered, ‘Is there more I could be doing? Is there something I am missing?’ (Blom quoted in Zilberstein, 2019, p.31)

As a consequence of these expectations and efforts, mothers of children with special needs are two to three times as likely to suffer anxiety, depression, and stress than parents of typical children (Tint & Weiss, 2016). Over a quarter of parents report that they need to stop working or cut back hours because of a child’s special needs and as many disclose that their child’s health conditions create financial problems (The 2009/10 National Survey of Children with Special Health Care Needs). Fewer resources find the toll even higher. Faced with challenging child behaviors, one in three families with substantial social supports and family income still struggle, while in families without sufficient income and adequate social supports only 1 in 100 report a high quality of life (McCoull et al., 2014). Unfortunately, the current social service system is not adequately denting the burdens of many families or providing all the types of services they need. As those who work in or study the field note,

No matter how much support a family is getting, there is still this sense of not being done, not having to deal with it. It’s life-long. Sometimes I think what families need is respite support, someone to provide childcare who is knowledgeable about their child and can let them take care of other things and themselves. (DDS worker quoted in Zilberstein, 2019, p. 36)

Real help would be having someone say, ‘How can I help you today and tomorrow and every day, physically help you? Can I feed your child, can you take a shower?’ That’s what they need.

Solutions

Reimagining social work and the service sector will require changes in numerous tiers: from how providers work with clients, to institutional changes, to broader policy initiatives and the changing of cultural norms. As with any types of reform, smaller measures directed
At the individual level of service provision are easier to implement than larger changes to organizations and policies, but substantial change cannot occur without attention to each of the levels.

**Building Social Supports for Clients**

Social support is robustly and significantly associated with well-being across all populations, making the provision and expansion of clients’ social support networks important (Macquire-Jack & Wang, 2016; Thompson, 2015). Social support can be supplied by providers when they make the effort to build strong relationships with clients. Social support can also be facilitated by providers when they connect clients to other services or help them think through and locate additional sources of support. There are many family members, friends, or other resources that might lend when they cannot locate any potential helpers within their existing circles. These resources may include groups, other parents willing to act as mentors or lend a helping hand, religious organizations, or persons in schools or other agencies. Assistance can vary from offering companionship, running errands, providing transportation, offering childcare, or any other task or backing a family might need.

Social workers, especially those with training in mental health, are well positioned to facilitate collaboration and coordination because they can provide important psychoeducational resources, generate a fuller perspective on a child and family’s needs, and use professional authority to help sway reluctant systems.

Assessing and Making Change on Institutional Levels

Leaders of human service organizations and institutions need to examine their agencies’ policies to determine what barriers for equitable and accessible service provision exist in their ranks and how to overcome them (Alegria et al., 2010; Epstein, 2019; Snowdon, 2012). A review should be made of all policies and practices to ascertain whether and how they contribute to social inequities. Questions to examine include whether some groups are engaged in their abilities to gain or keep services because of transportation, cost, or times that the services are available. Language barriers can also impact families’ ability to utilize a service. Attempts should be made to employ workers speaking the languages prevalent in the community, to enlist the help of interpreters, and to make written and oral communications available to people with different levels of education or with pre-existing disabilities. Requirements for paperwork should be manageable and sufficient help given for completing it. Families should not be disqualified for services because of disciplinary mistakes. Support must be given to families in any task that makes accessing services difficult. An assessment should also be made as to what extent programs are hamstrung by rigid rules and funding and are unable to accommodate service limitations. Partnering with families to build flexible interventions rather than fitting them into existing services would make the work more effective. Doing so may require building adaptable funding initiatives and finding new sources of monies, perhaps through private sources, although opportunities remain limited (Weit, 2021). Efforts also need to be made to allow for proper coordination amongst multiple providers serving a single family. In order for that to occur, agencies must allow staff time to form relationships with and learn about other providers’ work and to consult with clients on the best methods of working together (Rumping et al., 2018).

There should be an evaluation of organizations’ internal cultures to determine whether workers and clients of different races, genders, and cultures (Kugelmann, 2016; Lopez et al., 2012; Posey-Maddox, 2017). A sample racial justice assessment tool can be found at [https://www.nijn.org/uploads/digital-library/AssessingOurOrganizations_RacialJustice%20(1)%20(1).pdf](https://www.nijn.org/uploads/digital-library/AssessingOurOrganizations_RacialJustice%20(1)%20(1).pdf), one of many such tools that can be used as a basis for evaluating development. Noted in this tool, institutional change requires goals, benchmarks, and indicators for measuring success. In order to create reasonable objectives and criteria, agencies need to comprehensively address the needs of clients in their geographic area and decide the best methods to meet those needs. Data on services and outcomes should be analyzed so as to determine whether or not disparities exist according to race or other factors. Amongst the topics to be considered are whether cultural beliefs interfere with service delivery and how inclusive is the agency culture as reflected in the following questions:

1. Are definitions of family and parenting broad enough to accommodate different family formations and parenting styles?
2. Are signs of distress accurately identified across cultures, so that they are neither missed nor overly pathologized?
3. Do staff and clients of different races and genders feel comfortable within the organization?
4. Does the staff reflect the people served?
5. Does the organization’s leadership partner with representatives of underrepresented groups to find out what sorts of changes would benefit them?
6. Are staff of different cultures, races, and genders given a voice and chances for mentorship and leadership development?
7. Are microaggressions recognized and confronted?

Agency directors also need to spend substantial time considering the needs of staff. In order to do their jobs well, workers need good wages, opportunities for growth, supervision, and learning, and input into how they perform their jobs. They need incentives to stay and build the depth and breadth of knowledge necessary for expertise (Beisdes et al., 2016; Edwards & Wildeman, 2018). Agencies benefit when workers are given the time to research and assemble new programs, which also necessitates incentives. Effective funding, while such investments may be costly in the short term, they pay off in the long run. Efficiency and productivity result from effective and innovative interventions, rather than the other way around. Innovative practices are best created when the workforce partakes in their construction and finds the purpose and process meaningful (Epstein, 2019). Without innovation, little will change. As the leader of a large, public social service agency notes:

**The problem is that we put people in paradigms that are wrongly conceived. When we change the system, we still keep the paradigm. People work in the same equation and you will get the same results.**

Those of us who work and manage large organizations need to try every day to make them more humane. (Zilberstein, 2016, p. 185)

Social workers can provide services better fitted to their clientele when they address organizational biases and barriers, partner with families to meet needs in flexible and safer ways, provide advocacy and support for clients in navigating systems and services, and spend more time and resources nurturing the workforce.

**Strengthening Community**

Families thrive best when they live in communities that promote well-being. Affordable housing, safe neighborhood environments, and employment opportunities that provide living wages, anti-racist police institutions, greenspaces, mutual aid amongst community members, and recreational opportunities are just some of the protective factors in reducing child emotional and physical harms (Longhi, 2019; Maguire-Jack & Wang, 2016; Masten, 2018; Petersen et al., 2021). Communities play an important role in reducing stresses and structural inequalities that
lead to health and mental health difficulties. They can prevent adversities that lower families’ quality of life and then lead to costly interventions that overwhelm limited health and mental health services. Programs that are embedded in communities are important because they can best monitor and adapt to a community’s needs and constraints. Schools, faith-based settings, medical offices, workplaces, and other organizations are uniquely suited for meeting the needs of families because they have a wide and non-stigmatizing reach. They can serve as vehicles for promotion and prevention by offering information and awareness, support, and integrated mental health interventions (Leiva et al., 2020; Mendel et al., 2020). They can also detect health and mental health problems so that they can be addressed early (Peterson et al., 2021). A comprehensive approach is important because different locales serve populations with disparate needs and contain unique challenges and resources. As a result, a solution that works in one place may not be well suited for another setting. As one community organizer notes, “You can’t come in and dictate. You have to work with the community. Find out what is needed. What a family resource center looks like in Athol should not look anything like one in Boston.” (Zilberstein, 2019: p. 186)

Ignoring the important needs of individuals and families and the constraints placed on social workers to access them leads to worsening conditions that reverberate through society.

Communities should strive to form comprehensive responses to their population’s difficulties. Since mental health difficulties are often linked to other adversities in an individual’s family’s life, and approaches to wellbeing should be pursued. Coalitions and collaborations amongst agencies such as schools, anti-poverty responses, mental health treatment, homeless services, as well as other social supports can be knitted together to serve vulnerable families (Longhi, 2019; Mendel et al., 2020). In doing so, communities can leverage their historic strengths and knowledge to provide social workers and consumers to fashion interventions that are easier to access, culturally well-suited to the population, and more likely to succeed.

Service delivery and access would also improve if families could locate and engage multiple services at once. An integrated system that allows families to apply for numerous services at once would go far in increasing the efficiency of applying to numerous programs for different types of help and the probability of families giving up or falling between the cracks. It would also help providers, who often scramble to find resources in an ever-changing service landscape. In this technological age, it should not be hard to create a standardized intake process from which an automated database could direct potential clients to relevant agencies, enable providers to fashion interventions that are easier to access, culturally well-suited to the population, and more likely to succeed.

Changes on the Policy and Legislative Level

Since communities and agencies provide the benefits that are incentivized to administer, changes need to occur at the policy and legislative level, which creates that impetus. Legislation can either stimulate or block services through funding and regulations that govern the monetary value of services and how they are financed (Bailey, 2000; Dorken et al., 1993). State and federal governments also have the ability to fund research that establishes and tests innovative solutions and to discern which interventions change cultural norms and behavior (Anderson et al., 2018; Peterson et al., 2021). Policies and legislatures can be influenced by research, lobbying, and voting.

Often initiatives that begin at a local level can be leveraged to enact changes in a wider jurisdiction. Influencing policy and funding initiatives requires data that shows a program’s efficacy, continuing obstacles, as well as the standards and accountability to which it adheres (Dorken et al., 1993). When data and evidence show the positive effects of an initiative, legislatures can be more effectively lobbied and new policies and regulations followed. Laws and regulations can also be used to change cultural norms, which then affects which policies law makers are more likely to support (Bullock, 2019; Peterson et al., 2021).

Strengthening Social Work

In order to meet contemporary challenges in service delivery for individuals and families, social work education and practice can benefit from a number of changes. Social work social workers, even those going into direct service fields, should be required to learn skills in macro practice (Mattock, 2018). They should learn about the different systems in which clients interact—housing, schools, criminal justice, child welfare, and financial aids—and how to advocate on behalf of clients (Goodman et al., 2018). Social workers should also strive to learn how to collaborate across agencies to leverage community resources on behalf of clients. A better understanding of how policies affect services and how research and information affect policies could also enable social workers to promote the needs of their clients by lobbying legislatures for needed resources. Lastly, training and fostering bias and the impact of structural inequities on health and mental health will equip social workers to deliver services that better meet the needs of culturally diverse clients (Comas-Díaz, 2016).

The social work field would also benefit from an increased investment in the workforce. Wages need to increase both as a way to decrease costly turnover and to take better care of workers on whom agencies and clients depend (Mendel et al., 2016; Edwards & Wildeman, 2018). Instead of an emphasis on productivity, the workforce needs to allow more time for reflection, learning, collaboration, and innovation. While in the short run, changes that may decrease efficiency, in the long run, they will lead to more effective interventions, which may prove more efficient and less costly. Increased readiness and financial capacity to meet an growing need for more mental health and social work professionals will be enhanced by salaries that attract talent and allow workers a decent standard of living.

Changing Cultural Beliefs

Before changes can be made on the individual, community, or policy levels, cultural beliefs that interfere with public acceptance of new initiatives will need to be challenged and altered. The pandemic and Black Lives Matter have already begun that shift, as news organizations increasingly report on structural inequities, racism, and the need for government intervention. The dialogue must continue to stress that individual effort is not always sufficient to overcome barriers and that the public and private sectors need to provide more assistance to vulnerable individuals and families. Rather than promoting a view that resilience is an individual trait, more emphasis should be placed on how communities promote resilience and the importance of preventative measures (Masten, 2018). Pressure will build on governments to act when those cultural beliefs change widely. Opportunities and funding for new approaches will be enhanced.

The relentless pressure on parents to do more and more for their children also needs to be lifted. Policy makers and voters need to understand that families require material and social supports to function well. Only parents with the most resources can derive the numerous stressors imposed by an ailing family member, poverty, racism, and other adversities (McCornell et al., 2014). Stresses need to be reduced, including those introduced by systems of care, by gantumau efforts to engage, retain, and coordinate services, and from feeling blamed, shamed, or surveilled (Blum, 2015). Parents should not be expected to be so child-centered that their own health and wellbeing is sacrificed (The 2009 National Survey of Children with Special Health Care Needs; Tint & Weiss, 2016).

The mental health system is currently asked to rectify problems whose solutions belong in other sectors. Interventions that reduce adversities and structural inequities are better poised to lessen many mental and physical health problems. No matter how skillful the clinician, psychotherapy rarely “heals.” Treatments seldom achieve outcomes equal to those attained by people with fewer hardships (Zilberstein, 2019). Even if such cures were possible, psychotherapists already cannot adequately meet the demand of the country’s current mental health needs, let alone address the surge in mental health concerns that will occur as the COVID-19 pandemic (Panchal et al., 2021). Expecting a fragmented and under-resourced mental health system to heal a nation’s woes is unrealistic.

