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Monograph

National Organization for Human Services

National Organization for Human Services

The National Organization for Human Services (NOHS) was founded in 1975 as an outgrowth of a perceived need by professional care providers and legislators for improved methods of human service delivery. With the support of the National Institute of Mental Health and the Southern Regional Education Board, NOHS focused its energies on developing and strengthening human service education programs at the associate, bachelor‘s, master‘s, and doctoral levels.

The current mission of NOHS is to strengthen the community of human services by: (a) expanding professional development opportunities, (b) promoting professional and organizational identity through certification, (c) enhancing internal and external communications, (d) advocating and implementing a social policy and agenda, and (e) nurturing the financial sustainability and growth of the organization.

Members of NOHS are drawn from diverse educational and professional backgrounds that include corrections, mental health, child care, social services, human resource management, gerontology, developmental disabilities, addictions, recreation, and education. Membership is open to human service educators, students, fieldwork supervisors, direct care professionals, and administrators. Benefits of membership include subscriptions to Human Service Education and to the Link (the quarterly newsletter), access to exclusive online resources, and the availability of professional development workshops, professional development and research grants, and an annual conference.

Six regional organizations are affiliated with NOHS and provide additional benefits to their members. They are the New England Organization for Human Service, Mid-Atlantic Consortium for Human Services, Southern Organization for Human Services, Midwest Organization for Human Services, Northwest Human Services Association, and Western Region of Human Service Professionals.

NOHS is closely allied with the Council for Standards in Human Service Education (CSHSE). CSHSE, founded in 1979, has developed a highly respected set of standards for professional human service education programs and also provides technical assistance to programs seeking Council accreditation.

Membership information can be found on the organization‘s website by clicking "Join Now" at: www.nationalhumanservices.org.

Managing Editor

Guest Editorial Board

Guest Editors

Table of Contents

Introduction to the Winter Edition Monograph

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We are pleased to publish this Monograph on current issues in the field of human services. This Winter Edition Monograph is a supplement to the 34th edition of the Journal of Human Services.

In response to our quickly evolving field, the editors of the journal felt that it was paramount to address some of the issues and topics that challenge human services practitioners. Thus, a call for special topics articles was sent out to human services members of the National Organization for Human Services. Our call for articles required that interested authors submit a paragraph with a description of the special topic along with a two-sentence statement indicting why the topic is important to the field of human services.

As noted in the Introduction to the Special Topics Section in the Journal, we received an overwhelming response to this inquiry, with over 86 submissions. A total of 16 submissions were selected for the 34th edition of the journal based on a blind review and peer review ranking system. However, the editors felt that many of the special topic submissions were worthy of publication and could contribute to the field of human services.

Thus, the articles featured in this Monograph were accepted via a separate blind review and peer review ranking system from the editors of the journal. The editors ranked the submissions (not selected for the journal) on a ten-point scale. The highest average rankings were accepted for this publication. While 26 submissions were selected, only 15 submitted and/or met the guidelines for acceptance.

We are very pleased to offer this supplementary publication on current issues in the field of human services. Thank you to all of the guest editors to help make this publication possible!

Dual Focus Programs: Issues in Correctional Facility Drug Rehabilitation Programs

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Abstract

Substance abuse is an unyielding problem in our contemporary society, with identifiable correlations to crime. Given the growing number of offenders suffering from substance abuse, drug rehabilitation programs have been incorporated within numerous correctional facilities. Due to the broad scope of the human services profession, human service practitioners often work in correctional facilities and substance abuse programs in a variety of roles. The nature of the relationship between crime and substance abuse is discussed along with benefits of correctional facility drug rehabilitation programs related to reform and recovery. Issues these programs bear regarding methodology, accessibility, and funding are also explored, shedding light on the potential issues programs with dual focuses bear when servicing high risk populations, thus, revealing the need to improve correctional facility drug rehabilitation programs. Implications for ways in which various roles of the human services profession can impact these improvements are also highlighted.

Dual Focus Programs: Issues in Correctional Facility Drug Rehabilitation Programs

Substance abuse and crime are relentless issues facing our nation. According to the latest findings of the *National Survey on Drug Use and Health (NSDUH)*, in 2013 approximately 21.6 million United States citizens (age 12-years and older) were diagnosed with a substance use disorder, and more than 22 million (age 12-years and older) needed treatment for substance abuse (Substance Abuse and Mental Health Services Administration, 2014). In addition, over 80 percent of the national correctional facility population is incarcerated due to drug related crimes (Campbell-Heider & Baird, 2012). Numerous non-violent crimes connected with the substance abuse population can include, but are not limited to: theft or robbery, drug law violations related to the sale, manufacturing, trafficking or drug possession, driving under the influence, disorderly conduct, or public intoxication (Campbell-Heider & Baird, 2012; Nordstrom & Dackis, 2011).

The relationship between substance abuse and violent crime related to aggression, violence, and family conflict has been examined in multiple studies. Lundholm, Haggard, Moller, Hallqvist, and Thiblin (2013) examined the association of substance use and remanded prisoner's suspected of various types of violent crimes. It was found that there were high correlations between alcohol, cocaine, and benzodiazepine use and violent crimes (e.g assault, homicide, manslaughter, sexual assault, and illegal confinement and or kidnapping) and more than half of the remanded prisoner's recounted substance abuse within the 24 hours prior to committing the violent act and described violent triggers with use (Lundholm et al., 2013). Supplementary research examining substance abuse and its relationship to elder abuse, child abuse, and intimate partner abuse report direct correlations between repetitive abuse patterns and the abuse of drugs or alcohol (Hirschel, Hutchison & Shaw, 2010; Jogerst, Daly, Galloway, Zheng & Xu, 2012; Laslett, Room, Dietze & Ferris, 2012).

Drug Rehabilitation Programs in Correctional Facilities

Due to the correlation between crime and substance abuse, treatment for substance abuse has become part of rehabilitation programs offered to inmates in many correctional facilities (Wormer & Persson, 2010). In light of this, various investigations of substance abuse treatment in all correctional facility settings have been conducted through both independent and government ran studies. In research conducted on the subject, correctional facilities drug programs have been found to provide positive outcomes related to criminal reform and recovery from substance abuse (Campbell-Heider & Baird, 2012; Krebs, Brady, & Laird, 2003; Reyes, 2009). In a review of literature, there was an overall decrease in re-offending associated with correctional substance abuse treatment and identification of successful treatment related to immediacy and length of treatment and reveal better outcomes for offenders that receive long-term treatment immediately upon incarceration (Campbell-Heider & Baird, 2012; Powell, Christie, Bankart, Bamber & Unell, 2011; Reyes, 2009). Evans, Huan & Hser (2011) further substantiated this as they examined the recidivism rates of high-risk offenders in substance abuse treatment. They reported decreased rates of re-offending for those who received lengthier treatment.

In addition, research on the type and availability of correctional facility substance abuse treatment also revealed issues with these programs. Findings included issues with offender substance abuse treatment eligibility, identifying guidelines that restrict inmate access to substance abuse treatment services (Krebs et al., 2003; Wormer & Persson, 2010). Additionally, issues were discovered regarding the relationship between early release programs and substance abuse treatment, revealing the attraction of offenders interested solely in the early release incentive while discouraging those offenders ineligible for early release who possess serious treatment needs (Wormer & Persson, 2010). Campbell-Heider and Baird (2012) also found problems regarding the assessment of treatment needs, identifying the need for comprehensive screenings upon entering the criminal justice system, and the need for comprehensive substance abuse treatment which would incorporate care during incarceration as well as transitional care upon release. Moreover, in relation to the issues regarding correctional facility substance abuse treatment, the additional problem of funding was illuminated. Correctional facilities are both state and federally managed, and government funding is granted based on evidence of treatment success, thus, without proper assessment the potential for reduced funding subsists, identifying the need to further evaluate correctional facility substance abuse treatment programs in order to acquire necessary funding to elicit change (Krebs et al., 2003; Wormer & Persson, 2010).

Relevance to the Field of Human Services

Due to the broad nature of the human services field, numerous disciplines, roles, and settings are encompassed within the profession in order to provide competent and ethical care in serving diverse populations including, but not limited to, individuals, families, groups, and communities with substance abuse and or legal issues (National Organization of Human Services [NOHS], 2009; Neukrug, 2013). For human service practitioners, this can involve work in settings such as correctional facilities, court systems, and substance abuse treatment programs (NOHS, 2009). To effectively address the needs of diverse populations (e.g. the substance abuse and offender populations) human service practitioners fulfill many roles which can involve direct service, advocacy, education, research, and evaluation (National Organization of Human Services [NOHS], 2010; Neukrug, 2013).

Regardless of the manner in which service is provided, human service professionals are dedicated to fostering improved service access, delivery, accountability, collaboration, and coordination in their work with clients, communities, colleagues, agencies, and society (NOHS, 2009; NOHS, 2010). The implications for needed improvements in correctional drug rehabilitation programs can impact the ability to provide ethical and competent care for the substance abuse and offender populations. Through advocacy, evaluation, education, and research human service professionals can address the issues present in correctional drug rehabilitation programs.

An overview of the relationship between crime and substance abuse and a brief review of correctional facility drug rehabilitation programs has identified implications for needed improvements regarding the methodology, accessibility, and funding of drug rehabilitation programs in correctional facilities. Due to the broad scope of the human services field, human service professionals working with the substance abuse and offender populations serve in various roles, which can directly impact the improvement of correctional facility drug rehabilitation programs. As such, human service professionals can contribute to improving the efficacy of correctional facility drug rehabilitation programs, thus, increasing success in the fight against substance abuse and crime.

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Foster Care Advocacy

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Abstract

Advocacy in foster care is a significant concern for human service providers. Highlighted in this article are media incidents of note that brought issues in foster care to public attention. This resulted in legislative action, both effective as well as ineffective. Major reform efforts following class action lawsuits are reviewed that have occurred across the country in recent years within states such as Tennessee, Maine, and Florida. This brief history of helping young people emphasizes federal and state efforts to improve the lives of families in crisis. Over the years, best practices in foster care evolved to push quality approaches for family preservation, reunification, independent living, treatment, and support. Foster children and their families directly benefit from advocacy efforts by human service practitioners across the nation.

Foster Care Advocacy

Children and families have long been a chief concern in the field of human services. A complex list of problems and circumstances may necessitate the movement of young people into extra-familial living arrangements. This can include parent or caregiver issues like death or child abuse, delinquent behavior, psychiatric disorders, and similar difficulties. Traditionally, children and youth in crisis have been placed in orphanages, group homes, therapeutic boarding schools, residential treatment, institutions, and foster care. Although any placement away from one's parent(s) can be considered foster care, living in a home with a family generally distinguishes this aspect in the continuum of childcare.

Examples abound where advocacy in foster care has been desperately needed. In November of 2013, authorities found an 11-year-old in North Carolina handcuffed to a porch with a dead chicken hanging from his neck (Gordon & Bell, 2013). They arrested his foster parents. The mother was a supervisor in child protective services for the Department of Social Services (DSS) and the father an emergency room nurse. They also had four other adopted children. Despairingly, this was the second time in a year law enforcement alleged abuse in this family.

As a result of this publicity, the state legislature commissioned the Committee on Omnibus Foster Care and Dependency to study the issue (Hoban, 2014). The group spent months attempting to generate a set of recommendations for legislation to improve foster care in North Carolina. One of the co-chairs represented a county where foster children were being placed with a convicted child sex offender. The committee finally released a report with very few recommendations other than legislators spend even more time studying the issue and, contentiously, that the state should prevent employees of DSS from ever keeping foster children (Hoban, 2014).

The state of Tennessee can also provide a striking example, being that its foster care system has been under federal court order for over a decade. After years of complaints about the system, a highly publicized case, Brian A. vs Sundquist, resulted in substantial recommendations for changes to the state Department of Children's Services (DCS). Young people in state care were being inappropriately placed in institutions at one of the highest rates in the nation, warehoused too long in emergency shelters, put on large caseloads, and moved excessively (Yellin, 2000). The state did little to implement the settlement, necessitating additional legal action in 2003 (Children's Rights, 2014).

By then, a new governor had been elected, and the state embarked upon creating a model for the nation in foster care (Casey Family Programs, 2010). The number of children in foster care decreased by 34% between 2000 and 2009. The recurrence of maltreatment became less than the national average along with the rate per 1000 of foster children. Performance based contracting was instituted, paying human service organizations more for successful family placement than bed space.

