Letter from the Chair

As I embark upon my new role as chair of the Mental Health Committee of the National Association of Social Workers (NASW) Specialty Practice Section, I am reminded of the time I spent as president of the Connecticut chapter of NASW. Mental health practitioners always stood ready to advocate on behalf of their clients, to enhance well-being for those groups most in need. With large segments of the population being represented by persons of color who were living in urban poverty, it was a challenge to figure out how best to take action in meaningful ways that help to eliminate disparities in population dense areas.

Now that I’m in North Carolina, I see pockets of poverty and disenfranchisement in rural areas. What remains constant is social workers’ commitment to ethical practice using problem-solving methodologies. A plethora of factors influence mental health practice. Understanding the role of hope in the journey toward recovery for individuals with mental illness is an important aspect of helping clients/consumers, family members, and providers to achieve their treatment goals. Furthermore, describing the role of culture in mental health practice creates awareness that can facilitate greater access and improve clinical outcomes. In this newsletter, we discuss these two areas of practice to offer insight and provoke critical thinking. Additionally, we have included the NASW Legal Defense Fund’s Social Workers, Smartphones, and Electronic Health Information as a resource to explore the growing role of technology in the delivery of mental health services.

We welcome your feedback and input for further issues of Mental Health Section Connection.

Karen Bullock, PhD, LCSW
Raleigh, North Carolina
In the 1990s, advocates of clients/consumers, family members, and some providers began to challenge many of the old assumptions and stereotypes about mental illness and the lives of those with mental illness. These advocates—some speaking from personal experience and others from observation—argued that being diagnosed with a mental illness, even a serious one, is not a death sentence in terms of hope for the future. Instead, many people who have mental illness can lead fulfilling lives and can achieve universal goals: friendships, romantic partnerships, meaningful work, enjoyable recreational pursuits, and independent living. In other words, many people with mental illness can achieve “recovery.” These advocates soon coalesced into a recovery movement that, over time, succeeded in achieving a paradigm shift with mental health systems of care around the world at all levels “by challenging mental health providers, administrators, policy makers, funders, workers, and the people who experience mental health problems and their families to look at how negative or limiting assumptions are driving approaches to services, to funding, to treatment, to policies, and ultimately to the course of everyday lives” (Pennsylvania Office of Mental Health and Substance Abuse Services, 2005, p. 6).

“Recovery” should not be equated with “cure,” although many individuals with mental illness do experience what might be termed a cure, in that their symptoms—with or without treatment—recede and in that they do not have any subsequent episodes of illness. For example, about a third of individuals who experience an episode of psychotic illness that looks like schizophrenia have only one episode, get well, and never get sick again (Torrey, 2006). Today, we no longer call such illness schizophrenia; rather, the diagnosis is schizophreniform disorder. Someone who has schizophreniform disorder recovers in the complete sense.
of the word, in that they remain well with no reoccurrence of psychotic symptoms. For most people with serious mental illness, however, “recovery” means achieving a fulfilling life while living with and managing symptoms that may wax and wane over time.

But how is recovery defined exactly, and where does hope fit in? As an example, in November 2004, the Pennsylvania Recovery Workgroup developed a definition of recovery that was subsequently endorsed by the Pennsylvania Office of Mental Health Substance Abuse Services (POMHSA) as the definition to be used to guide transformation of the state’s mental health system. This definition is very similar to the general definitions of recovery used by other states and in other countries (see, for example, O’Hagan, 2001). Embracing recovery is not just an American phenomenon; it is a worldwide paradigm shift:

“Recovery is [defined as] a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, choices and opportunities that promote people reaching their full potential as individuals and community members” (POMHSA, 2004, p. 7).

One of the most important aspects in an individual’s journey of recovery is achieving and maintaining hope. But what is hope, exactly? Hope is generally defined as the desire for something, accompanied by the expectation of obtaining it. We still don’t know much about hope’s determinants or biological correlates, or why some individuals can have hope in the most dire of circumstances while others in similar positions cannot achieve or maintain it. What we do know is that lack of hope, or hopelessness, is often very detrimental to mental health and is often the key component in negative psychosocial outcomes, such as completed suicides. Thus, the development and maintenance of hope is important for mental health.