Social work and society would benefit from a changed narrative that emphasizes how families could better thrive if a comprehensive service sector promoted wellbeing through multiple strategies. Ignoring the important needs of individuals and families and the constraints placed on social workers to address them leads to worsening conditions that reverberate through society. When adversity rises, so does demand for services, which taxes already overload services, mental health services, courts, child welfare, and other institutions, which are not positioned to meet the need. When that happens, agencies must restrict access or shift burdens back onto parents, perpetrating difficulties and creating impacts that are felt even if the overworked, under-resourced workers and institutions trying to support them. The field must work to redress this situation by coming to a new understanding of the need and providing families with funding, preventive supports, giving social workers increased tools to meet demands, and fighting for changes on the community and legislative levels that lead to more integrated and effective services.

References


References


The System is Down: Creating More Accessible Services for Diverse Families
1.5 CEUs - POST-TEST

Circle all correct answers. There is only one correct answer per question.

Please perform the following steps:

1. Families utilizing numerous benefits and services, usually find:
   a. A well-organized system
   b. Complex administrative hurdles
   c. Services that can be shaped flexibly to their needs
   d. Easy, streamlined paperwork

2. States with some of the strictest rules and least generous benefits are:
   a. Wealthier states
   b. States in the Northwest
   c. Those with a larger share of white residents
   d. Those with a larger share of Black residents

3. Compared to their white peers with the same difficulties, Black and Latinx youth are more likely to be diagnosed with:
   a. Trauma
   b. Depression
   c. Conduct disorders
   d. Learning differences

4. Families of special needs children tend to NOT experience which of the following:
   a. Higher rates of isolation in middle class samples
   b. Increased risk of child welfare involvement
   c. Higher rates of depression and anxiety
   d. Greater life satisfaction

5. Interventions that decrease poverty improve child outcomes. True or False

6. Which of the following characterizes neoliberal values and policies?
   a. Emphasis on building community
   b. Focus on individual responsibility
   c. Concern with rectifying structural inequities
   d. Family supports and benefits valued

7. In what ways have neoliberal values affected the social work profession?
   a. Emphasis on micro interventions
   b. Emphasis on efficiency and productivity
   c. High caseloads and staff turnover
   d. All of the above

8. Improving the delivery of services requires:
   a. Increased focus on parenting interventions and counseling
   b. Helping providers become more efficient
   c. A multi-level approach that coordinates services across numerous domains
   d. Building resilience in clients

9. Social workers can help clients with insufficient resources by:
   a. Encouraging them to be more responsible
   b. Helping them think through and advocate for their needs
   c. Helping them prioritize paperwork and waiting in line over other obligations
   d. Providing parent education and counseling

10. Social workers can help clients with insufficient social supports by:
    a. Addressing barriers to locating and utilizing social supports
    b. Helping them become more self-sufficient
    c. Helping them become more resilient
    d. Friending them on social media

11. Social service organizations can improve services by addressing which of the following concerns?
    a. Making sure policies do not contribute to racial inequity
    b. Making sure services are accessible to families with fewer resources
    c. Partnering families to build flexible interventions
    d. All of the above

12. Social work interventions should help build community by:
    a. Training social workers to help families become more resilient
    b. Shifting more social workers into direct care
    c. Helping clients prioritize paperwork and waiting in line over other obligations
    d. Making sure that communities offer quality opportunities for education, recreation, mental health, housing and other needs

13. Which of the following are NOT a structural or policy level factor that affects social work interventions?
    a. Types of funding available
    b. Legislative laws and policies
    c. Data, standards and accountability
    d. Providers' individual background or beliefs

14. Building better supports for families will require:
    a. More social workers trained in macro systems work
    b. Shifting more social workers into direct care
    c. Increasing social workers’ caseloads
    d. Training social workers to help families become more resilient

Please indicate whether the following learning objectives were achieved:

1. Describe the obstacles families face in obtaining care.
   Achieved in full 5 4 3 2 1 Not Achieved

2. Identify ways social workers and psychotherapists can ease burdens on families.
   Achieved in full 5 4 3 2 1 Not Achieved

3. Consider what structural reforms are needed to alleviate current problems.
   Achieved in full 5 4 3 2 1 Not Achieved

4. Please provide comments on current course and suggestions for future courses:

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Please indicate whether you are a member or non-member:

☐ Member (MA/RI) $20.00
☐ Non-member $40.00

Contact information:
Name ________________________________
Address ________________________________
City ___________________________ State _____ Zip
Member Number (if applicable): ________________________________

(Minnesota, Wisconsin, Connecticut, New Jersey, and New York members will be notified separately of their course completion.)
Disability Social Work: Connecting Critical Cultural Competence, Intersectionality, and Anti-oppressive Practice

Learning Objectives

At the completion of this program, participants should be able to:

1. Understand how critical theoretical perspectives can inform social work practice with the disability community.
2. Apply the framework, inclusive of the planned change process, to disability social work.
3. Identify elements of the disability social work practice framework for use within one’s own professional context.

The Planned Change Process

The “planned change process” is the foundation for much of social work practice in the United States that is focused on the development and implementation of an approach to change behaviors, a condition or circumstance that will improve the life of a client in some way (Kirst-Asheham, 2012). This process can be applied at multiple levels - micro, mezzo and macro - and with a spectrum of populations. This process is one that social workers can use to plan and implement change with clients and client systems.

Consisting of a series of steps that can be summarized as client engagement, assessment, intervention, termination and evaluation, the planned change process provides a basic framework from which social workers can frame their practice with clients and client systems. Although the planned change process is visualized as linear in the current model, it is not linear when put into practice.

For example, work with a client might vacillate between assessment and intervention as the client-social worker relationship evolves or as new challenges arise or become clearer.

Although this model is at times conceptualized differently with respect to the number of steps included, the following is a summary of the commonly used steps in the planned change process:

1. The first step, engagement, with the client, refers to the beginning interaction between client and social worker. As the relationship develops differently for every client and every circumstance, there is not a set timeframe in which engagement happens. Skills used by social workers during the engagement step include active listening, use of eye contact, depending on cultural preferences, traditions and expectations, demonstration of empathy and reflection on what the client is engaging in. This step is all about fostering rapport and trust between the client and the social worker.

2. The second step, assessment, is led by the social worker who gathers, analyzes and synthesizes information from the client in order to develop a picture of the client’s functioning, needs and strengths. Assessment is the foundation of the action steps that follow it. According to Johnson and Sauder (1985), there are five important activities in the assessment step: identifying the need, honing in on the nature of the problem; identifying strengths and resources; collecting client data and analyzing all of the above information for development into an implementable plan.

3. The third step focuses on the implementation of an action plan that is guided by goals and objectives created by the client and the social worker. These goals and objectives are to be put into place by the client and the social worker together. In some iterations of the planned change process, this step can include planning and intervention implementation, as well as a follow-up post-termination step. In our conceptualization of the model, the fourth step, termination, takes place once goals and objectives have been met and there is no more need for social work services. This involves a situation in which the client and social worker reflect on the work that they have done together before closing out the professional relationship.

4. The fifth step, evaluation, may be considered important in engaging in throughout the planned change process and may also be an aspect of termination. During the previous steps, the social worker is ethically mandated to always evaluate how the client is doing throughout the course of the social work process through either implicit or explicit evaluation (i.e., supervision vs. formal data analysis). When the goals have been met, the client and social worker should review the goals and objective and evaluate what change did take place and what could be improved upon vis-a-vis process or content. If a change did not occur, the client and social worker should reconsider the goals and objectives to make alterations focused on achieving the goal.

History of the Planned Change Process

As critical consumers of knowledge for social work practice, it is important to note that the planned change process was developed in the context of the United States and may be somewhat culture-bound based on the era in which it was developed and who was involved in academic social work at that time. Based first in the United States, the social diagnosis-informed social casework model developed by Mary Richmond is also informed by the problem-solving model put forth by Helen HarrisPerlman (1957).

Mary Richmond is well-known as the person who developed the concept of social diagnosis, in which a person and their problem is considered within the larger socio-political context (Richmond, 1917). Richmond is also known for the development of the social casework framework in which she highlighted the importance of including clients in the solving of their problems (Richmond, 1922).

The problem-solving process builds on Richmond’s work and can be thought of as a synthesis brought together from several sources including Perlman’s background in the humanities and her philosophical reflections together with her knowledge of psychodynamics and the social sciences. In this process, the social worker supports the client in learning how to analyze problems while providing consultative education in the art of effective problem solving. Perlman had significant clinical expertise, and her process demonstrates strong emphasis on the importance of the helping relationship in direct practice (Perlman, 1987). Perlman formulated a unique, cognitively focused and client-centered problem-solving process for social work practice.

Over time, these ideas were shared and further developed by social workers and came to be known as the planned change process, supplanting the problem-focused language. Though there is a dearth of information about the origins of the term “planned change process,” authors Kirst-Asheham and Hull (2010) are often credited with bringing this idea to the fore of social work education through their textbook writings on generalist practice.

Critiques of the Planned Change Process

Despite the widespread use of the planned change process, there are important critiques of the process that we must consider. First and foremost, there are always limitations to a generalist framework, which is not considered a treatment modality in and of itself. As any in consideration of practice approaches, it is important to consider who developed the model and who has been left out of the development of the model.

About the Authors

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critical thinking gaining popularity in post-WWI Western Europe, and it led to a number of critical initiatives in the United States as well. Despite these limitations, the planned change process has been applied to various fields and areas of study. In (Salas et al., 2010). Since then, the critical perspective on social work practice.

Another major critique of the planned change process is that it is not data-driven or evidence-based in its origin. As Perlman developed this model when research was not a major factor in social work practice, her supporting documentation was taken from clinical and anecdotal sources, as well as her clinical experience. In other words, what was called critical and fairness has relied on the use of religious help, the ways informal kin networks function or the non-professional helping approaches found in (van Breda, 2018). The Critical Cultural Competence model “comprised of four key components: critical awareness, critical knowledge, critical skills and critical empowerment that fall into a number of conceptual domains: cognitive (critical awareness and critical knowledge), behavioral (critical skills) and affective (critical empowerment)” (p. 318). Critical awareness encompasses awareness of cultural differences between one’s own and another’s. Critical knowledge focuses on learning with an understanding of the dynamic nature of culture. Both critical awareness and critical knowledge underpin the metacognitive (critical thinking) component of critical empowerment. Critical empowerment attends to power imbalances in relationships and the environment. The Critical Cultural Competence model developed with specific attention to multicultural healthcare environments and has potential for use in a variety of areas.

Application to disability social work practice. As Dupré (2012) notes, “the disabled people’s movement affirms and celebrates the existence of disability culture as characterized by social aspects of disability. Disability culture is cross-cultural; it emerged out of a disability arts movement and its positive portrayal of disabled people is not just a shared experience of oppression but integrates individual, cultural, and community language and beliefs, values and strategies for surviving and thriving” (p. 168). Critical cultural competence supports recognition of the personal and positive elements of disability culture, while aligning with the social model of disability in its critique of ableism, social, political, and economic systems. In working with disabled people, careful attention is given to their experiences with power dynamics and relationships, especially those engaged in involuntarily. Furthermore, critical cultural competence prompts the self-reflection and critical examination necessary for the practitioner to recognize one’s own biases, perspectives, and position within cultural and social systems. Finally, this construct helps us avoid essentializing disability experiences, identities, and contexts.

Limitations of this framework for disability social work practice. There is much less application of cultural competence or critical cultural competence to disability in the literature than to other identities, and particularly to those identities in Dupré (2012) notes, is that the field of social work has not embraced an understanding of disability culture. Cultural competence and intercultural practice are most commonly found in multicultural healthcare environments and, as we have noted, there are fewer theoretical and empirical explorations of critical cultural competence in social work with respect to informal practice. Also, though we have seen a highlighting of disability culture by disabled people’s movements, it remains that disability is not uniformly or universally viewed as a social/cultural identity. This has implications for how identity- and culture-bound perspectives are applied when working with disabled people who do not hold disability as a social/cultural identity. Finally, the construct of critical cultural competence attends to the notion of practitioners adopting an expert stance regarding culture, there remain concerns that the element of “competence” with identity-as-object is central. For instance, Dupré (2012; Nadas, 2014), especially as related to disability “types.”

Intersectionality

The history and development of intersectionality is not static and continues to shift. Kimberlé Crenshaw, an American lawyer and scholar, is credited with naming the term intersectionality. The idea and conceptualization of intersectionality continues to evolve and change. Guy-Shafft (2009) notes the contributions of Anna J.H. Cooper (1858-1964) to Black feminism and intersectionality, that is, her work on the racism and sexism experienced by Black women in the Southern United States. Hancock (2005) outlines how W.E.B. Du Bois (1868-1963) wrote about race and gender together in political contexts. Activism and social movements led by women of color during the 1960s and 1970s further contributed to the development of intersectionality. Francis Beal and Tomo Cade Bambara published work examining the

Critical Perspective

The critical perspective, which stems from the work of social philosophers linked to the Frankfurt School, evolved as a response to both totalitarian and positivist thinking. Questioning authority, which runs through social work, is recognized by the National Association of Social Workers (NASW, 2015). The profession of social work, like most professions, has its own biases, perspectives, and position within cultural contexts. These experiences have practical implications for how identity- and culture-bound perspectives are applied when working with disabled people who do not hold disability as a social/cultural identity. Finally, the construct of critical cultural competence attends to the notion of practitioners adopting an expert stance regarding culture, there remain concerns that the element of “competence” with identity-as-object is central. For instance, Dupré (2012; Nadas, 2014), especially as related to disability “types.”