Eventually, the next governor was elected along with a new legislature, and the advances ceased (Gonzalez, 2013). A major scandal with a consequent lawsuit forced the Commissioner of DCS to resign. In addition, there was a resurgence of violence in youth detention, high turnover among senior staff at DCS, insufficient documentation, and neglected payments to foster parents and agencies. Recently, over 30 youth escaped from a Nashville detention facility. Television news showed teenagers chasing and attacking staff (Peralta, 2014).

Federal legislation to assist foster care began with New Deal legislation of the Social Security Act (Children's Bureau, 2014). Eventually, the Child Abuse Prevention and Treatment Act of 1974 enabled additional federal support for foster care and has been amended several times. President Carter signed The Adoption Assistance and Child Welfare Act of 1980, encouraging permanence planning, but the Reagan administration failed to create and enforce regulations. Even so, the legislation helped to diminish the number of children in foster care.

In 1993, specific financial incentives to expand family preservation and family support services became law as well as the Multiethnic Placement Act, requiring states to avoid discrimination based on race, color, and national origin (NCCPR, 2014). Other legislative milestones included bills to encourage adoptions, prevent child abuse, assist independent living, facilitate interstate adoptions, fight child pornography, and improve outcomes of care. Presently, the federal government requires the states to send specified data on foster care, which is aggregated and publically disseminated to encourage improvement of outcomes (Children's Bureau, 2014). This advocacy is apparently succeeding although progress is still needed. The following are significant indicators reported in 2014 by the Children's Bureau of the federal government.

1. Foster care cases in the US have been decreasing since 2002.
2. The number of children waiting to be adopted has declined since 2006.
3. Termination of parental rights have lessened over the past nine years.
4. Since 2002, a 47.1% reduction in foster children of African heritage has been reached.

A few key recommendations can advocate optimal practices in helping children and youth (Snow, 2013). Currently, most professionals in foster care consider it best practice to advocate that children or youth live with their biological or surrogate parent(s) except when dangerous or unrealistic. Family preservation should guide any intervention with sufficient resources made available (National Foster Parent Association, 1983).

When circumstances demand external placement, a continuum of care should target appropriate intervention and reimburse facilities for successful return to a home setting (Kerman, Wildfire, & Barth, 2002). Children under the age of 10 should always reside in foster care, even if therapeutic foster care is determined. Conversely, youth with very serious behavioral problems should not be placed in foster care unless the foster parents are capable and well-trained with a qualified, extensive support system. Placing violent or addicted youth into a family who would otherwise enable compassionate, competent foster parenting is insupportable (Strijker, Zandberg, & van den Meulen, 2005).

Much has been accomplished in foster care reform. Due to legal action, Alabama is transforming its entire system to emphasize family preservation, resulting in one of the lowest foster care rates in the nation while cutting in half the rate of re-abuse (NCCPR, 2014). In

Illinois, child safety has improved dramatically while placing two-thirds fewer children in foster care (NCCPR, 2014). Maine exhibited one of the highest foster care rates until a child was killed by a foster mother, kindling reform. Now, kinship care has skyrocketed and institutional care has nosedived (NCCPR, 2014). Florida followed suit after several negative episodes; for example, a foster child disappeared for over a year before anyone noticed (NCCPR, 2014). While work remains to be done, the state can be praised for improvements and innovations.

An enlightened citizenry and a progressive government should combine to generate the best possible care for children and youth having troubles. The most vulnerable should not have to suffer unnecessarily in a society with the values and resources to care for them. Much is now known about how to raise healthy young people. There is no satisfactory excuse for failure to generate an effective, compassionate, adequately funded system of foster care.

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Full Circle: Strategies for Effective Case Management

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Abstract

Effective case management requires the practitioner to complete a “full circle” of service provision to clients. Too often individuals are released from hospitals, rehabilitation centers, prisons and other facilities, with unstable plans and support systems, resulting in high recidivism rates. The lack of a thorough baseline assessment, plus poor development and follow through on a strategic plan, often contribute to less than desired outcomes. This article will include information on the significance of outcome-informed case management practice. It will also identify and describe the essential components of effective case management, as well as its usefulness in the human services professions. Whether one is practicing at an entry Associate Degree level or at a higher Master Degree level, the skills of case management will greatly enhance the practitioner’s competence and will contribute to effective service delivery and client satisfaction.

Full Circle: Strategies for Effective Case Management

Case Management is a circular process that comprises the identification, treatment, and the evaluation of human needs. It requires the practitioner to complete a full circle of services to optimize client outcomes. There are five essential components to facilitate the case management process. Those components are assessment, planning, linking and advocacy, monitoring and evaluation (Summers, 2014 and Orme, J. G. and Orme, T. C., 2012). An understanding and application of these five components aims to produce effective outcome-informed case management practice, as well as contribute to effective service delivery and client satisfaction.

The first component in the case management process is assessment. Assessment involves the full exploration of the person seeking help (client) and includes an examination of multiple aspects of the client’s life; e.g. the background and impact of the current problem, support systems, other strengths and desired outcome. There are at least seven broad categories to be explored during the assessment process (Summers, 2014). It is important for the human services practitioner to fully understand the complexities of the client’s situation, identify points of intervention and strategically design a plan that will bring satisfaction to the client as well as the service agency. This framework of understanding is known as the person-in-situation, or “person-in-environment” or PIE (Appleby, Colon & Hamilton, 2011). Some professionals refer to this beginning stage in the case management process as the baseline assessment. Vital to the assessment process is the practitioner’s ability to utilize deliberate, intentional, interviewing techniques (Ivey, A. E., Ivey, M. B. & Zalaquett, Carlos, 2010). The ability to allow clients to tell their complete story by asking appropriate and timely open and closed-ended questions, exercise active listening and attending behaviors and being self-aware of the human service practitioner’s own values and biases, are professional skills that can contribute greatly to a thorough assessment. Finally, a thorough assessment is the key to the design of a comprehensive plan. There must be a direct correlation between the assessment data and the treatment or intervention plan (Orme, 2012).

The second strategy in the case management process is planning. This component is essential because it maps a structure of interventions to accomplish the client’s goals. An effective practitioner will support the client’s goals by encouraging clients to verbalize their desired outcome and expectations. Human service practitioners should never attempt to coerce or manipulate the client to accept the practitioner's goal(s) for the client (Summers, 2014). Goals of treatment must be client-driven. Once a client articulates the desired outcome, the practitioner and client together designs a plan to accomplish those goals. The plan may include collaboration with other agencies and services, which the client might be involved. This unified effort of all the parties concerned with the client contributes to client satisfaction (Summers, 2014).

Every client situation is unique; therefore, every treatment plan is uniquely individualized. Some agencies may use a term other than "treatment" when designing their plan; especially if the services they provide are not clinical. In such instances, agencies might refer to this process as *intervention planning* (Orme, J.G. & Orme, T.C., 2012). A thorough plan will comprise of an outline, which clearly delineates the services ordered, the purpose and frequency of each service, the tasks involved in completing that service, the person who is responsible for completing the task, and the timeframe for completion.

For each goal, there must be a set of strategic steps known as objectives. Objectives must be SMART (Burgin, 2012); that is specific, measurable, attainable, realistic and timely. Each objective may have a series of action steps to accomplish those objectives. These action steps are sometimes referred to as strategies, methodologies, or implementation plans (Kettner, 2002). Thorough planning takes into account the client's strengths and interest and strategically weaves those factors into actions that will build client confidence, self-esteem and empowerment.

Next in the process is linking and advocacy. The absence of this component could leave a client in a stagnant state. It is the provision of information and referrals in its purest form. Linking and advocacy involves the careful connection of the client with the necessary resources that aims to help the client maximize their goals (Summers, 2014). These resources might be individual providers and/or provider agencies. Individual providers can include both professional and paraprofessional helpers. Provider agencies may include both formal and informal organizations with a mission to offer help in a variety of areas, such as food, housing, employment, health, literacy or other. Government agencies, such as social services or mental and public health, are examples of formal agency systems. These agencies can offer valuable assistance; however, the process of receiving help may be more time consuming than with informal agencies. Churches, community-based organizations and other non-profits are considered informal agencies, and usually easier to access. Careful linking often requires knowledge and utilization of both the formal and informal agency systems (Summers, 2014).

The fourth component is monitoring. To assure that the plan is being implemented according to design, it is necessary to monitor every activity documented in the plan. This component is not to be taken lightly. It is during this stage of case management that outcome-informed practice becomes evident (Orme, J. G., & Orme, T. C., 2012). Outcome-informed practice is a practice in which the practitioner:

1. Measures the client's outcomes at regular, frequent and pre-designated intervals, in a way that is sensitive and respectful to the client;
2. Monitor those outcomes to determine if the client is making satisfactory progress; and
3. Modify the intervention plan as needed (Orme, J. G., & Orme, T. C., 2012, p. xv).

Monitoring requires the practitioner to periodically follow up with the client and the providers to determine if progress is being made. Close monitoring helps the practitioner identify whether or not modification needs to be made to the interventions in the plan (Orme, 2012). For example, if a client is unemployed and a goal is set for the client to be employed within ninety days of the assessment; instead of waiting until the end of the 90 days to review the status of the client's employment situation, effective case management requires the practitioner to make frequent, periodic checks to assure the client is on track with preparing for employment. It should also be noted that a well-intended intervention could possibly turn out to be harmful to the client, requiring the practitioner to make immediate adjustments to the plan in order to protect the client's safety and health (Orme, 2012).

The primary focus of monitoring is outcome(s). Outcomes are deemed statuses of the client's problem(s) before, during and after intervention (Orme, J. G., & Orme, T. C., 2012). A comprehensive assessment will describe the status of the client's problem *before* any intervention is applied. The plan, linking, and monitoring phases will describe the status of the client's problem *during* the process of intervention. The evaluation stage of the case management process will document the status of the client's problem *after* intervention has been applied. (Orme& Orme, 2012).

The final component in the case management process is evaluation. At this stage, the practitioner conducts a final review of the client's problem(s) and status to determine if goals were accomplished according to the plan (Pennell, Joan & Anderson, Gary, 2005). If not, then the practitioner must investigate the reasons why the goals were not attained. There should be no sudden surprises at this stage in the case management process. Purposeful monitoring of interventions at frequent, predetermined intervals during service delivery should have identified any issues or new problems long before the final evaluation occurs (Orme, 2012). Moreover, if issues are identified during the process of monitoring, a plan for resolution should be made at that time of identification.

Some human service practitioners refer to this evaluation stage as termination, discharge planning or end assessment (Pennell, Joan & Anderson, Gary, 2005). Although this component is the final step in the process, it could also point to new problem areas to be addressed. In such instances, the practitioner and client return to the circular process of planning, linking and monitoring of the new situation. An important point to remember is that evaluation is not a single event that happens at the end of delivering services to clients (Orme & Orme, 2012). This stage in the case management process, is the culmination and result of every intervention during the helping process. The aim of each component, along with all of its actions, is geared toward the final evaluation. Evaluation completes the full circle of all the components involved. To reiterate, a system of quality outcome-informed case management practice requires periodic progress checks; from the identification of the problem (baseline assessment) to the plan for specific interventions, monitoring those interventions and then making a final evaluation (end assessment) of the client's progress after intervention.

In conclusion, the process of case management is an effective means of responding to diverse human service needs (Bigelow, Douglas & Young, Deborah, 1991). The successful completion of each component, in the appropriate order discussed, will yield valuable, outcome-informed service. It demonstrates the competent skill set of the practitioner and can result in a "win-win" situation for all the parties involved; adding to the satisfaction of the client.

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Hidden in Plain Sight: Survivors of Childhood Sexual Abuse and Human Services Practice

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Abstract

Survivors of childhood sexual abuse (CSA) may struggle with mental health issues, relationship difficulties, substance use/abuse, and education/career disruptions. Regardless of one's field of practice in human services, the incidence statistics of childhood sexual abuse (1 in 3 women, 1 in 6 men) increase the likelihood that all human services professionals (HSPs) will have CSA survivors as clients. It is important that HSPs understand the problems challenging this at-risk population link clients to essential services and support. The HSPs personal reactions to CSA are potential barriers to relationship building with this population. Building trusting relationships is can be difficult for survivors of CSA. Human services workers who use empathic responses help develop trusting relationships with survivors of CSA. Collaboration and referral are discussed as implications for human services practice.