In 2004, the Substance Abuse and Mental Health Services Administration (SAMSHA) released a consensus statement on mental health recovery, and it identified hope as one of the ten components of successful recovery when someone has a mental illness. Recovery provides our clients with the message that by maintaining hope they can achieve a better future and can overcome the obstacles and barriers that arise during the course of living with mental illness. Although maintaining hope requires that hope be internalized within the client, the development of hope can be initially facilitated by the client’s peers, family, friends, and treatment providers, including social workers. As one consumer stated, “My social worker provides me with hope—she had faith in me when I didn’t have faith in myself. Now, today, I feel I have achieved recovery and I have a decent life.” In other words, hope is the catalyst of the recovery process (SAMSHA, 2004).

In all areas of mental health care, it is critical to hear and respect the voices of those who receive services, particularly consumers and family members. Recovery and the maintenance of hope is a personal journey, and that journey differs for each individual; however, common threads cut across individual experiences. Hope is important for clients, it is important for families, and it is important for us as social workers.

The following quotes from the National Alliance on Mental Illness website (www.nami.org) illustrate what it means for individual consumers to have hope in recovery as expressed in their own words (retrieved March 18, 2009):

“Recovery does NOT mean I will be rid of my mental illness. It means I can learn how to manage my symptoms better and better all the time. I will still have occasional setbacks, but my mental health is in the process of recovery.”

“Recovery means properly managing my illness instead of my illness controlling me.”

“Recovery means learning to live your life successfully with a mental illness. It is a journey, not a destination.”

Social workers can facilitate hope with their clients by giving them the message of recovery and delivering services using a recovery orientation. This does not mean engendering false hope and unrealistic expectations; rather, it means supporting by helping them to set realistic and feasible self-determined goals, to learn how to overcome obstacles, and to self-advocate for what they want in life. This approach supports empowerment and engenders real hope in recovery.

Christina E. Newhill, PhD, LCSW, is a professor of social work at the University of Pittsburgh. She has more than 10 years of community mental health practice experience, primarily in psychiatric emergency and inpatient settings. She is currently writing a book on social work practice with individuals who have serious mental illness and their families. She may be reached at newhill@pitt.edu.

REFERENCES


Race, class, ethnicity, and a whole host of other differences can represent culture, which may help to facilitate or impede access to mental health care. Over the past two centuries, the number of racial and ethnic minorities has increased across the country. Federal projections predict that African Americans, Asians, Alaskan Natives, Pacific Islanders, Native Americans, and other racial minority groups will comprise the majority of the U.S. population by the year 2050 and non-Hispanic whites will be the minority. Furthermore, the largest increase will occur with the Latino population, which will outnumber all other minority groups by 2050, with approximately one-third of the population identifying as Latino (U.S. Census Bureau, 2012).

As the general U.S. population becomes more culturally diverse, so too will those individuals and families for whom we provide mental health services. The challenge for practitioners in an increasingly diverse society is to ensure that all patients and families have access to care. It behooves us as social workers to consider factors that influence our ability to provide culturally competent care in an increasingly diverse society because lived experiences, customs, traditions, and values affect how individuals and families make decisions about care. Furthermore, attention must be given to underrepresented and disenfranchised populations.

Culture represents the values, traditions, norms, customs, lived experiences, and a whole host of other factors that can facilitate or impede care (Bullock, 2012). As advocates for our clients, it is important to bring attention to the role of culture in mental health. Moreover, we must adhere to the standards for cultural competence in social work practice (NASW, 2001) to ensure that all persons have access to care.