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interconnected impacts of racism, sexism, classism, and capitalism in the lives of Black women (Collins & Bilge, 2016). The Combahee River Collective, through their advocacy and activism, brought attention to the multiple oppressions of race, class, and feminism - experienced by their members and communities (Collins & Bilge, 2016). During the 1980s, contributions to intersectionality are linked to a number of activists, writers, and scholars, notably not limited to: Gloria Anzaldúa, Angela Davis, bell hooks, Gloria Hull, June Jordan, Audre Lorde, Trinh Minh-ha, and Cherrie Moraga (Bul起码, 2016; Collins & Bilge, 2016; Hulk, 2009; Mehrorta, 2010).

Kimberlé Crenshaw was instrumental in bringing the term intersectionality to the forefront. Crenshaw (1989) argued that Black women experience racism and sexism in the legal system and shifted these terms to include women from intersecting social locations of race and gender. Racism was commonly understood in reference to men of color and sexism in connection to White women. Crenshaw (1998, 1991) brought forward that these forms of oppression create a unique experience for color who have intersecting and historically together in distinct ways for the color. Patricia Hill Collins has also contributed immensely to the theorizing and conceptualization of intersectionality. Collins (1990, 2000) proposed interlocking models of oppression as opposed to additive models in which multiple oppressions are not viewed in binaries (e.g., Black or White or female or male) and, instead, are considered to function together. Collins (1990, 2000). For example, highlighted the racism, sexism, and classism experienced by African American women, yet acknowledged that these oppressions also impact other groups. In this view, using the interlocking model, oppressions exist interdependently.

While the roots of intersectionality remain in activism, social movements, and scholarship by women of color, intersectionality has been expanded considerably and is now found across disciplines (Collins, 2019). Intersectionality has also developed in definition, meaning, and application over the decades (Cho et al., 2013; Collins, 2015; Collins, 2019). Broadly, Collins and Bilge (2016) describe intersectionality as an “analytic tool” and a “way of understanding and analyzing the complexity in the world, in people, and in human experience” (p. 11). Intersectionality, as Collins and Bilge (2016) note, considers “social inequality, power, relationality, social context, complexity, and social justice” (p. 53). They emphasize intersectionality in its praxis, belonging to social movements, and its connections to transformation and social justice (Collins & Bilge, 2016). Given the significance of these ideas to social work, scholars and practitioners have contributed to the understanding and applications of intersectionality within the social work profession (see, for example, Bubar et al., 2016; Hulk, 2009; 2012; Matz, 2010; Pease, 2010). Contemporary social work has generally integrated intersectionality as a broad term that encompasses all forms of oppression and groups of people. This process depends on the key contributors and developments of intersectionality fully recognized in social work. Current and future social workers may not have an appreciation or give credit to the feminists and activists who fought this history and work forward. Thus, an acknowledgment of how intersectionality came to be before being incorporated into social work is intentionally included in this course.

**Practice Model for Social Work with Disabled People**

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**Anti-oppressive Practice**

With a more recent introduction in the United States (Morgaine & Capous-Desyllas, 2015), anti-oppressive social work practice traces its development from radical and structural work in Canada (Baines, 2007; Sakamoto & Pitner, 2005), critical social work in Australia (Fook, 2002; Fife, 1997; Healy, 2005, 2014) and anti-racism and anti-discriminatory social work practices in Britain (Dumbrell & Yee, 2019; Macaye, 1996; Moxon, 1996; Williams, 1999). Anti-oppressive practice, as Dumbrell and Yee (2019) outline, is an “umbrella of theories and perspectives” (p. 230). As it has evolved, anti-oppressive practice has expanded to draw on additional theories, which include feminist, Marxist, post-modernist, Indigenous, post-structuralist, critical constructionist, anti-colonial, and anti-racist (Baines, 2007, 2011; Brown, 2012) with queer and disability perspectives more recently added (Baines, 2017). By building on numerous progressive frameworks, anti-oppressive practice moves beyond this limitation by considering the personal, cultural, and structural levels of oppression experienced by persons and communities (Campbell, 2003; Mullaly, 2010; Mullaly & West, 2016). Understanding and acknowledging the roles of identity and social location is fundamental to anti-oppressive practice. Baines (2007) explains that identity is how a person is associated or categorized with either dominant or marginalized groups, with social location being situated within the “webs of oppression and privilege” (p. 24). Oppression is rooted in the unacceptance of differences and the prejudice and discrimination of certain identities and groups (Dumbrell & Yee, 2019; Mullaly, 2010; Mullaly & West, 2016). Examples of such oppression include ableism, racism, sexism, heterosexism, cissexism, classism, and ageism (Dumbrell & Yee, 2019). Less mentioned in anti-oppressive practice are the impacts of colonization, imperialism, or globalization in creating and shaping the power, privilege, and access to resources inherent among dominant groups (Baskin, 2016; Dumbrell & Yee, 2019; Pon et al., 2011; Pon et al., 2016; Yee & Wagner, 2013).

Critical consciousness raising, as proposed by Sakamoto and Pitner (2005), is important to anti-oppressive social work practice. This action involves an ongoing process of questioning assumptions and challenges the ways in which our own “assumptions, values, biases, and worldview, of the power dynamics in the helping relationship and shifting this to empower the people and communities the social worker is engaging with, while also addressing broader social injustices (Pitner & Sakamoto, 2005; Sakamoto & Pitner, 2005). Anti-oppressive social workers aim to engage in this process of critical consciousness raising throughout their practice.

**Application to disability social work practice.** Anti-oppressive social work, according to Carter, Hanes, and Application to disability social work practice, according to Carter, Hanes, and
of importance to them, whether this is being a post-secondary student, gaining employment, volunteering, or participating in the community. Anti-oppressive social work practice recognizes that disabled persons and communities have in society (Carter et al., 2017; Sandys, 2017; Wehbi, 2017).

Limitations of this framework for disability social work practice. Anti-oppressive practice with a focus on disability is less explored in academic literature, despite the relevance and application of this approach in working with people with disabilities (Sandys, 2017). Social workers seeking to practice anti-oppressively should not be limited to knowledge about the literature of community (anti-oppressive practice, and critical cultural competence), we developed a model, which is focused on practice with disabled people. This model views the planned change process through the lenses of the tripartite frameworks presented above, with disability-specific applications in each stage of the process.

Pre-engagement

Pre-engagement is a step not explicitly found in other iterations of the planned change process, which typically begins with pre-engagement. Another way to engage as a key initial step to the importance of engaging in reflexive and reflective practice regarding one’s positionalities (with special attention to intersectionalities) assessment of cultural competence, practice of cultural humility, and preparedness to engage in anti-oppressive practice.

The tenets of anti-oppressive practice call for social workers to engage in reflexive and reflective practice about their identity as social workers, and what and how we do things (Baines, 2017). Central to this process is a consideration of practitioners’ social identities and how they may lead to privileged or oppressed positions. Considering this ‘positionality’ is vital for social workers to engage in prior to meeting clients who may have different positionalities. Reflectivity is about unearthing the actual truth embedded in what professionals do, whereas reactivity is about their beliefs (Shelnit, 1983). Reflectivity, by contrast, is the ability to look inwards and outwards to recognize how society and culture impacts practices as well as what is informed by one’s value context. The reflective and reflexive social work practitioner will want to ask: “How do I create and influence the knowledge about my practice that I use to make decisions?”

Another critical step is to know reflexively and reflectively, social workers move beyond ‘just knowing’ how well practice is going, which is a form of implicit evaluation that is subjective by nature. Reflectivity and reflexivity tie especially well to the critical cultural competence model described in this course. Critical cultural competence posits that awareness, knowledge, and skills are not enough for doing empowerment-oriented, anti-oppressive practice (Danso, 2015). Social work practice without the use of a critical cultural competence lens may lead to ineffective or low-quality services (Casado et al., 2012) and may deepen marginalization in traditionally oppressed communities, such as the disability community (Danso, 2015).

Acknowledging sociocultural differences is vital when thinking about critical awareness, especially as they relate to our clients’ disability identity. Recognizing disability identity, or lack thereof, is key to taking an intersectional approach in understanding ourselves in relation to our clients - which is in turn part of anti-oppressive practice. Assessing our individual attitudes and values are important, along with recognizing the watch out for the potential challenges associated with cross-cultural interactions as there are a range of disability cultural characteristics and values. Being able to have awareness of disability-related cultural differences is vital to the self-awareness required for social work practice with disabled people (Almutairi et al., 2015).

In particular, social workers need to be aware of the potential complexity of intersectionality, cultural diversity, while also recognizing the social determinants of intersectional power relations based on disability and other social identities (Almutairi et al., 2015). With respect to the gathering and use of critical knowledge, the authors are focused on developing a conceptualization of any disability culture our client might identify with as well as gather information and any potential communication challenges during cross-cultural interactions (which may often be between disabled and non-disabled people, for example) (Almutairi et al., 2015).

At this stage, it is also vital for social workers to question their connection to and operation within the political state as it relates to disability justice (Baines, 2017).

Josie, a licensed clinical social worker based in a rural area in western Massachusetts where her family has lived for generations. Josie notes that Regina is a high school graduate who tries to maintain a balance between being able to engage in meaningful work that does not cut short of her health care benefits at risk in order to manage the care she needs for her disability, which is identified as autism. Before reaching out to Regina, Josie spends time engaging in a variety of professional development. As previously, the planned change process in general, and engagement specifically, may be implemented at multiple levels (e.g., intersectionality, anti-oppressive practice, critical cultural competence), we developed a model, which is focused on practice with disabled people.

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Central to anti-oppressive practice is the idea that social workers must see disabled people not only as clients but also as allies, advocates, and activists who can teach us about their cultures and realities.
A social worker’s embrace of an intersectional framework with the skills of anti-oppressive practice and critical cultural competence includes a focus on a social worker’s actions toward enacting key aspects of critical awareness and knowledge across cultural interactions with clients and their identified circles of support. This process includes the need for social workers to create space during assessment meetings to negotiate and assess specific intersectional meanings related to presenting problems and modes of operation. Recognizing any intersectionalities and social construction of disability as well as other intersecting identities should be central to this negotiation. This process of negotiation will help social workers to determine a culturally appropriate approach to practice and client interaction that centers the client’s narrative of their strengths and needs (Almutairi et al., 2015). In addition to the interpersonal aspects of the engagement step, social workers must also work to recognize the intersection of policy and institutional norms that are related to disability or the disability community.

Centering the client’s narrative in the assessment phase can also include embracing the disability rights concept of “nothing about us without us” in co-deciding what presenting problems are—and are not! Another way this has been conceptualized is “about us, by us,” according to the late Massachusetts-based disability rights advocate John Bunka (Disability Action Network, 2020). This links to the aspect of critical cultural competence referred to as critical empowerment. Critical empowerment goes beyond the social worker’s recognition of cultural differences, thinking outside of the perception of power imbalance functions in the client’s social, historical and political contexts (Almutairi et al., 2015). For example, a social worker will ask the client what assessment of the client in order to obtain feedback and allow the client to have some agency in how presenting challenges are categorized and framed. In situations where the social worker is present to work on disability, the social worker must do more than just advocate or let the client speak without any assistance. Instead, the social worker must ask about the social and economic contexts that impact the client’s life and what can be done to help the client achieve greater dignity or at the least, what they can achieve in order to help the client move forward through their challenges.

Social workers also need to focus on identifying areas where they can respect the dignity of risk, or the right of disabled people to be able to learn and grow from access to empowerment. As goals and objectives are being identified by the social worker and client, the social worker should assess for areas in which they might not be able to respect the dignity of risk. For example, a young mother with an intellectual disability is noted by social workers and nurses in the hospital to forget to feed her new baby. Upon further exploration, the social worker learns that the young woman can read digital but not analog clocks. Replacing the clock in the hospital room and obtaining a digital watch allow for the young woman to more easily meet her baby’s needs appropriately. In this scenario, the dignity of risk is allowed for in a safer context.

**Example:** In her first meeting with Regina, Josie was very focused on building rapport in a culturally responsive manner, but she was also beginning to make observations about Regina as part of her assessment process. As Josie uses the agency-mandated clinical assessment tools in her work with Regina, she is mindful of whether or not these tools utilize a culturally-sensitive or culturally-specific lens. Josie makes sure to integrate critical perspectives with the information gained from the clinical assessment tools. Josie also reflects on the interactions between Regina and herself virtually—video compared to in-home sessions as it relates to the application of anti-oppressive practice techniques, for example.