Hidden in Plain Sight: Survivors of Childhood Sexual Abuse and Human Services Practice

Perez-Fuentes et al. (2013) define the characteristics of childhood sexual abuse (CSA) as any act to include vaginal/anal/oral penetration, manipulating a child's genitals, involvement in prostitution, and participation in pornography. Potentially 1 in 3 women and 1 in 6 men are survivors of sexual abuse (Perez-Fuentes et al., 2013). The research on Adverse Childhood Experiences (ACE) reported by Felitti and Anda, (2010) assessed individuals enrolled in Kaiser Permanente Health Services. They found a large cohort of individuals of both genders who reported childhood trauma involving domestic violence, physical abuse and sexual abuse (Felitti & Anda, 2010). These individuals also presented a number of serious medical and mental health problems (Felitti & Anda, 2010). Barnes, Noll, Putnam and Trickett, (2009) and Gallo-Silver, Anderson, and Romo (2014) report that survivors of CSA may meet the criteria for a diagnosis of Post Traumatic Stress Disorder (PTSD) by presenting symptoms of depression, hyper-reactivity, and difficulties modulating/regulating intense affect and disturbing thoughts, as well as interpersonal dysfunction concerning issues of trust and intimacy (Felliti & Anda, 2010).

Human Services Professionals Have Clients with Histories of CSA

The prevalence of CSA increases the likelihood that a human services professional (HSP) will assist survivors of CSA, including those with a potential diagnosis of PTSD. It may be particularly difficult to provide services and assistance to a population that is inherently mistrustful, suspicious, emotionally reactive, and hypersensitive (Barnes et al., 2009). Therefore, HSPs need skills that are effective in helping survivors of CSA. Anecdotal information from the following three case studies informs a trauma-attuned methodology, centering on increasing HSPs awareness of this population's needs for safety, reassurance, boundary maintenance, and protection. There is a need for interventions to emphasize 1) empathic response to disclosure of a sexual abuse history; 2) containment versus exploration of the history of abuse; and 3) negotiating protective interventions to address the sexual abuse of adult clients.

Empathic Responses to Disclosure of Sexual Abuse History

A disclosure of CSA is a pivotal event and potential crisis in service delivery. Communication Privacy Management Theory indicates that disclosure of CSA at first drives a wedge into relationships as the client awaits and fears the listener's response (Petronio, 2002). When a HSP learns something that is frightening and/or distressing about a client's history, the worker may feel unsure of how to respond. A natural pause may occur that a worker may fill with a placeholder such as "okay," "I see," or "I understand." A client may misinterpret the placeholder response as not empathic, emotionally disconnected, or distant. The HSPs straightforward reflective response, based on his/her sincere and human reaction(s) to the information, often conveys an appropriate mix of concern and comfort (Neukrug, 2012).

Case study: Roger, 33-year-old client of a court diversion project. Roger told his HSP that he hoped for the murder of a high profile person convicted of sexually abusing a child. Concerned about the intensity of Roger's anger the human services worker commented on Roger's distress. Roger disclosed his history of sexual abuse by his four much older stepbrothers from the age of seven until he was eleven when he went to live with his grandmother. The human services worker sighed deeply, shook his head, and responded by reflecting back what Roger said in a soft empathic voice. Roger began to cry, releasing feelings he held for many years.

Containment Versus Exploration of the History of Sexual Abuse

The human services worker must always be aware of the context and purpose of the worker/client relationship. Exploration of the history of sexual abuse is appropriate within the framework of some services, but not appropriate in others (Gallo-Silver & Weiner, 2006). Survivors of CSA seeking assistance with their trauma histories need a community mental health clinic that provides them with on-going psychotherapy, psychiatry, and emergency services as the examination of traumatic events can be psychologically destabilizing (Gallo-Silver & Weiner, 2006). In programs where the primary service being provided is counseling, it is important to be aware of suitably pacing the client's flow of information about her/his sexual trauma. "Too-much-too-soon" can inadvertently re-traumatize the client. If the HSPs program focuses primarily on case management, continued exploration of the sexual abuse history may be outside the scope of the relationship and risk being counter-productive (Gallo-Silver & Weiner, 2006). Under these circumstances, exploration of CSA material can seem intrusive to the survivor diminishing the overall worker/client relationship. In these situations, it is more effective to shift the client's focus to how the sexual abuse history affects him/her presently, rather than focus on the past historical details. This helps the client to remain grounded in the "here and now" and to contain intense feelings that can overwhelm the client's coping skills. Another "here and now" technique is to teach the client deep breathing (Gallo-Silver & Weiner, 2006).

Case study: Katrina, 40- year-old client at an HIV/AIDS clinic. Katrina formed a trusting relationship with her HSP and she disclosed that her father prostituted her at age twelve to earn money for his drug habit. Overwhelmed by hearing her own disclosure, Katrina became ill and vomited into the waste paper basket. The human services worker comforted her and asked Katrina about her needs right now. Katrina said she needed fresh air and they continued the session sitting on a bench outside of the clinic. Katrina comforted herself using the deep breathing exercises taught to her by the case manager. Following this session, Katrina's case manager provided her with a referral to a local mental health clinic with a trauma program.

Negotiating Protective Interventions to Address Sexual Abuse of Adult Survivors

Research indicates that the abuser frequently has a close relationship to the child, or is a family member, extended family member, caretaker, clergy, coach, teacher, etc (Barnes et al., 2009). This adds another level of complexity and confusion for clients (Barnes et al., 2009). Survivors are vulnerable to re-creating sexually exploitive and abusive relationships and are often targeted by predators seeking victims who are isolated and unprotected (Barnes et al., 2009). These re-creations are not the client's conscious choice, but rather stem from the client continuing to be hostage to a cycle of violence and abuse (Barnes et al., 2009). The client filled with despair and degradation may question his/her worthiness of protection (Barnes et al., 2009). The human services worker walks a fine line between respecting a client's autonomy and her/his wish to protect the client from further harm. The worker's feelings of anger at the abuser and worry over a client considering a harmful decision, requires the worker to pause before responding to this challenge. It is best to use interventions that increase the client's self-awareness of the inherent contradictions in her/his behaviors and decisions with regard to her/his current relationships (Felitti & Anda, 2010). Empathy is present when identifying the contradictions in the client's thoughts and feelings (Neukrug, 2012).

Case example: Latasha, a 24-year-old client in a domestic violence shelter was raped at age 14 by her uncle. Latasha told her HSP she wanted to give her abusive boyfriend another chance even though he is in jail after raping her at gunpoint. This most recent fight started when Latasha told him she wanted to get her GED and get a job. The human services worker pointed out that on one hand Latasha's plans to return to school and wishes were for more independence. On the other hand, she might return to a relationship where she could not leave the house or read a book. That seemed confusing to the human services worker and she wondered if it confused Latasha as well? Latasha agreed that she was very confused And that maybe the human services worker could help her with that.

Relevance to the Field of Human Services

The client/HSP relationship provides a bridge to other more specialized services needed to treat the complex psychological problems of this client population. HSPs find specialized services for referral through the use of the National Sexual Assault Hotline (1-800-656-4673), and the National Sexual Violence Center-Victim/Survivor Support Listing (http://www.nsvrc.org/organizations/victim-survivor-support-organization). The HSPs skill in researching appropriate services and effecting successful referrals extends a level of added protection to clients that present as distressed or psychologically destabilized. At times, the HSP needs to accompany the client to a new service in order to enable a successful referral and to demonstrate that the referral process is not an abandonment or rejection of the client. The HSP collaborates with other mental health professionals to provide comprehensive services to their mutual clients. The HSPs ability to understand this at risk population's difficulties and the human services techniques of empathic responses in various forms of reflection, clarifying feelings and contradictions can help ensure that clients receive the protection, services, problem solving and the acceptance that they need.

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Deinstitutionalization: Miscalculation or neglect?

Tara A. Garrison

Abstract

A complex social issue arose from the shifting of mentally ill persons to the community. Deinstitutionalization, combined with forced budget cuts, created a phenomenon known as a *bedless* culture. This *bedless* culture is the result of a failed mental health system plan, social, and economic factors. This literature review presents how the model of deinstitutionalization has failed and the impact it has on human services.

Miscalculation or Neglect?

Deinstitutionalization, the term given to the strategy of moving people with mental health disorders out of state-run hospitals and closing institutions. These closures have been a major factor in the number of increased homeless, acts of violence, and incarcerated individuals (NAMI, 2012). The introduction of anti-psychotic medication prior to the 1980s effectively set the stage for the beginning of deinstitutionalization. The rapid rate in which deinstitutionalization occurred created an exodus of individuals to be shifted into a transient state. The Virginia Tech Massacre, Sandy Hook Elementary school shootings, and the attack on Senator Deeds have one specific familiarity between them. The individuals charged with these crimes suffered from mental illness and were unable to receive treatment (Gold, 2013). Torrey, Kennard, Eslinger, Lamb, & Pavle state the lack of psychiatric beds and available resources has left the mentally ill neglected (2010) a *bedless* society is formed because to this neglect. Simply defined a bedless society is defined as a group of people where those in need emergency mental health care, beds to sleep in, and resources for proactive care do not exist. Literature about the deinstitutionalization impact on society and recent research will be introduced and the conclusion will identify the relevance of this phenomenon to the human services field.

Literature Review

Torrey, Kennard, Lamb, and Pavle (2010) authored a report that ultimately concluded that the rate of crimes committed by the mentally ill, due to lack of progressive treatment, is the leading cause of the rise in numbers within the criminal justice system. Honberg, Diehl, Kimball, Gruttadaro, and Fitzpatrick (2011) connected the *bedless* society to recent massacres and tragedies by exploring how budgetary cuts across the United States leads patients to fall through the cracks. It was inferred that policy evaluations, tighter screenings and control over the direction, prevention, and support of the mentally ill could be transformational.

Homelessness stems from the failure of the government to provide aftercare for patients once they are discharged from the hospital (Torrey et al. 2010). Fiscal burdens have spread from the departments of mental health to the department of corrections, social services, and to the court (Torrey et al., 2009). Statistical data from the Treatments Advocacy Center show the increase of violent crimes over the past four years and hypotheses that a majority of these crimes are related to mentally ill persons on the street (2012). There are three times more seriously mentally ill persons in jail and prisons than in hospitals" (Treatment Advocacy Center, 2012, p. 1).

Bed availability is down dramatically for emergency care since deinstitutionalization began (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2009). In 1955 there was one bed for every 300 Americans while in 2005 there was one psychiatric bed for every 3000 Americans (Treatment

Advocacy Council, 2012). Less than a decade later in 2012, there were 43,000 psychiatric beds in the United States, or about 1 for every 7143 Americans (Pan, 2013).

Due to widespread incarceration in prisons, homelessness, and overrun emergency rooms; that mental healthcare has been brought back to the pre-World War II conditions (Torrey & et. al, 2013). It has been suggested that improved flexibility of federal and state regulations could relieve this societal problem. The federal government excluded Medicaid payments for patients in mental hospitals in order to have these mentally ill patients treated as members of society (Treatments Advocacy Center, 2012). Exploring how the federal government miscalculated the mental health system provides a foundation to rebuild the mental health system structure again. It is important to note that the miscalculation or neglect, of the mentally ill is not only an American problem; it is now spread across the world (Treatment Advocacy Center, 2012).

The mental health system has operated through a one-size-fits-all approach (Searight, Oliver, and Grisso, 1986). The approach that has been the foundation of community mental health, the current approach of deinstitutionalization has not worked. An individualized approach to mental illness, though expensive, is the beginning of an ethical mental health system.

Relevance to the Field of Human Services

The decrease in funding for mental health creates an impact on the human services industry. There is a challenge to meet the increasing demand for services and a constant decrease in resources. The mentally ill are included in this demand of human need. The greatest problem presented throughout this review is the inability to create adequate and accessible modes for the mentally ill to access dire resources. One important factor is to develop policy and programs to address the human service shortfall before it creates an irreversible strain on human service systems.

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The Cure to Homelessness

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Abstract

This paper will focus on the long-standing problem of homelessness in America and the research that supports the position that the most effective way to achieve housing stability is through housing first programs. The need to replace negative stereotypes of homeless individuals with accurate portrayals which accurately assess their needs is explored. Supportive research of the housing first approach to ending homelessness will be examined. Finally, implications for human services professionals in program development for eradicating homelessness will be discussed.