Our clients’ cultures may not always be consistent with those of traditional Western-based medicine. If and when conflicts between the value systems of health care providers and clients arise, a failure to deal with them properly may result in inadequate care or no care. Because every individual is socialized by group norms, and group norms influence how one defines “health” and prescribes methods for maintaining health and well-being, it is important for us as clinicians to understand cross-cultural beliefs, value systems, interpretations of behaviors, and cultural expectations of help-seeking if we are to address the needs of vulnerable populations. People of color (African Americans, Latinos/Hispanics, and American Indians), in particular, are disproportionately affected by mental illness (Hunt et al., 2013).

A study of mental health outcomes for primarily low-income, African American children (Mancoske, Lewis, Bowers-Stephens, & Ford, 2012), documented that services perceived as culturally competent improved clinical outcomes, including access to care, participation in services, and satisfaction with services. Furthermore, it was argued that culture enables people to develop the resilience needed to deal with adversity.

Older adults with mental health problems are at risk of underdiagnosis, misdiagnosis, and undertreatment (Woodward et al., 2012). Mental illness is often aggravated by social isolation, poverty, and physical health problems. Many older Latino and African Americans tend not to seek services for a number of
reasons, including stigma, perceptions about normal aging, lack of insurance, transportation, and access to culturally appropriate services (Choi & Gonzalez, 2008; Guzzardo & Sheehan, 2012).

Cultural competence enables clinicians to work effectively across groups. While it is impossible to know everything about every cultural group, social workers can be culturally astute in recognizing when we need to listen to our clients about what is an acceptable approach to mental health care in their culture. Cultural competence helps us to understand the values, attitudes, and behaviors of our clients, and to avoid stereotypes and biases that create barriers to successful outcomes; it plays a critical role in the development and delivery of services that can eliminate disparities in mental health care.

One strategy that has been used (Bullock, Hall, & Leach, 2012) to enhance the cultural competence of social work practitioners is cultural consultation. It involves the use of expert experience in practice and offers services that supplement those provided by the primary worker, who may be less experienced with the cultural group. The consultant (typically a licensed clinical social worker) performs an assessment of the client system and follow-up consultation to the primary provider in an effort to assist the latter in understanding the cultural meaning of the client’s symptoms and the social context of their distress. Such services have been found to be successful in unearthing cultural misunderstandings, incomplete assessments, incorrect diagnoses, and the application of treatments that are culturally incongruent with the client’s belief system (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003).

Some suggested guidelines for achieving cultural competency in mental health practice are as follows: (1) garner knowledge about the patient’s ethnic group in terms of health practices, values, and attitudes toward the health care system; (2) assess communication style, decision-making processes, acculturation, and degree of integration into the ethnic community; (3) develop and implement culturally appropriate treatment/intervention plans that incorporate a systems approach and allows the client to self-determine; and (4) evaluate the degree to which the treatment/intervention helps the client system to achieve its goals of care. Collaboration with members of the client’s social support network—and including them in the discussions about culturally specific treatments, when possible—has been recommended for improving practice competencies and treatment outcomes.

Karen Bullock, PhD, LCSW, was a licensed clinical social worker at Hartford Hospital’s Institute of Living for the past 10 years. She previously served on the NASW National Committee on Racial & Ethnic Diversity (NCORED). She is the past NASW-Connecticut Chapter President and recipient of the NASW-CT Educator of the Year Award. She is currently the Associate Head of the Department of Social Work at North Carolina State University and serves on the Board of Directors for the Social Work Hospice & Palliative Care Network. Her current clinical practice focuses on clinical supervision for provisionally licensed social workers.

REFERENCES


Social workers are increasingly relying on mobile communication devices such as Internet-enabled mobile phones (“smart phones”), laptop computers and tablet computers in the course of carrying out professional social work duties. Some of the common issues that arise in the use of these devices include:

- Is it okay for me to email information to my clients?
- Am I required to use an electronic health record for clients?
- I’ve started storing my client files on a remote server through an IT vendor that provides password access to the records. Is that sufficient protection for clients’ confidentiality?

This article will provide highlights of current and emerging issues for social workers who use mobile electronic devices in practice and suggests steps for consideration and action.