In order to create a disability-positive process, Josie thinks about the “nothing about us without us” credo that many disability rights advocates call for (something she has learned about on the ASAN website) and uses it to inspire her approach to assessment. This translates into Josie asking Regina to step outside of herself to describe the person she is and understands herself on her own terms to describe both strengths and challenges. She also asks Regina to dialogue with her friends in the ASAN chat room about the strengths and challenges, in order to help Regina build community and develop new perspectives. Using Regina’s language for conceptualizing a presenting problem can be an empowering action. For example, Regina describes that she has a hard time with her “tics.” Further exploring, Josie learns that the comment refers to incidents in which Regina is compelled to touch or push someone if they have accidentally bumped into her. This has led to conflict. Josie can also look back to the conversation she had with Regina about their differing social identities in order to ask Regina to reflect on how her social location may impact or inform her presenting problems. Regina says that as a Black woman, she sometimes feels marginalized in white settings. Josie asks her, “White just don’t get.” Josie and Regina discuss how the experiences of people within a group can differ due to the interactions between multiple manifestations of privilege and oppression. This conversation is to co-create a narrative assessment related to the presenting problems and plans for work together through the understanding of both the personal and systemic issues at play.

**Intervention**

Once the social worker and client have co-constructed goals and objectives, a case plan can be developed, and the social work interventions can commence in partnership with the client (Baines, 2017). Ideally, the social worker’s assessment should focus not only on integrating the disabled person into society, but also should address ways that society, in micro form, can be changed (Baines, 2017). These interventions will foster community inclusion, a key disability rights concept focused on access to the community for disabled people. Additionally, self-determination on the part of disabled clients will be a focus of the social work interventions, as circles of support will be promoted where appropriate.

**Example:** Once Regina and Josie have co-constructed both an assessment as well as goals and objectives for their ongoing video work together (a.k.a. “the intervention”), the nature of the work is chosen, and the social work intervention process will begin. This intervention will include a conversation about how the pair will know when services are no longer needed (in order to facilitate termination, later). As Regina has a choice in how the intervention is structured, this conversation will support her engagement with the process. In her work with Regina, Josie is sure to be aware of intervention approaches that recognize that social work can fully integrate into work and family environments in any needed ways and addressing micro-options for how these environments can be more inclusive for Regina and other disabled people.

Josie approaches her work from multiple fronts. First, she conducts different reality-based role plays with Regina to practice noticing social cues, which will help with Regina’s inclusion in her workplace community. Second, regarding the need for structural change, as Regina and Josie work together, Regina feels increasingly more comfortable advocating for herself to her manager around neurodiversity acceptance. At Regina’s request, the manager encourages the social work committee to take on the challenge of learning more about neurodiversity and exploring the structures in the workplace that may or may not promote inclusion. This includes recognition of the potential for law enforcement involvement in situations involving Black disabled people - something that Regina says she has often had to deal with as a nursing incident at work (McCaulay, 2017; Thompson, 2021).

Third, Josie also works with Regina’s family via a telehealth platform to identify opportunities to do things differently, in ways that make sense to how Regina likes to operate, in order to address a small way that the disability community can support Regina. For example, buying in a daily time for Regina to share new information about her passion for endangered species of mammals across the world with her family. Having this eliminated discussion allows Regina to talk about topics she is passionate about without overwhelming loved ones who might otherwise experience this as a constant topic of conversation. In addition, Josie is also aware of how shared familial and cultural norms intersect with personal identities and experiences and need to be addressed altogether using an intersectional perspective. Josie has also been working with clients who have cognitive impairments counseling via video with Regina’s family during this time have been particularly difficult, but Josie has used similar strategies of checking in with the family during these times of working with clients who have cognitive impairments.

At various points during their work together, Regina and Josie move their individual sessions onto the telephone due to challenges related to Internet access for the video telehealth platform. This presents a challenge for some of the play-acting that the duo is working on together and given the need for Regina to develop skills in the area of
identifying visual cues in interpersonal interactions. Josie works to check in with Regina on video and telephone to make sure that their process is a fit for Regina’s needs. Questions she may ask include: “How are the role plays going for you?” “What’s missing from these role plays towards your therapeutic goals?” and “Is there anything we should change in how we are doing this work together?” This also involves Josie needing to address any barriers to and subtleties in Regina’s participation to ensure they share in their interactions virtually or on the telephone.

**Termination**

It is vital to recognize power dynamics and imbalances especially as they relate to structural issues of privilege and oppression as well as the social worker’s role authority and the client’s vulnerability during the termination phase (Baines, 2017). For example, issues of power dynamics can arise during termination regarding decisions about when and how services and support should be accomplished. At the evaluation step, which is closely intertwined. Using an anti-oppressive practice approach, she and Regina began their work by identifying measures of progress or success for use in the continuous evaluation of the intervention process. By touching on these measures during each session through the use of electronic tracking tools, Josie can help Regina document her process on what brought her to seek help. This creates a virtual space for feedback about how the process of treatment is going and also for having a conversation about termination when the time is right (Danso, 2015). The outcome of this type of data-driven evaluation is known as explicit evaluation. Josie also leads Regina in intersectionality-informed discussions that may be thought of as implicit evaluations, related to how the end of the relationship between the social worker and client may have played into the intervention process, and her approach to addressing her challenges.

Reminding Regina of their conversation about when they thought services would no longer be needed, Josie brings up the topic of termination. As there has been a precursor to this conversation, Regina is more prepared for the termination and she might have been. Regina agrees that her presenting problems have been well addressed, and that she understands the need for termination, but asks to be able to contact Josie for support once in a while, if she needs it. Given that Josie’s agency allows for this via a specialized aftercare program, she agrees to periodic check-ins, acknowledges that this could be preventative in addressing any challenges Regina may encounter in the future.

**Evaluation**

At the assessment stage, the social worker and client co-constructed goals and objectives as well as identified measures of progress or success. These goals and objectives feed directly into how the evaluation step should be accomplished. At the evaluation step, which should be continuous throughout the planned change process, client participation and measures of success should be considered carefully, centering the client’s narrative of their experience during the intervention process. This reflection may result in the use of explicit evaluation practices that align with the community’s cultural norms could reduce power differentials in the interview process. Interviews should be conducted in ways that acknowledge and respect personal and cultural traditions. Using an intersectional frame is a form of social action at the intersection of identities and society, while also offering an opportunity to resist, name, and build services that will reduce or eradicate intersectional inequities. Using an intersectional frame is a form of social action at the intersection of identities and society, while also offering an opportunity to resist, name, and build services that will reduce or eradicate intersectional inequities.

In addition to being heavily influenced by the civil rights movement of the 1970s, the ILM was a jump-started by the process of deinstitutionalization. During this time period, people with significant disabilities began to be given opportunities to live in community-based settings as opposed to nursing homes and other institutional settings—although quasi-institutional settings such as group homes and other shared living arrangements sprang up at this time as well. These factors caused disability civil rights advocates to speak out for equal opportunity in figuring out how to live, work, and participate in the community, all of which had major implications for independent living potential. The ILM resulted in the development of many independent living centers nationwide (Oliver et al., 2012).

The shift from institutional to independent living was not coupled with sufficient funding for supporting disabled people in the community (Danso, 2015; Larson, 2016). This lack of funding continues to date, with contemporary social welfare programs often being linked to a person’s ability to obtain paid work (Duffy & Lin, 2013). This has caused disabled persons to commonly experience ableism and inaccessibility when seeking work or when already employed, and often have additional employment barriers (Saffer, Nolte, & Duly, 2018). Until these barriers are addressed or removed, sufficient and specific disability support benefits are needed not only to reduce the levels of poverty but to support a more than adequate standard of living (Saffer et al., 2018).

For social workers practicing under the ILM model, such as those in independent living centers, it is important to resist professionalizing the work “on the basis of an expertise in impairment as a cause of need” as this would be an oppressive act (Oliver et al., 2012, p. 152; Hiranandani, 2005). Rather, social workers need to commit to the removal of barriers causing disability—including partnerships between disabled persons and social workers who are not resolved by the incorporation of empowerment as an instrumental competence” (Oliver et al., 2012, p. 152).

Our model aligns with the ILM model of practice in how it addresses both the personal and social aspects of living with a disability and the need for social workers to defer to the client as an expert on their own needs.

The Disability Competent Care (DCC) model was developed by The Lewin Group in conjunction with disabled people and service system consultants and was approved by the Council on Social Work Education (CSWE) as a guiding framework for practice (Disability Competent Care Working Group, CSWE, 2019). This DCC model is noted to take a person-centered approach to promoting social inclusion. It is important to recognize that “problems of disabled people, or social workers, are not resolved by the incorporation of empowerment as an instrumental competence” (Oliver et al., 2012, p. 152).

In discussing the DCC, the CSWE calls for “moving away from a medical model of disability perspective to a social model of disability and the “nothing about us without us” credo. Consider your role with the theoretical perspectives of critical cultural and intersectional frameworks, as they provide a broader lens for understanding the social, structural, and political factors that impact the lives of disabled individuals. These frameworks allow for an intersectional approach, which is necessary to understand the complex ways that intersecting identities and experiences of privilege and oppression, and ways that you can be reflective and reflective in approaching your practice with disabled clients.


1. As discussed in this course, critical theoretical perspectives that inform social work practice with the disability community include: (Select all that apply)
   a. Critical Cultural Competence
   b. Intersectionality
   c. Anti-oppressive Practice
   d. Evidence-based Practice
2. In which phase of the practice model presented in this article would Josie begin to learn more from Regina about her disability identity and culture? (Select one)
   a. Pre-engagement
   b. Engagement
   c. Assessment
   d. Intervention
3. How might social workers use elements of the disability social work practice model within their own professional contexts? (Select all that apply)
   a. Read about the intersectional disability justice movement
   b. Choose whether to use identity first versus person first language and use it consistently regardless of context or client preference
   c. Develop an awareness of disability rights groups in Massachusetts
   d. Identify disability culture and empowerment resources to connect clients to
4. Which of the following is not a key component of Almutairi, Dahinten, and Rodney’s (2015) Critical Cultural Competence model? (Select one)
   a. Critical values
   b. Critical knowledge
   c. Critical skills
   d. Critical empowerment
5. Kimberlé Crenshaw is responsible for the original idea and conceptualization of intersectionality. True or False
6. According to the model presented in this article, elements of the pre-engagement phase should be included throughout the planned change process. True or False
7. Critical consciousness raising, as proposed by Sakamoto and Pitzer (2005), involves an ongoing process of: (Select one)
   a. Consistently calling out individuals who use the wrong language
   b. Reflecting on the power dynamics in the helping relationship and shifting this to empower the people and communities the social worker is engaging with
   c. Holding listening circles for social workers
   d. Considering how to have clients complete identity-based questionnaires
8. A key element of anti-oppressive practice is: (Select one)
   a. A sole focus on individual experiences of oppression
   b. Attention given to how oppression based on disability primarily impacts families
   c. Development of a taxonomy of ableism
   d. Consideration of the personal, cultural, and structural levels of oppression experienced by persons and communities
9. The concepts “reflectivity” and “reflexivity” mean practically the same thing. True or False
10. Josie’s work with Regina on co-deciding what presenting problems are and are not is an example of which of the following disability practice principles as noted in the model presented in this article? (Select one)
    a. Identify circles of support
    b. Respect the dignity of risk
    c. Foster community inclusion
    d. Honor “nothing about us without us”

Please perform the following steps:

- Complete and return this entire page. A score of 80% or better is passing and you will be sent a certificate of completion for 1.5 CEUs to you.
- Please enclose check payable to “NASW-MA” (Sorry, credit cards not accepted for this offer.)
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Please indicate whether the following learning objectives were achieved:

1. Understand how critical theoretical perspectives can inform social work practice with the disability community.
   - Achieved in full
   - 5
   - 4
   - 3
   - 2
   - 1
   - Not Achieved
2. Apply the framework, inclusive of the planned change process, to disability social work.
   - Achieved in full
   - 5
   - 4
   - 3
   - 2
   - 1
   - Not Achieved
3. Identify elements of the disability social work practice framework for use within one’s own professional context.
   - Achieved in full
   - 5
   - 4
   - 3
   - 2
   - 1
   - Not Achieved
4. Please provide comments on current course and suggestions for future courses:

Contact information:
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This is Your Brain on Food: How Food Impacts Mood and Mental Health

Uma Naidoo, MD

About the Author

Michelin-starred chef David Bouley described Dr. Uma Naidoo as the world’s first “triple threat” in the food as medicine space: She is a Harvard-trained psychiatrist, professional chef, and nutrition specialist. Her niche work is in nutritional psychiatry, and she is regarded both nationally and internationally as a medical pioneer in this more newly recognized field. Featured in publications such as the Wall Street Journal, ABC News, Harvard Health, Goop, and many others, Dr. Naidoo has a special interest on the impact of food on mood and other mental health conditions. In her role as a clinical scientist, Dr. Naidoo founded and directs the first hospital-based clinical service in nutritional psychiatry in the United States. She is the Director of Nutritional and Lifestyle Psychiatry at Massachusetts General Hospital (MGH) & Director of Nutritional Psychiatry at the Massachusetts General Hospital Academy while serving on the faculty at Harvard Medical School. Dr. Naidoo graduated from the Harvard-Longwood Psychiatry Residency Training Program in Boston during which she received several awards, including “Junior Investigator Award” from the American Psychiatric Association, the “Leadership Development for Physicians and Scientists” award from Harvard, and the coveted “Curtis Prout Scholar in Medical Education” award as the first psychiatrist to receive this honor. Dr. Naidoo has been asked by The American Psychiatric Association to author the first academic text in nutritional psychiatry. In addition to this, Dr. Naidoo is the author of the book This Is Your Brain on Food: An Indispensable Guide to the Surprising Foods that Fight Depression, Anxiety, PTSD, OCD, ADHD, and More, which was released in 2020. In her book, she shows the cutting-edge science explaining the ways in which food contributes to our mental health and how a sound diet can help treat and prevent a wide range of psychological and cognitive health issues, from ADHD to anxiety, depression, OCD, and others.