The Cure to Homelessness

Homelessness carries costs for both individuals and our society, as the homeless are frequent victims of crime, do not receive necessary preventative care, require expensive emergency care and are more frequently incarcerated. Programs designed to end homelessness most often require individuals to demonstrate success in substance abuse treatment and employment before they are eligible for public housing. The ineffectiveness of such programs are examined, and instead provides support for the promising new approach of *Housing First* as a best practices model for Human Services.

Each year, roughly 405,000 Americans live on the streets and in shelters (U.S. Department of Housing and Urban Development, 2009). Continuum care programs designed to end homelessness often first requires success in employment, substance abuse treatment and/or mental health treatment before placing homeless clients in subsidized housing (Shier, Jones & Graham, 2010). These programs have been criticized in recent years as ineffective in reducing the number of chronic homeless (Groton, 2013; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

In a qualitative study, Shier, Jones and Graham (2010) interviewed sixty-five homeless adults and found that although participants held to a negative view of self, they expressed a common desire for permanent residences which was motivated by needs of stability, privacy and independence as well as distance from negative influences. Current research is challenging the negative and false stereotypes placed upon the homeless population, suggesting better methods of intervention and public development. Groton (2013) found greater success in *Housing First* programs, which take homeless individuals as they are, and offer a variety of services and support with initial housing placements. *Housing First* is a best practice model, which emphasizes stable housing as a primary strategy for ending homelessness (Arnaudo, Madrid, & Zappasodi, 2012). The model hypothesizes that the cure to homelessness involves initially providing individuals with safe, decent housing and providing more support with intensive services such as psychological, chemical dependency and vocational counseling.

Since 2000, *Housing First* programs have demonstrated effectiveness not only in reducing homelessness, but also in alleviating additional problems that often plague homeless individuals (Keretsz et al., 2009). Bean, Shafter and Glennon (2013) conducted a longitudinal evaluation of a program that provided Housing First with peer support. Ninety-eight percent of the participants remained in housing after 12 months, reporting significant increases in their access to and utilization of physician care, enhanced quality of life, and decreased involvement with the criminal justice system. In addition, after twelve months all participants expressed the desire to remain in housing.

Pearson, Montgomery, and Locke (2009) examined housing stability among homeless individuals with mental illness participating in three different Housing First programs. All programs were found to enforce placement into housing and used a service approach that did not require sobriety or treatment compliance. Despite their many personal challenges, 84 percent of the participants remained in housing after one year. Participants cited privacy, independence, safety, and quality of their housing as positive contributors to their successes. Participants also voluntarily participated in mental health services, because they understood participation would support their ability to stay housed.

It should be noted that not all reviews have found such high rates of success in treatment services among *Housing First* clients. Groton (2013) found use of substances and psychiatric symptoms remained constant among *Housing First* participants, which underscores the need for rigorous evaluations across *Housing First* programs.

Relevance to the Field of Human Services

Human services professionals are dedicated to solving social problems through direct services to all in need through evidence based best practices. Negative stigmas, which conclude that homeless individuals deserve stable and safe housing only if they are able to maintain employment and success in substance abuse and mental health programs have not alleviated rates of homelessness (Groton, 2013; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). Human services professionals have the obligation to advocate for services with demonstrated methods of effective and compassionate care (Council for Standards in Human Services Education, 1996).

Often, communities do not understand the unbudgeted costs for homelessness, which include ambulance, hospital, emergency room, police, jail, court, and fire department services (Arnaudo et al., 2012). As a contrasting case in point, the non-profit agency *Common Ground* in New York has demonstrated significant reductions in total costs to homeless individuals, citing that in 2013, the average cost per night for a city shelter was 54 dollars, while the cost was "$74 for a state prison cell, $164 for a city jail cell, $467 for a psychiatric bed, [and] $1,185 for a hospital bed" (Common Ground, 2014). In addition to housing, *Common Ground* provides supports needed to maintain housing, regain independence and restore overall health for 40 dollars only a night. The program uses local volunteers and professional social service providers who provide a range of services from registering and surveying neighborhood homeless populations to supporting housing placement stability through long-term partnerships. The retention rate for clients has been above 90 percent. *Common Ground* demonstrates an approach to ending homelessness that both recognizes the complexities of individual needs and utilizes monetary efficiency.

Putting *Housing First* for people who are the most vulnerable homeless individuals has the potential to improve people's health status, increase use of preventative medical services, and reduce interactions with law enforcement. The *Housing First* approach demonstrates effectiveness in decreasing substance abuse and improving the overall quality of life for the homeless individual. Human services professionals lead the way in advocating for policies based on both the micro and macro levels of care, using research based on the experiences of homeless individuals, as well as evaluations of life-changing effective programs. Housing stability through *Housing First* provides support for individuals with substance use and mental disorders, and offers a comprehensive model for ending chronic homelessness.

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Women of Color and the Affordable Care Act

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Abstract

As the United States continues to press forward with healthcare reform, it is important to understand the role that the human services field plays in the transformation in the healthcare for women of color. One in three American women are women of color and make up more than half of the country's uninsured women. Women of color have been disproportionately underserved by the past healthcare system. With the new Affordable Care Act in place, more healthcare opportunities arise by providing affordable private insurance, increasing Medicaid benefits and increasing the supply of obtainable healthcare systems. Availability to health services will be accessible for all women of color by the removal of previous financial constraints. The Affordable Care Act will make a positive impact on the field of Human Services by allowing women of color from all social and economic classes to obtain the needed care to maintain a healthy life style.

Women of Color and the Affordable Care Act

A growing number of statistics illustrate the disadvantages women of color face in healthcare access when compared to their European American counterparts (Kaiser Family Foundation, 2009). These comparisons also show that women of color have lower high school graduation rates, have higher levels of chronic health problems and disabilities, lack adequate healthcare packages and have a greater dependence on federal aid programs, such as Medicaid (Kaiser Family Foundation, 2009). Evaluating all components of wellbeing, including emotional stress and social stigma, is vital to social adaptability and mental health, which has a profound impact on women of color (Kaiser Family Foundation, 2009).

Clark, Fong, & Romans (2002) define the phrase *women of color* as women of racial and/or ethnic minority groups. A large portion of health disparities between women of color and Caucasian women can be attributed to differences in socioeconomic status and the lack of suitable health insurance (Kaiser Family Foundation, 2004). These disparities exist across multiple areas including: insurance rates, access to physicians, overall cost of healthcare, transportation, childcare and preventative health services (Kaiser Family Foundation, 2004). The statistics showing ethnic differences in health care access, more energy is being devoted to reducing these disparities.

Affordable Care Act

The Affordable Care Act (ACA) presents an opportunity to reduce healthcare disparities between women of color and Caucasian women (NASTAD, 2013) by providing affordable quality health insurance for all individuals (ObamaCare Facts, 2014). The ACA regulates health policies that are essential to eliminating healthcare issues such as access to quality care and inequities in services provided (NASTAD, 2013). Statistics suggest that women of color have been consistently and disproportionately underserved by the past healthcare system (National Partnership for Women & Families, 2013). The ACA is forecast to cover 32 million uninsured individuals by expanding Medicaid, eliminating preexisting condition exclusions and offering subsidies to purchase insurance

(Gostin & Garcia, 2012). Under the new healthcare guidelines, more healthcare opportunities will be available (National Partnership for Women & Families, 2013).

Health Disparities and Women of Color

Much of the current knowledge concerning health disparities between women of color and Caucasian women is drawn from national information sources including reports put forth by the Centers for Disease Control and Prevention (Kaiser Family Foundation, 2009). The Kaiser Family Foundation (2009) suggests that racial and ethnic health disparities in healthcare access, expand to every state in the nation. Even when income, health insurance and access to care are accounted for, health disparities between women of color and their Caucasian counterparts remain (NASTAD, 2013). These gaps in services have been an on-going problem among healthcare providers and health policy makers (Harris, 2011).

Basic healthcare needs can produce financial burdens when they are not covered by insurance plans and consumers cannot afford the out-of-pocket fees (Arons, 2012). This in turn delays needed treatment and prevention measures, which can lead to the overall care becoming more expensive for the consumer. Health insurance coverage is greatly influenced by the combination of annual salary and employment status (Kaiser Family Foundation, 2004). For women of color who are economically disadvantaged, obtaining basic healthcare coverage can be a constant challenge (Gostin, 2012). Efforts to improve the overall quality of healthcare are in the sights of the ACA, however at times, disparities seem to fall in its blind spot (Davis & Walter, 2011). Women of color can benefit from the improved healthcare plan regardless of their social or economic status.

Discussion

Women of color have much to gain under the ACA, especially those of whom have specific health issues or are underserved (National Partnership for Women & Families, 2013). The ACA addresses inequities and increases access to quality and affordable health coverage for women of color (National Partnership for Women & Families, 2013). By providing uniform access to quality care, there will be a decrease in health disparities between racial and ethnic groups (National Partnership for Women & Families, 2013). Closing the healthcare gap will make quality care easier for women of color to obtain.

Understanding all aspects of the ACA will take many years, but a baseline of care has been established by making health insurance more affordable and expanding Medicaid. This helps to decrease health disparities that have disproportionately impacted women of color (National Partnership for Women & Families, 2013). If properly implemented, the ACA creates a core set of minimum standards for women of color accessing healthcare.

Relevance to the Field of Human Services

Eliminating health disparities has emerged as one of the predominant goals set forth by the U.S. Department of Health and Human Services (National Partnership for Women & Families, 2013). This is relevant to the field of Human Services because tracking healthcare disparities can improve health outcomes and aid in the development of health prevention programs (National Partnership for Women & Families, 2013). Women rely on the healthcare system throughout their lifetime and the ACA aims to prevent avoidable health conditions and to end unfair practices (Arons, 2012). The immediate and long-term effects on the field of Human Services and treatment include offering improved yearly benefits, providing both acute and long-term healthcare services, and simply improving the quality of healthcare services for all women (NASTAD, 2013). In turn, the ACA places women of color back in charge of their healthcare by providing stability and flexibility in terms of healthcare usage and the availability of healthcare professionals and health services (Arons, 2012). "With this change and others, the U.S. Department of Health and Human Services will better be able to determine what health disparities exist across populations and to decide how to allocate resources to improve access and health outcomes" (National Partnership for Women & Families, 2013, pg. 3).

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Geographic Information Systems (GIS) and Human Services: People, Space, and Location

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Abstract

Human services practitioners are charged with understanding the health and welfare of their clients. Their work, whether under routine operations or catastrophic conditions, is undertaken with the expectation that high-quality services will be rendered. Geographic Information Systems (GIS) is a technology-based solution that may be implemented to help human services organizations to achieve this quality standard. GIS is designed to collect, process, analyze, store, and provide visualization of data that is spatially referenced. Collectively, information stored in GIS may help human services practitioners to better plan, organize, strategize, and, ultimately, make effective and timely operational decisions. This manuscript discusses the practical applications of GIS in human services and its use in decision support. It addresses the challenges of implementing the technology and offers potential users suggestions as to how GIS can be used in research.

GIS and Human Services: People, Space, and Location

Health and human services organizations have used Geographic Information Systems (GIS) for more than 20 years (Flanagan, Jones, & Heitgerd, 2010; Reish, 2009). GIS is a technology-based computerized mapping system that integrates geographic information comprised of layers of data sources or slices of visual and spatial data into one information system (ESRI, 2009). This technology may help human services practitioners with timely decision making. It may also provide added value through its ability to depict client needs by location, population density, demographics, relationship(s), and by using a multitude of other spatially related data (ESRI, 2009). Output is displayed in a centralized, user-friendly, and map-based format.

As a result of this technology's extensive applications, human services practitioners worldwide have begun to embrace and implement GIS (ESRI, 2009; Felke, 2014). For example, GIS has been used to examine many problems related to human conditions. Schwanke et al. (2013) conducted a study in Cambodia that explored the relationship between client economic status, distribution of services, and preventative healthcare measures to determine how well those services were administered. Rodrigues, Bonfim, Portugal, Dantas Gurgel, and Medeiros (2013) examined spatial patterns of infant deaths occurring in affected municipalities in Brazil. Their analysis and findings revealed that a GIS could be used effectively to understand and predict infant mortality rates within the first 12 months after birth (Rodrigues et. al., 2013). The aforementioned applications illustrate how GIS can be used as a tool to assist human services practitioners in a variety of settings.