BACKGROUND
Clinical treatments for a variety of emotional conditions and mental disorders are now offered through the medium of smart phone applications as well as computer-based videoconferencing, text and email. Examples of clinical smart phone applications include treatment of anxiety disorders, phobias and alcohol dependence and using dialectical behavioral therapy (DBT) coaching and biofeedback (Boschen, M.J. and Casey, L.M., 2008; Cuijpers, P., Marks, I.M., and van Straten, A., et al., 2009; Dimell, L.A., Rizvi, S.L., Contreras, I.S., et al., 2011; and Maier, E., Reimer, U. and Ridinger, M., 2011). Many other uses in behavior modification and management of medical conditions have been developed and are being tested, including remote monitoring of patients with chronic health conditions (Boulos, M.N, et al., 2011).

According to a study by the Office of the National Coordinator for Health Information Technology (ONCHIT), most mobile phones did not meet more than 40 percent of the HIPAA security standards without additional modifications (Mosquera, M., 2012). The ONC expects to develop best practices for securing smart phones by the fall and make them available online with a focus on providing guidance to small and medium-sized health care entities.

PASSWORD PROTECTION
Securing an electronic device, particularly a mobile device, with password protection is a basic and easy step to accomplish. Strong passwords are those that would not be easy to guess, are sufficiently long (minimum of 8 characters) and sufficiently complex (combination of letters, symbols, uppercase and lowercase, and numbers). Setting the device to go into a password-protected mode after a short period of inactivity will deter simple attempts to breach the device and it is one component of a good security protocol. It is important to regularly clean any touchscreens to remove fingerprint traces of the device password (Wagner, 2010).

Encryption software is one of the essential technology tools for a health provider to employ when using electronic devices and modalities for creating, receiving, transmitting and storing confidential client records and information. Affordable encryption technology is commercially available for securing the data contained on smartphones, laptops and tablet computers and for transmitting secure emails and text messages. If encrypted data are lost or stolen it is far less likely to be accessed by a third party in a useable format than unencrypted data. The HIPAA regulations specify that if encrypted patient health information is subject to a privacy breach, the health care entity is exempted from breach notification requirements. This is due to the decreased likelihood that encrypted data may be accessed in a useable manner (Morgan, S. and Polowy, C., 2010b).

Encryption software may be purchased online and downloaded directly to the device or it may be pre-installed on the device (see Wagner, 2010 for a discussion of default encryption software on the iPad).

DATA WIPING
Software is available to remotely locate and erase the data from your device (Mosquera, M.,...
This tool is useful as long as the device is connected to the Internet, such as via WiFi or an active GPS connection; however, if those connections are not available [such as when the battery dies], this feature will not be operable. Regardless, this is a simple application to upload and activate and it may be helpful in the immediate aftermath of a loss or theft to track the missing device.

**WIFI NETWORKS**

Small health care practices, such as clinical social workers’ offices, may use a WiFi network to connect computers to the Internet and many of these systems are not secure. Unless specific actions are taken, it is likely that a WiFi network is broadcasting a portion of its’ identifying signal that may enable a hacker to access the system without authorization. The service set identifier (SSID) has default settings that may be changed by a savvy consumer. A number of steps are recommended to increase the security of WiFi networks, such as disabling the broadcast of the SSID and resetting the administrative passwords and “upgrading the WiFi network security to Wi-Fi Protected Access (WPA) or Wi-Fi Protected Access II (WPA2).” Which are two security protocols and security certification programs to secure wireless computer networks. The Wi-Fi Alliance defined these in response to serious weaknesses researchers had found in the previous system, WEP [Wired Equivalent Privacy].” (Bradley, T., 2012; Mosquera, M., 2011). However, the regulations do require that entities subject to HIPAA develop a plan to identify vulnerabilities to the privacy and security of individually-identifiable protected health information (PHI) and to address those vulnerabilities (Morgan, S. and Polowy, C., 2005). For use by email which includes information beyond simple appointment reminders, encryption is a valuable technology. For some situations, even electronic appointment reminders may breach client privacy, such as when a person does not want their spouse to be aware they are receiving clinical services and they share email passwords at home or have a shared email account. Thus, a best practice would be to provide clients with an “opt-in” option for accepting emails or to only respond to emails that are initiated by the client. For client-initiated emails, it may still be appropriate to first confirm that the client consents to receipt of a return email. Emails may be considered part of the client’s record, so social workers should always be aware that electronic communications may be subpoenaed, accessed by auditors, requested by the client or otherwise disclosed and used in a variety of legal or administrative proceedings. Although emailing is an efficient means of communication, the same care should be taken in framing an email response as with any other client-related correspondence.