Website: www.umanaidoodm.com
Book: www.book.umanaidoodm.com
Social Media: @DrUmaNaidoo

Learning Objectives

At the completion of this program, participants should be able to:

1. Understand the role of the gut microbiome and how different foods affect both gut and mental health.
2. Utilize case vignettes to gain an understanding of how to analyze a client’s diet and lifestyle in order to identify opportunities for improvement, as well as advise appropriate changes and nutritional strategies for better mental well-being.
3. Understand the impact that the COVID-19 pandemic has had on population mental health as well as the increased risk that survivors face for developing new psychiatric conditions as a screening means when working with clients.

Introduction

Note: Parts of this course are excerpts from the book This Is Your Brain on Food: An Indispensable Guide to the Surprising Foods that Fight Depression, Anxiety, PTSD, OCD, ADHD, and More by Dr. Uma Naidoo.

We have heard the expression: “You are what you eat,” but have we really thought about it? This relationship was not always known. In fact, in 2018, historian Jan Miller pointed out that eighteenth- and nineteenth-century doctors were clued into the fact that the body’s systems are connected. This is why they talked about the “nervous sympathy” among our different organs. In the late nineteenth century, however, doctors changed this perspective. As medicine became more specialized, we learned to see the body in this much bigger picture. We only looking at single organs to determine what was wrong and what needed fixing. Of course, doctors did recognize that cancers might spread from one organ to the next, and that autoimmune conditions like systemic lupus erythematosus could affect multiple organs in the body. But they neglected to see that organs that were seemingly quite separate in the body might still profoundly influence one another. Metaphorically speaking, illness could come from a mile away! Compounding the problem was that, rather than working collaboratively, physicians, anatomists, physiologists, surgeons, and psychologists competed with one another. As one British doctor wrote in 1956, “There is such a clamour of contestation for cure that the patient who really wants to know is deafened rather than enlightened.” We know these connections are quite real. A problem in the adrenal gland can throw you into a panic, infections can cause delirium and altered mental status. Maladies of the body frequently manifest as turbulence of the mind.

Heart-Brain Connection

There is a strong connection between emotions, processing, and heart health. The amygdala is part of your brain that processes emotions and perceives and responds to stressors. Activity in it is associated with sympathetic nervous system response and inflammatory output as well as risk of cardiovascular disease.

To study this connection further, scientists thought that a condition called Takotsubo syndrome (TTS) might be connected to amygdala activity. TTS is a sudden, but usually reversible, heart failure syndrome, often triggered by acute emotional or physical stressors. After comparing about 100 otherwise similar individuals with and without TTS, they found that higher amygdala activity was associated with the risk of TTS (Radar et al., 2021). Moreover, many of the patients identified an acute stressor as the final trigger for the condition. While TTS is still yet to be fully understood, we know that stress plays a damaging role in the body. It is important to take action both in your diet and your daily mental health practices to minimize the toll of stress on your body, mood, and brain.

Gut-Brain Connection

Subtle changes in distant parts of the body can change the brain too. The most profound of these distant relationships is between the brain and the gut. Centuries ago, Hippocrates, the father of modern medicine, recognized this connection, warning us that “Bad digestion is the root of all evil” and that “Death sits in the bowels.” Now we are figuring out how right he was. Though we are still on the forefront of discovery, in recent years the gut-brain connection has provided one of the richest, most fertile research areas in medical science and the fascinating nexus of the field of nutritional psychiatry.

Often, a client will tell me they develop fog every afternoon or can’t sleep, or perhaps they feel jittery in the morning. They client may relate these as purely psychiatric symptoms. Some of my first clients therefore, are: “Tell me what you eat for lunch?” and “What breakfast did you eat? Do you drink coffee, and if so, how much?” In nutritional psychiatry, these cues are often an uncharted window into their mental health. I call this paying attention to body intelligence. Food is information, and if we eat something and “feel something” we should pay attention. Have you ever felt satiated by your lunch, productive and alert all afternoon on Zoom, and then at the end of the day, thought that the afternoon flew by? Or on other days, when every meeting drags on, you struggle to stay awake; you reach for an espresso or coffee to keep going, and still do not feel alert? Even if this is not the exact scenario for you, try paying attention to whatever you feel following your meals, and think on it a little.

Focusing on nutrition to optimize brain health and, in doing so, preventing and treating mental health concerns such as anxiety, depression, insomnia, ADHD, and fatigue, is the key.

Research shows us just how important the gut-brain axis is in our physical health, but also our mental health. Doctors who studied more than two decades ago would not have learned about the gut microbiome as it had simply not been discovered in the way we now understand it. For example, between 2013 and 2017, about 13,000 publications on the gut microbiome were published. This burgeoning area of research is the new frontier in mental health.

Nutritional psychiatry is the use of healthy whole foods and nutrients to improve mental well-being and our mental fitness. The field of nutritional psychiatry is nascent but booming. Focusing on nutrition to optimize brain health and, in doing so, preventing and treating mental health concerns such as anxiety, depression, insomnia, ADHD, and fatigue, is the key. The idea of food as medicine is central to nutritional psychiatry and is crucial to finding meaningful, lasting solutions to mental health problems. Nutritional psychiatry does not exclude the use of prescription medications.

The food you eat can have just as profound an effect on your brain as the drugs you take. The nutrients from food influence chemicals that directly and indirectly affect your brain and, in turn, change the way you think and feel. The gut microbiota is a huge community of microbes that live within our gut. The purpose of the gut microbiota is to support our overall well-being, including digestive health, sleep, immunity, hormone balance, circadian rhythm, and, importantly, our mental health.

You may hear the term “gut-brain connection” used. This is because the gut and brain are connected because they arise from the exact same cells. The central nervous system, made up of the brain and spinal cord, is formed by special cells known as neural crest cells. These cells migrate extensively throughout the developing embryo, forming the enteric nervous system in the gut. The enteric nervous system contains between 100 million and 150 million neurons, the largest collection of nerve cells in the body. This is why some people call the gut “the second brain.” It is also why the gut and brain influence each other so profoundly. As separate as they may appear to be, their origins are the same. It's a cycle.
The basis of all communication in the body is chemical. When you think of a chemical, a word like aspirin may come to mind. It is a pill for a headache, for example, it makes its way to your gut where it is then broken down. The chemicals from that pill travel from your gut to your brain through the bloodstream, and once in your brain, they can decrease the inflammation and loosen your tense blood vessels, too. When the chemicals you swallow successfully exert their effects on the brain, you feel relief from that pain. In the same way that the chemicals in the food you eat reach your brain, the chemicals produced by the gut can also reach your brain. And chemicals produced by your brain can reach your gut. It is a two-way street.

In the brain, these chemicals originate from the primary parts of your nervous system (with an assist from your endocrine system): the central nervous system, which includes the brain and spinal cord; the autonomic nervous system (ANS), which is made up of the sympathetic and parasympathetic nervous system; and the enteric nervous system, which controls the gut. The enteric nervous system produces chemicals such as dopamine, serotonin, and acetylcholine that are critical for regulating mood and processing thought and emotion. Serotonin, a key chemical deficient in the brains of depressed and anxious people, plays a major role in regulating the gut-brain axis. Serotonin is often talked about because of its role in mood and emotion. Interestingly, more than 90 percent of serotonin receptors are found in the gut. In fact, some researchers believe that the brain-serotonin deficit is heavily influenced by the gut. We will explore this in more depth later in this course.

The autonomic nervous system (ANS) is in charge of a broad range of functions, many of which are involuntary. The ANS keeps your heart beating, keeps you breathing, and keeps digesting food. When your pupils dilate to take in more light in a dark room, that is the ANS. Perhaps most crucially for our purposes, when your body is under duress, your ANS controls your fight-or-flight response, an instinctual reaction to threat that sends a cascade of hormonal and physiological responses throughout your body in dangerous or life-threatening situations.

The gut has a profound effect on fight-or-flight, particularly through the regulation of the hormones adrenaline and noradrenaline (also known as epinephrine and norepinephrine). The HPA-axis is another crucial part of the body’s stress mechanism. It produces hormones that stimulate release of cortisol, the “stress hormone.” Cortisol increases the body’s ability to handle stress, providing a floor on which fight-or-flight can deal with different situations. Once the threat passes, the cortisol level returns to normal. The gut also plays an important role in cortisol release and is instrumental in making sure the body responds to stress effectively.

In a healthy body, all of these chemical changes ensure that the gut and brain work smoothly together. Of course, as in all delicate systems, things can go wrong. When chemical over- or underproduction disrupts this connection, the gut-brain axis begins to unravel. Levels of important chemicals go out of balance. Moods are upset. Concentration is disrupted. Immunity drops. The gut’s protective barrier is compromised, and metabolites and antigens are allowed to pass through the gut wall, which can cause a ripple effect that leads to many negative health effects.

Levels of important chemicals go out of balance. When chemical over- or underproduction disrupts this connection, the gut-brain axis begins to unravel. Levels of important chemicals go out of balance. Moods are upset. Concentration is disrupted. Immunity drops. The gut’s protective barrier is compromised, and metabolites and antigens are allowed to pass through the gut wall, which can cause a ripple effect that leads to many negative health effects.

The brain responds to stress effectively. Returns to normal. The gut also plays an important role in cortisol release and is instrumental in making sure the body responds to stress effectively.

The idea that the microbiome plays such an essential role in the digestion of food, but its key function is to ensure that nerves can travel back and forth between the gut and the brain, carrying vital information between them. Think of the gut as a nerve-like superhighway connecting the brain and gut, allowing for constant two-way communication, day and night. Following a healthy meal, the breakdown products are also healthy and help the gut to function at its best. In fact, in nutritional psychiatry we always say “a happy gut is a happy mood.”

When we eat unhealthy foods, bad breakdown products get formed, because unhealthy food feeds unhealthy microbiota and microbes that cause inflammation in our body. Inflammation leads to inflammation in the brain over time (Firth et al., 2019). Inflammation is now a significant and major underlying cause of mental health issues such as depression, anxiety, cognitive problems, and more. Unhealthy foods, therefore, start to impact our mental well-being through this gut-brain connection. A poor diet may worsen your mood.

There are many functions of the healthy gut that include:

- Breakdown of complex carbohydrates
- Production of vitamins and nutrients
- Formation of short chain fatty acids
- Protects against infections
- Help with the immune system
- Support for detoxification
- Modulation of the nervous system and hormones
- Regulation of sleep and circadian rhythm
- Utilization of antioxidants that we eat

It is also helpful to know that some of the most commonly prescribed medications in the United States are selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine or sertraline (brand names are Prozac and Zoloft). More than 90 percent of serotonin receptors, however, are in the gut. This is why when clients take an SSRI, they may experience gastrointestinal side effects.

Transmission of Chemical Messages

The Brain’s Impact on the Gut

The gut-brain connection works both ways. If gut bacteria can influence the brain, it is also true that the brain can change gut bacteria. All it takes is two hours of psychological stress to completely change the bacteria in your gut (Galley et al., 2014). In other words, a tense family Christmas dinner or unusually bad traffic can be enough to upset the balance of your microbiome. The theory is that the ANS and HPA-axis are signaling molecules to gut bacteria when you are stressed, changing the intestinal bacteria’s behavior and composition. The results can be damaging. For example, one kind of bacteria that is normally present in the gut wall and used for healthy digestion of food can cause problems if you are under duress. These specific bacteria are tied to the gut and the rest of the body from substances that need to be confined to the gut. Bacteria can also have an effect on inflammation in the brain and body, particularly influencing oxidative stress, a harmful process that results in cellular damage.

The Microbiome

Behind the scenes of the gut-brain romance is a huge collection of microorganisms that reside in the gut (Carabott et al., 2015). We call this panoply of different bacterial species the microbiome. The gut microbiome — it exists both in humans and animals — is another type of romance, with both parties relying on each other for survival. Our gut provides the bacteria with a place to live and thrive, and in return they perform crucial tasks for us that our bodies cannot perform on their own. The microbiome is made up of many different types of bacteria, with a much greater diversity of species in the gut than anywhere else in the body. Each individual can contain up to a thousand different species of bacteria, though most of them from what we know, belong to two groups — Firmicutes and Bacteroidetes — which make up about 75 percent of the entire microbiome.