The United States has used GIS in the human services sector, most notably, during natural disasters such as floods and hurricanes. Pezzoli et al. (2007) put forth the claim that sophisticated technologies, such as GIS, should be used more extensively as a front-line defense during catastrophic events. For example, GIS could have been used more effectively as a support tool to aid vulnerable communities during Hurricane Katrina in 2005. Specifically, GIS may have been used as an agency-to-agency collaboration tool to help workers analyze the displacement and shelter requirements of over half a million people who suffered devastation to their homes, lives, and families (Pezzoli et al., 2007). Finally, Schuurman, Leight, & Berub (2008) argued that one of the strengths of GIS is its ability to create what-if scenarios and enhance collaboration during crisis events or day-to-day operations.

GIS Relevance to Human Services

Geographic information systems have evolved as computerized thematic mapping software over the past 50 years and are now considered to be relevant technology in the field of human services (Hogrebe & Tate, 2012). Job protocols within the human services domain are often information dependent when addressing social problems linked to people, space, and location (Nybell & Gray, 2004; Reisch, 2009). GIS may provide decision support to enhance efficiency in the work performed by human services practitioners as well as increase the quality of responses to geographically- related social problems (Jaskyte, 2012). Decision support systems are computer-based systems used to aid in problem assessment and resolution. The power of GIS as a decision support tool lies in its ability to integrate with other data sources (e.g. Microsoft Excel). This tool helps to form a complete visual picture of what could be a multi-dimensional problem (Martinez, García-Llorente, Martín-López, Palomo, & Iniesta-Arandia, 2013). GIS output data has a visual and graphic nature. This output may replace text- or paper-based information processing which can be: time-consuming to interpret, voluminous to manage, and overwhelming to understand all dimensions of a problem, especially if presented as disparate data sources (ESRI, 2009).

One problem that human services organizations face is the risk of losing institutional knowledge due to employee attrition (Van Dierendonck et al., 2001). This situation, coupled with technological inferiority, has resulted in tremendous knowledge gaps in some human services domains (Jaskyte, 2012). When support services fall short of quality delivery, funding may be questioned; at worst, clients are hurt by shortfalls and errors in the services rendered (Bess, 2009). However, if employee knowledge is captured in a GIS as an integrated information system, it may help to reduce the adverse impact of employee turnover. More specifically, it may help to retain institutional knowledge (Van Dierendonck et al., 2001). Finally, human services organizations facing high attrition rates may use a GIS knowledge base to train incoming workers and potentially reduce the time required to become proficient in business processes needed to maintain successful operations.

The quality of human services rendered tends to be tightly integrated with public perception and public trust (Patti, 2009). Kennedy (2014) posited that the lack of efficient data collection methods and improperly trained human services practitioners may lead to a major breakdown and failure of organizations charged with helping vulnerable populations. Elmore, Flanagan, Jones, and Heitgerd (2010) suggested that the use of modern technologies by health and human services practitioners may improve service delivery. GIS can be a powerful tool for human services researchers who seek to assess problems related to social and environmental conditions. This tool may help practitioners to understand how space and place (location) factor into solving problems related to human social conditions (Hawthorne & Kwan, 2012). Ultimately, GIS may aid human services practitioners by reducing the amount of time it takes to codify information and to make quality decisions.

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Substance Use within the Adolescent Sexual Minority

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Abstract

One area that continues to receive attention is substance use and/or abuse. There is ample research concerning substance use throughout several populations, yet there is little information regarding substance use within the adolescent sexual minority. Human services professionals are tasked with the responsibility of assuming multiple roles to attend to the needs of communities, individuals, and populations who face a number of challenges. Highlights of the prevalence of substance use and abuse among the gay, lesbian, bisexual, and transgender adolescent population is discussed, and factors are identified that are relevant to human services professionals as service providers to this diverse group.

Substance Use with the Adolescent Sexual Minority

Substance use and abuse affects all populations, yet in subpopulation of the adolescent sexual minority the issue is overlooked and has a lack of research. This paper examines the prevalence of substance use and abuse within adolescent sexual minorities. The sexual minority refers to individuals who self-identify as lesbian, gay, bisexual, or transgender (LGBT). Evidence demonstrates the adolescent sexual minority is more likely to use and abuse substances as compared to the heterosexual population (Marshal et al., 2008). This paper will explore how sexual orientation and gender identity effect factors surrounding sexual orientation as they relate to substance use or abuse. It will also examine best practices for human services professionals working with the LGBT teen population.

Literature Review

Substance use within the adolescent sexual minority is becoming more prevalent. Sexual orientation, an individual's attraction to a particular sex, is a key variable for adolescents who use or abuse substances. Marshal et al. (2008) conducted a meta-analysis to examine substance use in homosexual and heterosexual adolescents ages ten to seventeen. Marshal et al. (2008) found that the likelihood of using substances among LGBT youth was 190% higher as compared to heterosexual youth. Russell, Driscoll, & Truong (2002) also found gay male adolescents and lesbian adolescents who were romantically attracted to, or in a romantic relationship with the same-sex, were more likely to use legal and illegal substances in comparison to heterosexual youth. In addition, bisexual adolescent males and females reported greater likelihood of using substances such as cigarettes, alcohol, and marijuana within the past 12 months than heterosexual peers and peers attracted to the same-sex. Strikingly, the Marshal et al. (2008) revealed that bisexual adolescents are 340% more likely to use or abuse substances as compared to the sexual majority.

There is an indication that gender-typed performances also influence teens from the sexual minority to turn to substances. Rosario, Schrimshaw, and Hunter (2008) sampled seventy-six lesbian and gay adolescents who either presented masculine traits (butch) or feminine traits (femme) to observe differences in gender expression and its association with substance use and misuse among the non-heterosexual population. Sexual identification of adolescents, which were categorized as butch lesbian, femme lesbian or androgynous, was measured through self-identification, perceptions from peers, and the interviewer's perceptions that were assessed at each time interval. Rosario et al. (2008) found butch lesbians consumed substances at greater frequencies and quantities even when controlling for age, lesbian/bisexuality, and social desirability. These findings demonstrate that gender expression as well as sexual identity relate to problematic substance use.

There is reason to conclude that attitudes of peers and families of sexual minority teens are also associated with the use of substances. In a separate study, Rosario, Schrimshaw, and Hunter (2009) sampled 156 gay, lesbian, and bisexual (LGB) adolescents and found that family and peer reactions to disclosure were indicators of substance use. Negative reactions to disclosure, even when controlling for other emotional distress, were significantly correlated to LGB adolescents' direct use and abuse of substances. In contrast, accepting reactions to disclosure of sexual orientation decreased the likelihood of substance use and abuse. These findings suggest adolescent sexual minority use or abuse of substances is due to more than internal distress.

As researchers demonstrate the high incidence and complex factors influencing substance abuse among sexual minority adolescents, human services professionals have a vested interest in providing evidence-based best practices as they work with this specific population. To date, however, research has largely ignored adolescent sexual minorities, and substance abuse treatment for sexual minorities has focused primarily on adults. Adult studies, however, provide insights into treatment models, which should be paramount in the treatment of teens.

Specialized treatment programs for the LGBT community have demonstrated greater effectiveness than traditional treatment programs. Senreich (2010) sampled 187 gay, bisexual, and heterosexual men in traditional and specialized treatment programs and found participants were more likely to report satisfaction with treatment, feelings of connectedness, and feelings of acceptance from treatment counselors in specialized treatment programs. Senreich (2010) further showed that gay and bisexual men in specialized treatment services had an increased positive perception that the treatment was supportive, honest, and satisfying, and that the men were more likely continue in specialized treatment services. These results suggest that the sexual minority have an overall healthier well-being when their sexual identity is incorporated into treatment instead of overlooked. This information could be highly beneficial in terms of treatment for LGBT adolescents. The findings illustrate specialized treatment programs should be further explored to determine beneficial criteria needed to best help an often-marginalized population.

Relevance to the Field of Human Services

As the above researchers have found, sexual minority populations have an increased probability of using or abusing substances. Sexual orientation in adolescents, bisexuality, and self-presentation are variables that can influence substance use or abuse. Although these researchers suggest that sexual orientation is a key factor, other evidence implies that various elements such as discrimination and societal attitudes attribute to increased use of substances in the LGBT population. The rise of substance use within the sexual minority has evoked others to examine if services indeed exist for the LGBT population and if specialized services are more effective than traditional services. The research regarding the LGBT population is limited but exploratory research could be helpful to provide insight of substance use disorders and treatment services or alternatives.

It may also be beneficial to investigate if LGBT adolescent clients comprehensively benefit from specialized substance abuse treatment services compared to heterosexual adolescents. While there are specialized treatment services for LGBT population, specialized substance abuse treatment options are limited for the LGBT community at large. Cochran, Peavy, and Robohm (2007) found only 62 out of 854 United States substance abuse treatment agencies offered specialized services for the LGBT community, and these services were primarily found in California and New York State.

Future research should direct attention on the attitudes of the helping professionals who interact with the sexual minority. It may also be warranted to examine treatment service completion rates of providers who implement specialized service options. Future research should investigate the likelihood of decreased substance use in the sexual minority if therapeutic supports are in place at institutional establishments such as schools and health care centers. Further, it is fundamental to examine program completion rates of adolescents of the sexual minority who were placed under the direct care of professionals who participated in cultural awareness training. Results of the examination could reveal whether cultural awareness is associated with increased chances of completing and abstaining from substances after treatment.

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The Impact of Cultural Competence Training on Rural Human Service Professionals

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Abstract

Cultural competence among human service professionals is imperative given the rapidly changing American demographics. Current inadequacy in the delivery of culturally responsive social services is due to insufficient cultural competence training for human service professionals. This research study investigated the extent to which constructivist based cultural competence training influenced rural human service professionals' perceived level of cultural competence. In three regions of Tennessee, rural human service professionals (n = 44) completed an electronic survey which included the adapted California Brief Multicultural Scale (CBMCS). Using a correlational-descriptive design by surveying participants, the researcher discovered rural human service professionals perceive themselves as being culturally competent. The variable, training quantity, was a significant predictor of perceived cultural competence.

The Impact of Cultural Competence Training on Rural Human Service Professionals

The way human service professionals (HSPs) are trained to become culturally competent continues to be a concern (Taylor-Ritzler et al., 2008). The inability to deliver continual education courses (e.g., cultural competence training) remains as an on-going issue for the human services field. Cultural competency (CC) requires acknowledging different cultures and addressing the needs that occur because of the diversity within them (Medrano, Setzer, Enders, Costello, & Benavente, 2005). According to Munoz, DoBroka, and Mohammad (2009), human service contributors are being encouraged to have more cultural awareness and cultural responsiveness with their diverse clientele because of the ever-changing characteristics and multiplied differences in American society. This remains to be an issue because there are no standardized or core requirements for in-service courses with respect to public human service training (Milner, Mitchell, & Hornsby, 2004). In addition, the ever-changing conditions across regions, specifically rural areas, such as caseload ratios and limited time available for training, create barriers to accessing training. Milner et al. (2004) concluded that training is the catalyst in promoting culturally responsive practice within public human service agencies. Therefore, attainment is contingent upon how well the agencies goals and vision concurs with CC training, synchronization amid training, and success of other functions within the public human service agency (Milner et al., 2004). HSPs have the ability to mold the CC practice guidelines and training requirements noted in state policy and laws, intrinsically (Landsman, 2007).

One way of determining the appropriate methods of CC training is to determine if the relationship that exists between CC training and perceived cultural competence levels for rural HSPs is from a constructivist viewpoint; or the belief that, in a learning environment, knowledge gained is formed by the learner (Hunter, 2008). In order to develop culturally competent rural HSPs, the human services system may need to adopt a constructivist approach to training to ensure a direct relationship between the rural HSPs' perceived level of CC and the training. HSPs must be responsive to the cultural needs that arise from the unique cultural backgrounds of their clients. Responsiveness can be accomplished by developing cultural knowledge through exploring one's own ethnocentric ideas and by challenging personal prejudices and assumptions (Sue, 2006).