**AM I REQUIRED TO HAVE AN ELECTRONIC HEALTH RECORD FOR MY CLIENTS?**

Financial incentives are available to physicians and certain categories of practitioners, including hospitals, for the adoption of electronic health record technology; however, these benefits are not currently offered to independently practicing clinical social workers (CMS, 2010). Some health plans and health insurance companies may begin requiring reimbursement claims to be filed electronically, so private clinical social work practices will find it increasingly difficult to avoid the adoption of electronic claims filing processes unless they utilize a self-pay-only model. Filing electronic health claims is not synonymous with the adoption of electronic health records for clients’ clinical charts. Many small practitioners maintain a paper-based office, but use a third-party billing service that submits electronic claims on their behalf. This billing model still requires that the clinical social work practice adhere to all HIPAA privacy regulations, for both paper and electronic records.

**SMART PHONE ACCESS TO HEALTH RECORDS**

Models for allowing emergency providers to access patient records are being developed and legal standards permit such access, including access to electronic health databases (Morgan, S. and Polowy, P., 2011). The methods of securing access in a mobile environment are under study and some considerations include retaining data on the patient’s mobile device with password protection and biometric authentication (accessible even for unconscious patients) (Gardner, R., Garera, S. and Pagano, M. 2009). Health information technology scientists are attuned to the need for maintaining information as confidential while permitting access in appropriate and necessary circumstances only to the personnel who require access. Extensive policy analysis has been conducted to evaluate the best approach to preserving patient privacy while supporting mobile and in-home care (Kotz, D., Avancha, S. and Baxi, A., 2009) and this is an area of law and health care practice that is evolving rapidly.

**CLOUD COMPUTING AND HEALTH PRIVACY**

Use of secure, off-site computer servers to store data for rapid access via the Internet has increased exponentially as mobile electronic devices proliferate. Health care practitioners who seek to harness the potential for this technology to store and access patient information must carefully evaluate the business that offers such services. Data servers that are not located on U.S. soil may subject the provider to a risk of non-compliance with HIPAA. In order to meet HIPAA requirements the provider may need to be able to determine where the confidential “data is physically stored, how many copies have been made, whether or not the data has been changed or if the data has been completely deleted when requested” (Admin, 2012). A cloud data company providing storage services for health-related purposes should be willing to sign a HIPAA business associate agreement, requiring that information be maintained in accordance with HIPAA privacy and security standards (see Morgan, S. and Polowy, C., 2010a).

**ANALYSIS & CONCLUSIONS**

Working with new technology as a consumer does not automatically provide sufficient expertise or knowledge to apply the same technology in
social work practice. To meet professional standards, social workers must conduct sufficient inquiries into the applicable legal, technological and administrative safeguards that assure clients’ confidentiality will be protected and that they will be able to access their information readily [National Association of Social Workers, 2005]. New service delivery methods also require that social workers develop the professional competence necessary to provide effective client interventions. Encryption is a standard expectation for the use of electronic health information; however, new applications for mobile health data are expanding at such a pace that each adoption of a new program or device must be evaluated for potential vulnerabilities so that the promise of its potential for new health care delivery models may be realized responsibly.

Sherri Morgan, MSW, JD, is Associate Counsel for NASW’s Legal Defense Fund and Office of Ethics and Professional Review.

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Practice Perspective Excerpt

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• Administration/Supervision
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• Alcohol, Tobacco, and Other Drugs
• Child Welfare
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• Private Practice
• School Social Work
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