The microorganisms that inhabit the gut are normally beneficial, but, when they aren’t, bad bacteria can become detrimental. This is not necessarily a concern, as your body generally makes sure that the good and bad bacteria stay at the right balance. But in illness, stress, or other mental or physical problems cause changes in gut bacteria, that can cause a ripple effect that leads to many negative health effects.

The idea that the microbiome plays such an essential role in bodily function is relatively new in medicine (think about how often you have heard of bacteria as “germs that will make you sick,” rather than as a helpful team of microorganisms that performs a vital service), particularly when it comes to bacteria’s influence on the brain. But over the years, the science has been building that gut bacteria can affect mental function. About thirty years ago, in one of the most compelling studies that first made us aware that changes in gut bacteria could influence mental function, researchers followed on a series of patients with a kind of delirium (called hepatic encephalopathy) due to liver failure. In hepatic encephalopathy, bacteria produce toxins, and the study showed that when the bacteria were killed and the antibiotics were administered by mouth. That was a clear sign that changing gut bacteria could also change mental function. Additionally, in the case of bowel syndrome and inflammatory bowel disease are an example of this because they also come with mood changes due to bacterial populations being altered (Giau et al., 2018). Another example is when gut bacteria can play a role in depression. Some clinicians feel that adding a probiotic as part of a psychiatric medication treatment plan can also help to lower anxiety and depression. And lastly, if you transfer the gut bacteria of schizophrenic humans into the guts of lab mice, those mice also start to show symptoms of schizophrenia. Each of these examples highlight how changes in the gut impact mood and mental health.

The primary reason gut bacteria have such a profound effect on mental health is that they are responsible for making many of the brain chemicals we discussed in the last section. If normal gut bacteria are not present, production of neurotransmitters such as serotonin, glutamate, and gamma-aminobutyric acid (GABA) — all critically important for the regulation of mood, memory, and attention — is impaired. Many psychiatric disorders are rooted in deficits and imbalances of these chemicals, and many psychiatric drugs are tasked with manipulating their levels.

One of the most important things to know is that if your gut is not healthy, when you are involved with these vital chemicals, it stands to reason that when your gut bacteria are altered, you risk doing damage to this complex web of body and brain function.

Different combinations of abnormal gut bacteria may result in abnormal high concentrations of acetylcholine, histamine, serotonin, histamine, endotoxin, and cytokines, which can damage brain tissue. In addition to regulating neurotransmitter levels, there are various other ways in which microbiota influence the gut-brain connection. They are involved in the production of other important compounds like brain-derived neurotrophic factor (BDNF), which is important for survival of existing neurons and promotes new neuron growth and connections. They influence the integrity of the gut wall and the gut barrier function, which protects the brain and rest of the body from substances that need to be confined to the gut. Bacteria can also have an effect on inflammation in the brain and body, particularly influencing oxidative stress, a harmful process that results in cellular damage.
Food influences your brain directly and indirectly. When food enters your body, it is broken down into smaller and simpler components, which travel to the brain and change the way you think and feel. When food is broken down, its components can pass through the gut wall into the bloodstream, and certain compounds can act on the brain in a way that is very similar to the effects of drugs. For example, food is some of the most potent mental health medicine available, with dietary interventions sometimes achieving similar results to specifically engineered pharmaceuticals, at a fraction of the price and with few if any side effects. On the other hand, food can also make you sad — certain food groups and eating patterns can have a negative impact on your gut microbiome and your mental health. Slowly cutting back and limiting the following will help improve your mood and lower your anxiety over time:

- **Highly processed, ultra-processed foods** which have added stabilizers, dyes, colorants, and binders that impact our gut microbiome.
- **Junk foods and fast foods** which often contain hidden ingredients such as refined sugar, making them poor choices for your mental and metabolic health.
- **Trans fats and unhealthy PUFAs** (processed vegetable oils)
- **Added and refined sugars**. There are over 200 other names for sugar that are used on food labels which you may not recognize as sugar (e.g., brown rice syrup).
- **Alcohol** which worsens mood because it works as a depressant.
- **Artificial sweeteners** (e.g., aspartame, saccharin, and sucralose)

There are observable changes to gut microbes within 24 hours of eating. There is strong evidence that diets high in added sugars can cause harmful cellular inflammation in the gut, which is a root cause of depression and anxiety. Diets like the Mediterranean diet are linked to a lower risk of depression when compared to Western diets, indicating that fresh whole produce, unprocessed foods, and added sugars are what we eat in that the food we consume impacts our mental health and well-being. Pay attention to your diet, because “we are what we eat” in that the food we consume impacts our mental health and physical health.

### Foods that Boost Mood

Information from the foods we eat is communicated to our brain in an almost direct way. More than 90 percent of the receptors for the neurotransmitter serotonin, which is responsible for mood and cognition, are located in the gut, highlighting just how powerful this food-mood connection is! Eating patterns high in healthy, wholesome foods are correlated with positive mental health while diets higher in processed, sugary foods are associated with symptoms of poor mental health, such as depression and anxiety.

Luckily, we can take advantage of this relationship and modify the foods we eat as a way of improving our mental health. The following are some of the most powerful nutrients and foods for improving mental health that you can incorporate into your diet today:

**Omega-3 Fatty Acids**: Omega-3s are essential fatty acids (essential meaning that our bodies cannot make them, we have to obtain them through the food we eat) that are incredibly anti-inflammatory and support a healthy brain and reduce mood and anxiety symptoms. Fatty fish, including sock-eye salmon, sardines, and mackerel, are good sources of omega-3s. Choose wild caught fish rather than farmed fish, when possible, to increase the many mood-benefiting benefits of omega-3s. It is important to clarify the difference between omega-3s and omega-6s. Omega-6 is another type of essential fatty acid. Once ingested, omega-3s and omega-6s compete for enzymes to be converted into their usable forms by your body. Omega-6s are found in vegetable oils and are super prevalent in the modern American diet, while omega-3s are more challenging to find. Consuming too many omega-6s inhibit omega-3s from accessing the enzymes necessary for the conversion into its usable form. Therefore, it is crucial to consume the optimal ratio of omega-6 to omega-3 of 2:1, which is the typical ratio consumed in the standard American diet. Fortunately, simply diet changes and, if needed, supplements, can help balance your omega fatty acids and improve your health.

**Folate**: Folate is an important vitamin that supports the function of our neurotransmitters and keeps our brains running at full throttle. Studies have shown it to be associated with decreased symptoms of depression and slowing cognitive decline. It is found in leafy greens like spinach, romaine, collard greens, swiss chard, and mustard greens.

**Vitamin D**: Vitamin D supports our immune system and promotes the growth of healthy gut bacteria, which have been associated with reduced symptoms of depression, anxiety, and schizophrenia. Very few foods naturally contain vitamin D. Sunshine is the best source of vitamin D, so spend about ten minutes each day outside. It is important for a healthy brain and mind to consider supplementing as many of us are deficient. Always discuss this with your doctor.

**Berries**: Blueberries, strawberries, and blackberries are filled with antioxidants and fiber which decrease inflammation and feed the “good” bacteria in the gut.

**Magnesium**: Magnesium is an important anti-inflammatory mineral that helps calm the nervous system to reduce anxiety. Magnesium also improves sleep, which is crucial for a good mood. It can be found in avocados, almonds, chickpeas, and bananas.

**Prebiotics and Fermented Foods**: Fermented foods and prebiotics are powerful in their ability to reset our microbiome which help the gut have positive conversations with our brain. A probiotic supplement helps with physical and mental health and prebiotics feed the gut microbes. Fermented foods and prebiotic foods have been shown to relieve symptoms of depression and promote healthy hormone function. Probiotic-rich foods include plain, unsweetened dairy or non-dairy yogurts, and fermented foods like kefir, kombucha, miso, or sauerkraut. Prebiotic foods include legumes, oats, garlic, onions, and asparagus.

**Spices and Herbs**: Spices and herbs not only flavor your food, but also have antioxidant and antidepressant benefits. Some spices and herbs include:

- **Turmeric**: The active ingredient in turmeric, curcumin, is incredibly anti-inflammatory and protects the brain from toxic damage that leads to depression. Make sure you add a dash of black pepper to activate the brain-food benefits of curcumin. Turmeric’s active ingredient also decreases anxiety and changes the corresponding brain chemistry, protecting the hippocampus because stress can deactivate the hippocampus. Turmeric is an anti-stress spice. Turmeric can be added to smoothies, salads, soups, and even tea.
- **Saffron**: Saffron may be effective in increasing good mood neurotransmitters in the brain and has shown to be just as effective as antidepressant medication in reducing symptoms. It is an expensive ingredient, but a little goes a long way. You can also speak to your doctor about a supplement.
- **Oregano**: Similar to vitamin D, oregano is a great supporter of the immune system and our gut health. Its active ingredient, carvacrol, has been shown to be an effective neuroprotectant and antidepressant in animals.

### Extra Dark Natural Chocolate (cacao) is a probiotic food great for your gut and brain. Cacao flavanols are great antioxidants that beat oxidative stress in the brain and, by doing so, fend off stress. Chocolate is full of micronutrients including magnesium that fights off inflammation in your body and brain. Chocolate also increases blood flow in the brain, improving cognitive function. Find an unsweetened and raw version with 80 percent cacao or more. Real dark chocolate is also rich in serotonin, a chemical used in medications to treat anxiety and stress. This effect was researched in a population study of more than 13,000 adults and found that, even after adjusting for factors like age, sex, body mass index (BMI), and daily sugar intake, dark chocolate consumption specifically, but not milk or white chocolate consumption, was associated with a 70 percent reduced risk of depression.

### Vitamins and Supplements

It is best to get nutrients from healthy whole foods first, when possible. In addition, factors like stress play a huge role in our lives as do environmental toxins, pollution, and poor sleep, which worsens mood because it works as a depressant. Additionally, some doctors may recommend taking a vitamin or mineral supplement as a way of supplementing what you may be missing from your diet. When taking a supplement, it is important to talk to your doctor about a supplement.

### Food and Medication

Nutritional psychiatry does not exclude the use of medications to treat depression. In fact, some people may still need to take a prescription. Never stop taking a medication without first talking to your doctor. Nutritional psychiatry is an additional tool in your mental health tool kit to feel better. In some situations where depression may be quite severe or ongoing, food may not be simple enough to lift it. That said, food can always help how you are feeling and even contribute to helping your mood while you take medication. Additionally, eating healthy foods will help fend off the side effects of weight gain from some medications.

### Client Advisement

To better help explain how to work with clients, this section will cover working toward how to best advise a client.
Case Vignette: Beatrice

Beatrice was a 39-year-old Asian American female who lived with her beloved dog in the Back Bay area of Boston. She was referred by her gastroenterologist. During our first conversation, she told me that she had received a major promotion at work. From living at home, walking her dog daily, going for runs, and preparing most meals and lunches for her daily work, she was traveling most days of the month. She began eating for convenience. Since she exercised regularly, she had not gained significant weight, but her meal quality had plummeted. Between air travel, airport fast food, and late-night bar + restaurant snacks in hotels, she was simply eating very differently. And while she had been eating less, her sleep was disrupted, her period was sometimes delayed and irregular, and she felt poorly.

The issue was gut inflammation related to poor diet. We worked on an improved eating plan, which also included planning ahead for travel. We did the following:

- Worked on a healthy, nutrient-dense meal plan that included snacks for travel (e.g., raw almonds, hazelnuts, and macadamia nuts with a few dark chocolate chunks in each bag; and fresh fruit like apples and clementines)
- Planned ahead for travel, making sure she asked for a small fridge in her hotel room so she could prep at a local supermarket to buy cruciferous and hummus, and but a healthy salad for lunch
- Made a plan to re-start her meditation and mindfulness practice again, beginning with meditation five-minutes twice daily and building up from there to include yoga, journaling, and CBT-i
- Brought a metal water bottle (which she carried emptily to fill at the airport so she was always hydrated
- Limited herself to a glass of wine for work dinners by learning to sip slowly and only drink a half glass, then switch to a sparkling water with fruit which resembled a cocktail, so she did not feel the pressure to reach for another alcoholic drink

It took us six months of consistent work, but she felt results within a week, which helped motivate her to keep going.

Case Vignette: Carlos

Carlos was a 39-year-old male who was struggling with weight gain and low mood. He worked in high-end real estate and had a low-sodium diet and two young children. He ran his own company and was successful but stressed. He would get home after the family dinner, to a homecooked meal; however, he felt a hearty plate of food, he always craved ice cream or snack from his kids’ school snack cabinet. At the end of every evening, he would find himself eating cookies, snack bars, ice cream, and other sweet and salty snacks. He felt satisfied, but gained one or two pounds over the holidays, but he knows he just needs to follow his “rinse and repeat plan” as his wife calls it, to get back on track. Most importantly, what began as a nutritional psychiatry treatment plan, is how he lives.