Summary of Results

This research study quantified rural HSPs' (i.e., state employed case managers) perceived level of CC in order to define relationships that may have existed between certain demographic variables, identified independent variables, and rural HSPs' perceived level of CC. The independent variables are the training quantity and the training model (e.g., online, classroom). The dependent variable is the HSPs' perception of his or her CC level. The descriptive variables involved with the research study were gender, age, race/ethnicity, level of education, years of employment, and regional assignment.

Researchers administered surveys to 449 HSPs from three rural regions of the state's department. The final sample size, n= 44, was approximately half of the researchers' expected response size. The low response rate (15%) may have impacted the potential to note significant relationships between some of the individual traits and perceived level of CC. There were no relationships established between demographic factors (i.e., race, gender, highest degree obtained) or training mode and perceived CC level. Skewed results made conducting analyses to determine any existing relationships impossible. The sample (n = 44) was largely homogeneous, the majority being college educated Caucasian females between the ages of 30 and 39 years, decreasing the generalizability. Of the 44 participants, approximately 98% were female; 96% White; and 98% held a college degree (i.e., bachelor's or master's). Although there was a sufficient amount of normal data for age, education, and employment years, there were no significant relationships found.

The assessment tool inserted in the participants' survey for this study was the California Brief Multicultural Scale (CBMCS), a 21 item self-report measure designed to measure multicultural competency along four dimensions: Sensitivity, Awareness, Nonethnic Ability, and Multicultural Knowledge (Gamst et al., 2004). Based on the total mean scores at the 0.05 level with CBMCS (r_s= -.300, p= .048, two tails) and the total mean scores for the two subscales, Multicultural Knowledge (r_s= -.357, p= 0.017, two tails) and Socio-Cultural (r = -.326, p= 0.017, two tails), significant negative relationships were discovered. The revealed significant negative relationships were calculated utilizing the independent variable, training quantity and dependent variable perceived CC level. These significant negative relationships imply that more training completed by participants lead to less perceived knowledge of multicultural clients and less perceived ability to work with clients of a different social and/or cultural background. In essence, results indicate that participants perceived their level of cultural competence to be lower, with more training completed. This viewpoint suggests the trainings are ineffective. In contrast, it can also be assumed, the more training completed by participants, the more they realize what is unknown, as perpetuated through training. This assumption can lead to the view that the trainings are effective.

These implications discovered, regarding significant negative relationships, directly addressed the research problem of the need for the human services system to ascertain the effective method to train HSPs to work with culturally heterogeneous clients, successfully (Brown, 2004; Newell et al., 2010). Overall, the participants perceived themselves as being culturally competent according to CBMCS mean scores, defining two as the median based on scale statistics. A CBMCS mean score of 2.83 (70%) would fall in the top one-half, at or above the 50th percentile (Gamst et al., 2004).

Relevance to the Field of Human Services

The findings of this study may be beneficial for organizations and associations guiding the practice of human services. Organizations and associations can further analyze the perceived level of CC with the CBMCS and focus on promoting change within the human services industry through CC training efforts. The human services industry should continue to communicate actively with states about a CC model based on constructivist principles and the assessment tool, CBMCS. As pressure from federal government and national organizations still exist, increasing communication about constructivism and CBMCS can engage HSPs in the process of change. In addition, in order to promote successful change initiatives related to cultural responsiveness, leaders implementing change within the human services profession should acknowledge individual perceived CC levels and provide CC training centered on constructivism (Al-Weher, 2004).

Traditionally, HSP training is based on culture diversity curricula, which fails to increase the participants' knowledge base, skill level, or change their attitudes. The concern regarding CC in human services will remain until there is an achievement of more uniformity within the profession and across professions employing assessment as a practice. The utilization of future research will assist in determining the success of strategy implementation following the achievement of the desired uniformity.

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Perinatal Mental Health: A Brief Examination of Perinatal Mental Health and Infant Outcomes

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Abstract

Women with serious mental illness (SMI) are at a great risk of experiencing poor health and are less inclined to seek health care, which can result in poor birth outcomes such as lower birth weight, preterm births, and infant death. Single parenthood, lack of partner support, low educational attainment, financial barriers, smoking and substance use all contribute to mothers' mental health status during the perinatal period. It is critical for Human Service Professionals (HSPs) to collaborate with health care providers in an effort to bridge the gap in necessary mental health services during the perinatal period. The purpose of this article is to inform HSPs about the association between perinatal mental health and infant outcomes. HSPs who understand the societal impact of perinatal mental health issues and work as part of a multidisciplinary team may provide the key to mitigating negative infant outcomes.

Perinatal Mental Health: A Brief Examination of Perinatal Mental Health and Infant Outcomes

Perinatal mental health literacy is necessary for Human Services Professionals (HSPs). This literacy will aid pregnant and post partum women seeking support, services, and treatment. Among some health care professionals there is often a stigma, and in some cases, a reluctance towards introducing routine mental health screening during pregnancy and postpartum periods. Pregnant women may also be deterred from seeking access to health services due to intersectional factors related to ethno cultural identity and socioeconomic status (DeCesaris, 2013).

According to the National Association of Mental Illness (NAMI) (2012), approximately 10 to 15% of pregnant women in the United States experience serious mental illness (SMI). SMI is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment which substantially interferes with or limits on or more major activities (National Institute of Mental Health (NIMH), 2012). Common SMI in this population includes bipolar disorder, schizophrenia, and major depressive disorder (DeCesaris, 2013).

Factors that contribute to a women's emotional state include her emotional and physical health, living conditions, spousal and/or partner, familial, and social support (DeCesaris, 2013). Chronic stress resulting in serious mood changes and impaired behavior have proven to have developmental effects on infants and children (Dunkel-Shetter, 2011). Despite the impact that a mother's mental health status has on her child's development, millions of mothers in the United States do not receive the preventative care services or treatment they need (CDC, 2014). This lack of treatment is a result of no or limited access to health care, and/or lack of integrated services for medical care (Seshamani, 2012).

A primary component of recent healthcare reform in the United States is to address high infant mortality rates (Mental Health America (MHA), 2014). In 2011, in relation to countries with populations greater than 2.5 million, the United States ranked 34th in infant mortality or 6.9 infant deaths per 1000 live births (MHA, 2014). Approximately half of these deaths occurred during the birthing process or postpartum period. The WHO (World Health Organization, 2014) has designated the perinatal timeframe as 22 completed gestational weeks to seven days following birth.

Inadequate attention to the mother's mental health during the perinatal timeframe often results in adverse infant outcomes (Dunkel-Schetter, 2011).

Various psychological, behavioral, and social determinants may influence physical health outcomes (Bloch, Ryan, & Kensey 2012). Literature indicates that there is a significant association between the mental health status of the mother and her child during the perinatal period. There is a correlation between adverse prenatal stress such as financial problems, employment conditions, family relationships and intimacy issues between partners (Dunkel-Schetter, 2011). A study of domestic abuse during pregnancy indicated an increased risk of complications, including pre-term labor, reduced birth weight, and infant death (Boy & Salihu, 2004). Further, mothers who have a history of mood disorders, anxiety or depression are more likely experience increased risk for adverse infant experiences (Buultjens, Murphy, Robinson, & Milgrom (2013). A recent focus on prenatal stress, resiliency resources and multilevel analyses of pregnancy and birth outcomes has lead to the understanding that protective factors are equally important as risk factors (Dunkel-Schetter, 2011). "Knowledge of risk factors for adverse health outcomes is equally as important as knowing protective factors that ameliorate risk" (Boch, Ryan, & Kensey, 2012, pg. 825).

Future Strategies

In 2011, the American Congress of Obstetricians and Gynecologists (ACOG) began the Perinatal Depression Initiative to "improve OBGYNs' capacity to screen, assess, and manage perinatal depression through the provision of education, tools and resources" (2014, p. 1). This is a substantive step toward educating OBGYN providers on the importance of depression screening. However, women of marginalized socioeconomic statuses (SES) may not feel comfortable sharing their mental health concerns (Dunkel-Schetter, 2011). Finding, obtaining, and/or affording quality prenatal care is a barrier that exists for women of marginalized SESs. In some cases, pregnant women do not seek medical services during their prenatal period and instead choose to work with social workers and other allied health professionals. (Dunkel-Schetter, 2011)

In 2000, the National Children's Study (NCS) was mandated by the United States Congress to study 100,000 children from birth to age 21, longtitudinally. The NCS will allow researchers to evaluate the psychosocial, behavioral, and environmental determinants of perinatal health and potential factors that can influence health outcomes (Bloch, Ryan & Kensey, 2012). However, according to the National Institutes of Health (NIH), there is debate as to the design, affordability, and feasibility of this project advancing further (2014).

The Behavior Risk Factor Surveillance System (BRFSS) collects data regarding the health practices and risk behaviors among adults in the United States (Center for Disease Control (CDC), 2014). States who use the BRFSS may choose to include a separate mental health module, Patient Health Questionaire 8 (PHQ-8) to assess anxiety and depression in adults (CDC, 2014). The Action Plan for the National Initiative on Preconception Health and Health Care (PCHHC) developed a strategic plan from this data. They found that two primary challenges hinder women's ability to maintain good health during their child bearing years: first, a lack of health insurance prevents them from ogtaining needed physical and mental health services, and second, the lack of integration in the United states health care system, creating a healthcare crisis for women (PCHHD, 2014).

Relevance to the Field of Human Services

Human Service professionals are in a unique position to have an impact on expecting women. Human Services professionals have the systemic knowledge to provide support and connect clients with support in the community. The training of a Human Service professional includes problem analysis, understanding potential strategies and pathways, and helping clients get the services they need (National Association for Human Services (NOHS), 2014). All of these skills may benefit a high-risk expectant mother. The Patient Care Primary Care Collaborative (PCPCC) continues to evolve and promote the medical home model of care where human service professionals may be integral to favorable patient outcomes by promoting a healthy pregnancy and ensuring that women are involved in health care before conception (PCPCC, 2014).

As part of a multidisciplinary team, human service professionals are part of a 21st Century solution to improve the quality of patient healthcare. Understanding the link between perinatal mental health and infant outcomes is essential to that goal. Without a collaborative relationship between human services professionals and providers, mental health needs may not be addressed for women during pregnancy. Multidisciplinary teams, possibly including HSPs, a midwife, obstetric specialist, and mental health services will help to bridge the gap between outpatient and inpatient care (DeCesaris, 2013).

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Differentiating Factors between Foster Youth and Non-Foster Youth in the Juvenile-Justice System

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Abstract

Due to the high rates of foster youth in California, foster youth will have a higher likelihood than will non-foster youth of becoming involved in the criminal justice system due to various situations, including higher rates of mental health issues, multiple placements, and lack of independent living skills. Despite the disproportionate numbers of foster youth in the criminal justice system, human service practitioners often use interventions that do not account for the subpopulation of foster youth involved in the juvenile justice system's characteristics, and consequently many treatment approaches are found to be ineffective. Guided by the developmental assets theory, the goal of this quantitative design study is to understand how foster youth in the justice system and non-foster youth compare on differentiating factors that will ultimately impact mental health services that are provided to this subpopulation.

Differentiating Factors between Foster Youth and Non-Foster Youth in the Juvenile-Justice System

The state of California leads our nation with the highest U.S. prison populations and incarceration expenditures (Division of Juvenile Justice [DJJ], 2012). Currently, there are approximately 185,000 youth involved in the juvenile justice system (DJJ, 2012). The California Department of Justice spends roughly $240 million year for these youth, which equates to $179,400 per youth for incarceration (DJJ, 2012). During the fiscal year 2008-2009, $245,000 was spent for every incarcerated youth (DJJ, 2012). Moreover, there are over 175,000 prisoners in state and county jails for adults, and over $10 billion per year is spent on incarceration costs (Greene & Pranis, 2007). These expenditures surpass the amount of money spent on both the University of California and California State University's budgets combined (Greene & Pranis, 2007).

In addition to the juvenile-justice population, approximately 300,000 youth enter the foster care system every year (U.S. Department of Health and Human Services [USDHHS], 2012). Voluntary placement occurs when the biological parent or guardian cannot care for a child, either unable or unwilling. Involuntary placement occurs when a child is removed from his or her biological parent or guardian due to the occurrence or risk of physical or psychological harm. However, most children enter the foster care system due to neglect (USDHHS, 2012). Within California, the foster care population is more than 78,000, which represents 14% of the foster care population and is the largest number of any other state (HSDHHS, 2012).

Literature Review

The Division of Juvenile Justice treats youth up to the age of 25 who have the most serious criminal backgrounds as well as intensive treatment needs (DJJ, 2012). Although the United States professes its need for prevention and early interventions, there are millions of people every year who are incarcerated, on probation, or parole (U.S. Bureau of Justice Statistics, 2012). In 2012, 3%, or 1 out of every 32 adults in the U.S. were involved in the adult correctional system (Bureau of

Justice Statistics, 2012). Moreover, in 2011 there were 34,192 juveniles incarcerated in juvenile detention (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2013). The characteristics of the DJJ facility population are typically male (97.3%), Hispanic (58.2%), or African American (28.1%) with crimes committed of assault (36.7%), robbery (29.1%), or other (17%) (OJJDP, 2013).

In addition to the juvenile-justice population, approximately 300,000 youth enter the foster care system every year (USDHHS, 2011, 2012). In 2012, there were 397,122 children in the foster care system (USDHHS, 2012). While in the foster care system, many foster care youth have multiple placements (Zlotnick, Tammy, & Soman, 2012) and are 5-10 times more likely to become involved in the juvenile justice system (Freundlick & Morris, 2004). Freundlick and Morris (2004) also note foster youth are more likely to be detained versus non-foster youth due to judges' perceptions that foster youth are less stable and more unsupervised because of lack of caregiving. The authors further note that foster care youth have a higher rate of involvement with the juvenile justice system than the general population of adolescents (Freundlick & Morris, 2004).

Findings from research studying this subpopulation include that within the first 2 years of emancipation from the foster care system, 25% of former foster youth will be incarcerated (Zlotnick et al., 2012). Further, one-third to one-half of former foster youth were arrested and/or jailed (Courtney & Dworsky, 2006). This figure is considerably higher than their non-foster at-risk youth counterpoints who will have 3.1% involved in the criminal justice system after the age of 18-years-old (U.S. Census Bureau, 2012).

In order to assist juvenile-justice involved youth, mental health services attempt to provide various mental health treatments to this population. However, such attempts are typically treatment modalities that are more "universal" in nature, or a "one size fits all." (Drake, Aos, & Miller, 2009). According to Henggeler and Schoenwald (2011), there are many treatment approaches provided to delinquent juveniles that are found to be ineffective and even increase negative behaviors including, but are not limited to, surveillance (Lipsey, 2009), "Scared Straight" (Drake et al., 2009) and residential placements (Sedlak & McPherson, 2010). Hence, it seems plausible that the failures and inabilities to succeed with specific subpopulations are due to the overuse of universal interventions designed to inoculate a broad population rather than targeting interventions toward a specific subpopulation (Drake et al., 2009).

Relevance to the Field of Human Services

Due to the rising increases of youth entering the foster care system and dually being involved in the juvenile justice system, there is a need to understand the various aspects of this special population. Foster youth involved in the juvenile justice system are a subpopulation with differential factors that can negatively impact their lives (Henggler & Schoenwald, 2011). Moreover, it is imperative to understand how these variables differ from non-foster youth (Zlotnick et al., 2012). Research studies illustrate that there are higher incidents of mental health issues amongst foster youth than compared to non-foster youth as demonstrated by rates of 65-70% of youth having at least one diagnosable mental health disorder, such as depression, anxiety, or mood disorders (Shufelt & Cocozza, 2006). In addition, independent living skills are not typically learned by foster youth from biological families, and 33% of youth felt "not very" or "not at all" prepared for independent living (Courtney & Dworsky, 2006). Furthermore, there are effective and ineffective interventions that have been utilized with these populations in order to address such issues (Henggeler & Schoenwald, 2011). If the impact of factors amongst foster youth involved in the juvenile justice system can be appropriately assessed, including mental health diagnosis co-morbidity and independent living skills, human service practitioners can have a better understanding of how these subpopulations differ and how to help improve treatment and intervention strategies.

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Critical Incident Stress for Child Welfare Workers

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Abstract

This paper reports the interventions of 83 child welfare workers who identified themselves as having experienced a critical incident event related to their profession as child welfare workers. An interview was conducted related to these experiences. Workers had significant stress symptoms related to these experiences and they often relied on avoidant coping strategies. It is suggested that while a critical incident debriefing would be helpful, educating the child welfare culture through all levels of the organization, with particular attention to direct line supervisors continues to be needed.

Critical Incident Stress for Child Welfare Workers

Currently, there has been little research conducted to address the particular experiences and means of coping of professionals who experience critical incident stress in child welfare. This paper is the result of a program designed for child welfare workers who experienced a self identified critical incident. The intention of this paper is to examine existing knowledge and theory regarding critical incident stress and expand the knowledge of critical incidents for child welfare providers.

Mitchell and Everly (1995) differentiated the experience of PTSD and critical incident stress (CIS). The reaction of PTSD is attached to those who are participants in the actual event while CIS refers to those who respond to the needs of the event. The primary concern regarding this dimension of CIS refers to the experience and resulting symptoms for those Mitchell called “secondary responders". By secondary responders, Mitchell and Everly (1995) defined a critical incident as “any significant emotional event that has power, because of its nature or because of the circumstances in which it occurs, to cause unusual psychological distress in healthy normal people” (p. 271).

Experiencing a critical incident may result in symptoms of critical incident stress for these Child Welfare Workers (CWW). CWWs can experience symptoms such as poor health, decrease in job performance, violation of professional boundaries, as well as psychological distress in persons who are typically healthy (Declercq, Meganck, Deheegher, & Van Hoorde, 2011). Two national events that brought focus to critical incident stress and debriefing involved the Oklahoma Federal building bombing in September of 1995 and the terrorist attacks of September 11, 2001. Research conducted by the military concerned with war-related stress dates back as far as the Civil War (Franz et al., 2013). According to Franz et al. (2013), by the 1960s, forensic psychologists had recognized the syndrome in police officers after the death of a fellow officer, and began to employ strategies of debriefing borrowed from the military.

The field of debriefing for critical incidents is heavily influenced by the evolving concepts of post-traumatic stress syndrome and more recently concepts of acute stress disorder. The diagnostic criterion for acute stress disorder is found in the Diagnostic and Statistical Manual of mental disorders (5th ed.). It includes six major categories of symptoms. Those symptoms include exposure to a traumatic event, a sense of re-experiencing the event, avoidance of stimuli associated with the trauma, symptoms of increased arousal, an experience of disturbance for more than one month and significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013, p. 287)

Critical events research dates back to the crisis intervention used in response to the 1942 Coconut Grove fire conducted by Lindemann (1944). Everly and Lating (1994) introduced the

"Mitchell Model," a debriefing model to be used with those first responders to various traumatic events. It was quickly developed to be the standard intervention for such events. They broke this intervention into eight phases: introduction, recounting of the facts, cognitive reactions, identifying symptoms, education, developing a support strategy and developing a coping plan. Since the early 2000s, there has been a research focus on the utilization of the debriefing method for various first responders and in other professional settings such as schools and places of employment (Slawinski 2013). Slawinski (2013) notes that the Mitchell model has come under criticism and no certain formula of intervening for first responders has been shown to be a blanket response but each individual and event carries its own meaning for workers. Importantly, it has been found that the experience of such an event and participation in a debriefing should be voluntary, may need several interventions, can be done with individuals and in groups, and that those who intervene with responders need to have an understanding of the work culture (Slawinski 2013; Walling 2003).

Critical Incident Stress for Child Welfare Workers

In this study, workshops were held throughout the state to educate workers about critical incident stress and the use of critical incident debriefing. From these workshops, workers volunteered to participate in interviews and critical event debriefings with follow-up sessions. Eighty-two participants were recruited over five years with a age range of 25 to 58-years. The years of experience in social service ranged from one to 28-years of service (M = 10).

It was a goal for this program to understand better what participants, as social service providers, identified as a critical incident. A content analysis examined what the workers identified as a critical incident. Several participants reported the death of a client as the preceding critical event. One of these deaths were considered natural and one related to a chronic illness. Several involved the violent death of a child by someone related to or known by the child. Two of the deaths were the suicide of an adult parent. Four were the suicide of a child client. Twelve of the participants reported working with adult clients who had participated in violent activities ranging from assault to murder. All of these acts of violence were directed towards family members who were also clients of the participants. Nine participants reported incidents in which clients had made a serious threat to commit violence against the worker. Five of these workers had actually experienced violence inflicted by the client. One participant reported the arrest of an adoptive parent for conducting child pornography of a client.

Relevance to the Field of Human Services

The question of what could be seen as an extreme event in child welfare was raised from the inception of this program. Parents hurting and neglecting children, parents experiencing the removal of children from their care, children losing their parents and becoming dependent on a bewildering group of strangers is what these workers face on a daily basis. How could one expect them to identify an event as extraordinary or critical if it is something they experience with frequency? However, these were atrocities they felt went beyond their daily experiences in child welfare. This supports the conclusion that these are indeed critical incidents for these workers and are not just a part of the day-to-day job.

The sense of isolation reported by the workers was an important and significant symptom of stress. This isolation seemed to result from multiple factors. One factor identified was the worker's personal sense of guilt and feelings of incompetence related to the incident. Often, these feelings were attempts to gain control or understanding regarding the incident. If they could blame themselves for the event then they could understand how such a terrible event happened. Thinking in these terms, however, certainly does not encourage one to share these thoughts with others. This internally motivated isolation is also a part of the depressive feelings and shock after being involved in such an event. They often felt that no other person could possibly understand the tragedy they had experienced as a child welfare worker. These notions also contribute to a sense of loneliness and further isolating behaviors. Not surprising was that support persons outside of the helping professions could not comprehend the worker's experiences and therefore could not assist them in coping with the critical incident. Often people outside of the field did not want to hear about these incidents. They feared the effects hearing about the incidents might have on themselves.

These workers were overwhelmed and their narratives were disrupted as evidenced by reports of shock and disbelief regarding the events they had experienced. They were uncomfortable with their feelings, perceived themselves as incompetent, and felt disoriented. It was hard to put the incident "together and make sense of it," they reported. Their narratives were not cohesive, comprehensive, or complete for them. Child Welfare Workers do experience critical incident stress when exposed to traumatic events occurring in their relationships with the clients they serve. A major implication then is that those in child welfare services should be aware that critical incidents exist and need not be denied. Further, these events have a significant impact on workers. Those in child welfare services should find acceptance of the fact that workers can experience critical incident stress when working with at-risk clients. Those in child welfare services need to promote the knowledge that these are normal responses to abnormal circumstances.

In this study, workers reported many symptoms of critical incident stress and during a one month follow up interview most workers were able to identify that the debriefing assisted in their reduction of symptoms. The workers identified that the intervention assisted in their breaking through feelings of isolation allowing them to re-engage with their support networks. They reported that through the process of talking with the facilitator about the event, their thoughts and feelings they were able to develop a "new perspective" that allowed them to regain their sense of self-efficacy. It is recommended that such interventions continue to be made available to these very dedicated workers who assist some of the very at risk clients that they serve.

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Stigmas of African American Clergy Regarding Mental Health and Mental Health Services and Their Effect on the African American Community

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Abstract

Mental health issues are prevalent among all races of people. The present article highlights a gap in the literature regarding mental health services and the African American community. Stigmas held by the African American clergy regarding mental health and mental health services may influence African Americans' decisions to seek or not seek mental health services such as counseling. The author encourages future research and discussion that will provide insight into the African American clergy's responsibility to provide effective services and referrals regarding spiritual and psychological issues. Questions related to African American clergy's perceptions, stigmas, and beliefs need to be identified and discussed in order to develop an environment that promotes and supports mental health for African Americans. Research related to this topic provides implications for African American clergy, counselors, mental health service providers, and mental health suffers to address stigmas that may prevent individuals from seeking help for mental health issues.

Stigmas of African American Clergy Regarding Mental Health and Mental Health Services and Their Effect on the African American Community

African Americans tend to have traditional values that are rooted in Western African Cultures (Asante, 2011). Embedded traits related to religion, family structure, moral values, and faith are intergenerational and influence African Americans today (Brisbane, 2011). Cultural beliefs and practices such as faith, language, social norms, and political understanding inform stigmas, and perceptions influence decision making for African Americans regarding whether to seek or not seek assistance for mental illness (Paniagu & Yamada, 2013). Lumpkins, Greiner, Daley, Mabachi, and Neuhaus, (2013) asserted that the Black Church is a trusted organization in the African American community and that African Americans seek help from clergy for both spiritual counseling and counseling for non-spiritual issues related to social, financial, educational, health and a variety of personal needs.