We did the following:

- Paid attention to self-care in his daily routine by building in time for exercise four days of the week, including running outdoors which he enjoyed and allowed for sun exposure to help his vitamin D levels
- Asked his wife to help him prepare a hearty, colorful salad for lunch and healthy snacks such as zucchini sticks and homemade salsa for dipping
- Avoided the fast food he had been buying for lunch
- Switched to drinking only water and bought a 20-ounce glass water bottle which he refilled at least four times daily
- Cut back to two small cups of coffee early in the day so it did not cause insomnia
- Switched to plain almond milk in his coffee with no sweetener
- Gave up energy drinks, soda, and diet soda
- Drank green tea for an afternoon pick-me-up which improved his focus
- Asked his wife to hide the kids’ snacks as he adjusted as an environmental control measure
- Got home earlier and ate dinner with his family
- Learned mindful eating, so he was eating more slowly and savoring his food
- Asked his wife to make healthier options for the entire family to eat together
- Took short walks after dinner with his wife to decompress and chat about the day

These changes were done slowly and over time so that changing a few healthy habits did not feel overwhelming. Within two weeks he noticed that he was sleeping better, feeling lighter, more alert, and in a more hopeful mood. He gained 18 pounds in a year, which he has since kick-started and still uses the above plan to stay the course. He may gain one or two pounds over the holidays, but he knows he just needs to follow his “rinse and repeat plan” as his wife calls it, to get back on track. Most importantly, what began as a nutritional psychiatry treatment plan, is how he lives.

COVID-19’s Impact on Mental Health

The start of the COVID-19 pandemic made us hyper-aware of health and hygiene in efforts to keep ourselves well. We learned which supplements to take to strengthen our immune systems, what songs to sing while washing our hands, how to properly wear masks, and how apart we should stay from others to protect our physical health. Efforts to protect our mental health during these unprecedented times have not been as successful and so we are now facing the repercussions.

Statistics prior to COVID-19 showed that more than 40 million Americans were dealing with a mental health concern — more than the populations of New York and Florida combined (Mental Health America, 2016). Mental disorders are among the most common and costly causes of disability (Healthy People, 2019). Depression and anxiety are on the rise. Suicide is a top cause of death, to matter of age and gender. We are grappling with a mental health crisis, no matter how many people are in denial about it.

With COVID-19, the mental health statistics are much worse. In fact, mental health is the silent pandemic. In March 2020, we were forced into quarantine which, by definition, is isolation. Those living alone were suddenly faced with extreme loneliness with no end in sight. Systematic reviews have shown loneliness and social isolation to be both risk factors for poor mental health and cardiovascular disease, a metabolic risk factor for COVID-19 mortality (Leigh-Hunt, 2017). On top of this, we faced the fear of an unknown virus and fear for the health of our loved ones, which increased anxiety levels and reduced our capacity for quality sleep (Rajkumar, 2020). COVID-19 has killed millions of people worldwide, and with such loss comes grief and sadness. Depression rates are currently reported to be higher than before the pandemic and are associated with increased alcohol and tobacco use and overall poor health behaviors (Stanton et al., 2020).

Research has shown that in the first three months following a COVID diagnosis, 20 percent are diagnosed with a new psychiatric disorder (Taquet et al., 2021). Another study by the same researchers that found if you follow the patients for 6 months, the number goes up to 4 percent (Taquet et al, 2021). Of the 3 in 100 people who get diagnosed with COVID will be diagnosed with a new psychiatric condition within 6 months. This number is higher than for cases of other viruses, such as influenza. The main reason is that someone so boldly approaches an appointment with pandemic stress. While these psychiatric conditions ranged from dementia to Parkinson’s to stroke, by far the most prevalent were those related to stress. These primarily included anxiety, depression, and insomnia. The researchers hypothesize that the link between these two is somehow related to the viral invasion of the CNS or the viral effects of the cytokine storm. As of now, this is unclear as of now how they are directly correlated. It is also possible that a psychiatric diagnosis may be a risk factor for COVID-19.

In addition to impacting our mental health, this pandemic has also impacted how and what we eat, in a way that is contributing to such mental health trends. Long lines at grocery stores, food shortages, and efforts to reduce the frequency of shopping trips led individuals to purchase processed, shelf-stable foods, consuming more calories, and while decreasing their intake of fresh, nutritious, and fiber-rich produce. Similarly, while quarantined, many took up baking as a coping mechanism or turned to food for comfort. While it is true that family members and friends of these amateur bakers surely enjoyed the byproducts of their new hobby, the consumption of these “comfort foods” are actually inflammatory foods, many of which can be detrimental over time. Foods such as baked goods, or those high in sugars and refined flours, are inflammatory and support an unhealthy gut and poor metabolic health. We can take advantage of the gut-brain connection by modifying what we eat to support both our metabolic health and mental health, as well as our immune system, in efforts to subdue the evolving silent pandemic of poor mental health as the COVID-19 pandemic continues and in its aftermath.

Eating in a way that could optimize your immune system and your brain/mental health is important, especially right now.

Advising Clients on Nutritional Strategies

Approaching a client about using nutrition as a strategy to feel better is something that should be done carefully, as there are many diet wars that we face in the media, and these leave many people confused. I consider myself a holistic and integrative nutritionist, and I am here to help you how I can help someone use nutrition to improve how they are feeling. Rather than judge someone’s diet, my goal is to help clients feel better and support their efforts to help their overall mental health. We can take advantage of the gut-brain connection by modifying what we eat to support both our metabolic health and mental health, as well as our immune system, in efforts to subdue the evolving silent pandemic of poor mental health as the COVID-19 pandemic continues and in its aftermath.

Eating in a way that could optimize your immune system and your brain/mental health is important, especially right now.
The incredible field of nutritional psychiatry emphasizes the value in using food and medicine that what we eat has a direct impact on the function of our digestive tracts, our brains, and ultimately our mental health. It puts the power back into our own hands to choose foods that will make our bodies and our minds happy.

With proper education, we each have this power at the end of our forks, highlighting the potential that nutritional psychiatry has in reversing the silent pandemic of poor mental health, especially during COVID-19.

**Dr. Uma’s Mood-boosting Golden Milk**

**Ingredients:**
- 1 cup almond milk (or oat milk for extra creaminess)
- 1 tablespoon of ginger powder
- 2 tablespoons cinnamon powder
- 1 teaspoon nutmeg
- 1/2 teaspoon raw honey
- 1/2 teaspoon ground turmeric
- 1 teaspoon ground cinnamon
- 1/4 teaspoon powdered ginger
- 1/4 teaspoon turmeric powder

**Method:**
Heat milk and let it simmer. When it is hot, add all the ingredients except the turmeric to a medium-sized saucepan. Let it simmer and heat for about 5 minutes. Pour into your favorite mug, sprinkle with nutmeg, and enjoy!

**References**
This Is Your Brain on Food: How Food Impacts Mood and Mental Health
1.5 CEUs - POST-TEST

Circle all correct answers.

1. Takotsubo Syndrome (TTS), a sudden heart failure syndrome often triggered by acute emotional stressors, is connected to the ________, or the part of the brain responsible for processing emotions and responding to stress, highlighting the heart-brain connection. (Select one)
   a. Frontal cortex
   b. Occipital lobe
   c. Amygdala
   d. Cerebellum

2. Nutritional psychiatry utilizes only dietary changes to improve mental health symptoms, acting as an alternative to traditional psychiatric care, and excludes the use of prescription medications. True or False

3. What is the purpose of the gut microbiota?
   1. To support digestive health
   2. To support immunity
   3. To support hormone balance
   4. To support mental health
      a. 1 and 3
      b. 1, 2 and 4
      c. 1, 2, 3 and 4
      d. None of the above

4. Eating unhealthy foods feeds unhealthy microbes, leading to ________, which we now know to be an underlying cause of mental health issues.
   a. Low blood sugar
   b. Inflammation
   c. Hunger
   d. Gastrointestinal pain

5. Which of the following foods are associated with increased anxiety? (Select all that apply)
   a. Leafy green vegetables
   b. Stevia
   c. Probiotics
   d. Processed vegetable oils

6. Which of the following foods help heal inflammation in the gut? (Select one)
   a. Coconut Oil
   b. Fermented foods
   c. Agave
   d. Fast foods

7. Turmeric is incredibly anti-inflammatory and beneficial for mental health symptoms but must be combined with a pinch of black pepper for the curcumin to be bioavailable. True or False

8. Loneliness and social isolation, as was experienced during the COVID-19 pandemic, has previously been associated with:
   1. Poor mental health
   2. Diabetes
   3. Cardiovascular disease
   4. Cancer
      a. 2 and 3
      b. 1 and 3
      c. 1 and 4
      d. None of the above

9. One in ______ people who survive COVID will be diagnosed with a new psychiatric condition within 6 months.
   a. Five
   b. Ten
   c. Fifteen
   d. Three

10. Nutritional psychiatry follows specific guidelines of using food as medicine for mental health. Which of the following are also suggested?
    1. Mindful eating
    2. Practicing gratitude
    3. Cleaning out the kitchen
    4. Movement
       a. 1 and 2
       b. 1, 2 and 4
       c. 3
       d. 1, 2, 3, 4

Please perform the following steps:

☐ Complete and return this entire page. A score of 80% or better is passing and we will send a certificate of completion for 1.5 CEUs to you.
☐ Please enclose check payable to “NASW-MA” (Sorry, credit cards not accepted for this offer.)
☐ Mail to: NASW-MA, 11 Beacon Street, Suite 510, Boston, MA 02108

Please indicate whether the following learning objectives were achieved:

1. Understand the role of the gut microbiome and how different foods affect both gut and mental health.
   Achieved in full  5  4  3  2  1  Not Achieved

2. Utilize case vignettes to gain an understanding of how to analyze a client’s diet and lifestyle in order to identify opportunities for improvement, as well as advise appropriate changes and nutritional strategies for better mental well-being.
   Achieved in full  5  4  3  2  1  Not Achieved

3. Understand the impact that the COVID-19 pandemic has had on population mental health as well as the increased risk that survivors face for developing new psychiatric conditions as a screening means when working with clients.
   Achieved in full  5  4  3  2  1  Not Achieved

4. Please provide comments on current course and suggestions for future courses:

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Contact information:
Name ___________________________________________________________
Address ________________________________________________________
City __________________________ State ____ Zip ______
Member Number (if applicable): ____________________________

☐ Member (MA/RJ) $20.00
☐ Non-member $40.00
Understanding and Acknowledging History as we Support People in their Vaccine Choices

Lamont D. Simmons, EdD, MSW and Elspeth Slayter, PhD, MSW

Learning Objectives

At the completion of this program, participants should be able to:

1. Summarize the long history of medical experimentation on oppressed communities - communities of color and the disability community - that creates a problematic backdrop for vaccine acceptance.
2. Recognize the need for professionals to build trust with BIPOC and disability community members as it relates to vaccine decision-making.
3. Integrate choice and self-determination in vaccine decision-making for BIPOC and disability community members into case practice.

Introduction

Today, we are talking about vaccine choice for a range of communities, the disability community as well as a range of communities we will refer to as people who are Black, Indigenous, and other People of Color or BIPOC communities. It is important to remember that these communities have significant overlap too. For example, one in four members of Black and African American communities have a disability as do one in six Latinx or Hispanic people, and American Indians and Alaskan Natives die of COVID-19 about two times as often as white people (National Center for Health Statistics (NCHS), 2021). We see that 1 out of 735 Black and African Americans are dying from the disease, according to recent data (APM Research Lab, 2021). For White Americans, that figure is 1 in 1,030. The disability community constitutes 26 percent of the adult U.S. population (Centers for Disease Control and Prevention, 2021a). This community is more likely to be institutionalized – in congregate care like nursing homes, assisted living, and group homes – making it near impossible for them to isolate themselves as a preventative measure while waiting for the vaccine. We know that COVID-19 has hit this community harder than the non-institutionalized community. Others with disabilities require care at home, which while less risky than staying a nursing home, for example, still exposes people to the vectors of infection that disabled people cannot do much to avoid because health care workers are coming in on a daily basis (Palrang, 2021). One fear affecting the disability community from the start of the pandemic is that the government and fellow citizens do not care if they die. This idea is rooted in a century of on-and-off encouragement for what is known as “Eugenics” – or, colloquially, the concept that society is better off without disabled people, and that they are “better off dead” (Palrang, 2021). We must not forget that communities of color and the disability community are not separate - there are overlaps and intersections between them.

There are widespread conspiracy theories related to the COVID-19 vaccine across our populations. In commenting on conspiracy theories, Romer and Jameson (2020) point out the importance of understanding the role of conspiracy theories in vaccine acceptance. They argue that “Conspiracy beliefs regarding the coronavirus pandemic in the US were widespread and persistent over four months, more likely to be held by either persons with conservative political ideology or in disadvantaged racial-ethnic groups and more likely to be associated with the use of conservative media outlets. Additionally, persons with non-White racial-ethnic identity and those using social media were more likely to believe that the MMR vaccine is harmful.” Conspiracy beliefs and their associations with perceptions of vaccine harm present continuing challenges to the control of the coronavirus pandemic because of their persistence and association with non-acceptance of recommended action, especially mask-wearing, and increasing unwillingness to receive a vaccine when it becomes available. Confronting these conspiracy beliefs will require action by journalists and commentators, especially those with politically conservative audiences, to increase acceptance of medically recommended actions to control the pandemic. (p. 263)

This is potentially important information to pay attention to in listening to the people and communities we serve. The people we serve may have been exposed to a range of conspiracy theories about the COVID-19 virus or the vaccine, ranging from the origin of the virus being a Chinese bioweapon or coming from “bat soup” to the availability of a range of miracle cures that may supersede the need for a vaccine. All of this may lead people to feel hesitant about taking the COVID-19 vaccine. It is important to explore the reasons for this before we engage in discussions with the people we support and serve on this topic. But no topic is more important to explore than that of medical mistrust rooted in the history of medical experimentation.

Noted medical historian Harriet Washington, author of Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present, understands a problem without history is like trying to treat a medical patient without taking a medical history. The historical context provided in this course will assist you in supporting the people and communities you work with, in making decisions about whether or not to get vaccinated. Our perceptions of vaccines reflect the seriousness of the diseases they are related to as well as popular values, culture, human risk assessment, and politics, but acceptance of a vaccine is never totally determined through a rational balancing of risks and benefits because that decision differs from person to person (Allen, 2020).

The truth is that vaccines may be a “hard sell” since they prevent rather than cure disease and may seem scary even though they are relatively safe. Successful vaccination campaigns rely on a lot of trust in the people that are going to be administering them. Trust in science, as well as trust in government, are not always high in the community and vaccine acceptance is a result of the trust in communities of color and in the disability community. Existing knowledge tells us that people’s willingness to be vaccinated linked and connected to either their access to vaccines or trusting their trust in vaccination (Collins, 2021). Your work on this issue relates heavily to the trust factor.

We can look back approximately 120 years ago to use history as our guide. In the late 1800s and early 1900s, government workers fighting smallpox epidemics sent public health vaccinators out with police to enforce people getting a vaccination shot. For example, they would enter factories where smallpox cases had been reported, lock the doors, and force all workers to get vaccinated in what was known as a “vaccination line” (Allen, 2020). That vaccine sometimes caused people to have swollen arms, fever, and bacterial infections. Vaccination could, therefore, cause people to lose income for up to a week. Of course, there was resistance to getting vaccinated. Imagine the tone that this set in the community around vaccine acceptance.

Today, we have a politically divided nation. There is a lot of evidence that trust in science is low, and experts, including politicians, are often distrusted. If we look at views about vaccinations for children, we see hesitancy in parents. It must also be acknowledged that efforts to fight COVID-19 in the United States have been clumsy and inept at best, leaving Americans to doubt the competence of their governments and institutions in addressing the disease. This may make it challenging for people to embrace the promises of a COVID-19 vaccine campaign.

Vaccine Hesitancy

Vaccine hesitancy is well-studied in public health and medicine, and social service workers such as social workers should be familiar with this research. “Vaccine hesitancy” refers to the delay in acceptance or refusal of vaccines despite the availability of vaccine services in the face of contagious diseases (World Health Organization, 2020). It is related to factors such as access as well as affordability and availability of the vaccine - and the value of the vaccine to the intended audience. How well people trust the idea of vaccination is a factor in vaccine hesitancy too. Trust in vaccination is related to the factors of effectiveness, safety, reliability, the competence of health care systems in general, and people’s belief in the actions of policymakers who are addressing vaccination.
Vaccine hesitancy is a complex as well as a context-specific phenomenon that varies across time, place, and specific type of vaccine (e.g., MRV vs. COVID-19 vaccines). Additionally, vaccine hesitancy is influenced by a variety of factors including uncertainty, convenience, and also confidence. Although vaccine hesitancy is a well-studied phenomenon, to date, very little effort has been made to spend COVID-19 funding on preparing people to take this vaccine. Rather, the majority of funds have been focused on creating and manufacturing the vaccine in record time.

There is data from the Kaiser Family Foundation about vaccine hesitancy in the U.S. population by a few racial and ethnic groups. We know, for example, that Black and African American and Latinx and Hispanic adults are more likely to want to "wait and see" what happens with other people’s vaccinations before making a decision about their own shot (Hamel et al., 2021).

The literature gives insight into how to address vaccine hesitancy. Standard responses by medical professionals to vaccine hesitancy in the non-COVID-19 literature include the following practical tips, which have some application to social service professionals as well (Shen & Duby, 2019). It is important to note that this list is presented from a medical provider’s perspective, and may differ somewhat from how people in social services might approach discussions with the people they serve (using a more self-determination-oriented perspective):

1. Start early with encouraging people to get the vaccine or consider getting it
2. Present vaccination as the default approach
3. Build trust with the provider
4. Be honest about side effects
5. Provide reassurance about the robust vaccine safety system
6. Focus on protection of the person and community via the vaccine
7. Address the reality of limited pain experienced with the shot

We feel that this approach to vaccine hesitancy needs to be considered in the social work context by focusing medical experimentation on BIPOC and disability communities and will present a modified framework for you to consider after reviewing this history.

To study this connection further, scientists thought that a condition called Takatsubo syndrome (TTS) might be connected to amygdala activity. TTS is a sudden, but very rare, medical condition that is caused by an abnormality in the heart muscle. This abnormality can cause the heart to become enlarged and flaccid. TTS is often associated with stress, and it is more common in women than men. In the United States, TTS often occurs in adults, for example. It has been pointed out that there may be a causal relationship between TTS and amygdala activity. This is because the amygdala is involved in the processing of emotions. TTS is a sudden, but potentially serious, medical condition. It is important to recognize that TTS may be related to stress and that women are more likely to experience it than men. 

To further investigate the relationship between TTS and amygdala activity, researchers conducted a study in which they compared the amygdala activity in people with TTS to the amygdala activity in people without TTS. The results of this study showed that people with TTS had higher amygdala activity than people without TTS. In addition, the researchers found that the amygdala activity in people with TTS was associated with the severity of the TTS symptoms. This study suggests that amygdala activity may play a role in the development of TTS. Further research is needed to fully understand the role of amygdala activity in TTS.

Case 1: Hepatitis Injection with Children with Intellectual Disabilities

The United States Centers for Disease Control and Prevention’s Non-Binding recommendation is to offer vaccines to disabled and chronically ill people “aged 16—64 years with underlying medical conditions which increase the risk of serious, life-threatening reactions from COVID-19” – in Phase 1c of the vaccine rollout.

In this case, we are talking about children with intellectual and developmental disabilities (IDD). The children involved in this experiment lived at the Willowbrook State School in Staten Island, New York. This was a large, heavily publicized institution for children with IDD. The children were intentionally given live hepatitis injections as part of an experiment by the Army Chemical Corps with the goal of developing a vaccine to prevent hepatitis. The researchers believed that this would be a safe and effective way to prevent hepatitis in children with IDD. However, the children did not give their consent, and many did not understand the risks involved. The children were subjected to painful and invasive procedures, and many died as a result. This experiment has been widely criticized for its unethical practices and the harm it caused to the children involved.

Case 3: Medical Experimentation on Black and African American People

There is an extensive legacy of medical experimentation on Black and African American people that has occurred throughout the United States and beyond. Many Americans of Central American origin are citizens, for undocumented immigrants, there may be other concerns about getting vaccinated as well. These might include concerns about health care access that is linked with the U.S. Immigration and Customs Enforcement, also known as ICE. We know that this has been a prominent factor in the delivery of social services in recent years (Kriz et al., 2016). Undocumented immigrants might not show up for vaccination unless authorities are open about what information is collected as people get the vaccine, what that information will be used for, what it cannot be used for, and where it is going to be shared. This may be especially challenging after reports last December from President Trump’s administration that people who get the vaccine will have their immigration status reviewed.

There is a well-documented history of unethical medical experimentation on Black and African American people, leading to significant mistrust. Collusion between stakeholders and doctors who exposed slaves to significant risk in sadistic, and exterminating experiments was widespread (Miller, 2007). For example, if you see a mention of this kind of experimentation, watch “How the bad blood started” an episode of the 1619 podcast series by the New York Times (https://www.nytimes.com/2018/12/23/podcasts/1619/podcast.html). While some may say that slavery times are long gone and that we do not need to speak of them anymore, we may need to revisit our current moment when we listen to the Black and African American community about how present-day experiences connect to the past from slavery through present times. Miller (2007) reflects on Dr. Harriet Washington’s book Medical Apartheid, referenced previously, saying: "We learn of sterilization of black mothers, injection of radioactive substances into uninformed and unaware research subjects, sedation and trickery of parents so that their children could be used in high-risk experiments and invasive surgery, and even release of dengue, malaria, and yellow-fever-bearing mosquitoes in African-American neighborhoods as part of an experiment by the Army Chemical Corps to test the efficacy of dengue-bearing mosquitoes as a..."
That was a local term used to describe syphilis as well were being treated for what was known as “bad blood.”

American men – 399 with syphilis, 201 who did not might get COVID-19 from the vaccine (Altman, 2020).

reported this was their number-one concern, whereas 59 hesitant Black and African American people surveyed.

Encouraging people to take the vaccine and to believe in vaccines, it is important that “sources of authority” from health establishment when it comes to vaccines.

{}
Suggested Guidance on Supporting People who are Making the Vaccine Choice

So how should you go about supporting the people you work with in their vaccine decision-making? We recommend considering the following framework for your conversations.

1. Acknowledge root causes of vaccine hesitancy
2. Help people think about vaccination as a social responsibility and family
3. Consider reframing vaccination as a form of empowerment
4. Emphasize the right to choose and self-determination in vaccine decision-making
5. Encourage people to do their research.

As Mental Health America notes, “Fear is often based in the unknown, so learn as much as you can. Consider what is worrying you, whether it’s the side effects, how recommendation decisions are being made, or uncertainty about how the vaccine works, and make sure you’re informed.”

6. Engage in critical thinking so you can distinguish facts from opinions
7. Stay up-to-date and consider following a vaccine tracker. Also avoid consuming too much news via social media.

8. Look toward officials you trust. As Mental Health America notes, “Many American voters say they trust their personal physician, Dr. Anthony Fauci (Director of the National Institute of Allergy and Infectious Diseases), and the Food and Drug Administration regarding vaccine safety. The Centers for Disease Control and Prevention and World Health Organization are also considered credible sources.”

9. Think about the benefits compared to the risks given that the vaccine has been approved under an Emergency Use Authorization requiring that benefits outweigh known and potential risks.

10. Make decisions in your best interest. As Mental Health America notes, “If the anxiety surrounding vaccination is too much to bear with, it’s okay to step away from it all for a bit.”

We hope that this framework will assist you in guiding conversations about vaccine decision-making that follow the fraught sociopolitical discussion we have reviewed in this course.
Understanding and Acknowledging History as we Support People in their Vaccine Choices
1 CEU - POST-TEST

Circle all correct answers.

1. How has the long history of medical experimentation on oppressed communities - communities of color and the disability community impacted vaccine acceptance? (Select one)
   a. It has created a problematic backdrop for vaccine acceptance for BIPOC communities
   b. It has created a problematic backdrop for vaccine acceptance for the disability community
   c. It has not created a problematic backdrop for vaccine acceptance for any community
   d. It has created a problematic backdrop for BIPOC communities and the disability community

2. Practitioners must understand the history of problematic medical experimentation before acknowledging and accepting people’s truth before seeking to support them in vaccine decision-making because: (Select all that apply)
   a. People should not have a choice about whether to get the vaccine
   b. This fosters respect and self-determination
   c. It is important for history to inform current practice with the people we serve
   d. Different populations experience the medical system differently

3. Professionals must build trust with BIPOC and disability community members as it relates to vaccine decision-making because: (Select all that apply)
   a. People should not have a choice about whether to get the vaccine
   b. This fosters respect and self-determination
   c. Building trust between practitioner and persons served is a best practice in promoting vaccine acceptance

4. Integrating choice and self-determination in vaccine decision-making for BIPOC and disability community members into case practice is vital because: (Select all that apply)
   a. People should not have a choice about whether to get the vaccine
   b. This fosters respect and self-determination
   c. It helps to address historical inequities related to medical atrocities experienced by these communities

5. Health policies centered on eradicating structural oppression that will foster long-term trust among oppressed communities are needed because: (Select all that apply)
   a. This will help to address historical inequities related to medical atrocities experienced by these communities
   b. Health policy has nothing to do with vaccine acceptance in the long term
   c. Health policy has nothing to do with structural oppression in the long term

6. Standard approaches to addressing vaccine hesitancy among people and communities served include: (Select all that apply)
   a. Starting early with encouraging people to get the vaccine
   b. Presenting vaccination as the default approach
   c. Building trust with the provider
   d. Being honest about side effects
   e. Providing reassurance about the robust vaccine safety system
   f. Focusing on protection of the person and community via the vaccine
   g. Addressing limited pain experienced with the shot

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1. Summarize the long history of medical experimentation on oppressed communities - communities of color and the disability community - that creates a problematic backdrop for vaccine acceptance.
   Achieved in full  5 4 3 2 1 Not Achieved

2. Recognize the need for professionals to build trust with BIPOC and disability community members as it relates to vaccine decision-making.
   Achieved in full  5 4 3 2 1 Not Achieved

3. Integrate choice and self-determination in vaccine decision-making for BIPOC and disability community members into case practice.
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