There is a growing body of research dedicated to understanding the role that clergy play in mental health needs being addressed in the African American community (Bopp, Webb, Baruth, & Peterson, 2013). Weaver, Smith, Walter, and Larson (2013) asserted that clergy in the African American community are often the first point of contact for addressing issues such as personal problems, physical health concerns, grief and loss, and divorce or broken family systems. One of the main findings of this research was that African Americans that identify with or are a member of a fundamentalist denomination utilize clergy at high rates and reject the use of a psychologist or psychiatrist (Bopp et al., 2013). Even though there is a lack of specific research on stigmas held by African American clergy, Gardner (2013) found that the level of stigma increased as clergy's civic, social, and religious associations grew.

In the African American community, the general perception of African American clergy is that they are emotionally stable and balanced individuals (Patterson, 2013). African American clergy act in various capacities for members of the church and community, including helping to identify and address psychological issues (Chatters, Mattis, Woodward, Taylor, Neighbors, &

Grayman, 2011). One of the responsibilities of the Black church and Black clergy is to affect change within the church membership and members of the community spiritually, emotionally, and practically (Lumpkins et al., 2013). Mental illness and sin are linked in almost all scriptures found in the Bible, affecting the attitudes of both congregants and clergy (Harris, 2010). Because of this shared belief, congregants are unlikely to disclose mental health issues to clergy, and clergy are likely to view mental health concerns with stigma, associating those concerns with weak faith rather than illness and not referring to counseling (Harris, 2010). The African American church and clergy hold a historical responsibility for caring for the bodies and souls of members of the church and community.

Background

There are a number of elements such as religion, spirituality, and race that inform and influence individuals' mental health services seeking behavior. Data obtained from a National Comorbidity Study among individuals' mental health services seeking behavior shared that 24% turned to clergy, while 17% turned to psychiatrists and 17% sought help from physicians (Nieuwsma et al., 2013). Fukuyama, Puig, Wolf, and Baggs (2013) assert that religion and spirituality intersect with race, ethnicity and stigmatization in counseling. Stigmas held by African American clergy regarding mental health and mental health services have not been studied extensively. Specifically, how African American clergy promote or discourage the use of mental health services is a gap in the literature. Most of the existent research discusses how clergy provide services to address practical and spiritual problems but fail to address mental health concerns such as depression because depression is correlated with having weak faith (Chatter, Mattis, Woodward, Taylor, Neighbors, & Grayman, 2011; Payne, 2009).

Relevance to the Field of Human Services

The African American community in general does not trust the American health system (Scharff, Mathews, Jackson, Hoffsuemmer, & Martin, 2010). Scharff et al., (2010) posited that African Americans level of mistrust dates back to the events such as the Tuskegee experiment. Additional reasons include interpersonal distrust that is based on personal experiences with the health care system and societal distrust, which is based on perceptions of a larger population of life experiences in society in general (Durant, Legedza, Marcantonio, Freeman, & Landon, 2011). More importantly, African American clergy and African Americans believe in general that mental health sufferers have weak faith preventing services outside of clergy being sought (Anshel, 2010; Payne, 2009). Does a bias against mental health services exist among the African American clergy? Such a bias, if it existed, may explain the lack of referral, and hence limited accessing of mental health services by African Americans in general. Issues such as a lack of money, no insurance, and access to affordable and effective services along with severe mistrust have been listed as reasons why African Americans do not seek mental health services or underuse mental health services (Masada, Anderson, & Edmonds, 2012). Stigmas on the other hand, have been determined to be the most critical hurdle that African Americans need to clear as it relates to the use of mental health services (Masada et al., 2012). Thus, research is needed to discover African American clergy's perceptions of mental health and mental health services. Knowledge regarding their views that influence their actions as gatekeepers is of wider interest to the whole African American community and those interested in the utilization of mental health services in the United States.

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America's Working Poor: Affordable Care Coverage Gap

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Abstract

The Affordable Care Act is important to the human services profession because it is a groundbreaking, quality of life changing healthcare reform that impacts our clients and their ability to access services. More than 8 million Americans have signed up for marketplace insurance (Holst, 2014). Those families who work and yet fall below the official poverty level have been dubbed the working poor and have become part of a phenomenon called the healthcare coverage gap (Klein, Rones, 1989). The purpose of this article is to provide information on the Affordable Care Act including the pros and cons, healthcare options available to those in the coverage gap, the effects on the working poor, as well as the impact to state economies.

America's Working Poor: Affordable Care Coverage Gap

Nearly 5 million of the working poor remain uninsured in states that have not chosen to expand Medicaid eligibility levels (Hamel, 2014). The working poor earn too much income for Medicaid eligibility while earning too little to qualify for the Affordable Care Act (ACA) marketplace tax credit subsidies through the exchange. The median eligibility level of parents in states that have chosen not to expand Medicaid eligibility is 46% of the federal poverty level amounting to approximately $9,000 annually for a family of three (Hamel, 2014). This eligibility level means a large portion of the population is still ineligible for coverage, leaving over 27% uninsured in the states refusing to expand Medicaid eligibility (Hamel, 2014). While the ACA is designed to address the healthcare coverage gaps, the voluntary state expansion significantly reduces coverage opportunities. Human Service Professionals (HSPs) benefit from gaining an awareness of the pros and cons of the ACA as well as having knowledge of the impact of these programs on state economies. The HSP's focus on human needs includes providing access to healthcare thereby, increasing the self-actualization aspect of becoming self-supporting (Maslow, 1968).

The ACA was passed by the Senate on December 24, 2009. The legendary initial open enrollment period began on October 1, 2013 and closed on March 31, 2014 with a reported 8 million people registered for coverage through the marketplace. While these numbers are optimistic, 5.7 million people will remain uninsured in the 24 states that have chosen not to expand Medicaid (Holst, 2014). The healthcare legislation permits voluntary Medicaid provision by states to offer coverage for adults up to the 133% federal poverty level (Health Insurance Marketplace, 2013). Adults with an income category below 100% of the federal poverty level, fall into the healthcare coverage gap (Health Insurance Marketplace, 2013). Thus, given that HSPs strive to protect and enhance the personal well-being of all individuals, HSPs are tasked with addressing the needs of the vast number of individuals falling into the coverage gap (Hasenfeld, 1983).

In order for HSPs to be aware of the healthcare coverage gap and to advocate for those they serve it is important to understand the effects of the financial bottom line. The Congressional Budget Office (CBO) presents insights into the federal spending rational of the ACA (Congressional Budget Office, 2014). The CBO speaks to the impact of the ACA on graduated state spending and reports on the federal deficit and how the healthcare coverage gap actually serves to decrease government spending. Arguments both for and against the ACA remain on the table for discussion. HSPs may benefit from understanding each side of the argument (Fiscella, 2011).

The primary concern voiced against the ACA is sustainability of cost as this has significant implications for state's long-term budgets. The federal government has pledged to pay states 100% of the costs during 2014-2016 and a share declining to 90% of the costs in 2020, and thereafter for newly eligible Medicaid recipients (Congressional Budget Office, 2014). Nonetheless, concerns remain that the federal deficit constraints will not allow for follow through on the ability to consistently fund Medicaid expansion. Another concern of state leaders is the remaining 10% share of costs that will be required after 2016. Despite the seemingly low percentage there will still be an unanticipated cost incurred that state budgets are not likely equipped to absorb. Although, growing healthcare costs have slowed to a record crawl since the healthcare law passed, many states fear their payment contribution will increase over time as healthcare costs rise (Congressional Budget Office, 2014).

In relation to the federal deficit, those in favor of the ACA adhere to the CBO estimate that the costs of insurance coverage provisions will be offset by the decrease in Medicaid recipient eligibility, resulting in an $84 billion eleven year spending deduction (Congressional Budget Office, 2014). It is this aspect of spending that HSPs must take into consideration during the decision making process of resource allocation. While decreased Medicaid eligibility is one of the main culprits in the healthcare coverage gap, it serves as a plus to both state and federal cost-cutting. A direct result of the court's decision to allow states to determine whether or not to expand their Medicaid is that approximately 6 million fewer people are covered. Those unable to enroll in marketplace coverage become uninsured causing federal spending to decrease by $6,000 per average person (Congressional Budget Office, 2014). HSP advocates are encouraged to note that not only has the ACA brought the rising cost of healthcare to a record low, the surplus generated by increased enrollment and the lessening of Medicaid eligibility greatly contribute to decreased spending (Holst, 2014). CBO along with the Joint Committee on Taxation (JCT) also estimates that to repeal the ACA would increase federal budget deficits by $109 billion over the 2013-2022 period (Congressional Budget Office, 2014).

Contemporaneous literature also suggests that the ACA addresses the historical gaps in Medicaid eligibility and remaining limited access to healthcare for those falling into the coverage gap (Hamel, 2014). Given the fact that Medicaid expansion is a core component of the ACA coverage provisions there remains an opportunity to make healthcare coverage available to millions of uninsured people including the working poor (Hamel, 2014). Taking into consideration the income levels of those falling into the healthcare coverage gap, cost is the key barrier to healthcare access for the uninsured (Fiscella, 2011). The ACA supports the establishment of community based collaborative care networks (Fiscella, 2011). These networks can improve overall access to the healthcare system for those vacillating within the coverage gap. HSPs must be informed of the availability of community based collaborative care networks to point individuals falling into the healthcare coverage gap in the right direction for services.

Another option for the uninsured is Federally qualified community health clinics (FQCHC) which are nonprofit health centers that adhere to federal regulations, and receive federal grants to provide primary care in low income, underserved neighborhoods (Salooner, Kenney, Polsky, Rhodes, Wissoker, Zuckerman, 2014). Within FQCHCs 200% of patients are either at or below the federal poverty level. However, many of the working poor are still disqualified to receive care (Salooner et al., 2014). Some providers have been dubbed "look-alike" agencies, which are nonprofit clinics that have the same mission without federal support. Both FQCHCs and their look-alike counterparts serve as viable options for many who fall into the healthcare coverage gap. They both provide sliding scale fees for uninsured patients, while maintaining a mission of caring for people with low-incomes and other vulnerable populations (Salooner et al., 2014, 1). Salooner et al. (2014) accessed the appointment availability for each coverage category for the new patients. The uninsured new patients received an appointment availability rate of 15% by private providers while FQCHCs appointment availability rate was 54% for the same demographic (Salooner et al, 2014). The results of the study point to FQCHCs as being 39% more likely to offer new patient appointments to the uninsured (Salooner et al, 2014).

A barrier to locating healthcare for the uninsured is the generalized language of "community health centers." The author of this paper completed ACA conferences in thirteen different cities providing information on marketplace sign up, and term health insurance information for numerous people. It was found in these cities that the names of the community health centers frequently do not use terms even remotely similar, thus impeding awareness and decreasing access to available care (Salooner et al., 2014). A reported 5 million people enrolled in plans to meet the ACA standards outside of the Marketplace. However, there are those in the coverage gap who are unable to meet those cost demands and still need some type of medical coverage (Holst, 2014). Those seeking healthcare coverage may benefit from educational opportunities to learn about term health insurance coverage, and an introduction to the agencies in their own communities that provide healthcare assistance.

Relevance To The Field of Human Services

In summary, it is important for HSPs to be aware that coverage gaps cause osculation between Medicaid eligibility and marketplace tax credit incentives. Additionally, the working poor are forced to rely on federally qualified health clinics, price selective private primary care, or term health insurance to meet healthcare needs. Minorities and people of low socioeconomic status are disproportionality affected by the healthcare coverage gap resulting in an added dimension to the already existing health care disparities. The ACA reforms however, will begin to minimize disparities in resources between providers whose patient populations differ by social disadvantages (Fiscella, 2011, 80).

Further, the ACA directs the Department of Health and Human Services (DHHS) to evaluate health and healthcare systems, to promote accountability, and to enhance collection and reporting of data (Fiscella, 2011). Provider network participation in federally sponsored healthcare disparity monitoring will serve to enhance collection of the disparity data submitted to the DHHS bettering intervention quality. HSPs are responsible for ensuring adherence to these regulations within their practices. There is an opportunity for HSPs to increase patient advocacy and ethical standards in allocation of healthcare resources. HSPs also have the prospect of creating a well-managed organization that effectively meets the needs of the populations served.

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